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TESE DE DOUTORAMENTO

MENTAL HEALTH AND WELL-BEING OF THE ATI PEOPLE IN PANAY AND GUIMARAS ISLANDS, PHILIPPINES

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PROGRAMA DE DOUTORADO EN MEMORIA, IDENTIDADE, TERRITORIO E LINGUAXE

DEDICATION

It's a pleasure to honor my Tatay and Nanay, Angelico and Corazon, who taught me curiosity, goodness, and perseverance, and likewise, who first introduced me to the Ati people.



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RESUMO

Amo kami kadja kay amo dja ang amon naabtan
(Isto pasou de nós, chegando a isto)
Tay Floro

Despois dunhas palabras educadas, un ancián dunha comunidade indíxena da provincia insular de Guimaras, Filipinas, fai esta declaración mentres se levanta da súa posición agachada diante da súa cabana de bambú para saudar a un visitante. Forma parte da cortesía dar a benvida e, ao mesmo tempo, lembrarlle ao convidado a súa sinxeleza de vida. Isto tamén amosa unha conciencia do presente que sitúa a súa identidade e, ao mesmo tempo, o proceso polo que chegaron a esta circunstancia. Con esta visión, pódese empezar unha conversación sobre as súas vidas tanto co visitante como co anfitrión indíxena a través dunha aceptación do propio destino a medida que a vida avanza ante o cambio material nunha das illas filipinas.

En resumo, Filipinas ten un bo número de pobos indíxenas (PI), que representan entre o 10 e o 20 por cento dos 110,8 millóns de cidadáns do país (POPCOM, 2021). Estes grupos superviventes da época colonial (españois, americanos e xaponeses) demostraron que, dada a súa cohesión e relativo illamento, a súa existencia segue sendo viable. Non obstante, a verdadeira natureza da súa imaxinada circunstancia tranquila pode ser enganosa, dado que de cando en vez aparecen noticias sobre asasinatos de indíxenas, ademais das súas preocupacións expresadas pola tala ilegal e contra os plans gobernamentais de construír enormes encoros nos seus territorios.

Esta visión miope desmente o feito de que as comunidades indíxenas apenas sexan autónomas das mesmas presións debilitantes que afectan á maior poboación, xa que tamén necesitan educación, sistemas de saúde e outros mecanismos de apoio social para formar parte do país. O artigo 2, sección 22 da Constitución filipina de 1987 establece que "O Estado recoñece e promove os dereitos das comunidades culturais indíxenas no marco da unidade e desenvolvemento nacional" (Phil. Cons., 1987). Esta disposición xeral afirma claramente o deber positivo do Estado ante a existencia de PI e desenvólvese nos apartados posteriores da Constitución. No artigo 12, apartado 5: "O Estado, con suxeición ao disposto nesta Constitución e ás políticas e programas nacionais de desenvolvemento, protexerá os dereitos das comunidades culturais indíxenas ás súas terras ancestrais para garantir o seu benestar económico, social e cultural". Así mesmo, no artigo 13, apartado 6: «O Estado aplicará os

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principios da reforma ou custodia agrarias, cando proceda conforme a lei, na disposición ou aproveitamento doutros recursos naturais, incluídos os terreos de dominio público en réxime de arrendamento ou concesión. para a agricultura, con suxeición a dereitos previos, os dereitos de propiedade dos pequenos colonos e os dereitos das comunidades indíxenas sobre as súas terras ancestrais".

Paralelamente aos seus dereitos sobre a terra hai unha disposición habilítante no artigo 14, sección 4, que leva a obriga do Estado de: "Promover os sistemas de aprendizaxe non formal, informal e autóctona, así como os programas de auto estudo, estudo independente e extraescolares, en particular aqueles. que respondan ás necesidades da comunidade...". Así o avala o artigo 14, apartado 17, que di: "O Estado recoñecerá, respectará e protexerá os dereitos das comunidades culturais indíxenas a preservar e desenvolver as súas culturas, tradicións e institucións. Considerará estes dereitos na formulación de plans e políticas nacionais"; e, no artigo 16, apartado 12, "O Congreso poderá crear un órgano consultivo para asesorar ao presidente sobre as políticas que afecten ás comunidades culturais indíxenas, cuxos membros deben proceder maioritariamente de tales comunidades".

Estes instrumentos que recoñecen os dereitos e privilexios dos PI, se reciben a atención e o apoio adecuados por parte do Estado e dos seus organismos, conducirán sen dúbida a unha vida saudable. Ademais, en 2007, Filipinas ratificou a tan esperada Declaración das Nacións Unidas sobre os Dereitos dos Pobos Indíxenas (UNDRIP), adheríndose así á visión da ONU de "un marco universal de estándares mínimos para a supervivencia, a dignidade e o benestar do mundo". pobos indíxenas, e desenvolve as normas de dereitos humanos existentes e as liberdades fundamentais tal e como se aplican á situación específica dos pobos indíxenas" (UNDRIP, 2007). É importante nesta doutrina a afirmación do “carácter colectivo” das PI que, ante a “asimilación forzosa”, os seus dereitos deben ser protexidos “como pobos distintos”. Ademais, identifica a experiencia recorrente dos PI de ser desprazados das súas terras sen o seu pleno consentimento como unha ameaza fundamental que pode socavar os seus "dereitos, supervivencia e benestar". Este é un claro recordatorio de que o benestar, a saúde e a saúde mental dos PI non son categorías separables das súas experiencias vitais e comunitarias.

Volvendo á preocupación pola saúde mental dos PI filipinos, a investigación sobre isto podería enfocarse adecuadamente tendo en conta os marcos legais e as orientacións dos diferentes Estados. Ademais, antes da adopción da tan esperada Resolución da ONU, Filipinas xa promulgara unha lei específica sobre os dereitos dos PI titulada "Lei dos Dereitos dos Pobos

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Indíxenas de 1997" (IPRA, 1997). Esta lei, aínda que non recolle ningunha disposición específica en materia de saúde mental, recolle varios conceptos como "saúde" e "benestar", citados nove e cinco veces, respectivamente, que sinalan facilmente a intención global da lexislación de promover o benestar holístico do PI. Atópanse exemplos diso na Sección 2.b, Capítulo 2: "O Estado protexerá os dereitos das ICC e as IP (Comunidades Culturais Indíxenas e Pobos Indíxenas) aos seus dominios ancestrais para garantir o seu benestar económico, social e cultural e recoñecer a aplicabilidade das leis consuetudinarias que rexen os dereitos de propiedade ou as relacións para determinar a propiedade e a extensión do dominio ancestral; e, na Sección 2.f, Capítulo 2 desta Lei IPRA, que di: "O Estado recoñece as súas obrigas de responder á forte expresión dos ICC/IPs para a integridade cultural, garantindo a máxima participación dos ICC/IPs na dirección de educación, saúde, así como outros servizos dos ICC/lPs, para facer tales servizos máis sensibles ás necesidades e desexos destas comunidades" (IPRA, 1997).

Un trazo distintivo da Lei IPRA é a creación dunha oficina específica, a Comisión Nacional de Pobos Indíxenas (NCIP), cuxo mandato está expresado nos artigos 38 e 39 do capítulo 7 "será o principal órgano de goberno responsable da formulación e execución. de políticas, plans e programas para promover e protexer os dereitos e o benestar dos ICC e os PI e o recoñecemento dos seus dominios ancestrais, así como os seus dereitos sobre os mesmos"; e "protexerán e promoverán os intereses e o benestar dos CPI/PIs tendo en conta as súas crenzas, costumes, tradicións e institucións". Actualmente, esta oficina depende da Presidencia, actuando así facilmente como a oficina enlace para promover e facer escoitar as voces dos PI ante o goberno, ademais de tramitar diversas necesidades e solicitudes en defensa dos seus dereitos e terras (IPRA, 1997).

Un ano despois da creación do NCIP, saíron á luz as normas e regulamentos de aplicación do NCIP (NCIP IRR, 1997), que de novo non mencionaban a saúde mental, aínda que abundan os conceptos xerais de saúde e benestar indíxenas. É certo que o NCIP IRR vai moito á hora de definir o estado, os dereitos e as reclamacións procesuais dos PI a estes dereitos e, ao facelo, reforza aínda máis o marco xeral de apoio ás necesidades de saúde mental dos PI. Exemplos inclúen a Norma 5, Sección 4.a.1-9, que garante aos PI o goce da igualdade de oportunidades e beneficios no traballo, a non discriminación e o acceso á asistencia médica e social. Ademais, a Sección 1 da Norma 6 recoñece e garante os dereitos dos PI á súa plena "participación na

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condución da educación, a saúde, así como noutros servizos, respondendo ás súas necesidades e desexos" (NCIP IRR, 1997).

En xeral, a Lei IPRA e o NCIP IRR, aínda que recibiron algunhas críticas serias pola súa falta de claridade e seriedade á hora de honrar as reivindicacións de terras ancestrais dos IP, foron aclamadas como transcendentais á hora de lexislar unha lei que valora o benestar, a saúde ou saúde mental dos IP, entre outros. É dicir, cando se busca o benestar dos PI centrándose na saúde, o Estado non carece de fundamentos legais para cumprir coa visión xeral da Declaración, aínda que non expresa necesariamente estas preocupacións, senón que se compromete a salvagardar saúde. dos IPs.

Non obstante, a lexislación máis relevante que podería ser útil para formular políticas para apoiar a saúde mental dos PI podería extraerse da Lei 11036 da República de Filipinas ou coñecida como "Lei Mental de Filipinas de 2017" (Lei de Saúde Mental de Filipinas, 2018). Esta recente lexislación, ademais de afirmar o dereito á saúde mental, tamén establece disposicións para servizos accesibles ao longo da "promoción, prevención, tratamento e atención posterior" das necesidades "psiquiátricas, neurolóxicas e psicosociais" de todos os cidadáns do país. Aínda que non menciona os pobos indíxenas, obriga a que o acceso e a atención á saúde mental deben ser "culturalmente apropiados" ou "culturalmente relevantes". En concreto, o desfrute deste dereito articúlase no apartado 5 do capítulo 2 para que sexa “en condicións de igualdade e non discriminación” para todos, e como tal, no apartado f, di: “Acceso a un tratamento integral e coordinado que integre prevención, promoción, rehabilitación, atención e apoio holísticos, dirixidos a atender as necesidades de saúde mental mediante un plan de tratamento e recuperación multidisciplinar e orientado ao usuario". Ademais, o disposto no artigo 14, apartados a e b do capítulo 4, subliña claramente que para que os servizos de saúde mental sexan eficaces, aínda que deben basearse na "investigación médica e científica", tamén deben "responder ás necesidades clínicas, necesidades especiais de xénero, culturais, étnicas e outras das persoas atendidas". Igualmente importante, esta lexislación valora igualmente a necesidade de integrar o apoio e enfoques comunitarios (mencionados 12 veces) nos esforzos xerais de prevención e tratamento da saúde mental (Lei de Saúde Mental, 2018).

No caso dos pobos indíxenas do país, estes marcos legais aínda non foron traducidos a nivel da súa saúde mental, dada a pre-valencia do analfabetismo e do desemprego, reflexo da pobreza xeral da poboación. Ademais, coas súas terras, fonte da súa estabilidade económica e

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identidade cultural, ameazadas polas empresas concesionarias da explotación madeireira e mineira, así como dos proxectos de encoros hidroeléctricos, é probable que o seu desarraigo teña un efecto colateral nos seus modos de vida tradicionais. Estes son só os problemas xeralmente coñecidos aos que se enfrontan, xa que dentro das súas comunidades como individuos, estas ameazas externas atoparán un eco sinistro nas súas vidas persoais.

Ao saír, sempre lembraría a voz suave de Tay Floro mentres se sentaba cómodo diante da súa porta: "Ti, san-o naman ikaw mabalik dire?" (Cando volves aquí?). Cando te acollen casualmente ao marchar, non obstante, lémbrache esa relación persoal establecida nun curto período de tempo, que é significativa para as persoas que estaban afeitas a vivir na confianza e na obriga mutua. A afirmación tamén pode levar un pensamento sutil de "nunca nos esquezamos", xa que ao asegurarlles que un volverá, calquera preocupación emocional circunscrita pola distancia e a inseguridade pode ter certa sensación de confort grazas á seguridade dunha futura visita. Pero na vida de Tay Floro e do resto do seu grupo cultural, o ton da declaración ten certo peso premonitorio de angustia, dado que el, xunto coa súa muller e os seus dous netos adoptivos, ten que facer mingau para dúas comidas ao día.

Nas súas caras podes ver que unha das traxedias da vida é nacer discriminado material e psicoloxicamente sen que ninguén che axude. Ou, simplemente, nacer nunha comunidade Ati. Aínda que un indio pode sentir algo de comodidade e seguridade, especialmente nun sentido nostálxico, xa que o mundo se contrae coa expansión da economía de mercado en nome do desenvolvemento e do beneficio, calquera chisco de esperanza que haxa probablemente pareza só un flash. Os Ati de Guimaras, Filipinas, non son unha excepción, xa que a maioría dos pobos indíxenas de todo o mundo enfróntanse a diferentes niveis e intensidades de presión que actúan de forma conxunta, se cruzan e seguen minando as súas vidas, relacións, cultura e identidade. Xa sexan supervivientes, descendentes ou vítimas de trastornos sociais ou naturais provocados por conflitos, deforestación ou cambio climático, entre outros. O proceso de recuperar un mínimo de vida con sentido é sempre unha carga que dificilmente se pode remediar nunha vida. Pero tamén hai un raio de esperanza, como exemplifican algúns colectivos que conseguiron continuar ou puideron recuperarse para celebrar os seus rituais e afirmar as súas identidades. Porén, estas son as excepcións, xa que a maioría segue a depender dos privilexios que lles proporciona o Estado ou dos seus veciños dominantes e da axuda dos colectivos doadores, de xeito que, sen eles, moitos nunca poderían iniciar melloras na súa vida. vidas. Por outra banda, a nivel internacional e local, desenvolvéronse diversos instrumentos para abordar os agravios

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indíxenas, e aínda que tardan ou tardan en producirse, produciuse e evidenciouse o reto de como traducilos positivamente en diversas comunidades do mundo.

Recentemente, un documento de transcendental importancia que require a súa aplicación exhaustiva e sistemática é o Plan de Acción Integral de Saúde Mental 2013-2030 da Organización Mundial da Saúde (OMS CMHAP 2013-2030). A primeira vista, parece centrarse só no aspecto médico da mente, pero se se mira máis de preto, leva a esperanza de facer realidade outros dereitos e benestar da humanidade, especialmente de cara a cumprir os Obxectivos de Desenvolvemento Social (ODS).).) das Nacións Unidas (UN DESA, 2023a e b). Pero algo que parece pasarse por alto é a mínima mención aos pobos indíxenas, aínda que ben se di o termo sensibilidade cultural e acomodación. Porén, este aparente abandono sitúa aos pobos indíxenas como unha poboación subsumida, cando non separada e insignificante.

Ademais, esta CMHAP da OMS 2013-2030 pode parecer minúscula en comparación con problemas máis graves como a dislocación ou o xenocidio, pero cando se examina a súa amplitude, leva promesas, aínda que lonxe de ser perfectas, que, non obstante, ofrecen unha visión informada sobre como avanzar na creación de programas para mellorar e protexer a vida dos pobos indíxenas. Con un concepto de saúde mental ao alcance da man, correspóndelles aos gobernos locais como facer isto significativo para os seus cidadáns, e en particular para os indíxenas en calquera condición en que se atopen. É un acto de tradución.

A inclusión do Pobo Ati en calquera plan de saúde supón non só ter unha exposición literal dos significados para o consumo de académicos e investigadores, senón tamén implicar a análise e posible aplicación da intención e visión dunha palabra cando sexa necesario e posible. Así, a inclusión pode non ser a mesma en todas as sociedades, xa que os distintos contextos requiren un punto de vista diferente, pero, con todo, o esforzo e a sinceridade para darlle sentido transcende fronteiras. No caso dos pobos indíxenas, a inclusión de que a tradución e implantación do CMHAP da OMS 2013-2030 non só se produce a nivel cognitivo, senón tamén a nivel emocional, social e cultural. Isto significa que os límites dos conceptos deben ser o suficientemente dinámicos como para evitar erros de tradución que poden ocorrer de moitas maneiras, como cando as políticas e o financiamento non son congruentes coas necesidades das persoas ou cando os responsables de executar as accións só seleccionan as disposicións que mellor lles conveñan. axilizar os informes. Do mesmo xeito, nas fases de planificación e execución dos esforzos de inclusión ou entrega pódense cometer erros, pero cando se fan de

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forma aberta e sincera, pódese conseguir unha mellor cooperación e sinerxía coas comunidades afectadas.

Como este estudo pretende botar unha man no proceso de realización dos beneficios fundamentais do CMHAP da OMS 2013-2030, pretende explorar e ofrecer valiosos conceptos extraídos da literatura actual e dun rexistro etnográfico dunha comunidade Ati en Filipinas para concretar a súa conxunto de obxectivos. Para iso, este documento constará de tres partes principais: En primeiro lugar, presentarase un relato e descricións etnográficas do pobo Ati como tema central; En segundo lugar, revisarase a literatura relevante e actual que aborda os problemas de saúde mental dos pobos indíxenas; e, finalmente, a partir destas dúas fontes de datos, desenvolverase a formulación de políticas e programas de intervención específicos e relevantes. Dado que o obxectivo é a inclusión do pobo Ati no CMHAP da OMS 2013-2030, o modelo xeral será, polo tanto, os mesmos principios e conceptos contidos neste documento.
Ao destacar a inclusión positiva dos pobos indíxenas no CMHAP da OMS 2013-2030, pódense examinar e avaliar conceptos relacionados entre eles e destacados relacionados coa saúde mental das comunidades indíxenas de todo o mundo. Isto tamén pretende establecer unha opinión unánime de que os pobos indíxenas non só experimentan problemas de saúde mental, senón que tamén teñen retos únicos relacionados coa recuperación das súas terras e a protección da súa identidade cultural. Así, en función das súas experiencias de discriminación, desarraigo e outros episodios de auto odio nas súas vidas, é probable que se faga fincapé nun enfoque diferente.

É necesaria unha pequena análise e revisión do CMHAP da OMS 2013-2030 para marcar a dirección do estudo e identificar aquelas disposicións que sexan relevantes para os pobos indíxenas en xeral e para os Ati en particular. A escaseza de referencias aos pobos indíxenas non supón un descoido absoluto dos seus dereitos; De feito, dise claramente que a saúde mental é un dereito. Con isto, dedúcese loxicamente que dado que os pobos indíxenas son humanos, o seu benestar mental convértese necesariamente nun dereito que require protección e posta en valor na sociedade.

A segunda parte é necesaria xa que son a comunidade receptora no proceso de inclusión, tradución e realización dun plan de saúde mental. En parte, isto relataría os antecedentes socioculturais e históricos do pobo Ati, como un dos moitos grupos nómades pre-coloniais ou de busca de alimentos que sobreviven, cuxos modos de vida tradicionais xa desapareceron. Aínda que poderían ser tomadas como unha comunidade separada en Guimaras, con todo, entre

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outros grupos indíxenas do país, as súas experiencias de marxinación socio política e desprazamento de terras poden ter certos puntos en común. A inclusión, polo tanto, de textos comentados doutros grupos afíns, aínda que en diferentes illas ou rexións do país, aínda que comparten a mesma sorte, é necesaria para salientar as experiencias xerais e comúns de pobreza e continua dislocación dentro do arquipélago. Ao ter un foco localizado na construción dun plan de saúde mental que teña como obxectivo a inclusión e realización das experiencias dos pobos indíxenas, tamén sería factible identificar como tal CMHAP da OMS 2013-2030 podería ser especialmente beneficioso.

A última parte implica a construción dun mecanismo, marco e estratexia significativos segundo a literatura sobre as condicións e necesidades recorrentes de saúde mental dos pobos indíxenas. Xunto co contexto existencial narrado do pobo Ati, e utilizando o CMHAP OMS 2013-2030, pódese xerar o plan de saúde mental Ati. Este é só un acto parcial na inclusión, tradución ou realización do acto de saúde mental, xa que a actualización depende da vontade e determinación das axencias gobernamentais interesadas, que teñen o liderado e o mecanismo para poder desenvolver investigacións fundamentadas, verificables empiricamente e culturalmente sensibles. plan de saúde. Isto significaría que só cando o goberno levase a cabo activamente programas positivos para as comunidades indíxenas e os Ati, esa inclusión vería a luz no campo.

Reforzando esta perspectiva e oportunidade de estender a intervención específica ás necesidades de saúde mental dos pobos indíxenas, o Banco Mundial expuxo a súa posición a través do documento titulado "Pobos Indíxenas: Comprender a Pobreza", publicado en 2022 (BIRF-IDA, 2022). Nel, reiterou as condicións dos pobos indíxenas, que se atopan na súa maioría en lugares xeográficos marxinais dentro de estados máis grandes e posúen un reclamo crítico sobre o interese global do planeta dado que gran parte dos principais recursos vivos e non vivos da Terra están dentro dos seus territorios. Ademais, a ciencia tamén sostén que as súas crenzas, puntos de vista e estilo de vida menos extractivo poderían ser un modelo para a vida sostible de hoxe, se non os coidadores da diversidade ecolóxica do planeta.

Estas distintas sociedades, debido aos seus vínculos culturais e ancestrais coas súas terras, que comprenden preto do 6% (aproximadamente 476 millóns) da poboación mundial, seguen sufrindo desigualdades e, en moitos casos, exclusión na educación, os servizos sociais e a economía e política. sistemas e gozos sitúaos entre o 19% dos pobres extremos da terra. Esta postura vese aínda máis exacerbada polo limitado, cando non inexistente, recoñecemento das

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súas terras ancestrais, o que aumenta a súa vulnerabilidade ante enfermidades e doenzas físicas e mentais. Así mesmo, tamén se observou como diversas institucións e organizacións están a participar activamente para o avance da supervivencia cultural dos pobos indíxenas, e os seus programas son xeralmente paralelos aos Obxectivos de Desenvolvemento Sostible (ODS), que inclúen a adopción de varios instrumentos e mecanismos internacionais. dedicada a defender e promover os dereitos dos pobos indíxenas (DESA, 2015).

Dado que a condición de pobos indíxenas dos Ati os fai aptos para pertencer aos grupos prioritarios que obrigan aos estados ao cumprimento deste plan, identificáronse actuacións estratéxicas e dotáronse dos agregados necesarios que reflictan e atendan ás necesidades locais. Trátase de dar tratamento en atención primaria; poñer a disposición medicamentos psicotrópicos; proporcionar coidados na comunidade; educar ao público; implicar comunidades, familias e consumidores; establecer políticas, programas e lexislacións nacionais; desenvolver recursos humanos; vinculación con outros sectores; vixiar a saúde mental da comunidade e apoiar máis investigación

No desenvolvemento deste traballo, comprobouse que, cando se realicen accións concretas, estarán dispoñibles varios beneficios, incluíndo a redución do sufrimento e a mellora da saúde e o benestar mental, a realización da equidade de acceso a todos os que padecen enfermidades mentais, a promoción dos dereitos humanos, unha atención de calidade que conduza á redución de estigma e discriminación, facendo valer unha percepción que conduza á mellora social e económica e a realización dunha maior participación e inclusión social. Así, os principios fundamentais do plan proposto terían os seguintes elementos: liderado e goberno; promoción da terra, da cultura, da identidade e dos coidados comunitarios; e sistemas de información e investigación de prevención.

Para realizar de forma axeitada as políticas a nivel comunitario, estas deben incluír mecanismos para reforzar a súa cultura, identidade, prácticas de curación e oportunidades de aprendizaxe. No ámbito xurídico-político, ademais de centralizar a súa reivindicación de dominio ancestral e de autodeterminación para compensar a demanda de xustiza e dereitos humanos como pobos indíxenas, debe dispoñer de fondos suficientes para concretar o compromiso necesario para superar as barreiras. Ademais, hai que incluír na curación o apoio á participación comunitaria e multi sectorial, xunto coa identificación de espazos onde se poidan realizar experiencias de cura de apoio.

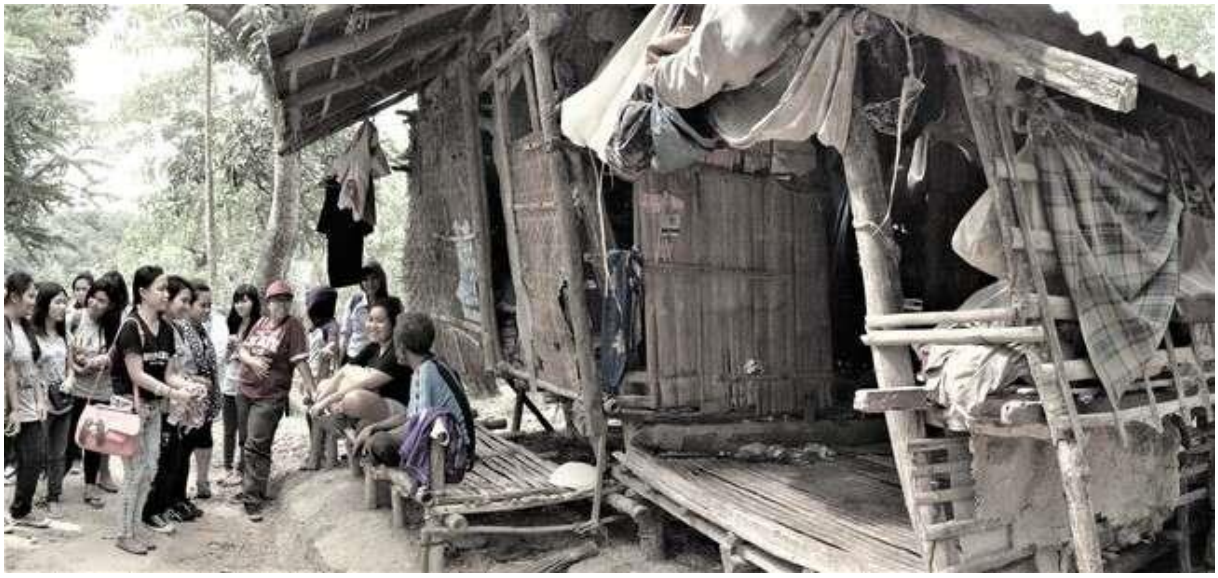
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En xeral, esta investigación reitera que, ademais de ser unha experiencia individual, a saúde mental está determinada ou estruturada por factores máis amplos como influencias socioculturais e xeopolíticas, ademais da dispoñibilidade ou acceso a produtos básicos como auga e alimentos, servizos en forma de educación. e protección legal, e recursos como a terra e a integridade cultural. No seu estado actual, xa que a súa mobilidade está restrinxida debido á falta de espazo seguro para continuar co seu estilo de vida tradicional, o máis probable é que a ruptura económica supoña a interrupción das redes sociais, o que aumentará aínda máis a ansiedade, a vulnerabilidade ás enfermidades mentais e físicas. e a desigualdade económica. Igualmente, estes non poderían manterse sen un apoio positivo ás iniciativas e defensas locais en forma de educación, contacto e protesta. Estes non só poderían mellorar a conciencia, senón tamén mellorar a confianza e a estima no espírito de aceptación e aprecio. Ademais, debe entenderse que as campañas de protesta e incidencia son actividades de auto empoderamento xa que son formas formais nas que estas persoas poden presentar as súas queixas. Neste sentido, os grupos comunitarios de auto axuda ou defensa deben ser fomentados afastados do control paternalista e do dominio das estruturas neocoloniais ou neo-feudais para que eles mesmos consigan e celebren os seus propios merecidos dereitos inherentes e unha vida digna na actualidade. nas xeracións vindeiras.

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1. INTRODUCTION

Amo kami kadja kay amo dja ang amon naabtan.
(This has become of us, having arrived at this. - Tay Floro)



Every time guests drop by an Ati community, their huts become an animated space where life's simplicity, hardship, and optimism are shared. (Sansait, personal collection).

After some pleasantries, this statement is made by an elder in an indigenous community living in the island province of Guimaras, Philippines, as he rises from his squat position in front of his bamboo hut to greet an incoming visitor. It is part of courtesy to welcome and, at the same time, remind the guest of their simplicity of life. This also shows a consciousness of the present that locates their identity and, at the same time, the process through which they arrived in this circumstance. With this insight, a conversation about their lives can be started with both the visitor and the indigenous host through an acceptance of one's fate as life travels along in the face of material change on one of the islands of the Philippines.

As an overview, the Philippines has a fair number of indigenous peoples (IP), with them comprising about 10 percent to 20 percent of the 110.8 million citizens of the country (POPCOM, 2021). These surviving groups of colonial times (Spanish, US, and Japanese) proved that, given their cohesiveness and relative isolation, their existence is still viable. However, the true nature of their imagined tranquil circumstance may be deceiving given that occasionally news about IP killings surfaces besides their voiced concerns over illegal logging and against government plans to build huge dams within their territories. On the other hand, for

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many ordinary citizens, they are "out-of-sight, out-of-mind" groups and are often seen as immune to the urban poverty that plagued the nation.



In this vast area of the island, the Ati people have yet to gain recognition of their claim to ancestral domain. (Sansait, 2009).

This shortsighted view belies the fact that IP communities are barely autonomous from the same debilitating pressures that affect the great populace, for they too require education, health systems, and other social support mechanisms to be part of the country. Article 2, Section 22 of the 1987 Philippine Constitution states that "The State recognizes and promotes the rights of indigenous cultural communities within the framework of national unity and development" (Phil. Cons., 1987). This overarching provision clearly affirms the positive duty of the state toward the IP's existence and is further elaborated in the subsequent sections of the constitution. In Article 12, Section 5: "The State, subject to the provisions of this Constitution and national development policies and programs, shall protect the rights of indigenous cultural communities to their ancestral lands to ensure their economic, social, and cultural well-being." Likewise, in Article 13, Section 6: "The State shall apply the principles of agrarian reform or stewardship, whenever applicable in accordance with law, in the disposition or utilization of other natural resources, including lands of the public domain under lease or concession suitable to agriculture, subject to prior rights, homestead rights of small settlers, and the rights of indigenous communities to their ancestral lands."

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Parallel to their rights to land is an enabling provision in Article 14, Section 4, which carries a state obligation to: "Encourage non-formal, informal, and indigenous learning systems, as well as self-learning, independent, and out-of-school study programs, particularly those that respond to community needs..." This is supported by Article 14, Section 17, which says, "The State shall recognize, respect, and protect the rights of indigenous cultural communities to preserve and develop their cultures, traditions, and institutions. It shall consider these rights in the formulation of national plans and policies;" and, in Article 16, Section 12, "The Congress may create a consultative body to advise the President on policies affecting indigenous cultural communities, the majority of the members of which shall come from such communities."

These instruments that recognize IP rights and privileges, if given appropriate attention and support by the state and its agencies, will undoubtedly lead to healthy living. Further, in 2007, the Philippines ratified the eagerly sought United Nations Declaration on the Rights of the Indigenous Peoples (UNDRIP), thus adhering to the UN's vision for "a universal framework of minimum standards for the survival, dignity, and well-being of the indigenous peoples of the world, and it elaborates on existing human rights standards and fundamental freedoms as they apply to the specific situation of indigenous peoples" (UNDRIP, 2007). Of importance in this doctrine is the affirmation of IP's "collective character" that, in the face of "forced assimilation," their rights must be protected "as distinct people." Furthermore, it identifies IP's recurrent experience of displacement from their lands without full consent as a fundamental threat that may weaken their "rights, survival, and well-being." This is a clear reminder that IP wellbeing, health, and mental health are not detachable categories from their community life and experiences.

Going back to the Philippines IP mental health concern, research on this could appropriately be well focused given the various states' legal frameworks and orientations. On top of this, prior to the adoption of the eagerly sought UN Resolution, the Philippines had already enacted a law specific to the rights of IP entitled "The Indigenous Peoples Rights Act of 1997" (IPRA, 1997). This law, although having no definite provision on mental health, bears several concepts like "health" and "well-being", mentioned nine times and five times, respectively, that readily point to the encompassing intention of the legislation favoring IP holistic welfare. Examples of these are found in Section 2.b, Chapter 2: "The State shall protect the rights of ICCs and IPs (Indigenous Cultural Communities and Indigenous Peoples) to their ancestral domains to ensure their economic, social, and cultural wellbeing and shall recognize

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the applicability of customary laws governing property rights or relations in determining the ownership and extent of ancestral domain;" and, in Section 2.f, Chapter 2 of this IPRA Law, which says, "The State recognizes its obligations to respond to the strong expression of the ICCs/IPs for cultural integrity by assuring maximum ICC/IP participation in the direction of education, health, as well as other services of ICCs/lPs, to render such services more responsive to the needs and desires of these communities" (IPRA, 1997).



Separated from the larger Panay Island, the Guimaras island province is now well connected by larger boats that can accommodate up to 50 passengers. However, those who use locally made sailboats are still around for fishing or recreation purposes. (Sansait, 2009).

One hallmark of IPRA Law is the creation of a specific office, the National Commission on Indigenous Peoples (NCIP), whose mandate is expressed in Sections 38 and 39 of Chapter 7: "shall be the primary government agency responsible for the formulation and implementation of policies, plans, and programs to promote and protect the rights and well-being of the ICCs and IPs and the recognition of their ancestral domains as well as their rights thereto;" and "shall protect and promote the interest and well-being of the ICCs/IPs with due regard to their beliefs, customs, traditions, and institutions." At present, this office operates under the Office of the President and so readily acts as a liaison office to promote and make IP voices heard to the

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government, besides processing various needs and requests in defense of their rights and lands (IPRA, 1997).

A year after the NCIP establishment, the NCIP implementing rules and regulations (NCIP IRR, 1997) came to press, which again failed to mention mental health, yet the general concepts of indigenous health and wellbeing abound. It is true that the NCIP IRR is heavy on defining IP status, rights, and procedural claims over these rights, and in doing so, it further strengthens the general framework in support of IP's mental health needs. Examples of these are in Rule 5, Section 4.a.1–9, which ensures IP enjoyment of equal opportunities and benefits at work, freedom from discrimination, and access to medical and social assistance. Further, in Rule 6, Section 1, IP rights are recognized and guaranteed for their full "participation in the direction of education, health, as well as other services, responsive to their needs and desires" (NCIP IRR, 1997).

Overall, the IPRA Law and the NCIP IRR, while receiving some serious criticism for lacking clarity and tooth in its seriousness to honor the IP ancestral land claims, were hailed as momentous in legislating an act that values IP wellbeing, health, or mental health, among others. In other words, when IP wellbeing is sought with a focus on health, the state is not lacking on legal grounds in accomplishing the overall vision of the UNDRIP, although it is not necessarily expressing these concerns but readily obliging itself to safeguard IP mental health.

The most relevant legislation, however, that could be useful in formulating policies supportive of IP mental health could be drawn from the Philippine Republic Act 11036 or known as the "2017 Philippine Mental Act" (Phil. Mental Health Act, 2018). This recent piece of legislation, besides affirming the right to mental health, likewise spells out provisions for accessible services along the "promotion, prevention, treatment, and aftercare" of "psychiatric, neurologic, and psychosocial" needs of every citizen of the country. While it makes no mention of indigenous peoples, it directs that mental health access and care must be "culturally appropriate" or "culturally relevant." Specifically, the enjoyment of this right is articulated in Section 5 of Chapter 2 to be "on an equal and nondiscriminatory basis" for all, and as such, in subsection f, it says, "Access to comprehensive and coordinated treatment integrating holistic prevention, promotion, rehabilitation, care, and support, aimed at addressing mental health care needs through a multidisciplinary, user-driven treatment and recovery plan." Furthermore, the provisions in Article 14, Sections a and b of Chapter 4, clearly emphasize that for mental health services to be effective, while they must be based on "medical and scientific research," they

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also must be "responsive to the clinical, gender, cultural, ethnic, and other special needs of the individuals being served." Of equal importance is that this legislation values likewise the need to integrate community support and approaches (mentioned 12 times) in the overall mental health prevention and treatment efforts (Phil. Mental Health Act, 2018).



The Philippine laws recognize and protect indigenous peoples. But allowing them to fully realize their identity, culture and land remains a great challenge. (Sansait, 2009).

In the case of the indigenous peoples of the country, these legal frameworks have yet to be translated at the level of their mental health, given the prevalence of illiteracy and unemployment reflective of the general poverty of the populace. Further, with their lands, which are the source of their economic stability and cultural identity, under threat by logging and mining concessionaires as well as hydroelectric dam projects, it is likely that their dislocation will have a deleterious effect on their traditional lives (Delina, 2020). These are just the

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generally known problems they face, for within their communities as individuals, these external threats will find a sinister echo in their personal lives.

Upon leaving, one would always recall the soft voice of Tay Floro as he adjusted his seated position in front of his door: "*Ti, san-o naman ikaw mabalik dire*?" (So, when are you coming back here?). As one is welcomed casually, upon leaving though, you are reminded of that personal relationship established in a short period of time, that is meaningful to people who were accustomed to living in mutual trust and obligation. The statement may also carry a subtle thought of "never forget us," since by assuring them that one is coming back, every emotional concern circumscribed by distance and insecurity might have some sense of comfort through the assurance of a future visit. But in the life of Tay Floro and the rest of his cultural group, the tone in the statement has some foreboding weight of distress given that he, together with his wife and two adopted grandchildren, has to gruel a two-meal a day.

In their faces, it is apparent that one of the tragedies in life is to be born materially and psychologically discriminated against with no one to help you. Or, simply, to be born in an Ati community. Although an indigenous person might have some taste of comfort and security, which is mostly in a nostalgic sense, as the world is getting constricted with the expansion of the market economy in the name of development and profit, whatever ray of hope there is likely seems only a flicker.

The Ati of Guimaras, Philippines, are not the exception, for most indigenous peoples all over the world are facing various levels and intensities of pressure that interact, intersect, and continue to undermine their lives, relationships, culture, and identity. Either one is a survivor, a descendant, or a victim of any social or natural upheavals brought about by conflict, deforestation, or climate change, among others. The process of recapturing a modicum of meaningful living is always a burden that could hardly be remedied in a lifetime.

But there is also a gleam of hope, as exemplified by some groups that managed to continue or were able to bounce back to celebrate their rituals and assert their identities. Nonetheless, these are the exemptions, for the majority remains dependent on the privileges provided by the state or by their dominant neighbors and on the assistance of donor groups, such that without these, many would never be able to initiate improvements in their lives. On the other hand, at the international and local levels, various instrumentalities have been developed to address indigenous grievances, and although these may be late or slow to happen, the challenge has been forwarded on how to translate them positively in various communities around the globe.

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Lately, one document of momentous importance that calls for its thorough and systematic implementation is the World Health Organization's Comprehensive Mental Health Action Plan 2013–2030 (WHO CMHAP 2013-2030). On the surface, it sounds partial to the medical aspect of the mind alone, but at a closer look, it carries with it the hope of realizing other rights and the welfare of humanity, especially towards fulfilling the United Nations Social Development Goals (SDG) (UN DESA, 2023a and b). But one thing that appears to have been glossed over is the minimal mention of the indigenous peoples, although the term cultural sensitivity and accommodation is well said. Still, this seeming neglect puts the indigenous peoples as a subsumed populace, if not a separate, negligible one.

Further, this WHO CMHAP 2013-2030 might look minuscule compared to graver problems like dislocation or genocide, but upon examining its breadth, it carries with it promises, though far from perfect, nonetheless giving an informed insight on how to move forward in bringing about programs to uplift and protect the lives of the indigenous peoples. With a mental health concept now at hand, it is up to local governments how to make this meaningful to their citizens, and particularly to the indigenous peoples in whatever conditions they might be. This is an act of translation.

Inclusion of the Ati People to any health plan means not only having a literal exposition of the meanings for the consumption of academia and researchers, but also involving analysis and possible application of the intent and vision of a word when necessary and possible. Thus, inclusion might not be the same throughout societies, as different contexts require a different point of view, yet nonetheless, the effort and sincerity to make it meaningful transcend boundaries. In the case of the indigenous peoples, inclusion which translation and realization of the WHO CMHAP 2013-2030 does not only happen on the cognitive level but on the affective, social, and cultural levels as well. This means boundaries of concepts should be dynamic enough to avoid mistranslation which this could happen in many ways, like when policies and funding are not in congruence with the needs of the people or when implementors only select the most convenient provisions for them to expedite reports. Likewise, in the planning and implementation phases of the inclusion or realization efforts, mistake might be made, but when done in an open and sincere fashion, better cooperation and synergy could be attained with the concerned communities.

As this study aims to lend a hand in the process of realizing the core benefits of the WHO CMHAP 2013-2030, it seeks to explore and offer valuable concepts drawn from current

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literature and from an ethnographic record of an Ati community in the Philippines to make concrete its given set of goals. Towards this end, this paper will have three main parts: First, an ethnographic accounts and descriptions will be presented with Ati people as the central subject; second, relevant and current literature addressing indigenous people's mental health challenges will be reviewed; and lastly, out of these two sources of data, the formulation of specific and relevant policies and intervention programs will be developed. Since the aim is the inclusion of the Ati people to the WHO CMHAP 2013-2030, the overarching template therefore will be the same principles and concepts contained in this document.

By highlighting the positive inclusion of indigenous peoples in the WHO CMHAP 2013-2030, interrelated and prominent concepts related to the mental health of indigenous communities across the globe can be examined and assessed. With this, it is aimed further to establish a unanimous view that the indigenous peoples are not only experiencing mental health issues but also have unique challenges related to their land claim and protection to their cultural identity. Thus, based on their experiences of discrimination, dislocation, and other self-depreciating episodes in their lives, a different approach would likely be emphasized.

A short analysis and review of the WHO CMHAP 2013-2030 is necessary to set the direction for the study and identify those provisions that are relevant to the indigenous people in general and to the Ati in particular. The paucity of references to the indigenous peoples does not mean an outright neglect of their rights; in fact, it is clearly stated that mental health is a right. With this, it follows logically that since the indigenous peoples are humans, their mental wellbeing necessarily becomes a right that requires protection and enhancement in society.

The second part is required since they are the recipient community in the process of inclusion, translation, and realization of a mental health plan. Partly, this would recount the Ati people's socio-cultural-historical background, as one of the many surviving pre-colonial nomadic or foraging groups whose traditional modes of living are now gone. While they might be taken as a separate community in Guimaras, nonetheless among other indigenous groups in the country their experiences of socio-political marginalization and land dispossession may have certain commonalities. The inclusion, therefore, of annotated texts of other related groups, though on different islands or regions of the country, yet sharing the same fate, is necessary to emphasize the general and common experiences of poverty and continued dislocation within the archipelago. By having a localized focus in the construction of a mental health plan aiming at the inclusion and realization for the indigenous peoples' experiences, it would likewise

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become feasible to identify how such a WHO CMHAP 2013-2030 could be specifically beneficial.



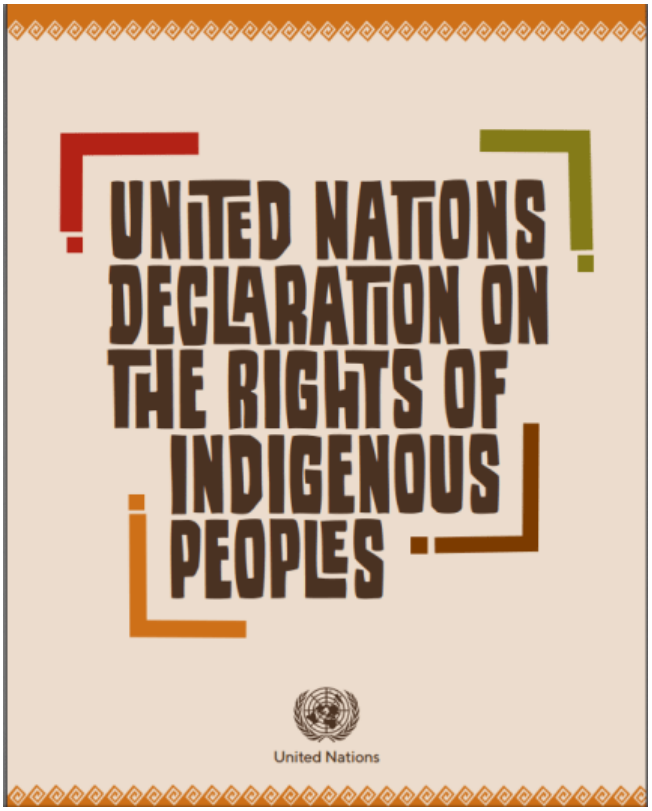
Activists, defenders, and indigenous peoples themselves, in defense of their land, culture, identity and resources, are often victims of violence with impunity. (Amnesty International, 2020)

The last part involves the construction of a meaningful mechanism, framework, and strategy as informed by literature on the recurrent mental health conditions and needs of indigenous people. Along with the narrated existential context of the Ati people, and using the WHO CMHAP 2013-2030, the Ati mental health plan can be generated. This is only a partial act in the inclusion, translation, or realization of the mental health act, for the actualization depends on the will and determination of concerned government agencies which has the leadership and mechanism to implement research based, empirically verifiable, culturally sensitive mental health plan. This would mean that only when the government had been actively pursuing positive programs for the indigenous communities and the Ati such inclusion would see light in the field.

Reinforcing this outlook and opportunity to extend specific intervention to indigenous people's mental health needs, the World Bank outlined its position through the document entitled "Indigenous Peoples: Understanding Poverty," published in 2022 (IBRD-IDA, 2022). In it, it reiterated the conditions of indigenous peoples, who are mostly at marginal geographic

locations within larger states and possess a critical claim to the overall stake of the planet given that much of the earth's prime living and nonliving resources are within their territories. Besides, science too maintains that their beliefs, views, and less extractive lifestyle could be a model for today's sustainable living, if not caretakers of the planet's ecological diversity.

These distinct societies, due to their cultural and ancestral ties to their lands, comprising about 6% (approximately 476 million) of the global population, continue to suffer inequality, and in many cases, exclusion in education, social services, and economic and political systems and enjoyments puts them among the 19% of the earth's extreme poor. This positioning is further exacerbated by the limited, if not nonexistent, recognition of their ancestral lands, which increases their vulnerability to physical and mental diseases and illnesses. Likewise, it was also noted how various institutions and organizations are actively engaging for the advancement of indigenous people's cultural survival, and their programs are generally in parallel with the UN Sustainable Development Goals (SDGs), which include the adoption of several international instruments and mechanisms dedicated to upholding and promoting indigenous people's rights (DESA, 2015).



Cover page. 2007. United Nations Declaration on the Rights of the Indigenous Peoples.

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2. THE RESEARCH PROBLEM, METHODOLOGY, AND CONTEXT

With better knowledge to understand and explain human diversity right now, it is a great leap that humanity has acknowledged that people today belong to one species, and so racism has been greatly downgraded as baseless (Smithsonian, 2020). However, due to differences in experiences and cultural habits, which include the development of advanced technologies and political and economic systems, some communities were able to go way beyond others in developing material, educational, and medical infrastructures. But this does not mean that these differences in progress are a measure of genetic fit or an excuse to ignore those lagging. Rather, for social scientists, the diversity of circumstances and needs poses a challenge to creating a dignified life, if not a just and humane society across the globe. Specifically, while the academy and researchers continue to pursue the production of knowledge through research, there is also a constant need to apply or find ways to apply this bulk of information in libraries across different gaps and human needs (National Geographic, 2023).

This research looks at the Ati of Guimaras as a marginalized cultural group and begs that they be provided with a framework through which they could rely on for their mental health needs. At present, there are two magnificent windows of opportunity to frame policies for such pursuit. The first are the generic laws of the Philippines – the IPRA law and the National Mental Health Act, among others—that, with a little patient elaboration, could positively affect local indigenous groups' conditions in life. The second – the World Health Organization's Comprehensive Mental Health Action Plan 2013–2030 – is broad yet very dynamic and wide-ranging in its directives to each state on why and how mental health programs should be operationalized across cultures. Looking at the Philippine context, and specifically for the Ati people, this research work is done to enable these documents to gain momentum in reaching out to their mental health needs.

2.1. The Problem

2.1.1. The General Problem

The general research problem thus is, from the current literature about indigenous people's lives and welfare and from the existential description of the Ati people of Guimaras, Philippines, how would the World Health Organization's Comprehensive Mental Health Action

Plan 2013–2030 (WHO CMHAP 2013-30) be meaningfully operationalized in their socio-cultural context?

2.1.2. The Sub-Problems

To sufficiently address this question, the following sub-questions will be clarified:

1. What is there in the current indigenous mental health literature that could positively inform and help frame the application of a mental health plan in the lives and wellbeing of the Ati people of Guimaras, Philippines?

2. What is there in the existential condition of the Ati people that, with the described indigenous mental health literature above, could lead to a more specific framing of mental health policies and practice in the country? And,

3. How could specific and relevant policies and interventions reviewed become applicable to the Ati people reflectively and within the frame of World Health Organization's Comprehensive Mental Health Action Plan 2013–2030?

2.2. Methodology

This research, given the objectives above, necessitates a well-grounded set of literature on mental health that is meaningful to indigenous peoples in general and whose relevance will soon intersect with the existential condition of the Ati people. Second, the World Health Organization's Comprehensive Mental Health Action Plan 2013–2030, being a prescriptive document for all states, stands to be taken seriously to obtain its desired health goals for all. Thus, this paper will devote more than a page to this WHO health plan, and as often as it needs to be, it will keep tabs on its provisions to filter out the important concepts relevant to the needs of the Ati people. Lastly, the Ati community, being the recipient, necessitates being documented and presented comprehensively enough to establish their existential context in the island province of Guimaras, Philippines.

In identifying relevant literature, three general topics must be satisfied: those that deal with the mental health of the indigenous people, those that helped describe the Ati people, and those that further reinforce ideas contained in the WHO CMHAP 2013-2030. But soon it becomes obvious that anthropological contributions are also significant in establishing culturally sensitive and meaningful mechanisms for dealing with indigenous people's mental health

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issues. Thus, in the policy intervention, the design will likely be informed by the appropriate tools of applied anthropology to make sense of any program for an indigenous community.

In fulfilling the first set of readings, researchers nowadays are greatly benefited by the availability of online peer-reviewed journals. This opportunity must be maximized, and so at the University of Santiago de Compostela, the first thing done was to seek access to these journal articles with a specific topic and date in mind. The first search was about "indigenous mental health and wellbeing." This produced more than a hundred of entries but narrowing these down by the date of publication (from 2020 to 2022), the most significant ones were those of the first 50, or those that directly examine or discuss indigenous mental health conditions. The rest surfaced in the list because they alluded to the topic via their mention of the key words in their review of literature or in their list of references.



Before the COVID-19 pandemic, this type of motorized boat was the common means of transportation between Iloilo and Guimaras Island. (Sansait, 2009).

The next search involves inputting the key words "indigenous peoples and the World Health Organization's Comprehensive Mental Health Action Plan 2013–2030", and a long list appears, but again, by examining relevance and date, only less than 10 were chosen. Lastly, another round of searching was made, inputting "intervention on mental health for indigenous peoples," and a long list likewise appeared. With the same closer examination, only less than 20 were retrieved, the rest appearing as redundant literature or having already appeared earlier in the first or second rounds of searches. To contribute knowledge, quality has to be preferred over quantity, and so the decision to keep the minimal number of retrieved literature to less than a hundred is well grounded.

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The search for literature that has the potential to clarify and reinforce the ideas contained in the WHO CMHAP 2013-2030 has been casual given that the UN and WHO web pages already have an enormous list of interconnected topics supporting health and wellbeing. Given the unnecessary redundancy of topics, only some were retrieved, like those documents preceding this WHO CMHAP 2013-2030, but in closer examination, such a plan could stand on its own given that it contained specific references and examples for anyone curious to review it further. For other related concerns, articles were searched as needed.

In the first part of this paper, which is the Review of Literature on Mental Health vis-à-vis Indigenous Peoples, the literature retrieved was categorized according to its key emphasis and grouped to form a related idea that has the potential to become a subtopic. In all, after some shuffling of terms, eight subtopics were identified, which nonetheless have overlapping interests with the other subtopics. The important thing is that by grouping articles under a certain category, a particular idea that is likely already contained in the WHO CMHAP 2013-2030 can be sustained or elucidated that is relevant to the experiences of the Ati people. Certainly, not all provisions of the WHO CMHAP 2013-2030 are covered by the retrieved literature, given that social science researchers, especially anthropologists, are keen on looking only at the meaningful cultural template of the community and indirectly at the models posed by western science. However, upon closer examination of the WHO CMHAP 2013-2030, it is consistent in its advocacy to make mental health promotion available to all; hence, every article has the potential to comment either in support directly or indirectly or in identifying gaps in the plan when necessary.

The second part focuses on the few but remaining communities of the Ati people in Guimaras Province, Philippines. The descriptive information about them is plain and straightforward, for the intention was to introduce them in their condition as a product of history and local policies affecting them. The author, being a trained cultural anthropologist and a social science teacher at a local university, the University of the Philippines Visayas, has had the privilege to befriend or become accustomed to them on many occasions in life. In Iloilo or in any part of the province, one can occasionally encounter the Ati people in various states of stereotype because of their itinerant behavior, carrying along a set of medicinal herbs and concoctions, or through their lean-on encampments some distance away from the main town area. Except for their color and peculiar behavior, there is not much of a special interest in them, for they just come around in any street, such that their presence may initiate curious

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conversation, however trivial it may be about their whereabouts. The talk often ends with jokes about their stereotypes, which they have grown to ignore if not resent in some subliminal way.

Unlike in any literature produced by someone new to their behavior and cultural patterns, one may cite strict processes for getting into the field, which may include vaccination, obtaining insurance, and obtaining permissions through various bureaucracies. This strange behavior may sound very strange indeed to a local researcher, though in principle such protocol must be kept to avoid unnecessary exploitation and harm in whatever form to both the community and the uninitiated researcher. To a local researcher, it is like ringing a bell before getting into your cousin's house, which you may forgo at will, although one has to do the ritual in front of someone to demonstrate respect to the owner. Having some kind of protocol before getting into their community is better than being left without proper guidance to start with. In many circumstances, cordial relationships are sufficient to start a lifelong confidence, for it is commonly understood by any Ati individual that, at the end of the day, by failing to demonstrate the capacity to trust someone who is already in front of them, one could result to losing a prospective ally in life.



Whenever students visit Ati families in their huts, the latter feel recognized and comforted, and their optimism in life is strengthened as friendships are rekindled. (Sansait, 2009).

While such insecurity makes them easily vulnerable to intrusion, it also motivates them to risk connecting with people of good faith. Usually, then, protocols must be followed mostly for

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legal or record-keeping purposes, but this does not mean that people are living in a controlled container where each must obtain permission every time one desires to get into their territory.

There is some kind of deep irony there if one is to reflect upon the extent of following strict protocol in getting into their village. It appears that these Ati people are managed as prized possessions that one must pass by the gatekeeper before getting in touch with them, but the focus ends there, for these people continue to trek on a constrained, limited space without adequate social and medical attention. For the researcher, all these have been noted in the formal sense and in the practical sense. Formally, the researcher's permit was processed by the National Commission for Culture and the Arts (NCCA), which was obtained way back when there was a need to do a description of this community in 2009 (Sansait, 2009). The rest is a story of friendship and admiration along the resiliency of this people.

Regularly, in person or as a teacher, he would bring along his students to one of the Ati communities to enable them to understand that there are other communities that need to be encompassed by their educational goals. These students, however, are not randomly brought in; rather, their visit is part of a social science syllabus. In every visit, the most important thing was first to establish informal communication initiated by the students with the community leader in order to agree on a particular date for the visit, which is usually two months ahead. Then, if availability is gained, both for the students (who have many tasks as well) and with the identified community in Guimaras, a formal letter is made addressed to the legal agency responsible for maintaining a proper protocol, the National Commission for the Indigenous Peoples in Region 6 (NCIP-6).

Depending on the load credit assigned to the author as a teacher, usually each semester one or two visits are done one at a time in different communities by separate student groups. There are times when such protocol is not repeated in cases where students want to return for the giving of tokens or by those students who have already made separate friendly meetups with their fellow youths. Again, in the province and elsewhere, there are many friendly relations going on between the Ati and the people in nearby communities. The problem arose when the Ati community felt aggrieved for not having compensated enough with their lost time, resources, or talent in spending time with the visitors. This is understandable enough; first, they are not an object of entertainment. Second, they too have their needs of the day, which may not be attended to if not for a "pesky" visitor. Lastly, though they do not want to name their expected payment, in the context of sealing a friendship, something is expected from a visitor.

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In every visit, all these are explained to students, and as much as the author wanted them to be anthropologists, the best he could expect was a short but descriptive reflection paper so that they would learn to process their encounter in an academic and relational fashion. Directly or indirectly, the author accumulated knowledge about these people even prior to his reading of ethnographies about them. His readings, however, eventually made him decide to likewise contribute something for their wellbeing, and there is no formal or better way than by seeking out ways that the WHO CMHAP 2013-2030 with all its promises can be translated into their lives.

The ethnographies about the Negrito of the Philippines are highly instructive and emotive for those who are passionate about extending humanity to these people. While few were shortly written, many have gone to great lengths to answer core anthropological questions about human diversity, but in hindsight, these authors too were positively affected by their subjects. This is the prize of doing anthropology—something of a baggage, but a delectable one brimming in and out of oneself all throughout one's life.

In the Province of Guimaras, a small group of Negrito communities who self-ascribed themselves as the Ati were found to exist in the four municipalities, and to establish their current condition, an ethnography was conducted in 2008. The date could be much earlier, but this was the time when the author got the motivation from the National Commission for the Culture of the Arts to produce a booklet to have a textual representation of the group through which subsequent researchers might do better (Sansait, 2009). The main tool used was key informant interviewing, supplemented by an informal survey, household visitation, diary keeping, and four weekend sleepovers in the community. It must be stated again that the author was not a stranger to the group, as he had built friendships among them because their place is within the region, and there is no difficulty in language because everyone can shift from Hiligaynon to Kinaray-a. Besides, the Ati community leaders occasionally meet with the author at gatherings or conferences about Indigenous groups in the province. Nonetheless, for this research, it is worthwhile to review the important ethnographic discussion about key informant interviewing.

In 1957, there appeared an article that generally endorses key informant technique in the American Anthropologist journal written by Marc-Adelard Tremblay, entitled "The Key Informant Technique: a Nonethnographic Application." From the title itself, there is somewhat of a tentative attitude with the claim that key informant interviewing is "nonethnographic," for at that time anthropology had been widely admired because of its consistency with the long

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field immersion requirement through participant observation (Tremblay, 1957). But despite this, Tremblay made a push towards a formal acceptance of key informant interviewing by describing it as "preeminently suited to the gathering of the kinds of qualitative and descriptive data that are difficult or time-consuming to unearth through structural data-gathering techniques such as questionnaire surveys." He might be saying that while interviewing is not participant observation, its merits lie in its efficiency in terms of time and money. Thus, this could really work well, especially for those who are new to the site of study and need a better preliminary approach to get a good feel for and evaluation of the community. Or that, being pragmatic, other things would just come easily if one became familiar with the people and the place. However, there is no guarantee that everything will be known through one's presence alone; thus, among the other options available, it is good to start consulting with a suitable informant.

Tremblay noted that one must identify an "ideal" informant as a first step. With this, he meant to look for somebody who possesses a sound knowledge of the community, such as those who have a recognized role in the community and are willing to communicate ideas. Whereas their knowledge and impartiality might be tentative at first, a frequent conversation may soon yield profound data for the research.

The interviewing is not a smooth one-act accomplishment, though, and for this, Tremblay assures that it is indeed "a self-developing technique." This means that frequent contact will allow the generation of information as the interviewee will have the opportunity to recall facts and useful memories. As regards the obtained data, it must be assessed for internal consistency, productivity, and reliability.

Internal consistency means that the data agrees with other concepts within the provided information. It is not simply a collection of statements, but such statements should have the potential to be understood meaningfully. Productivity means that new information can be deduced further if other facts are brought into the analysis. By reliability, researchers are reminded that they should always double-check or more the information they obtain, not dominated by the preferences of the informant but on the focus of the research.

Related to Tremblay is Section 4 of the UCLA Center for Health Policy Research, entitled Key Informant Interviews. In this paper, the key interview process is broadly defined as a qualitative one done "with people who have first-hand knowledge about the community," and that it is usually done face-to-face. One of the recognized uses of this technique is describing community life, events, and experiences in general. If one chooses this technique, the following

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steps must be observed: gather and review existing data, determine what information is needed, determine target population and brainstorm about possible key informants, choose key informants, choose type of interview, develop an interview tool, determine documentation method, select designated interviewer(s), conduct key informant interviews, and compile and organize key informants.

The steps were of use to this Ati research, but some steps were merged because the population target is small and people know each other very well, which makes cross-checking handy. Further, the researcher's various visits to different sites and his stay for days in the area allowed him to absorb information well understood in the community. Nonetheless, the recommended processes to start with the study were well noted, which include the introduction, followed by the conduct of the interview, then additional probing questions, and lastly, getting into a closing or summary question.

As regards choosing informants, Hyrman and Goedhuys in the article entitled "The Multiple Key Informant Survey: a Method for the Comparison of International Qualitative Data" added additional criteria in order "to safeguard validity" (Heyrman & Goedhuys 2011). This could be carried out by safeguarding that informants must not have conflicts of role or status in the community. This is enlightening since, while informants might be knowledgeable, their position, because of their personal interests, could influence the intent of their narratives. This, however, could be detected through early cross-checking of the data. Further, it might be inevitable not to include them at some stage of interviewing, for they too have some ideas that could be part of gaining alternative views in processing other competing ideas.

Second, by counter-checking any narrative, the best strategy is to take it as tentative, if not false. In this regard, ideas become acceptable only if the competing ideas have been proven inconsistent. This can likely be achieved through a continuous dialogue in the community or with the informants.

Third, a triangulation technique must be carried out, which means different sources and angles have to be sought to add credence to a given claim. Lastly, thick descriptions can be utilized if doubts exist so that by providing more details, readers will be able to judge for themselves the core ideas being presented.

In the Ati community, the use of the triangulation technique has been good advice. So, besides having a key informant at hand, efforts were made to hear other voices in the community. This happened through regular visits to older people or to a person whose type of

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work brought him or her closer to the topic that needed explanation. Likewise, the researcher pays respect to the pace of informants in relating their ideas, that is, not in a hurried manner, to allow them to process their intentions, words, and interpretation. By allowing another day before repeating or continuing a particular contentious topic, the interviewee had the opportunity to clarify the previously stated ideas. But the most providential was the attitude of key informants, who, in their eagerness to make their statements accurate, often suggested consulting another person who could provide a better view of the case. Triangulation is therefore facilitated within the community when everyone else becomes eager to share their point of view in the research.



At any moment, though talking with them about their lives appears to be ordinary, students have to keep an ear to the lessons and knowledge being shared. (Sansait, 2009).

Following this need to be methodical in the conduct of interviews, Kumar, in his article "Conducting Key Informant Interviews in Developing Countries," underscored that this technique has "the capacity to provide quality data and insight" because of its versatility (Kumar, 1989). However, good planning is indispensable, which includes reviewing documents, preparing a conceptual framework, preparing an interview guide, selecting the informant, making initial contact, establishing rapport, wording questions, and allowing the informant time.

One of the salient points learned aside from those already described above is the idea of having a good review of documents ahead of time in the planning stage, which includes

planning out one's initial contact as well as the way to establish rapport and how to restate questions on sensitive topics. The assumption of a knowledge gap between the researcher and the community is useful to make researchers continually self-check their level of preparation.

In the Ati community, while the language is mutually shared, the researcher was conscious not to be too intrusive most of the time to catch them off guard, as there was no need for this. But rather, his earned rapport from a long time ago allowed him some degree of trust that kept conversations within a controlled and courteous tone. Again, rapport is important, and this is earned through a patient process of encounters and familiarity as a researcher in the community.

In 1999, the same core ideas of Kumar were reflected in the USAID directives for the conduct of the monitoring and evaluation phases of each of their projects. At this period, the concept of rapid appraisal research techniques is coming into fashion, and part of them is key informant interviewing (USAID, 1999). While the technique is seen as prone to bias, because of the quality of voices obtained and its cost efficiency, it remains very valuable. The most profitable steps should start with good preparation by listing the topics and revising them as often as necessary. Then, establishing a rapport is to be done prior to engaging the informants with questions. However, in bringing out questions, the factual ones should be presented first, followed by probing some other details. Lastly, one should take time to review the recorded notes and be ready to set an appointment for another meeting if clarifications are needed.

As regards the Ati community, the idea of bringing about factual questions has not been carried out rightly given that the community is not used to seeing things in terms of discrete facts. Nevertheless, they have a built-in view that things and conversations have some connections to community life. So, the strategy always carried out to arrive at information is to identify someone who has some personal knowledge that the community can share. Rather than asking, "How much money do you have by the end of the day?" it is preferable to restate it as, "How much would likely be your savings after your hard work today?" Of course, they could be told any questions one may like, but the informant would soon lose interest in responding to other questions that are not personally meaningful to them.

Also, expect a lot of biases given their poverty and insecurity over a limited land. This means they are prone to misrepresenting themselves as the disfavored or misunderstood one, and most likely this is correct. Nonetheless, researchers must be able to weigh their statements at the end of the day. This self-depreciating bias is still a bias, but it shows how informants still look at their community's welfare as a desired good that they must be concerned with. As

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expected, despite their hardship, when their community's image is depicted in an unpalatable frame, they readily try to change the topic or suggest reconsidering a different view with a corresponding reason. In other words, they are amenable about their poverty, but when reminded about their undesirable lack of desire to improve their hygiene, they are likely to look the other way and talk about something else. It is not that they are not eager to talk about their poverty, but that they want to bring out their own interpretation that would effectively keep their community's image positive. Overall, this shows their in-built view of life, which helped define their resiliency by acting protectively and favoring their community. With this, there remains a strong optimism and strength to carry on with their lives regardless of what others say about them.



The great interest of children during interviews or household chores is welcomed by older children, allowing them to share stories and experiences about their culture and life. Children are also asked to join in conversations that they easily share or that they observed in their own home. (Sansait, 2009).

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The best a researcher can do is remain sensitive to cues in their language and, at the same time, note what is being said in comparison to what is being observed. Thus, the USAID instructions would always remind researchers of their privilege over the informant's society. To stay consistent, though, one has to check for reliability and validity, check for personal biases, look for counterevidence, get feedback, and always triangulate data. These precautions, however, when in the field setting, can sometimes make the research more distant, leading to uneasiness about the data collected in fear of transgressing the stages set. On the other hand, so long as one remains open to dialogue, including over one's biases, some information that might appear irrelevant would still be appreciated in the process of describing a community.

Around half a century ago, in 1971, in the field of anthropology, Pelto wanted to provide an early justification for making use of ethnographic interviews, yet due to criticism, he raised two basic questions: "How can I do valid research?" and "How do I know when to believe the conclusions of other researchers?" (Mcnett, 1971). It should be recalled that in that period, the dominance of hard data was strong, with the sarcasm that although anthropologists know how to describe, they do not know how to count the occurrences of variables. Likewise, at this time, the emic and etic themes were trending, allowing researchers to distinguish what they were investigating and so establish the point of view of their interpretation, either about something observed or about those behind habits and behavior.

Since ethnographers were in pursuit of the emic view, Pelto reviewed likewise the traditional anthropological methodologies, including key-informant interviewing, structural interviews, questionnaires, ratings, and reviews, among others. In unfamiliar and distant localities, other qualitative research techniques were of importance to anthropologists, with participant observation being the first choice. This is followed by semantic studies, the collection of life histories, and unobtrusive measures. In all these cases, starting from the beginning of any formal research towards seeking clarifications of interpretations and analyses, interviewing informants has always been helpful.

Another important clarificatory attempt towards the question of validity and reliability is by Weller and Batcheler in their article, "Culture as Consensus: A Theory of Culture and Informant Accuracy." Following Pelto's dilemma, they too asked how "anthropologists get to know what they know and write in the first place." For them, key informant interviewing requires an epistemological resolution to the question, "How do we know when we know?"

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The discussion of Weller and Batcheler points to the reality of culture as not fully individualized nor unknowable, but rather having a mark of consensus in it. In other words, culture is continually lived out and interpreted by people who have a shared general agreement on the meanings or ways of life in the community. This dynamic shared understanding forms the consensus of the people who have their lives kept in regular fashion without difficulty. Thus, given a particular or proportional number of informants, that is, within the statistical probability rule, a consensus can be determined. This is the task of an anthropologist in having a conversation with informants or in using the key-informant interviewing method: to have a view of culture as a consensus. Thus, the question of validity and reliability in interviewing does not rest on the informants per se but also on the number and variety of individuals interviewed.



With low literacy and competitive skills in society, many conventionally enter relationships early, yet their determination to become productive is shown in their selling of their community-produced amulets (one of which are the red bracelets at her left hand). (Sansait, personal collection).

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Reinforcing the consensus model is the view of Magnarelia expressed in the article, "Anthropological Fieldwork, Key Informants, and Human Bonds" (Magnarella, 1986). He thought that while informants come from different backgrounds or localities, the continual encounter with the researcher would likely bear a positive result: a formal friendship bond. These informants will always be cherished, not only because of their willingness to provide information but also because they allow the researcher to attain his or her objectives within a given time. Such contributions will become priceless among other encounters, for time and individual personalities are all involved in a dynamic fashion in the context of research. Thus, in the process of interviewing, after getting through with trust and sincerity, it is expected that mutual respect and admiration may be established. Such genuine friendship will likely become one of the joys of fieldwork, which could never be achieved in some other structures of doing research.

In the Ati community, friendship is inevitable because the orientation of the community or their disposition in their day-to-day lives is towards mutual respect, kindness, generosity, and trust. As they are courteous in so many things and encounters, the researcher is grateful to get to know the informants he had who are open and spontaneous with sharing their observations, lives, and experiences. Along with this appreciation, it becomes obvious how consensus becomes a very informative word that made each informant's statements valuable in this study.

2.2.1. The Conceptual Framework of the Study

The figure that follows illustrates that the Ati Mental Health Plan (D) is intricately connected to land, culture, and identity (C), as consistently articulated in the UN and the WHO documents (A) and by vast literature that describes Indigenous Peoples' mental health (B). This theme is taken because, while the UN and WHO documents have universal appeal, their demand for accountability rests only with state governments. (This will be discussed in detail in the subsequent sections.) This means that on the unique experiences and needs of indigenous peoples there is a danger that they will only be taken secondarily, sacrificing their rights to self-determination and ancestral domain, which are necessary conditions for mental health integrity. To correct this gap, anthropological literature is presented and analyzed so that the comprehensive conditions of indigenous peoples' mental health and significant variables can

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be highlighted. This view then implies the urgency and the advocacy for the acknowledgment of the deep association between their historical trauma of displacement and dispossession and their precarious identity and culture that sustain their mental health. Thus, the output, which is the Ati Mental Health Plan as a local realization of the generic WHO CMHAP 2013-2030, is characteristically informed and nourished by two sources of knowledge: the shared experiences of other indigenous peoples through literature and the lives and voices of the Ati people themselves.

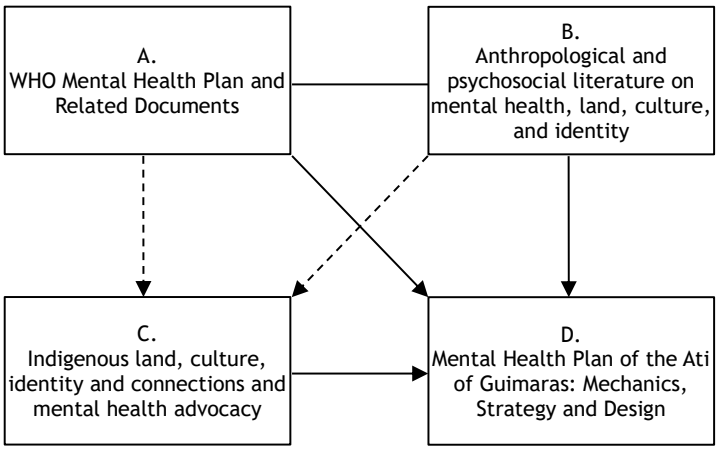


Figure 1. The Conceptual Framework of the Study

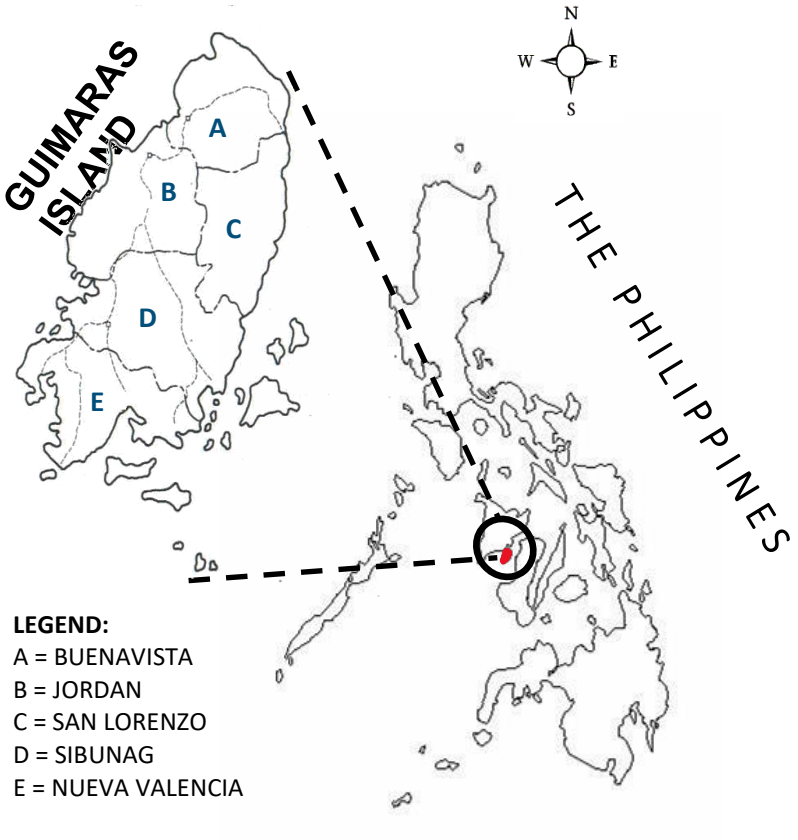
2.2.2. The context: Guimaras history and topography

> *Indigenous peoples have the right to determine their own identity or belonging according to their customs and traditions. This does not undermine the right of indigenous people to obtain the citizenship of the States in which they live.*
> (Article 33, no. 1. UNDRIP, 2007

Guimaras is an island province found between Panay and Negros islands in the western part of the Visayas region of the Philippines. It is bounded mainly by the Sulu Sea on its western side and Iloilo Strait, Guimaras Trait, and Panay Gulf on its north and east sides (see

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coordinates: 10034'N, 122035'E) (Philatlas, 2023). It has a land area of 611.87 square kilometers and a total population of 187,842 as of 2020. With around 300 people per square kilometer, it is still considered the least populated province in Region VI, but with an annual population growth rate of 1.33 percent, the province's density is expected to bloom in the decades to come. As a province, it has five municipalities: Jordan, Buenavista, San Lorenzo, Nueva Valencia, and Sibunag.



(Sansait, 2009)

Figure 2. Map of Guimaras Island, Philippines

As an island that looks like it stumbled off from Panay and Negros islands millions of years ago, Guimaras is mostly surrounded by steep ravines, if not mangroves, that protect its sides from further onslaughts from the sea (Forest Land Use Plan Province of Guimaras. 2019). Its ragtag plains, found mostly in the southwest area, are fed by a long process of erosion from the central rolling hills of the island that left a thin layer of topsoil over a compact land of limestone, dolomite, and silica. In this condition, secondary forests abound as a result of almost a century

of forest use along with intentional agro-forestry and the prominent mango, cashew, and other orchard plantation ventures.

The rainy season, which happens during the southwest monsoon from June to September and during the northeast monsoon from October to November, can bring about 25.95 mm of water, usually in August. The average reported temperature is 27 degrees Celsius, but this could drop to 22–25 by December. Overall, given its tropical location, this island with sparse forest remains to produce an alluring ambiance with its fresh, soft wind that continues to stream through the hills, bringing along with it a benign, cool temperature the whole night. This is one of the many reasons why most residents have the desire to go home at all costs each day back to the island, for in just a 15-minute boat ride, one can already feel the enveloping comfort of calmness, quietude, and simplicity you call home away from the restive environment of Iloilo City.

Before the COVID-19 pandemic, motorized wood, and bamboo outriggers at improvised mini ports located at Ortiz Street, Parola, Muelle Loney, or Barangay Lapuz, in Iloilo City, were busy plying back and forth commuters, be they traders, tourists, or holidaymakers, from dawn to dusk each day. But for safety reasons, people are now made to use the larger port, regularly plied by accredited modernized ferries. As in any third-world community and with the absence of manufacturing industries, people are generally tied to land as farmers, in clerical or sales support services supplying the needs of government bureaucracies, or at tourism infrastructures, if not in construction businesses. This limited opportunity, however, did not prevent many from becoming entrepreneurs or finding employment abroad (n = 6,802 in 2015) as nurses, domestic helpers, or ship crew, as testified by the capacity of a good number of those who were able to buidl architecturally designed houses that are scattered across and around the island.

Being surrounded by water, besides fishing and seaweed farming, the province benefited greatly from its tourism industry. This, however, has to find a wider economic niche, given that the province is overshadowed by the prominence, accessibility, and allure of Boracay Island, further north of the region. In a sense, the province has yet to design a strategic path to go beyond its former shadow as a mere offshore and service island of Panay and Negros.

Despite its limited budget, the province has been trying to comply with its health and education mandates. Since 2006, its enrollment rate of 73.43 percent at elementary levels has been steadily improving, which has helped the province maintain a competitive literacy rate, as shown by its cohort survival rate of 98.5 percent in SY 2017–2018. In the health sector, the

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province has sustained its immunization and vaccination efforts and the provisioning of vitamin A and iron to address the prevalence of pneumonia and the observed stunted growth among infants. Likewise, BCG and Hepa B1 were administered as required and as opportunities arose among infants. Follow-up pentavalent and oral polio vaccines were also reported to have been provided (Profile of Guimaras, 2018).

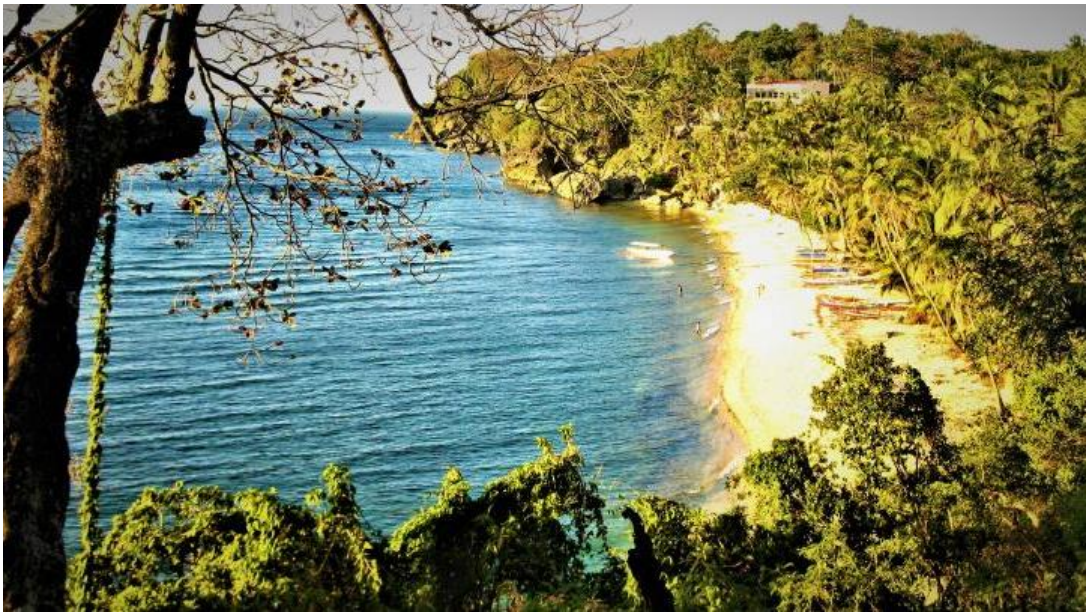


Because of its safety features, after the COVID pandemic, this type of boat became the mandated mode of transportation to Guimaras Island, visible in the background. (Sansait, personal collection).

Like the rest of the provinces lacking in archaeological evidence suggesting their prehistory, Guimaras came into recognition only with the first mention of the island by Governor General Dasmariñas in his report to the Spanish King dated June 20, 1591, regarding the Augustinian friar-led missions under the parochial jurisdiction of Oton (History of Guimaras, 2018). Because of friar quarrels over saving souls in the Orient, in 1742, the island was transferred to the care of the newly arrived Jesuits, and so the supervision was shifted to the Jesuit Dumangas Parish. But with the Jesuit expulsion in 1768, the Guimaras' mission fell into the hands of the favored Dominican friars. By the last quarter of the 19th century, one of the several pueblocitos, or little towns in the southwest of the island, had grown into a stable, sufficiently large, and compact community in Navalas that justified the construction of the Baroque-style church, with San Isidro de Labrador as the patron saint. Most likely, if not for the incursion of the Americans and the Japanese, other pueblocitos (Nayup, Nabilhan, and Igang) would have had their churches built as well given the momentum of the reform which the church was initiating then across the country. One of the testaments to the Spanish's renewed interest in developing the country, though late, was the construction of the Faro de Punta Luzaran in 1896.

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With Spain wanting to get over her parochial mercantilist policies in the country, at the second quarter of the 19th century, she opened international ports in various strategic provinces, one of which was Iloilo. This paved the way for the arrival of a visionary entrepreneur, the British Vice-Consul assigned in Iloilo in 1856, Nicholas Loney, who wanted to flood the market with British textile fabric, outcompeting the Chinese imported and locally household-made fabrics. To increase his revenue, he initiated the large-scale production of sugar through the hacienda system in Negros and Panay by giving investors access to seedlings and machinery through credit. To expedite efficiency, trains were procured, and rail track networks, roads, and warehouses were also built as conduits in the great enterprise that connected, through direct trade, the sugar-producing region to the markets of Europe.



Guimaras has a lot to offer, from picturesque coves and grounds to profitable and welcoming hills, attracting investors and competitive real estate companies. In addition, the region is endowed with an industrious and culturally rich people, whose recognition and close inclusion in the region's development objectives would probably benefit everyone. (Sansait, 2009).

Meanwhile, despite the burgeoning economy based on sugar-fabric tandem enterprises in Negros and Panay, Guimaras remained a passive entrepot between the two islands. As of today, the colonial houses and major streets in Negros and Panay bear the names of those who benefited from this deal. Nonetheless, the most obvious involvement of Guimaras could be seen through the defunct storage facility in Jordan, and in no small sense, the island itself has a perfunctory participation. Due to its being located strategically just a small sea channel, its presence did and continues to protect foreign ships while berthing along the Panay Gulf from

storm surge. But passive though the role of Guimaras may be, nonetheless, vast areas of the island and the islets surrounding it were not spared from ownership by those who profited from the sugar industry boom.



This defunct storage and transshipment facility is a testament to how Guimaras played an important role during the sugar boom at the turn of the 20th century, which fueled the rise of the landowning middle class in the region. (Sansait, 2009).

At the beginning of the Philippine-American war in 1898, when the Spaniards were scuttling around before ritually surrendering at many places and returning home to Spain, the American navy and cavalry were equally busy, pursuing their goals to seize every port and to force the surrender of Philippine nationalist defenses (Constantino & Constantino, 2008; History of Guimaras. 2018). One of the dramas happened in Iloilo when the American navy and infantry forces were on their warships had to grumpily wait for directives to attack – at least for more than a month at Panay Gulf – for the signing of the tragic Treaty of Paris and the McKinley's sham benevolent assimilation policy. Nonetheless, the subsequent events probably convinced the Americans, headed by Douglas MacArthur in 1908, of the strategic position of Guimaras, so they decided to build viable ports and roads at various locations of the island, including that found in the municipality of Buenavista. While MacArthur in effect continued what Loney had started, he did something more for Guimaras by constructing various infrastructures, including a military headquarter and fortifications, and by conscripting local labor. In a sense, he expedited the economic activity of the province.

The Japanese interlude was such an annoyance to the populace's relative tranquility that, except for some memories of trauma, fear, and bravery, everybody was eager for the

continuation of material progress under a peaceful setup. Little by little, those once scattered small villages were transformed into compact towns, to be governed by appointed leaders who were soon replaced by elected ones in a *rigodon* fashion by family and in-group members since leadership then required language competency and literacy besides prestige and economic status, which only a few could afford. Despite the many political upheavals happening in Manila and elsewhere in the region, Guimaras remained an economic and political satellite of Iloilo for decades until 1966, when it gained sub-province status, and in 1992, after some lobbying and bickering for positions by local politicians, it achieved its status as a province.



The gleeful Ati youths are once represented on the front web page portal of the Guimaras Province. (https://guimaras.gov.ph)

Across these centuries of changes, one may wonder: where would one insert the Ati's history and contribution, and how should their presence be incorporated into the evolving public consciousness of the province? To what extent were they recognized or ignored in a small island community with whom they too likely had a share of distress and pleasure across the colonial years up to the present? Today, despite their marginal lives defined by poverty, recognizing that they are still around suggests that both they and their surrounding community have in a sense built a working, if not meaningful, understanding and interaction.

The perceived serene, contented, and joyful lives of the indigenous peoples are not symmetrical across the globe. The world over, literature abounds with research and testimonies of the lives of indigenous peoples threatened, if not traumatized by dispossession, poverty,

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illiteracy, unemployment, discrimination, and state neglect. Their obstinacy to carry on their traditional habits, which are looked upon as archaic and a burden to society, puts them outside any government projects and programs. But since most of these people are in resource-rich lands, they are often the target of harassment, bribery, militarization, and abuse, if not victims of genocide.

In Guimaras province, the Ati people were lucky enough to be included in the web page of the province, section 17 under the Social Services Category, just ahead over the last topic about poverty (Guimaras profile. 2018). This might be unintentional, but this shows the real position of the Ati people on the island: their less than 300 recorded households are minimal and declining. Given that their economic contribution is almost negative, this may put them as a liability to the province and so their integration and relation to the general populace are generally expressed in a passive modality. In other words, they are just around, probably something of an anomaly to the province's desired goals and wishes. In contrast however, there must be something in their existence that while they do not reap proportionate economic and social benefits, the province's put them in that webpage at the center stage, appearing gleeful and celebrating.

However, the texts narrated in the province's web page is in contrast with the mood espoused in the photo. The meager ten sentences devoted to the Ati probably is more than enough to appease the people who were supposed to live in resettlement areas. Nonetheless, the web page's honesty must be recognized about the people who are still "in private lands, which they cannot call their own" (Guimaras profile, 2018). This idea of a resettlement is a problem in and of itself since, before the founding of the republic and of the province, they were already existing in the region or in this wider archipelago. In this context, most likely what is happening to them today, is just an extended version of colonization in the local setting. Thus, at this age, it is always a mark of a prudent and humane society to keep its laws and rationality attuned to advance the dignity of all, which includes acceptance and tolerance of differences. This also reminds everyone that there is so much happiness that awaits everyone given the willingness of those in power to work out a society towards a healthy coexistence across history and cultural life.

Probably without the inspiration and mechanism to accommodate the land question, the prevalent idea is to admit that the province has not identified any ancestral domain land for their remaining surviving indigenous people. However, in a separate government report, it is claimed

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that as much as 95 percent of the land area in Guimaras is alienable and disposable. The reluctance therefore to allow the Ati to prevail in their autonomous claim of ancestral land is that much of these lands are reserved to private claimants, who, though they might have all the privilege of owning legal proofs, yet have not tilled any piece of land in Guimaras.



This photo reminds policy makers of the importance of early positive experiences of friendship and group identity, especially among young people, to generate the esteem necessary for everyone's mental well-being. (Sansait, 2009).

This inability to resolve the land problem of the Ati people reflects the fate of almost all indigenous peoples of the world in as much as doing good to a displaced minority group may upset the general populace, who are in the mainstream of socioeconomic and political life of the country. This latter populace too had a share of suffering, poverty, and unemployment, and so the urgency could not just be raised with an indigenous group in respect to providing fair services to all. These concerns, however, should not be an obstacle but rather an opportunity to reconsider various options that could open up a host of positive actions for the benefit of everyone.

The description further notes that besides poverty, there is among the Ati community a prevalence of school dropouts and malnutrition, as well as a lack of farming tools, a potable water supply, and personal hygiene. With all these, without any intervention, it is likely that

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these people, especially the children, will be locked in a cycle of discrimination, if not bullying. Further, the last paragraph devoted to the Ati reads, "Interventions for persons with disability and senior citizen are also given priority in the province" (Guimaras profile, 2018). Probably, this is an adjunct with the noble intention that there is an earnest effort to address the problems of the province, but with a mark of distinction by associating the problems of the Ati people close to a disability, and so intervention is required.

Looking at the common folks' experiences living outside the Ati resettlement area, the apparent ordinary habits of the rest do not merit any special treatment as a separate constituent of the province. In a sense, everyone around has a fair share of poverty, landlessness, and unemployment, and so it would be inconsistent that the Ati be given priority over those who are active in the socio-economic and political life of the province. The same goes within the minds of local leaders given their limited resources: they could not accommodate everyone. So, the best way forward is to keep the traditional connections and conventions of governance intact, which would keep the patronage of the electorate in order to preserve one's political life, being the source of income and family security. The most apparent question would likely then be, "Why would not the Ati people strive like the rest of the community, given that all their grievances are similarly experienced by the rest? Why would they not discipline and educate themselves to become competitive individuals in the modern world, where they would likely be welcomed as victors?

These questions, besides assuming too much about economic comparative advantage, connote pitting the Ati against the rest and are so divisive. Besides, they too glossed over the continued historical and cultural trauma these once-foraging people are experiencing and so downplays their unique heritage and potential to determine their lives without antagonizing the larger society. There is actually no need to look any further to find a workable alternative for a meaningful development that accommodates the province's indigenous people's aspirations than to reread and reflect upon various United Nations principles and doctrines expressed in its Social Development Goals, the WHO Comprehensive Mental Health Action Plan 2013–2030, the Sustainable Development Goals, the 2007 United Nations Declaration on the Rights of Indigenous Peoples, and the International Labor Organization Convention No. 169, among others.

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In implementing this Declaration, special attention will be paid to the rights and special needs of the elderly, women, youth, children, and indigenous people with disabilities.
(UNDRIP, Art. 22, nos. 1, 2007)

3. MENTAL HEALTH AND INDIGENOUS PEOPLES IN LITERATURE

3.1. Humanity's Incipient Quest to Mental Health

"Men sana in corpore sano"
- Juvenal

The quest for mental health has always been part of humanity since the rise of *Homo sapiens*, which were noted through cave paintings and on bone remains that show care of the sick (Greshko, 2018; Curry, 2020). While these are external behaviors, nonetheless, they revealed the workings of the mind that, in doing these arts or any representations done by the producers, could elicit satisfaction through those processes. Or perhaps the recipient or spectator of the act could find meaning, connection, and relief that will enhance their confidence in life, and in the end, those early forms of encounters or engagements, though in an abstract fashion, would likely be mentally satisfying if not curative (Marchant, 2016).

In the past, people were not devoid of pleasure and difficulties, and in their experiences of wonder, fear, or inexplicable incidences in life, they practiced adaptive mechanisms that would allow them greater control over their existence. Understandably, then, one of the earliest professions was that of a shaman or healer, with roles involved in the cycle of life and death faced by each family (Brazier & Murrell, 2018; Wilson, 2011). Certainly, in each ritual divination, dream interpretation, or in many forms of their songs and dances, and in their protective habits and superstitions, the desire to recapture, regain, or sustain their recognized or desired idealized self, health, or community life could be filtered out (McClenon, 1997; Thomson et al., 2023). Thus, mental health, whatever or wherever its manifestation may be, is always embedded in the health of the body and, by extension, in the stability of the social world.

When Descartes attempted to salvage the epistemology of knowledge, he dissected the whole person into two irreducible phenomena: the mind and the body (Jones, 2001). This might not be a medical field of analysis, but he opened the idea of a mind that, though separate from a mechanically extended body, is united in the process of forming ideas and interpreting reality. His discussion of the nature of human mind and reasoning could be identified as a turning point in philosophy and science that produced current approaches to mental health as an integral experience of body and mind. Nonetheless, despite the prevailing mechanical or medical interpretation of the mind, scanning through history across the globe, the practice of resolving

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mental illness could be located way earlier and from various origins than what is conventionally thought.

Perhaps even much earlier than what the Mesopotamian civilization could inform science, the practice of exorcism, atonement, incantations, and rituals could be found in various ancient texts (Strahil, 2018). In those time, the prevailing assumption then was that the unconventional, if not bizarre, behavior of people was the product of demons or evil spirits that took possession of the victim. Rituals in various forms, from dance to votive offerings to week-long incantations, were then necessary to relieve, if not drive, the devils away from the possessed person. One advanced method then involved a primitive surgery on the brain called trepanning, to open the window where the devil could be sucked out (Handwerk, 2023; Foxhall, 2018). The interpretation might be ancient, but the practice is so advanced since it requires a specialist, a good understanding of cranial structure, and a recognition that the head is the locus of the problem.



Except for poverty, old age is appreciated and bearable in the Ati community, as is its contribution and functionality in everyday life. As bearers of tradition and memory in the community, the anxieties, and trepidations they may have, are compensated by the respect and care of the people around them. (Sansait, 2009).

Between the 5th and 3rd centuries BCE, Hippocrates held that there were four essential elements—blood, phlegm, yellow bile, and black bile—that, by their unique composition, could define the state of health and mind of a person (Breitenfeld et al., 2014; Van der Eijk, 2002). This simple suggestion moved the burden of mental health explanation from myths to empirically verifiable facts of life and thus paved the way for a holistic approach in medicine.

But, in the prescribed set of remedies, rather than involve a continuation of ancient understanding of the brain, the Greeks favored the practice of the arts since it was thought there is symmetry, harmony, and balance in music and painting, and catharsis in theater (Conrad, 2010). The Greek approach had similar imprints in Egypt, Babylonia, and the Near East region in the promotion of healthy activities (David, 2008). In the Middle Ages, traces of the Hippocratic principle could be found in the use of laxatives or emetics as a way to purge impurities in the body and through tapping specific veins, the use of leeches, or cupping (Witts, 1937; Runwal, 2022). Through bleeding out the excess elements of the body, it was hoped that balance could be restored. This sounds Chinese in their yin-yang principle (Wang, 2022).

In the Middle Ages, the recurrent war and experiences of torture, criminality, famine, poverty, and plague created disproportionately high stress levels for the populace, which did not favor a healthy lifestyle (Forcén, 2016; Hurlock, 2019). Those who ended up mentally ill were either found in the streets or locked up inside the houses, and as always, they were the source of embarrassment and an economic drain. To relieve the families from burden, asylums and hospitals were created, with Baghdad in 792 CE as the first to open, then in Spain (1406), followed by Mexico (1566), France (1641), and Vienna (1784), among other cities (Berdzenishvili, 2022; Perez, et al., 2012; Ikkos, 2017; Houston, 2019). But rather than treat the illness, these hospitals rather functioned to restrain the patients, thus preventing disturbance. In effect, the patients were often shackled to the wall and kept in a dark room in unhygienic conditions. Religious institutions too were recorded to display their care in a manner fit to their beliefs; thus, rather than creating care institutions, they had madhouses where patients were made to pray to atone for their sins (Ruggeri, 2016). In the United Kingdom, some mentally ill people were even used as sources of entertainment in various freak shows (Historic England, 2023).

In 1792, Philippe Pinel made a breakthrough with his advocacy for a healthier lifestyle and in treating patients with care separate from criminals (Woods & Carlson, 1961). For the first time, mentally ill people were seen as less of a threat since they could be remedied with proper medication and attention. This medicalization of mental illness was later adopted in England and the United States, with varying degrees of success, and in line with Pinel's moral recovery advocacy, the electroconvulsive therapy (ECT) of Cerlett and Bini in 1935 was experimented (Science Museum, 2019).

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However, it was the discovery of chlorpromazine after World War II that revolutionized psychopharmacology starting in the middle of the 1950s (López-Muñoz, et al., 2005). Later, with the discovery of monoamine oxidase inhibitors and tricyclic antidepressants in the 1970s, and despite their limited early success, the subsequent improvements resulted in many patients moving out of psychiatric wards and living fulfilling lives (López-Muñoz, et al., 2008). As of now, there are several drugs being developed, and many are still in clinical trials, which would likely result in a speedy recovery if not a healthier lifestyle for many.

While institutional inpatient care resulted in better treatment of mental illness, the increasing number of patients against the limited facilities and staff led to a decline in the quality of care. To prevent a return to medieval times, Dorothea Dix, a nurse in the 1840s, dedicated her life not only to the care of mentally ill people but also campaigned for more psychiatric hospitals in the US (Parry, 2006). But by then, with new effective drugs on the market, the trend towards the deinstitutionalization of care will become more acceptable in the long run.

Deinstitutionalization, besides contributing to a renewed sense of confidence in life for others, has its own challenges, like the financial and psychological cost of caring for an ill person (Turner, 2004). Some, due to poverty and without supportive families, had difficulty with their social reintegration (Bjørlykhaug et al., 2022). A middle ground solution is thus now popularized by including in the responsibilities of the care institutions their continued professional support and monitoring even after the discharge of their patients.

As ever, mental illness carries with it a stigma, being implicated as a sign of shame and weakness in either one's character, genes, or identity. Since it is socially experienced and sustained, the fear of receiving this stereotype poses a big wall to treatment, as it prevents one from obtaining proper and timely care (Cacciatore, J. Frøen, J., & Killian, M. 2013). This experience of discrimination, if not resolved early on, will simply result in hopelessness, guilt, and self-pity that may weaken the family's sense of integrity, economic security, and social life (Yakeley, 2018).

With wide available resources to treat mental illness, yet due to inequality, which is greatly felt in third-world countries, mental health treatment takes on a moral dimension. Because of the lack of access to effective and timely treatment and the lack of health professionals, mental health remains a great source of stigma, discrimination, and economic and social burden for patients. In this background, in spite that the Ati people will likely receive timely and quality medical treatment soon for their mental health experiences, the best that social researchers could

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supplement further is to make sense the available laws, policies, and documents in their behalf reflective of their needs and status. Through this review and analysis of various ethnographic records, and by incorporating the lessons towards the realization of a culturally sensitive UN Mental health plan, various government agencies and the Ati likewise will likely achieve a framework that is mutually beneficial, cost efficient, and culturally responsive.

> *The states shall establish and apply, together with the indigenous peoples concerned, a fair, independent, impartial, open, and transparent process, which recognizes the laws, traditions, customs, and land tenure systems of the indigenous peoples, to recognize and judge the rights of the indigenous peoples. indigenous peoples belonging to their lands, territories, and resources, including those that have traditionally been owned or occupied or otherwise used. Indigenous peoples will have the right to participate in this process.*
> (Art. no. 27, UNDRIP, 2007)

3.2. Tracing back the early steps of the United Nation's Mental Health Plan

> "*As the world's leading public health agency, WHO has one, and only one option – to ensure that ours will be the last generation that allows shame and stigma to rule over science and reason.*"
> Dr. Gro Harlem Brundtland

The previous topic reminded us that humanity has never been indifferent to anything that upsets health and a pleasurable life. Second, approaches to health were mostly determined by people's beliefs, knowledge, and available technology. Third, while the medicalization of mental health has created positive hope for the sufferers, the deinstitutionalization of care does require substantial financial and emotional burdens beyond the capacity of ordinary citizens. Lastly, stigma and discrimination will always compound the pain of those suffering from illness, given that access to effective and timely interventions is far from the reach of most of the poor and marginalized sectors of society.

This second part moves the focus and urgency to address mental health problems from individual communities and states to a greater united act informed by updated knowledge. At first, the approach was selected based on the emerging medical knowledge of the brain and behavior, but soon it encompassed the social conditions that predispose to the occurrence of mental illness. Then, to recognize and address an individual's right to health, the United Nations and other governing bodies associated with it, like the World Health Organization, and further,

the World Bank, including the International Labor Organization, among others, openly and consistently advocated for the acceptance and realization of a universal mental health policy across the globe.

In 2001, the World Health Organization came up with the report entitled "Mental Health: New Understanding, New Hope." Although it was published more than two decades ago, this WHO report echoes the same topics that are deemed important today (Brundtland, 2001). By reading it, the core insights remain valid for the understanding of mental health and the role of the government, health advocates, and researchers, among others. It was centered on the new breakthroughs in science, especially in the key operations of the brain that are considered to direct behavior, plus new inputs from psychological and behavioral fields. Thus, armed with this new incontestable empirical evidence on neural and genetic science and applying these to mental health, the paper's theme is apt in its claim, "new understanding, new hope."

The unprecedented attention given to addressing mental health issues was brought about by three historical events. Firstly, in the field of psychopharmacology, with the discovery of new neuroleptics and antidepressant drugs along with new forms of psychosocial interventions, Secondly, the phenomenal advancement of the recognition of human rights just after the establishment of the United Nations. Lastly, upon the birth of the WHO, the mental component was positively acknowledged to be within the definition of health.

This hope, which has been rekindled, aspires that the WHO document should guide governments in promoting mental health for all. The idea that genetic, biological, social, and environmental factors are inseparable sustained the view that in treating patients, it should be in a holistic manner. In doing so, efforts should be informed by the rights of the mentally ill, which prohibit discrimination in access to care, the right to be treated in one's community, and the fact that the treatment should not be intrusive and restrictive. With this new insight, the lessons at hand become an opportunity and a challenge not only for health professionals and governments but also for various communities and the public.

While many suffer silently due to mental illness, not only personally but also due to stigma and social exclusion, it is emphasized that when properly responded to by governments, given the availability of better care paradigms and medicines, remedies "can be obtained at no great cost." Thus, this report, in broad terms, was aimed at raising public and professional awareness through the provision of updated knowledge about mental health, forwarding analysis of factors affecting mental health, examining the systems and infrastructures affecting the delivery of

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health care, and enumerating broad actions that could be dynamically adapted in various community contexts. The core ten guiding principles are:

1. Provide treatment in primary care. To enable it to become efficient in the provision of care, training and refresher courses should be available to personnel based on their specialization needs.
2. Make psychotropic drugs available. Drugs, as the best initial approach to severe cases, should be made available through the enactment of the necessary legislation and policies.
3. Give care to the community. At the community level, treatment is cost-effective and, at the same time, often the best location where the human rights of patients are best protected.
4. Educate the public. By increasing awareness through the facts of mental illness that it is treatable and enshrined in human rights, stigma and discrimination could be reduced.
5. Involve communities, families, and consumers. Since mental illness has a social dimension, communities, families, and consumers must be involved in the process of crafting programs and policies affecting mental health.
6. Establish national policies, programs, and legislation. For mental health programs to be sustained, relevant laws with adequate funding must be enacted.
7. Develop human resources. Especially in third-world countries, care professionals must be updated with relevant training, especially specialists, to work side by side with the creation of health teams.
8. Link with other sectors. Through their specific experiences and orientations in life, nongovernmental organizations and other sectors of society can play a role in the rehabilitation and prevention of mental illness.
9. Monitor community mental health. Monitoring is important since the measurement of indicators and the data obtained can inform the program of the subsequent intervention required.
10. Support more research. With new knowledge on the factors and variables affecting mental health at the local and international levels, effective interventions could be developed. In many developing countries, the capacity to do research must be scaled up.

Minding the financial and resource constraints of poorer countries, the United Nations, with its technical and developmental agencies, has the mechanism to assist them in establishing infrastructures, training personnel, and building research capabilities. In these countries, no matter how resource poor they are, "training of all personnel, making essential drugs available at all health facilities, and moving the mentally ill out of prisons" can be applied (Brundtland, 2001).

In this WHO report, mental health as subjective well-being is associated with "perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others." Whereas these concepts can be

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scholarly assessed, the cross-cultural perspective remains a big challenge given the differences in conditions, experiences, and meanings people attach to their behaviors. Nonetheless, the conventional view that mental health is a lack of mental disorders leads the WHO to reconsider the advances in neuroscience to explain the mechanisms of the brain as the seat of awareness, interpretation, and behavior. The newer medical knowledge discussed the following interesting components and processes of the brain: neurons, neuroglia, synapses, transmitters, and circuits. While these core factors operate in a very complex way, genes and the social environment may also confound neural interactions.

While genes may affect brain structure and processes, it has been shown that the brain "remains plastic across the lifespan." This means that although the brain has a genetic template, subsequent exposure of the child to affection or trauma in the social world may lead to a different trajectory in character and mental states. This malleability of the brain likewise offers hope to scientists, since with this potential, it could be argued that recovery is possible for many given positive interventions in life. However, for many, no matter how promising help can be, the path is difficult or impossible given their poverty and the inaction of the government. This scenario is well captured in the WHO diagram about the "vicious cycle of poverty and mental disorders," linking mental illness to limited economic opportunity, which would lead to poverty and eventually back to vulnerability to mental problems (Brundtland, 2001). A special mention goes to women's welfare, which should not be set aside since in many contexts their conditions and roles are left unappreciated or not taken seriously.

In all these cases, to address the gap in the delivery of services or in knowledge, the document recommends taking up the integrated public health approach. Having this in mind, the following goals could be fully addressed:

1. formulating policies designed to improve the mental health of populations
2. assuring universal access to appropriate and cost-effective services, including mental health promotion and prevention services
3. ensuring adequate care and protection of human rights for institutionalized patients with the most severe mental disorders
4. assessment and monitoring of the mental health of communities, including vulnerable populations such as children, women, and the elderly
5. promoting healthy lifestyles and reducing risk factors for mental and behavioral disorders, such as unstable family environments, abuse, and civil unrest
6. supporting stable family life, social cohesion, and human development
7. enhancing research into the causes of mental and behavioral disorders, the development of effective treatments, and the monitoring and evaluation of mental health systems

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The document has only mentioned the indigenous peoples once: that they are migrating to cities because of urbanization, and so it was assumed such an event would likely create a threat to their mental health. The generalized silence over the cases of indigenous peoples could be the result of the enthusiasm of the WHO for the breakthroughs in knowledge of the processes of the brain that seem to easily shorten mental health problems. So, the paper has a consistent view that, given government attention and budgeting, mental health could be fully addressed. But the cases of the indigenous peoples remain a challenge, given that many of them still live in an atmosphere of discrimination and cultural trauma even before the onset of any mental health condition. Thus, their stigma could be multiplied, and their experience of mental health would likely be complicated by their unique conditions as a nearly segregated people besides sharing the poverty, landlessness, illiteracy, and unemployment of most of the population.

As the report offers hope, there is indeed reason for optimism, as the same paper contains numerous concepts that may work favorably for the needs of the indigenous peoples. With a culturally appropriate modification, the concern for indigenous people's mental health could likely be addressed. For example, in a graph depicting the cycle of poverty, the concept of social and psychosocial factors could just be extended to include the unique or separate experiences of displacement and stigma of the indigenous peoples. Likewise, in another graph depicting the needs of people with mental health problems, the community as a category is included, which could also be extended to various indigenous people's communities' conditions. Overall, since none of these concerns could not be applied directly to indigenous peoples, thus, without specific focus, programs like this could easily be interpreted as an extension of subtle indifference to their plight, who historically have been marginalized if not suppressed in their own basic wants and needs. Anyhow, this document will always be a welcome inspiration to in building an appropriate mental health program based on the indigenous people's experiences and needs.

> *Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals, and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.*
>
> (Article 24, no. 1., UNDRIP, 2007)

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3.3. The United Nations Declaration on the Rights of Indigenous Peoples and the Grand Challenges in Global Mental Health

Fundamental to succeeding documents is the United Nations' affirmation of how crucial it is to recognize the rights of the indigenous peoples for their survival as distinct peoples. This idea is articulated in the Declaration on the Rights of Indigenous Peoples (UNDRIP, 2007), which recognizes the rights of indigenous peoples to self-determination (articles 3 and 4), their collective right to own and control their lands and resources (articles 25–27), their right to free, prior, and informed consent in relation to legislation, measures, and projects that may have an impact on their rights (articles 10, 11, 19, 28, 29, and 32), and their right to participate in decision-making processes (articles 5, 18, and 27). Overall, the report hopes that with due recognition of these key indigenous rights and lessons learned from history and world events, the UN Sustainable Goals will bear good benefits for all.

Meanwhile, as regards to the construction of mental health as a global concern, one of the first initiatives in contemporary history that calls for its concrete and comprehensive approach or resolution happened in 2011. Due to the increasing incidence of mental, neurological, and substance abuse (MNS)-related illnesses side by side with relatively little research about them, a consortium of researchers, advocates, and clinicians endeavored to come up with a grand agenda to address this gap and likewise to call for urgent action and budgeting. This initiative, entitled "Grand Challenges in Global Mental Health," "has identified priorities for research in the next 10 years that will make an impact on the lives of people living with MNS disorders" (Collins et al., 2011).

There were in total 594 nominated researchers, advocates, program implementers, and clinicians on the panels, representing diverse fields from genetics to behavioral sciences. In general, the group will have to identify, in three separate phases, "a specific barrier that, if removed, would help to solve an important health problem. If successfully implemented, the intervention(s) it could lead to would have a high likelihood of feasibility for scaling up and impact." In Round 1, the participants identified 1,565 challenges in global mental health, which they reduced to 154 and ultimately to 40 in Round 2. Then, at Round 3, after the panelists had ranked "each challenge on a four-point scale for: ability to reduce disease burden; impact on equity; immediacy of impact; and feasibility," they then weighted the scores to produce a list of challenges.

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With this data at hand, they proposed that the best measure in addressing the challenges is the use of a life-course approach as "MNS disorders begin or manifest early in life," the inclusion of family and communities to cover the issue of "social exclusion and discrimination," and lastly, the importance of recognizing the relation of environmental exposures to each disorder. With poverty, conflicts, and natural disasters continuing to undermine the human population, the convenors and participants call for all researchers, funders, organizations, and advocacy groups to at least address one of the challenges in collaboration with stakeholders for "integrated research and policy interventions" as a long-term investment for the wellbeing of all.

While the Grand Challenges initiative was in its initial stage of finalizing proposals for targeted programs, the United Nations Inter-Agency Support Group (IASG) drafted a special report on the health of indigenous peoples in preparation for the 2014 World Conference on Indigenous Peoples, of which two important sub-topics are deemed important. One is on topic 1.3, which recognizes that while mental health is a negative condition, it could nonetheless be remedied by access to health services, goods, and facilities, including traditional medicine, clean water, sanitation, and enough trained health workers. Furthermore, in Topic 2.2 on Traditional Health Systems, this is defined to "include the entire body of ideas, concepts, beliefs, myths, procedures, and rituals (whether explainable or not) connected with the maintenance of health or health restoration through the treatment of physical and mental illness or social imbalances in a particular individual, community, or people." It thus calls for complementarity and alliances so that by incorporating local skills and voices into national health care systems and at all stages of health care development and implementation, further marginalization and discrimination may be mitigated.

It should be recalled at this juncture that the concept of health has already been operationally described—as the simplest yet the most straightforward one—in the 1946 Constitution of the World Health Organization as "a state of complete physical, mental, and social well-being." Thus, it is not a mere absence of illness but the positive improvement of those three categories, which could be achieved through the principles of equity, involvement, and partnership in health (Rutgers Global Health Institute). Other concepts that would continually surface have likewise been defined in the same constitution, such as: a. equity, which refers to the elimination of disparities and greater access to health care; b. involvement, which refers to the participation of different disciplines and perspectives towards a holistic

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solution; and c. partnership, which involves the active exchange of resources and capabilities to attain the best "practical and long-term solutions" to the health problem.

3.4. Intervening Documents: The UN's Department of Economic and Social Affairs' State of the World's Indigenous Peoples: Indigenous Peoples' Access to Health Services

> *States shall also take effective measures to ensure, where appropriate, that programs for monitoring, maintaining, and restoring the health of indigenous peoples, as developed, and implemented by peoples affected by such materials, are properly implemented.*
>
> (Article 29, no. 3, UNIDRP, 2007)

By 2015, the State of the World's Indigenous Peoples: Indigenous Peoples' Access to Health Services, Volume 2 by the UN's Department of Economic and Social Affairs (DESA) had come out of press (UN DESA, 2015). This document starts with a lucid reminder of the United Nations' great milestone with its Declaration on the Rights of Indigenous Peoples (UNDRIP) in September 2007 that, after more than 20 years of debate, has been signed by most states. In the years that followed, other mandated issues were reviewed and updated as well, like the right to health in the 12th session of the Permanent Forum on Indigenous Issues, which includes "the well-being of an individual as well as the social, emotional, spiritual, and cultural well-being of the whole community." This further echoes the 2007 UNDRIP, which notes that "indigenous peoples have the right to be actively involved in developing and determining their health programs; the right to their traditional medicines; the right to maintain their health practices; and the equal right to the enjoyment of the highest attainable standard of physical and mental health." This was considered a big step from the first forum in 2009, when it only examined broadly the emerging issues to promote awareness of the core issues affecting the indigenous people.

In this report, the core threats to Indigenous peoples' health status are linked to destruction of their lands, territories, and resources, and the major obstacles for them to access health care include geographical isolation and poverty, discrimination and racism, a lack of cultural understanding, and the sensitivity of health systems, usually because of a lack of data. In addressing these gaps, it was recommended to include the indigenous peoples in the design and

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implementation of program stages as well as in utilizing their cultural meanings and language. But the bigger view was the recognition of the historical harm done to them through colonization and assimilation policies, including the imposition of foreign development models that led to their further experience of discrimination. All these will always happen if they are not given the opportunity to exercise their "right to determine their own policies, strategies, and interventions."

The document likewise advanced a working definition of "indigenous" as phrased by Martinez Cobo, which pertains to people who self-identify themselves as a distinct group through culture, language, and history, have been in their territory since pre-colonial times, and are, although non-dominant, "determined to preserve, develop, and transmit" to future generations their identity and cultural lifeways (UN DESA, 2015). From this view, an indigenous person likewise may be recognized through his self-identification, complemented by the recognition and acceptance of a group that has the "sovereign right and power to decide who belongs to them without external interference." This formula is also expressed in Article 33 of the UNDRIP.

Meanwhile, the ILO Convention No. 169 (1989) identifies indigenous peoples as those who are descended from people who have retained their pre-conquest cultural, economic, and socio-political systems. These definitional modifications were made to accommodate other groups that, although they had no experience of colonization, had, or continued to experience "subjugation, marginalization, dispossession, exclusion, or discrimination." The core basis of these is their self-identification, together with their deep attachment to their land and tradition, which are crucial to their "collective physical and cultural survival." Lastly, it listed the 21 documents since 1957 up to 2014 as a testimony of the UN's resolve to advance indigenous people's welfare, which could be a resource for researchers and advocates alike:

1. 1957: ILO Convention 107 on Indigenous and Tribal Populations is adopted (http://www.ilo.org/ilolex/english/convdisp1.htm)
2. 1972: The Study of the Problem of Discrimination Against Indigenous Populations is Launched (also known as the Martnez Cobo Study)
3. 1982: The Working Group on Indigenous Populations is established by the United Nations. (http://www.ohchr.org/english/issues/indigenous/groups/groups-01.htm)
4. 1984: The Study of the Problem of Discrimination against Indigenous Populations is submitted to the UN
5. 1985: The Voluntary Fund for Indigenous Populations is created

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6. 1989: ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent States is adopted. (http://www.ilo.org/ilolex/english/convdisp1.htm)
7. 1992: The Rio Earth Summit adopts the Convention on Biological Diversity (http://www.biodiv.org/convention/default.shtml)
8. 1993: The World Conference on Human Rights recommends the establishment of a Permanent Forum on Indigenous Issues
9. 1993: International Year of the World's Indigenous People
10. 1994: The first International Decade for Indigenous People is launched (1994–2004)
11. 1994: The Voluntary Fund to Support Small-Scale Projects During the Decade is Created
12. 1998: First Roundtable on Intellectual Property and Indigenous Peoples, organized by the World Intellectual Property Organization (WIPO) (http://www.wipo.int)
13. 2000: Establishment of the United Nations Permanent Forum on Indigenous Issues (UNPFII) (http://www.un.org/esa/socdev/unpfii/index)
14. 2001: The mechanism of a Special Rapporteur on the Human Rights and Fundamental Freedoms of Indigenous People is established by the Commission on Human Rights (http://www.ohchr.org/english/issues/indigenous/rapporteur/)
15. 2002: A Voluntary Fund for Indigenous and Local Communities is established by the Convention on Biological Diversity (http://www.cbd.int)
16. 2003: A voluntary fund is established by the United Nations to support the Permanent Forum
17. 2005: The Second International Decade for Indigenous People is launched (2005–2015), including a fund to support small-scale projects
18. 2005: A Voluntary Fund for Indigenous and Local Communities is created by World Intellectual Property Rights
19. 2007: The UN Declaration on the Rights of Indigenous Peoples is adopted by the UN General Assembly (http://www.un.org/esa/socdev/unpfii/en/declaration.html)
20. 2007: The new Expert Mechanism on the Rights of Indigenous Peoples is established by the Human Rights Council
21. 2014: High-Level Plenary Meeting of the United Nations General Assembly, also known as the World Conference on Indigenous Peoples

Within the same report, Dr. Mukta Lama wrote a subtopic entitled "Access to Health Services by Indigenous Peoples in Asia," which touches the 12–15 million indigenous peoples of the Philippines belonging to seven collective groupings, including the Negrito and Ayta of the Visayas (UN DESA, 2015). Furthermore, Dr. Lama raised the obvious health treatment gaps, which would likely lead to a vicious cycle if poverty, discrimination, illiteracy, and a lack of access to health care were neglected. His data revealed the prevalence of infectious diseases such as tuberculosis and rheumatic fever, as well as higher incidences of lifestyle diseases including obesity, heart diseases, cancer, type 2 diabetes, and physical, social, and mental disorders (UN DESA, 2015).

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While these might be attributed to inaccessibility to proper health care services and poor disease prevention services, the consequential effects of colonization, market expansion, and state neglect, if not the doctrine of assimilation, have a hand in these diseases and illnesses. Necessary intervention is being called for to avoid further disorientation and cultural identity loss among these people by providing them access to quality care, recognizing and promoting complementary indigenous knowledge and practices, allowing the use of cultural meanings and language, and instituting "representation in the health management system."

With this evaluation of indigenous health at hand, states therefore must combat the key social determinants, which include income, education, employment, living conditions, social support, and access to health services—all of which encompass forms of human rights violation. Meanwhile, it reminds world leaders of the earlier commitments they had to the Millennium Development Goals (MDGs) so as not to remain "blind to the needs of social groups such as indigenous peoples with specific conditions of disadvantage," along with the importance of "the relational and holistic concept of indigenous health that defines health and well-being in broader terms than the absence of disease and physical health" (WHO, 2018). These were also stipulated in the ILO Convention No. 169 on Indigenous and Tribal Peoples, specifically in Article 25, which directs attention to resolving discrimination and marginalization in health access and provisions through revitalization of the local language and capacities as well as in partnership and collaboration with the concern groups in improving not only health but the overall socio-economic and political status of indigenous peoples.

On the other hand, commenting on the need to comprehensively understand the mental health of indigenous peoples, Margo Greenwood mapped out the determinants affecting health (Greenwood & Lindsay. 2019; Greenwood, & Leeuw, 2012). She identified three categories: the proximal, intermediate, and distal determinants. The proximal determinants are those that are immediate to the experience of the person, like income, education, and gender, while the intermediate determinants are those in the state dispensation, like health care and educational systems. Lastly, the distal determinants include their broader historical and social experiences like colonization, marginalization, and dislocation. By recognizing how these concepts continually shape the health status of indigenous peoples, researchers and policymakers may better frame their analysis and understanding of this issue.

More than a couple of years later, by 2020, the World Bank published on its website a short feature story entitled "Everyone Equal: The Resilience of Indigenous Peoples Across the

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Globe," narrating the need for government to seek inclusive growth (WB, 2020). This means that by addressing the needs of indigenous peoples, especially their mental health, each country will be greatly benefited, which in the long run will produce a positive economic atmosphere. The article likewise noted that in various indigenous people's communities, like in Asia, which make up two-thirds of their population, given the limited if not nonexistent social and medical infrastructures, any timely help that they may receive may lead to equal, dignified, and empowered lives.

Again by 2021, the Department of Economic and Social Affairs (DESA) of the Secretariat of the Permanent Forum on Indigenous Issues, in its volume 5 report entitled "State of the World's Indigenous Peoples: Rights to Lands, Territories, and Resources," reminds various states about its comprehensive outlook on the fate of the world's indigenous peoples. Proof of its commitment to the indigenous people's welfare is that in 2007 and 2018, it consistently held that the cultural, spiritual, social, and political identities of indigenous peoples are connected to their land, and such is enshrined in a collective relationship. The lesson is clear: wherever there is failure to recognize their ownership of their lands and resources, their vulnerability to displacement, poverty, discrimination, and marginalization is aggravated.

> *Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. The States will establish and apply assistance programs to indigenous peoples for this conservation and protection, without discrimination.*
>
> (Article 29, no. 1, UNDRIP, 2007)

3.5. The World Health Organization's Comprehensive Mental Health Action Plan 2013–2030 and related updates

Concerned about the prevalence of mental and psychosocial illnesses and disorders and their concomitant discrimination and abuse of sufferers on a global scale, the World Health Assembly in 2012 (WHA65.4) proposed "a comprehensive, coordinated response from health and social sectors at the country level" (WHO, 2021). Identified as a priority by WHO's Thirteenth General Programme of Work (GPW13) and endorsed by the Seventy-fourth World Health Assembly (WHA74), this updated report attempts to further reinvigorate the earlier Comprehensive Mental Health Action Plan 2013–2020. In effect, although it keeps the

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emphasis, goals, and methods, the indicators and options for their realization have been modified. Further, rather than duplicate other UN global action plans, this is conceptualized "to create synergy with other relevant programs of organizations"—like the WHO's Mental Health Gap Action Programme (mhGAP), among others—to guide national and local government's action plans in addressing overlapping health concerns (WHO, 2019).

In defining mental disorders, it uses the terminologies contained in the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10), which covers depression, bipolar affective disorder, schizophrenia, anxiety, and autism, among others. Vulnerable groups are identified due to their defining circumstances, which could be appropriately addressed in each national context. Meanwhile, mental health is defined positively "as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Maintaining its fundamental view of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," governments therefore have the primary duty to provide "services, policies, legislation, plans, strategies, and programs to protect, promote, and respect the rights of persons with mental disorders." Furthermore, since health is affected not only by personal attributes but also by social, economic, political, and cultural conditions, vulnerable groups like children, women, and indigenous groups may require special protection and social support.

The report notes the economic toll of mental disorders across the globe, which would amount to "US$ 16.3 trillion between 2011 and 2030. " As an example, depression "alone accounts for 4.3% of the global burden of disease and is among the largest single causes of disability worldwide (11% of all years lived with disability globally), particularly for women. "Among the many consequences if actions are not carried out on time is the exacerbation of poverty and homelessness, besides incarceration and continued stigmatization for many, restricting their rights "to work and education, as well as reproductive rights and the right to the highest attainable standard of health" (WHO, 2019).

The gap between intervention and needs is huge, with 76% and 85% of people in low- and middle-income countries having no access to treatment for their mental disorders, and only 36% of people living in low-income countries are covered by mental health legislation. Likewise, especially in poor countries, there is less than US$ 0.25 per person allocated to stand-alone

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mental hospitals, resulting in poor health outcomes and human rights violations. In addition, there are a few specialized and general health workers who could deliver interventions, like one psychiatrist to serve 200,000 or more people. These limitations and scarcity are not because the countries are poor; often there is an "inequitable distribution and inefficient use of resources."

While advocacy groups and civil society movements for mental health in low- and middle-income countries are few, it is emphasized that basic medicines and cost-effective interventions are available. In these resource-poor settings, the 2008 WHO Mental Health Gap Action Programme's evidence-based technical guidance, tools, and training packages become useful to address this gap. Overall, besides other practical interventions, the key to success ultimately rests on strong leadership, where commitment to health could be desirably transformed into action.

The structure of this plan is guided by its vision, goal, objectives, and principles. The vision includes the concepts of human rights enjoyment, access to high-quality and culturally appropriate care, and freedom from stigma and discrimination. Meanwhile, the goal involves the promotion of the holistic mental well-being of every person, which could be attained through the following objectives:

1. to strengthen effective leadership and governance for mental health
2. to provide comprehensive, integrated, and responsive mental health and social care services in community-based settings
3. to implement strategies for promotion and prevention in mental health
4. to strengthen information systems, evidence, and research for mental health

Along with the objectives are the indicators, which function as guides to measure the achievements of states towards mental health goals. For each member state to maintain a coherent act or program, six fundamental principles and approaches are provided:

1. Universal health coverage. Regardless of age, sex, socioeconomic status, race, ethnicity, or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

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2. Human rights. Mental health strategies, actions, and interventions for treatment, prevention, and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

3. Evidence-based practice. Mental health strategies and interventions for treatment, prevention, and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.

4. Life-course approach. Policies, plans, and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood, and older age.

5. Multisectoral approach. A comprehensive and coordinated response to mental health requires partnerships with multiple public sectors such as health, education, employment, judicial, housing, social, and other relevant sectors, as well as the private sector, as appropriate to the country's situation.

6. Empowerment of people with mental disorders and psychosocial disabilities. Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research, and evaluation.

The WHO recognizes that there "is no blueprint action plan that fits all countries," so depending on the priorities or conditions of each state, the principles above can modify the implementation so long as the accomplishments are recorded and reflected based on the given indicators provided along this plan. Furthermore, as states belong to the larger community, it is expected that each should work with crucial partners like the funding agencies, the academic and research institutions, and various local civil society advocacy groups. The possibility of overlapping roles by these groups could nonetheless be sorted out through regular assessments of their roles in each country.

Finally, in the appendix of the plan are lists of indicators according to the expressed objectives, to which the member states could set their own targets. It is considered important since the information becomes essential to the reporting needs of each member country to have adequate monitoring of the action taken. Since the targets are voluntary and global, there is no expectation that all countries can attain similar results, except that the reported data could provide a total picture of the plan's achievement.

While the aim is to maintain a measurable collective plan and action, other countries may set a higher standard if their situation warrants it. Also, member states are reminded that there

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is an instituted Secretariat that, at any time, is tasked with becoming the source of guidance or providing technical assistance upon request. Thus, by having the "inputs, activities, and outcomes" of mental health programs capture the given indicators, each member state helps in the "building of existing information systems rather than creating new or parallel systems."

As regards the case of indigenous peoples, they are mentioned once in the whole document and are categorized among the vulnerable groups. This is understandable since the focus is on the member states capacity and obligation to provide a mental blueprint for their citizens. Thus, the opportunity is open given that the plan has not failed to centralize the importance of human rights issues and culturally appropriate strategies in the design, implementation, and evaluation of each country's program. In consequence, it is up to the academy and the researcher to enable this plan to become sensitive to the cases of indigenous peoples located in their respective regions.

More than two decades after the publication of the WHO CMHAP 2013-2030, with states preoccupied by other concerns during this period, like the birth of the European Union in 2007, the invasion of Iraq in 2003, the war in Afghanistan from 2001 to 2014, the great recession in 2008, earthquakes in Chile and Haiti in 2010, and the Ebola outbreak in 2014–2016, among others, the plan appears to have been mostly put at bay in many states. But with the continuing prevalence of mental health problems and wanting to achieve its target halfway through 2030, the WHO sends the message again of hope by restructuring the mental health plan to accelerate the participation of all member states. In doing so, it produced a refresher report entitled "World Mental Health Report: Transforming Mental Health for All" that has integrated lessons from the past and has set up a new enthusiasm to keep the focus forward to the realization of its vision.

Mindful that this report will be the template for proposing the incorporation of indigenous people's circumstances, it would be helpful to restate pertinent ideas relevant to contextualizing mental health as a global phenomenon, with gaps that states should address. Part of this is the appreciation that the United Nations World Health Organization, with its mandate and overarching position over the health of humanity, acknowledges the "important role of mental health... in achieving global developmental goals." This is a strong reminder to all member states to strongly appreciate and abide by what is expressed in the UN's Sustainable Development Goals, where the concept of mental health is well articulated, such that it is not merely a condition of the absence of mental disorder since it is a product of a host of interrelated

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factors outside the individual's experiences. In its positive form, mental health falls within the concept of well-being, where each person celebrates his or her own identity and capacity to grow and contribute to the community. It is therefore seen as fundamental to humanity's existence, which calls for states' "promotion, protection, and restoration" wherever and whenever it is necessary.

To sum up again, the key understanding endorsed by the WHO is that mental health is fundamental to one's life and to a community's collective functional identity and development, and so it is affirmed as a basic human right. Further, mental health exists in different forms and degrees among individual individuals, so it has a different expression or mode of appearance in society or in clinical assessment. Impairments of mental health may lead to personal mental disorders and psycho-social disabilities manifested in mental distress, which could cause harm to individuals and to society.

Besides genetic, psychological, and biological factors that require clinical interventions, "social and structural determinants" should likewise be taken into serious appraisal as they expose and put people at risk across different regions of the world. These include "unfavorable social, economic, geopolitical, and environmental circumstances—including poverty, violence, inequality, and environmental deprivation." With this view, the UN would like to project mental health as intersecting realities in the community and interacting with and affecting individual lives. This perspective opens the view that individuals or groups of people could be put at risk given their circumstances by various undermining forces in history and in society.

On the other hand, the UN likewise recognizes the existence of protective factors that could be utilized to build resilience and healing towards recovery and that the states could utilize, such as "quality education, decent work, safe neighborhoods, and community cohesion, among others." With all the risks and threats around, like disease outbreaks, famine, or displacements, identifying or recognizing these protective factors could mean a lot to those who are vulnerable to mental distress. Thus, it becomes necessary for states to adopt mental health promotion and prevention measures utilizing their current understanding of mental health, from its determining factors to risk groups to protective factors.

In the promotion and prevention schemes, the WHO is keen to insist on including "the education, labor, justice, transport, environment, housing, and welfare sectors" to be worked out through "multisectoral collaboration and coordination." In this endeavor, the state could securely implement its program through appropriate legislation, the creation of organizations,

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and the training of individuals to carry out activities promoting mental health. This becomes a question of delivering mental health services to various homes and communities, which may involve specialists and nonspecialists alike, and other platforms from radio to the internet in so far as to make mental health available across diverse populations.

Transitioning these doctrines to the lives of the indigenous peoples requires, furthermore, a reiteration of the UN's urgent advocacy on mental health, which was presented earlier, including the program initiated in 2019: the WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health, which is being operationalized in 12 countries of priority. Another initiative currently in practice is the Mental Health Gap Action Programme in 110 countries in support of quality of life for all. Another document in place that binds UN member countries is the "Comprehensive Mental Health Action Plan 2013–2030" (already discussed above), which covers strengthening of leadership and governance, better strategies at the community level, and research, among others. Further, in response to the "Mental Health Atlas 2020," which reflects so much work to be done in many countries, there is the "World Mental Health Report: Transforming Mental Health for All," which calls for concerted efforts "to deepen the value given to mental health," "reshape" spaces and environments, and "strengthen mental health care" so that the program will become accessible and affordable in its quality delivery at the community level.

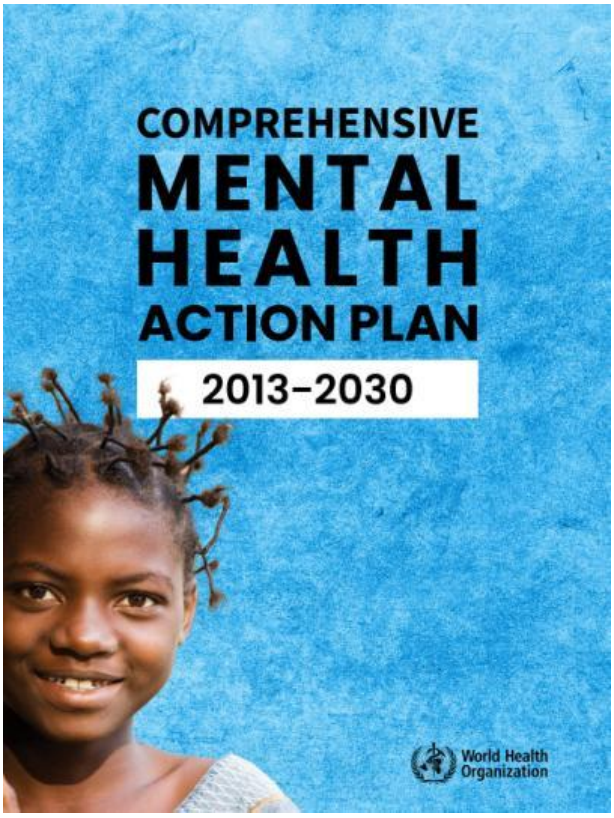
What does this mean for the Philippines? Guided by the WHO Regional Framework for the Future of Mental Health in the Western Pacific Region, the country is challenged to enact strategies that "champion mental health for all," involve "community-based ecosystems of health" and other "ranges of interventions and are underpinned by a responsive information system." The core values that should propel the effort are to see mental health as "critically important for everyone," that it is "integral to well-being," involving "interrelated factors" from the physical to the cultural and spiritual, and that "there are inseparable links between mental and physical health." Overarching all these is the view that mental health is a human right.

How likely are the above paragraphs to address the IPs need for mental health access? In the region where the Philippines is located, the WHO points out that besides the threat of pandemic diseases, the people are facing "a looming mental health crisis" due to "social pressures, vulnerabilities, and unrest," which go along with "rapid and unplanned urbanization." Taking these into account, given the poverty and marginality of small-scale indigenous populations in the country, the urgency of intervention, help, or protection by the state for them

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becomes a serious matter. However, as the WHO stresses, given the vulnerability of these groups, proper consultation has to be observed, sensitive to their condition, and the well-being of the community must be regarded equally as important as well.

While indigenous peoples might have different terms describing their various psycho-social states, the WHO, however, presents the following categories of mental disorders that could undermine an individual's mental health: anxiety disorders, depression, bipolar disorder, post-traumatic stress disorder (PTSD), schizophrenia, eating disorders, disruptive behaviors and dissocial disorders, and neurological disorders. Terms may be different—apart from the clinically prescribed ones—in various localities, but as human beings, these indigenous peoples may experience them at varying degrees and on varying occasions in their lives. In their case, the most important thing is for researchers to characterize their mental conditions in their own circumstances and from a point of view circumscribed by their vulnerability to "poverty, violence, disability, and inequality."



Cover page. 2021. WHO Comprehensive Mental Health Action Plan 2013-2030.

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4. THE ATI PEOPLE: THEIR CULTURE, IDENTITY, LAND, AND NARRATIVES OF MENTAL HEALTH

> *We are not myths of the past, ruins in the jungle, or zoos. We are people and we want to be respected, not to be victims of intolerance and racism.*
>
> Rigoberta Menchú Tum
> The Nobel Peace Prize 1992

This section will narrate the existential conditions of the Ati People and those of other indigenous groups who shared the same fate circumscribed by the laws, values, and expectations of their dominant Filipino neighbors. The first part will include the Ati People's short prehistory, geographic location, cultural practices, land question, and selected notes about their mental wellbeing experiences. Since the paper aims to generate a mental health plan fit for indigenous peoples in the country, especially the Ati community, parallel histories of cultural transformation will be reviewed as well, like those of the Batak of Palawan and the Agta of Casiguran. This description, reinforced by imagery and the appreciation of multiple voices, will show that there is a common thread affecting all former hunter-gatherer groups and so inform policies that should not be too particularistic to the point of being indifferent across space and time. Thus, this endeavor will likely be able to demonstrate that the urgency of the mental health program is not only due to one case of mental vulnerability since the same scenario is likewise encoded in the lives of other indigenous groups at different locations. Lastly, a brief note of Cultural Survival's appeal is included to acknowledge that this paper shares advocacy with other concerned groups for the rights and welfare of indigenous peoples wherever they are.

4.1. The Ati People: A Glimpse of the Past

Several explanations were advanced to explain the presence of the Ati in the archipelago. One is that they came through land bridges that once existed between mainland Asia and the Philippines through the southern route. While it was claimed that they were the aborigines of the country, it is now held that they came second only to the fair-skinned Malay people. Another

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explanation maintained that an enormous geological rupture and disintegration of the peripheral lands in Asia (while they caused deaths in other groups nonetheless) allowed the surviving Ati to drift away from the mainland continent. Furthermore, it is likewise held that the Ati's presence was just plain accidental, as they were brought into the archipelago by early traders and explorers who rescued them from a shipwreck.

During pre-colonial times, however, the Ati thought of themselves as having lived in abundance, sovereign and independent from the incursion of outsiders, in forested mountains, where they practiced a distinct cultural life. This strongly suggests that their contact with the lowland communities was more due to chance than will. Today, in their present status as fledgling communities, it could be argued on the surface that they were hardly fully controlled or influenced by the different colonizers who once dominated the country. Although the Ati probably had meet those foreigners, yet, most likely, they eluded whatever strategies were aimed at settling them down.



This family's hut, which is located on the outskirts of their assigned space, manifests the displacement of Ati's existence by modernization. However, with resilience, they can overcome any obstacle if their legitimate rights to land and cultural respect are recognized, neither of which they currently possess. (Sansait, 2009).

4.1.1. Early Speculations about Ati Origins

The history and origin of the Ati in Guimaras are as old as or could be older than any migrant communities in the province. Described under the colonial gaze as physically and

culturally distinct, the Ati ancestry was easily categorized by William Allan Reed as people belonging to the "early forms of society and the non-civilized races," which could justify colonization to uplift the "mental and social development" of the people towards civilization. One common theme that is generally agreed upon, according to Eva Gabrielle Bielouss (1938), is that the Negritos were the earliest among the present inhabitants of the islands and that they were driven back deeper into the mountain fastnesses by the succeeding Indonesian and Malayan invasions. Some of the Negrito groups have retained relative purity, while others have become very mixed with the Malay. Nonetheless, in the absence of paleontological records, the Guimaras province's initial populace would have been fisher folks, hunters or gatherers, horticulturalists, or all of them in relative time difference, who arrived from the bigger islands of Panay and Negros.



The Negritos, located in Zambales, Philippines. This photo was taken during the American occupation (1932). (Group of Negritos, Luzon, Philippines. 1932. Archives of the State of New York, New York. (Original Document ID: BC49654803CFEC83BCA3FEF188937343). In, John Tewell. https://www.flickr.com/photos/johntewell/52844237872 /in/ album-72177720307767602/)

An early serious attempt to hypothesize the existence of the Negritos was offered by David J. De Laubenfels (n. d.) in an article titled "Australoids, Negroids, and Negroes: A Suggested Explanation For Their Disjunct Distributions," who compared appearances with other similar

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groups as the first basis to satisfy his curiosity. Thus, for him, a Negrito, besides being "normally short of stature and dark of skin, noses are broad and low at the root, jaws are prognathic, lips somewhat prominent, and crania of rather small capacity, he was distinguished from those Aborigines because of his distinct brown brows, which are "vertical and without eyebrow ridges," and because he has "wooly black hair on his head and sparse body hair." This racial profiling was thought necessary not only to explain their differences with other neighboring groups but also to place them as the "earliest known Homo sapiens" in the area where they were found. Their scattered locations were seen because of a series of migrations and invasions, or as being "pushed" by the Malays "in and through." Because of this, Laubenfels felt confident that there were two Negroes as an output of their adaptation after a long period of time in their current location.

Reinforcing this view, Keiichi Omoto (n. d.), in an article entitled "The Genetic Origins of the Philippine Negritos," reported his analysis based on the dendrogram, the only tool available during his time to describe the genetic profile of this people. According to him, "by comparing the Negritos (Aeta) with eight other populations on the basis of genetic distances computed by Cavalli-Sforza and Edwards's method, and, on the basis of neutral mutation random genetic drift theory, the Aeta, or the Negritos," he concluded that these people have different origins in terms of migration to the Philippines.

4.1.2. Early literary representations of the Ati

With limited data and tools, early observers, especially during the colonial period, had their curiosity set on identifying the differences, if not the inferiority, of the Ati people and of others who exhibit their atypical features in height, color, and other body forms. From this view, many indigenous peoples were regularly carted to Europe or the United States of America to be exhibited in their annual fairs. In one critical essay by Oscar V. Campomanes (2008) entitled "Images of Filipino Racialization in the Anthropological Laboratories of the American Empire: The Case of Daniel Folkmar," he recounted the fancy efforts of the colonial power to calculate differences in the body parts of indigenous peoples of the country, including the Aeta representative. In the end, in the face of inconclusive evidence out of such racialization, Campomanes scoffed the colonial ambition as a failure, thus calling Folkmar "the imperial racist who claims that power cannot fully know his subjects and objects of control."

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One classic example that sustained the view that the Ati are morphologically different is by Dr. A. B. Meyer (n. d.), who sustained Eurocentric curiosity in the name of science. The account speaks of its period, where humans were still classified based on race. But this knowledge could further justify colonization given the assumed inferiority of the people in the evolutionary ladder, which thus needs the nurturing of western civilization. His work, now deposited at the Royal Ethnographic Museum of Dresden, was then acclaimed to be a pioneering effort to classify the Negritos, having been thoroughly examined as belonging to "pigmy races," with males standing height to be "1401 to 1575" millimeters and "1300 to 1485" millimeters for females. These people according to him, featured "thick lips, retreating foreheads, concave noses, and protecting teeth," with a head having "an extremely brachycephalous profile." Based on jaw structure, they were seen further as "ape-like," and wanting to pamper his curiosity, he further endeavored to shave the heads to examine hair follicle groupings, which were found to be less "exaggerated among these people," but nonetheless "all woolly haired."



For comparison purposes, the photo shows non-Ati people taken during the US occupation. (Filipino children). 1932. New York State Archives, New York.
(Original document identification: BC49654803CFEC83BCA3FEF188937343). In, John Tewell. https://www.flickr.com/photos/johntewell/52844237872/in/album-72177720307767602/)

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On a cultural note, the subjects were noted to have had combs like other "Negrito races," but were found to be "suckling children smoking cigars." On the other hand, their basket crafts were appreciated for being "extremely ingenious" and that their arrows were "rather complex in formation," but their bows were "for the most part simple." Like other inhabitants, besides having beads and trinkets, they have tattoos and are found to be "happy, lively people," except in "procuring their food." This is consistent with the view that they "love to lie in laziness" and have songs that "consist of monotonous, endless unison chants."

Lastly, he claimed that Negritos were found to be all over the major Philippine islands, including Panay and Negros, thought to have had a "language of their own" before but now speaking the "grammar and vocabulary of a pure Malayo-Polynesian." Overall, true to his interest, Meyer hoped that more knowledge could be further obtained if these people had been examined by their "anatomical structure."

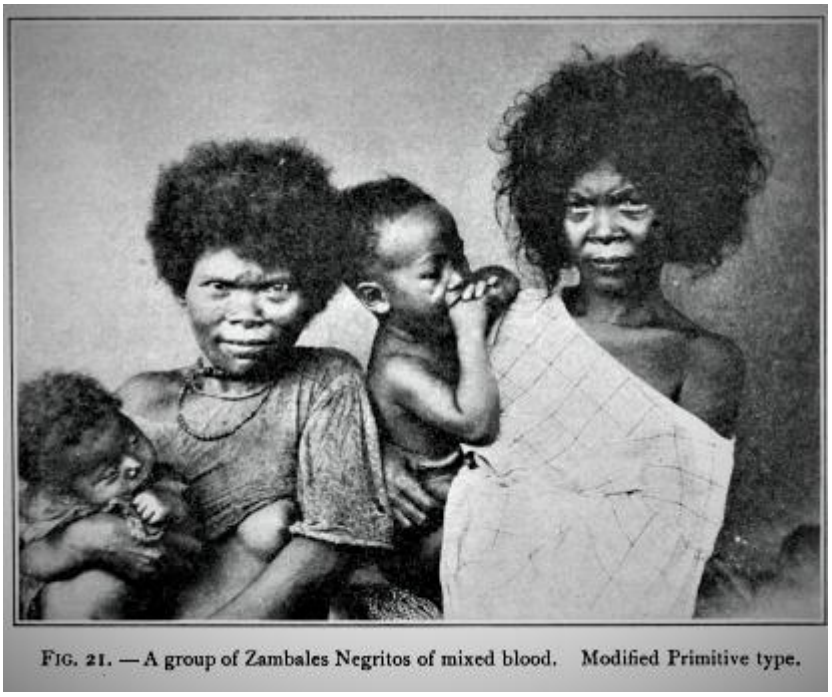


FIG. 21. — A group of Zambales Negritos of mixed blood. Modified Primitive type.

Photo of Ati (Negrito) women from Zambales, Philippines.
(In, Bean, R. B. (1910). Negrito types in the Philippine Islands 1. American Anthropologist, 12 (2), 220–236. https://doi.org/10.1525/aa.1910.12.2.02a00040)

In an article entitled "Races and Peoples in the Philippines" (n. d.) found in the Far Eastern Quarterly, one can find an early valuation of those who resisted conversion under the Spanish period as "conservatively pagan," "*infieles* (unbelievers or heathens)," or those belonging to

"wild tribes." It classifies the Philippine natives as belonging to an Indonesian race and geography (found in Borneo, Sumatra, Java, Celebes, and the Philippines) that assimilated the prestigious Malay culture. The author noted the scattered existence of the Negrito in the archipelago, who "for the most part live in permanent, self-supporting communities, dividing their time between the chase, the cultivation of maize, tobacco, and vegetables, and the gathering of forest products for trade with coast people. Among them, the most primitive were found on the Bataan Peninsula, while the purest were in the northern Tayabas. As for the Negrito in Panay, they were earlier identified as the "Ati, and are found all over the interior mountainous portion of the island," and with those on the island of Negros, they were evaluated as having "preserved their wildlife, are therefore free from mixture with the Visayan Filipinos, and are rapidly disappearing."

As regards cultural responses to colonizing power, his paternalistic view surfaced with the observation that some of the "peoples of the Philippines have not shared equally in their inheritance." This sadly refers to "the diminutive, woolly-haired, black Negrito, who roams the forested uplands... and was content to borrow from his immediate neighbor a working vocabulary, as well as those traits of material culture that suited his meager requirements for survival."

The widespread of this denigrating impression of the Ati people is reiterated by Sandra Khor Manickam (n. d.) in her article entitled, "Africans in Asia: The Discourse of ‘Negritos’ in Early Nineteenth-century Southeast Asia." She reviewed the accounts of John Crawfurd and Stamford Raffles about races in Southeast Asia, specifically how their explanations and descriptions extended the literal and figurative misrepresentations of the Negrito people based on physical attributes and unqualified assumptions. The degrading portrayal of the *negritos* stems from the early explorers’ and missionaries’ descriptions of these people that were simply passed along and accepted as part of the background information attached to the "Negrito label" and, by extension, to the *negrillos* "on the island of Panai."

Both Crawfurd and Raffles, being persons in authority assigned by the colonizing powers in the Malay Archipelago, appeared to have the authority and legitimate disposition to cast interpretations over their claims reflective of their European position over the alien looks of the natives (Manickam, n. d.). Thus, it was easy for them to maintain, through "the combination of the text and drawings," their confidence that the Negritos were like or "assumed to be indigenous only to the African continent."

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As a specimen in his framework, Raffles saw the Negritos as primitive, exotic miniature people and as descendants of stowaway African slaves. But by focusing on the inferior nature of the Negritos as slaves, he was able to transform himself into the benevolent savior and so could plead for more privileges to accomplish his "civilizing mission" in the region. On the part of Crawfurd, his depiction of the Negritos through the engraving of William Daniell, which was likewise used by Raffles, sustained the inferior status and the negative connotation of their subject. In other words, the Negritos' "stunted growth", revealed their "deficiencies" and so required protection, control, and emancipation.

4.1.3. Early illustrations of Ati cultural behavior

While the following may not be accurate, it is worth noting the persistent attempts to reconcile Ati behavior with the expected behavior of the general populace. Morice Vanoverbe (1933), in an article entitled "Philippine Negrito Culture: Independent or Borrowed?" narrated his accumulated knowledge from his 24 years of missionary work with the "pygmies" of the mountain province of Luzon. In the paper, he described the material, social, spiritual, and psycho-cultural world of the Negrito in contrast to their neighboring "Malay" societies, the Kalingas in the north and the Isnegs in the south. Except for the bow and arrow, the rest of the material possessions of the Negritos were thought to be selectively borrowed from their neighbors, like body ornaments from the Kalinga, while dance and rituals were from the Isneg.

In character, Negritos were stereotyped as trusting, artless, gullible, boisterous, volatile, outspoken, and impetuous, in contrast to the Malay's suspiciousness, artfulness, and shrewdness. On the other hand, the Negritos never practiced divorce or killed twin babies, as the Kalingas conventionally practiced. As for their superstitions, it was observed that Negritos did not subscribe to any beliefs and practices, unlike the Malays, who had built elaborate rituals like shamanism and trance to restore health or appease their dead ones or the spirits they believed were affecting them. Death for the Negritos is understood as a natural event, and they are not in any way affected by fear of ghosts. As regards celebrations and rituals, Negritos has the simplest of all through a token gesture of partaking of a small piece of meat from a hunted animal or a piece of fruit to the spirit of the forest for its generosity. This contrasts with the Isneg, which involves the sacrifice of dogs, chickens, or pigs, followed by feasting and rejoicing at every life event they had: weddings and harvests, among others, including times of sickness

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and death. Thus, for the author, the simplicity and pattern of the Negritos cultural and religious rituals reflect their borrowings from their Malay rice-farming neighbors.

Of more particular interest is the report by Rev. Manuel Gloria (n. d.), entitled "A Visit To The Negritos Of Central Panay, Philippine Islands," since his observation happened to be in the same region of the Ati of Guimaras, hence the likelihood of shared ancestry. His narrative is dated to 1934, when he visited a community of "Ates" in the interior part of Panay. There he met Ramon Gregorio, the leader of the community, who recounted that as early as 1908, the governor of Iloilo gifted them land to settle down on. However, not long after, they moved in between the local community and the mountain area, where they could, in times of need, seek help from the local folks or go to the mountain to collect food.



Photo of Ati in the central part of Panay Island, retrieved from Gloria, M. (1939): https://doi.org/10.2307/3316366

Gloria found that the community then was already organized like a political unit with a roster of officers and committees, but this is probably the imprint left of the local government's efforts to settle them. Of interesting note was how they named their children after the prominent plant species or the geo-morphological feature of the place where each was born. The marriage was said to involve bride price, bride service, and the chase of a male to a prospective bride in

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an open field. As regards their burial practices, their lack of integrated belief in the afterlife reflects any absence of ritual before the burial of a deceased person. Lastly, Gloria attested that while the Ate could understand and had some shared vocabulary with neighboring farmers, the latter had difficulty comprehending the Ate language.

Furthermore, although it was a short account, Rev. Ciriaco Serrano (n. d.) made sure to report the "gambling among the Negritos of Panay." He identified the following activities of Negritos that revolve around entertainment and betting: *sukatay sa pana, pukol, and kasing*. The "sukatay sa pana" involved shooting the farthest one's arrow, the "pukol" is about rolling one's mud ball against another mud ball and bet which one cracks first, and "kasing" is attempting to outspin in time someone's spinning top. According to Serrano, these were observed to be indigenous to them, and although they used crop products in betting, the activity has not led to addiction.

An early academic effort to describe the Negrito people came through the contribution of Francis X. Lynch (n. d.) in the article entitled, "Some Notes On A Brief Field Survey Of The Hill People Of Mt. Iriga, Camarines Sur, Philippines." As a response to Dr. H. Otley Beyer's 1947 Negrito Symposium at the Institute of Archaeology and Ethnology in Manila to resolve the question of the "origins and interrelations of Negrito and negroid groups in the Philippines," Lynch spent eight days along the vicinity of Mt. Iriga, Camarines Sur, to obtain ethnographic data on the Agta people, whom he identified as "semi-negroid hill people." His observation led him to justifiably claim that there is no homogeneity in the term "negritos," but rather, it should be used as a generic term for people who have a varied level of interactions with lowlanders.

In the case of those on Mt. Iriga, the language spoken revealed itself to be like a variation of the lowlanders' Bicolano, and further observation shows that the structure is like the rest of Malay morphology as a generalized byproduct of Austronesian influence. Further, Lynch observed that most of the families were relatively nomadic since their abaca trade often demanded that they keep close to their partners. Likewise, their impulse to move camp is due to their learned desire to pursue their traditional fruits, root crops, and game animals in the forest.

Given their nomadism, they preferred to build new huts each time their dwellings became derelict, since the act of redoing may require more unnecessary labor than constructing a new one. As part-time horticulturalists, they use planting sticks to push the seed on the ground, and as for their need for fire, they prefer to keep embers rather than start a new one each day. As to

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the question of Beyer for the symposium, the current tools available, especially DNA analysis, could greatly help in resolving questions of biological affinity between indigenous groups in the Philippines.

> *Indigenous peoples and people are free and equal to all other peoples and people and have the right not to be the object of any type of discrimination, in the exercise of their rights, in particular because of their origin or indigenous identity.*
> Article 2, UNDRIP, 2007

4.1.4. Recent representation of Ati in literature

In her article that appeared in the American Anthropologist, "Hunter-Gatherer/Farmer Exchange," Jean Treloggen Peterson (n.d.) offered an ecological interpretation of exchange relationships, as an interdependent behavior between hunters and farmers. This relationship was found to be common throughout the Philippines and the world. Besides, hunters too were observed to provide labor in farming, or in different contexts, as guides or as herders. While this relationship may lead to longer warm exchanges, others tried to avoid or have it, and still some require threats from farmers, especially when advances are made. Nonetheless, it was noted that these interactions may produce friendly partnerships; nonetheless, sedentary people may at times bear a superior attitude while also showing deference to the unpredictable ferocity of the hunters.

Such relationships may also have humanitarian or religious dimensions. This may happen when a farmer adopts children of the foragers or when a farmer uses beliefs to sanction an erring forager, just as hunters may provide specialists to effect healing for farmers. In some instances, farmers may assist hunters in resolving conflicts, but in longer relationships, hunters adopted cultivation practices. But the most subtle consequence of regular contact is language learning.

Peterson, however, laments the depictions of these interactions as though the hunters were the only benefiting group given their "constant need of rice." But for Peterson, the foods obtained from the farmers "are not necessarily preferred, but they are simply easier to obtain. "So far, beyond the ethnographers' notes, contacts and exchange had been going on for hundreds of years; thus, it might be helpful to measure the "extent of that interdependence."

Meanwhile, Lawrence A. Reid (1994), in an article entitled "Possible Non-Austronesian Lexical Elements in Philippine Negrito Languages," made some clarifications about the core linguistic morphology of the Negrito language. On the surface, according to Reid, Negritos

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generally speak Austronesian, but vocabulary analysis led him to discover persistent "non-Austronesian substratum." The current use of their conventional language was hypothesized to follow three broad steps: acquisition and pidginization of Austronesian through trade contacts, then creolization to accommodate continuous engagements with non-Negritos, and lastly decreolization when, after some time, they unconsciously regularize their newly learned language in their daily lives.

He took the view of Jared Diamond that this process is a natural outcome given that the Austronesians expanded quickly with their farming dominance. Probably then, the Negritos came to absorb much of the vocabulary of the dominant group. Along this line of thinking, Reid noted further that along "contiguous geographical regions," the Negritos would have "shared bodies of vocabulary" like those found in the Inati language of Panay and those who live in other regions.

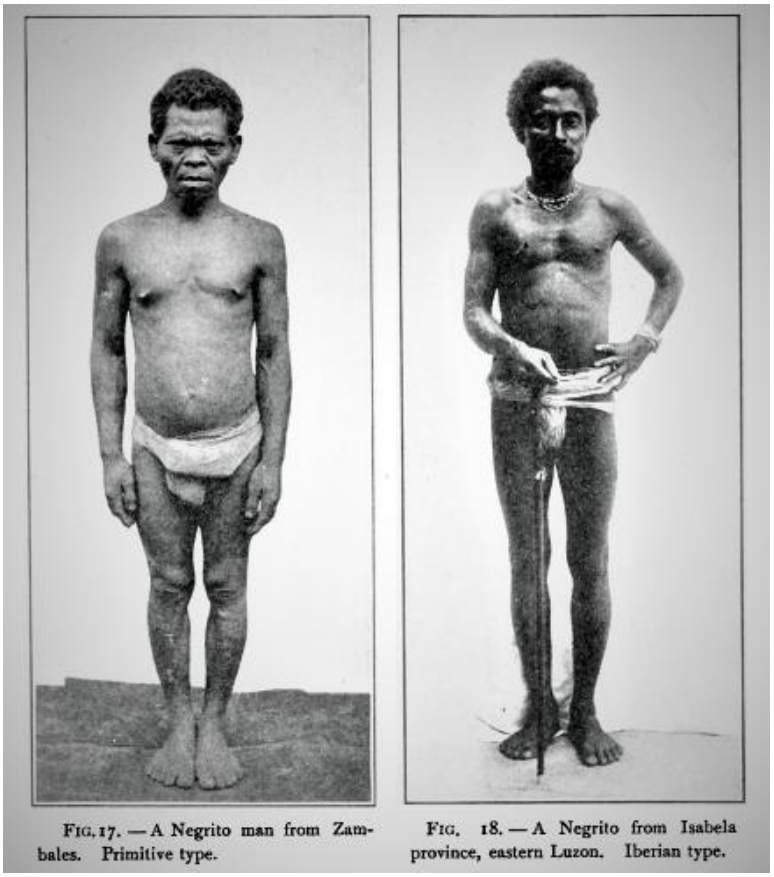


FIG. 17. — A Negrito man from Zambales. Primitive type.

FIG. 18. — A Negrito from Isabela province, eastern Luzon. Iberian type.

Initial photo of Ati men (Negritos in the provinces of Zambales and Isabela, Philippines. (In, Bean, R. B. (1910). Types Of Negritos In The Philippine Islands 1. American Anthropologist, 12(2), 220–236. https: / /doi.org/10.1525/aa.1910.12.2.02a00040)

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Further, by lexical analysis and comparison of 50 wordlists of the Negritos in Luzon, Reid identified the "shared exclusively... neither clearly inherited nor borrowed from non-Negrito languages... that constitute an early Negrito substratum of these languages." Thus, while the morphology and syntax appear to be of non-Negritos, through the processes identified above, the Negritos were able to keep some terms of both theirs and of early Austronesian groups that could otherwise have been lost.

4.1.5. The genotypic evidence of Ati ancestry: the Denisovans

The prevailing hypothesis now is that from Africa, *Homo erectus* moved to Eurasia around 700,000 years ago, and then around 370,000 Denisovans and Neanderthals genetically and geographically split (Britannica, 2023). While the Neanderthals moved to Europe and West Asia, the Denisovans spread to East Asia and Southeast Asia. At 30,000, these archaic humans, or new homo species, were thought to have gone extinct, yet their genomes were found among the indigenous groups of the Philippines as well as in Papua New Guinea, Melanesia, and Australia, strengthening the view that they were capable of seafaring and were able to interbreed with the incoming H. sapiens group.

In this trajectory, Larena et al. (2021b) provided a solid claim about the Ati ancestry in an article entitled, "Philippine Ayta possess the highest level of Denisovan ancestry in the world." From their genotypic analysis of 1,107 individuals from 118 ethnic groups in the Philippines and 25 self-identified yet ethnolinguistically diverse Negrito populations, the appearance of a high genetic trace of an archaic species, the Denisovans, supports the hypothesis that there was a multiple admixture of genomes that happened in the past, not one. Through principal-component analysis (PCA), Negrito diversity is found to cluster within five distinct groups, and the Ati of Guimaras most likely belong to the Southern Negritos category. This means that while the Ati people possess the Australasian genes, they were nonetheless able to retain a high degree of archaic hominin heritage. Further, the study supports the redrawn Negrito migration paths into the Philippines via the Palawan-Mindoro or Sulu-Zamboanga corridors, leading to their diversity within their regional niches.

Recently, the authors observed that these Negrito people are into mixed foraging and farming and/or an urbanized lifestyle for their subsistence. It is lamented that in a span of four decades, the combination of forest degradation, expansion of agricultural lands, increased

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accessibility brought about by rapidly expanding infrastructure development, and the inroads of a modernized lifestyle have transformed the cultural practices of Negritos away from their traditional nomadic hunter-gathering mode of living. As of today, their most economically viable activity was said to be in local trades and/or seasonal contractual labor.

To date, there are 30 self-identified Negrito groups who speak the Malayo-Polynesian (MP) branch of the Austronesian language family, which is mostly severely endangered. Due to long periods of isolation, these languages, in the first orders of their respective subfamilies, produced broad and unique adaptations, sustaining their differences among non-Negrito linguistic expressions.

With an updated tool and information at hand, Larena et al., (2021a) in article entitled "Multiple migrations to the Philippines during the last 50,000 years," illustrated with confidence how the early inhabitants of the archipelago came about. This was to resolve one of the puzzles about the obvious differences between the Negrito group and the general populace by postulating their origin and the way they expanded the country. One popular explanation is through wave theory, which posits that the first wave of migrants were the Negritos, followed years later by the Malaysians using the southern corridors. While there are other modifications to these, given the data at hand, the recent one nonetheless, is most promising. Broad as it may be since it is based on gene analysis, and it is setting a good precedent for archaeologists and paleontologists to investigate.

The collection and analysis of the population-genomic data of 1,028 individuals representing 115 distinct cultural communities from all geographical regions of the Philippines, which involved around 2.5 million single-nucleotide polymorphisms (SNPs), revealed that the Philippines was populated by at least five major waves of ancient human migrations for the past 50,000 years.

Through looking at different statistical patterns, five major migration events are possible to explain the population of the Philippines. The first and the second were carried by the Northern Negritos and the Southern Negritos, respectively, into the Philippines from Sundaland (southern land corridors before the rise of sea level). But prior to their arrival, it is postulated that probably the Denisovans (the archaic counterpart of Neanderthals) were ahead, and their encounter likely resulted in an independent and localized admixture event, which explains the high presence of archaic genes among these first two migrant groups. Then, at the end of the Last Glacial Period, the Manobo-related and Sama-related populations arrived through south-

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to-north movement. The last expansion during the Holocene period was by the Cordilleran-related populations thought to be from Taiwan, although initially they were not rice producers. Because of their advanced cultural tools, especially seafaring capabilities, they now have the "legacy of linguistic dominance resonant in present-day populations of the Philippines and beyond." As regards the Spanish and European admixture, the analysis showed that although the country was a Spanish colony for 333 years from 1565 until 1898, the latter's gene influence was almost insignificant except for those who are mainly concentrated in urban centers.

> *Indigenous peoples have the right to the full enjoyment, as a group or as individuals, of all human rights and fundamental freedoms recognized in the Charter of the United Nations, the Universal Declaration of Human Rights and international human rights law.*
>
> Article 1, UNDRIP, 2007

4.2. Brief Ethnography of the Ati People

4.2.1. Accessibility, Health conditions, and Demography of the island

Before the COVID-19 pandemic, motorized bancas at various locations, especially at the periphery of Ortiz Street and at Aduana in Iloilo City, were busy plying back and forth commuters, be they traders, tourists, or holidaymakers, from dawn to dusk each day. But for safety reasons, people are now made to use the larger port, now plied by accredited modernized ferries. As in any third-world community and with the absence of manufacturing industries, people are generally tied to land as farmers, in clerical or sales support services supplying the needs of government bureaucracies, or at tourism infrastructures, if not in construction businesses. This limited opportunity, however, did not prevent many from becoming entrepreneurs or finding employment abroad (n = 6,802 in 2015) as nurses, domestic helpers, or ship crew, as testified by the robustly designed houses that are scattered across and around the island.

Being surrounded by water, besides fishing and seaweed farming, the province benefited greatly from its tourism industry. This, however, must find its niche, given that the province is overshadowed by the accessibility and allure of Boracay Island, further north in the region. In

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a sense, the province has yet to design a strategic path to go beyond its former shadow as a mere offshore and service island of Panay of Negros.

Despite its limited budget, the province has been trying to comply with its health and education mandates. Since 2006, its enrollment rate of 73.43 percent at elementary levels has been steadily improving, which has helped the province maintain a competitive literacy rate, as shown by its cohort survival rate of 98.5 percent in SY 2017–2018. In the health sector, the province has sustained its immunization and vaccination efforts and the provisioning of vitamin A and iron to address the prevalence of pneumonia and the observed stunted growth among infants. Likewise, BCG and Hepa B1 were administered as required and as opportunities arose among infants. Follow-up pentavalent and oral polio vaccines were also reported to have been provided.



From 4:00 AM to 6:00 PM, for those who prefer to drive their vehicles, there is an hourly ferry from Iloilo to Guimaras and vice versa. Photo retrieved from: https://www.barkota.com/2021/04/29/iloilo-to-guimaras-ferry-schedule-fare-rates/

4.2.2. Vegetation

In areas where the soil is favorable, vegetation and woodlots are dense, but in areas where limestone features are profound, shrubs, grasses, and sturdy short trees grow in patches (Sansait,2009). While indigenous tree species are found just elsewhere (that are exploited for house building and fuel wood), introduced species, however, have been vigorously promoted for commercial and domestic uses. In different Ati settlements, gmelina (*Gmelina philippensis Chamiss*), bananas, ipil-ipil (*Leucaena glauca*), madre de cacao (*Gliricidia sepium*), and

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mahogany are common. In Sitio Ubog, besides those common species, acacia, eggplants, golden rosary, and sugarcane are visible. In Sitio Kati-kati, they have papaya, bamboo, malunggay (*Moringa oleifera Lam.*), and root crops. At Sitio Maabay, they have mango trees and a vegetable patch planted with legumes and trailing plants. In Sitio Sirum, they have a communal garden and corn plots nearby.

4.2.3. Land of the Ati

Foremost, the Ati consider their land an area in which they can reside and find their source of livelihood and never conceived of their territory as something to protect and fight for. Lately, however, as more and more "Uta" (a term they use to denote those non-Ati) settled alongside them, they came to realize the urgency to conceptualize or define a land to claim for as their own. In Ubog, for example, there were originally 40 hectares of land promised to 84 families through the Comprehensive Agrarian Reform Program (CARP), as initiated by their local government. However, when no other Ati families showed interest in settling down on it, the area was reduced to 20 hectares, and the remaining land was eventually offered to the Uta.



Although this lot may look like a strip of forest, it is nevertheless a garden for the Ati in Kati-kati, cultivated with roots, vegetables and pandan grass (Pandanus odoratissimus L), the leaves of which are used in their handicrafts. (Sansait, 2009).

In Kati-kati, there are 301 families living in an Uta territory close to the road. As regards their land, there is a 10-hectare lot promised for them through the CARP scheme that has yet to

be realized, located almost a kilometer away from the road. As of 2019, the whole Kati-kati community has been relocated to a bigger space half a kilometer away from the road. In Maabay, 32 families settled on yet-to-be-fully-paid CARP grant land with a size of 20 hectares. In Sirum, 81 families settled on an estimated 20 hectares of land they claimed to have inherited from their ancestors. Among the four communities, this latter group has the best claim to land since, besides having continuously occupied the territory, they likewise possess tax declaration documents bearing dates far earlier than the ones held by any Uta around.



Nang Ninfa from Sirum, among others, is very optimistic as she tells how the local government, with the help of CARP, had promised her almost two hectares of land. This mode of ownership (individual and private) of land is something new, and its social and cultural consequences await to be observed by the next generation that aspires to define a territorial claim among the Uta. (Sansait, 2009).

As to the use of their land, besides recognizing it as a place of residence, they also considered it a place to farm. Farming, however, is dependent on rain, and thus, at best, they could only realize two harvests a year. In areas where there are springs, they maintain a vegetable patch nearby, pigs tied to trees, and small fishponds. Streams, besides rain, are usually their source of water. In these water pools, they obtained fish, snails, crabs, and shrimp. They also cultivate garden plants like sweet potatoes, cassava, and bananas.

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4.2.4. Population

As of 2008, the office of the National Commission for the Indigenous Peoples (NCIP) has estimated that there are less than a thousand Ati in Guimaras, distributed in its four municipalities: Buenavista, Jordan, Sibunag, and Nueva Valencia. In Buenavista, the majority is in San Nicolas (Sitio Sirum), numbering about 84 individuals belonging to 19 families. The rest are in Sto. Rosario, Matangingi, and San Fernando. In Jordan, the Kati-kati is the only reported locality for the Ati, with 301 individuals composing 65 families. In Sibunag, the Sitio Maabay has 154 individuals (32 families), and in the municipality of Nueva Valencia, Barangay Ravena has 42 (9 families), and Barangay Lanipe has 81 individuals (18 families).



Typical Ati house for the economically well-off, incorporating the Uta basic structures such as a *papag* that welcomes visitors and an indoor workspace known as a *payag*. Their sleeping quarters are elevated on the left. At night, all openings that function as doors or windows are simply covered with whatever cloth, plastic, or bag is available. (Sansait, 2009).

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4.2.5. Dwellings

Besides the kind of structures or the way their houses are built, the distance or location of their huts relative to the roads nearby reflects the strength of their willingness to participate in a new mode of life. Most often, those closer to the roads have a house partly made of cement

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and gravel with iron roofs, while farther away are the simpler huts, weak as they may be, but at least such structures provide them with greater autonomy from outsiders.

In Sitio Ubog, for example, since there are houses owned by Uta close to the road, only three Ati houses could be identified or spotted nearby; the rest are scattered farther away. At Sitio Kati-kati, the same observation is made except that the houses of Uta are relatively far from their community. In Maabay, generally, the Ati houses are situated far down from the main road, which leads to the top of the hill where both the municipality's wet market and an Ati cooperative shop are located. At Sitio Sirum, Ati houses are generally far from each other, most of which are made of light materials.

4.2.6. Kinship Pattern

Unlike in horticultural or pastoral societies, where extensive knowledge of genealogical lines is important to claim rights over limited resources, the Ati people have not built this elaborate system as part of their life strategy their life strategy. The recognition of distant kin most often becomes useful only when one has to visit or live with a relative for some time. Seldom do they deny affinity with each other, which serves to strengthen their group identity. With this view, often they would rather ask a newcomer where he had been from than to whose lineage he belongs, for after all, they are all relatives.

Some important terms are "*ibo*" for grandfather, "*bayi*" for grandmother, "*nanay*" for mother, and "mama" for father. For the ego's generation: "*kaka*" for any older sibling and "*ari*" for the younger sibling; "*ontoy*" for a boy; and "*inday*" for a girl. They recognize cousins without strict distinction, whether they come from the mother's or father's side. They use categories like "*pakaisa*," "*pakaduha*," "*pakatlo*," and so on, like their Uta neighbors, to reckon distance between their relatives. However, in most cases, they just intuitively accept or recognize as relatives anybody who would come to their community bearing a similar physical semblance to them. This is for them the most convenient way to facilitate greater flexibility and integration in their social life, for in their reasoning, being few around, it is impossible to doubt somebody's affinity who obviously appears like oneself.

4.2.7. Celebrations

Festivities and celebrations require a degree of savings or a reliable source of funds to finance the whole event. On their own, they hardly acknowledge a festivity of significance apart

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from the ones celebrated by their Christian neighbors, like birthdays, Christmas days, and fiestas, among many others. The most they could recall, as their old folks told them, were the events when men, women, and children gathered after a hunt with their neighbors or a harvest in which they had participated. This occasion will lead some men to procure or buy cocoa wines or liquor while the women cook rice or any root crop or meat available. Customarily or in a spontaneous manner, given a favorable ambiance, the rest of the group and children will start to sing their known songs or begin to dance to the beat of their wooden or bamboo-generated sound accented by their claps.

4.2.8. Costumes

Wearing costumes is associated with formal events in the community. Ati culture, however, recognizes naturalness, such that according to their elders that in the past there was an absence of dichotomy between formal and informal spheres in their lives. Only lately, as influenced by their neighbors, they have they learned how to present themselves "formally" as deemed appropriate in the bigger society. While they had no traditional costumes separate from the ones they used to wear before, they just mentioned those newly acquired dresses as the ones that would make them appear appreciable to their visitors and guests. As in the past, they remain fond of accessories, from necklaces, earrings, bracelets, and anklets.

Among their children, they pin or string a red pouch filled with one or two crystalline quartzes or stones, wood chips, dried roots and seeds, along with coconut oil sealed in a miniature bottle to ward off malignant spirits. Many adults would, from time to time, use one or two of these pouches. From shells, colored pebbles, wood, and seed, they produce an array of tied or stringed adornments. Most likely, given their simplicity in life, the combinations of their dress and accessories form their costume.

4.2.9. Material Culture

The degree of assimilation and the income of an Ati family are generally projected by the kind of dwelling they are investing in. Near the roads are houses built with a combination of cement, wood, and iron roofs. Farther away are houses common to rural agricultural communities—those that are made of bamboo and thatched nipa (*Nypa fruticans*) or coconut leaves for their roofs. Huts are generally elevated and have an approximate dimension of three by four meters on average.

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In these houses, there are no significant furnishings except the cut-out posters of their favorite artists or religious images posted on the walls. Bamboo or wooden tables and chairs (they call them "*bangko*") are found only in a few houses; the rest make use of wooden or bamboo benches or their bamboo flooring (a form of "*payag*") to rest on, to eat on, or to entertain guests. Outside their house, one can find benches where people congregate from time to time. Hanging around in many houses are horizontal wires or nylon ropes to dry their clothes.



The way the community incorporates these Kalibugan children demonstrates the malleability of their kinship. When they were young, their parents abandoned them, but now an Ati family takes care of them. They are known as "mga escrap" due to the nature of their daily task: searching for discarded plastic bottles or anything of value nearby. This accommodating and supportive attitude attests to the Ati's cherished custom of extending care to children who may come to their huts. (Sansait, 2009).

Within the vicinity of their house, one can find a pail or plastic cans for fetching and storing water. Likewise, wooden and metal garden implements like a hoe, axe, bolo, and bamboo poles to pick fruits nearby could be found, kept under or beside their house. At the back is the laundry area, where a flat stone or slab is found besides the water container or water faucet (in the case of Ubog) for those few who have access to the water system supplied by the municipality.

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Those with motorcycles or bicycles have tools or parts found around their house like bolts, screws, tires, and gasoline or oil cans. Inside the house, dresses are kept in boxes or plastic bags. In the kitchen, one finds a metal cooking pot, a frying pan, a few spoons and forks, a knife, two or three glasses and cups, and laundry soap.

With this cache at hand, it is still very erroneous to judge them as poor or to be stricken with poverty without understanding the degree to which they are integrated into their community and the kind of expectations they have put into their lives. The most one can say is that many persist in remaining unsophisticated and less accumulative in life, or, if not, they have yet to catch the consumerist and accumulative zeal common among the Uta.



Tay Floro and Tiyay Dolores, who have been exposed to Uta's dressing style since their childhood years, now show off their best outfit of the day at lunchtime with their guest students. (Sansait, 2009).

4.2.10. Economic Activities

The development of farming communities in conjunction with the fishermen could have been developed way back centuries ago as a natural output given the rich alluvial plains of the

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island. Later, as the Philippine lands became available to enterprising speculators, the early aristocrats from Iloilo, wanting to have a stake in the island's resources and with the hope of establishing plantations for export, were able to acquire tracts of land through their money and influence. So far, among the many agribusinesses introduced to perk up the local economy, only the mango industry has become successful and famous. The island is likewise being marketed as a distinguished tourist destination, with pristine beaches in its southeastern section

In the past, for the Ati, who were not yet fully restricted to their present lifestyle, they successfully managed a kind of symbiosis with the people in settled communities. This relationship was characterized by their obtaining products not easily accessible to the villagers nearby in exchange for staple food. Such a relationship and lifestyle had been sustaining in as much as their foraging remains viable in a spacious region. But as to their experience, they are now increasingly constrained in their mobility and have even found themselves almost fenced off from their neighbors and from the land they used to exploit.

Found inland in the province, the Ati could hardly now have any opportunity to go fishing around the island; at most, they are into farming, although in a limited sense, being mainly employed as seasonal laborers in Uta farmlands. For those in Kati-kati, although considered settlers on land claimed by the Uta, farming and keeping cattle were still available to them, being "allowed temporarily" by the landowners. This means that at any time, the owner can just notify them to find another kind of livelihood or, if not, to find another settlement.

A portion of their earnings from farming or cattle raising is, however, shared with the owner or caretaker of the land. Another additional source of income is from their involvement in handicrafts commissioned by religious nuns nearby, the Contemplatives of the Immaculate Heart of Mary (CIHM) or the Consolers of the Poor (COP). Commonly, the nuns would give them capital to buy raw materials, over which they would work for a week or until the materials were used up.

They will be paid according to the number and kind of crafts they have produced, minus the capital advanced to them. The products they conventionally produce are coin purses or bags out of "nito" (*Lygodium circinatum*) or "buri" (*Corypha elata*). In many instances, it is the middleman who would buy the handicrafts in bulk and retail them off in Boracay or in other stores to which he has access.

Charcoal making has been observed in Ubog and Maabay, and it regularly provides them with needed income. In Sirum and Ubog, hunting for wild reptiles and birds is still done, but

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very rarely. For those in Ubog, they complement their hunting with the collection of herbal plants for sale in Iloilo. Those in Kati-kati, the adults, observed that the younger ones are becoming less knowledgeable about the beneficial herbal plants that were utilized then by their ancestors. In Maabay and Kati-kati, many are beginning to give up hunting because they must walk far and be away from the community for more than three days.

On lean months, they made themselves available as contractual or paid laborers in carpentry shops or worked in the rice harvesting of their Uta neighbors. On the other hand, it was observed that in Ubog, Sirum, and Kati-kati, some own a motorcycle for transport and for hire. This reveals that some of them are now learning to become active in the transportation system, venturing into a new profit-oriented life.



A fully equipped kitchen with water containers, bowls, teapot, jugs, oil and vinegar bottles, kerosene lamp and pasta boxes for washing dishes. It should be noted that embers are usually kept alive in case it is necessary to start a fire. Dishwashing drains can go directly to the ground because of the open space in the floor. (Sansait, 2009).

4.2.11. Social Organization

A society that had ten thousand years of successful nomadic life certainly would have difficulty giving up such a tradition and lifestyle in exchange for the Uta's way of life. Undeniably, they are today learning to live a settled life characterized by a cohesive community

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with a marked pattern of residence. Although they tend to cluster together, most of them remain distant, or at least their huts' windows or doors are off from their neighbors' gaze.

Those close to Uta either have an Uta spouse or have identified themselves comfortably with the values and lifestyles of their neighbors. Although they recognize a common identity that separates them from the Uta, their loyalty is far stronger with their immediate kin, composed of parents, siblings, and first cousins. They often acknowledge affinity for people around them as part of their extended family, not necessarily because of their recognized sanguinal affinity but more so because of an assumed and felt commonality in appearance. In many cases, cousins (cross and parallel) are considered to have the same status as brothers and sisters in the family so long as such bonds are affirmed or reinforced by their presence in the household or community.

Parents or adults are not selective as to whom they deal with. Their house is seldom thought of as a place to exclude others but as a space that can provide rest to those who wish to visit them. Parents are expected to feed and care for their children, but in times when they are visiting other places or away for so long, they can entrust their children to their uncles and aunts. Caring for a child seems not to entail or require any specialized role since any member of the family can just volunteer to watch over a baby in need of care. When the child starts to walk, he will just be allowed to explore his surroundings with the rest of the children.

Cooking is often done just once, either in the morning or in the evening, and, at the next meal, family members will just partake of whatever food is left on their table. If resources are available, one may volunteer to cook them. In case they ran out of food, they would visit their neighbors and ask for whatever was left. Rarely is one refused food if food is available, and for doing so, one runs the risk of being denied any kindness on other days. Cleaning the house is seldom done on a regular basis, but instead, adults will just think it is needed when many things become unaccounted for or scattered in the house.

The same with their laundry, almost everyone would come to decide to wash their clothes only when most of their outfits have been used or when nothing can be modestly reused again. So far, borrowing, sharing, and visiting have been instrumental in strengthening their kinship ties rather than deeming them negative. Stealing does happen, however, very rarely, and the victim is usually pacified upon hearing about the times he has been shared with certain goods by the culprit in the past.

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Weddings and deaths are moments when people spontaneously gather around as relatives and friends come to share the grief and related experiences as members of the community. Depending on the host and the contribution or support of their relatives to provide food and drinks, the celebration can be for the whole day or for a short time in a day. The gathering reinforces group solidarity through each person's recounting of their kinship with the rest.

A return from a successful hunt or a good harvest is certainly cause for merriment since the mood is high over an expected amount of food. The gathering is not dictated by the host but by those around, recounting their participation directly or indirectly in the success of the hunt or the harvest. On ordinary days, however, words will just be passed around about who has just arrived from hunting in a nearby forest or from begging or trading in the city. Each return to the community is expected to bring in some goods for the rest to converge on and beg for a share. Initially, complaints will be aired out by the host, but no one will ever notice, for this is just part of the whole ritual that everybody commonly experiences in the community.



Tiyo Floro at the center is with his wife, Violeta (left) and a neighbor, Carolina. Although Tiya Violeta and her neighbor are Uta, they prefer to identify more with the Ati world because it is the place where they feel most at home and valued. (Sansait, 2009).

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4.2.12. Traditional political structure

Leadership does not require a separate or specialized role or training in the Ati community. Each nuclear family or band is almost self-sustaining as an egalitarian group. It is not a permanent or extremely edifying role, but one recognized only on special occasions. Planning for a hunt requires a leader; the same is true for organizing labor for planting, and so is preparing a meal for a wedding or a wake. Each one therefore has the potential to be a leader, as dictated by the need for a particular skill to influence the rest. The followers, however, give their cooperation to their buddy because, by doing so, they will receive a calculated benefit in return.

To be a follower or a leader expresses a role that continually shifts as deemed appropriate in a specified context. Usually, a leader is the one who has the greater knowledge and experience over a task to be accomplished, and, expectedly, they are often the older folks in the group. In return, the leader expects no praise or salary for it, except that a task is accomplished as planned by him. Lately, at the direction of the National Commission for the Indigenous Peoples (NCIP), they collectively select a leader called their "chieftain" or "tribal leader" to represent their group in any meeting called. Being so, such a leader has no other influence except to become an intermediary in communication between their community and the NCIP.

In their community, social behavior is guided by simple rules inherited from observing the practices of adult community members around them. Knowing these rules does not require a leader to legislate or execute them, given that each one simply has to observe what their parents are expecting of them to do in their own less stratified community. They have no formal way of learning these rules except by abiding by what their parents expect of them. As they were always on the move, most rules only governed the household or the group to which they belonged. Besides their parents, their neighbors and peers likewise reinforce norms that their parents may otherwise have overlooked. Conflicts, which do regularly occur, especially when one has failed to return the generosity one has once received from a neighbor, can be effectively avoided by simply moving away.

Children at an early age have to obey their parents, but not for so long since their parents are always on the move. With greater autonomy, teenage members of the community could easily establish marital relations with those willing and available. To seal the union, it only requires that the parents of the boy visit those of the girl, informing them about the relationship. Such a relationship will be fully stable upon the birth of a child.

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In the past, people recalled how marriage was done through a dance ceremony wherein the groom or his kin would have to get hold of the designated handkerchief from the bride, surrounded by her own kin. By doing so in a dramatic way, that is, by dancing to the beat of the drums made of wood or bamboo, it will not only entertain the crowd but also make the event memorable. While the groom holds his bride, their parents, one at a time, will counsel them to be thoughtful and generous neighbors to their group.

The choice of marriage partners is not dictated by any complex rule, except that both do not belong to the same nuclear family. Thus, a girl can have a union with her cousin. Sex is not totally confined to marriage, and thus, as expected, there are lots of premarital unions that a girl or a boy can experience before deciding to take seriously his or her future spouse.

4.2.13. Religious Life

Contrary to the Uta God, who possesses metaphysical attributes and is symbolized in a very abstract manner, the Ati people only recognize that there exist unseen forces that proceed from the natural world. They fervently believe in the existence of these fearsome energies but never care so much to know them or to fully explore the nature of each of them. They are just content to maintain their observed distance or respect by avoiding possible disturbance or causing any offense to these invisible beings living in their perceived sphere of control.

Unlike the enjoyment of health, which has no supernatural attribution, sickness or illness, however, is seen to be the consequence of spirits who wished to get even after having been offended in a space or location imperceptible to humans. Most of the vulnerable ones are the children and those whose "spirit characters" are not tough or strong enough against the debilitating infliction of the avenging or mischievous spirits. In case one becomes sick, an adult female, usually the one who had previous experience in healing, would be summoned to diagnose the nature and cause of the sickness, after which she would then recommend appropriate material or ritual to prepare. Selected roots, vines, or leaves will be rubbed over the body or set around specific sites in the forehead, neck, or chest to calm or soothe the discomfort.

When trusted females are not around, a male member of the family can temporarily volunteer to do the healing. Sickness of the aged is seldom attributed to unseen spirits; instead, it is seen as natural, and so most deaths are not given any additional speculation other than acceptance of the expected natural order of any observed mortal being. In the case of children, their sickness and death are unanimously ascribed to unseen spirits or to a malicious person

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who has held a deep grudge against the victim or against his family. The same explanation is raised over mishaps or accidents while at work—caused by spirits around.

Few taboos exist for children to observe that govern the places they roam or play. Children are warned to stay away or to lower their voices near thick groves and big trees, as they are still weak against any action or trick of any unseen spirit. For adults, they would just utter a few salutatory words, then afterwards proceed with their task in an unexplored place. Sometimes, they accompany their salutations with the tossing of bits of food they brought along.



As seen in the photo, a child wears bracelets made of a translucent tube containing oil and a mixture of dried roots, bark, and quartz, which are believed to possess protective energies against playful or malicious spirits or the evil intentions of those who wear them. But beyond health, having light skin is considered a cut above the rest, as the possessor will likely suffer less stigma in their growing years. (Sansait, 2009).

While they have the knowledge of medicinal plants they used to rely on before, many of them now prefer to take medicines available in stores. Despite this, they still discreetly hang medicinal oil in their house, and a diminutive version of it is worn by a few children to ward off any afflictions that may be cast on them by ill-boding spirits. The most common were the

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amulets in the form of stringed red beads worn as bracelets. An extended form of such are the small transparent tubes fitted around the arm, which are commonly filled with the same medicinal materials (chips of wood, oil, seeds, stone, dried leaf, vine, or roots) thought to ward off or counter any spell or evil actions coming from malicious spirits. Jealous neighbors, who were thought to have the capacity to harness the negative energy of the spirits, are thought to do likewise to cause sickness in unwary ones. The souls of dead people or animals can also cause illness when their names or memories are insulted.

4.2.14. Aesthetic Expression

The absence of complex art forms—be it in dance, literature, or music—does not in any way make them less appreciable to their Uta neighbors. While they appreciate the songs and dances performed by their ancestors, many of them are now much more eager to know the songs and other aesthetic expressions of their Uta friends and reinterpret them according to their material context. Even their own dance form imitating a hovering bird moving in a circle is likewise popular among other tribal communities, and it is likely they learned it from their interaction with the latter. In dress, art is appreciated because it is either newly acquired, newly washed, or possesses a design well esteemed by their Uta neighbor. But what is more pleasing is for them to see their neighbor's kindness, hospitality, and generosity.

A house is judged beautiful once it has been cleaned or decorated with posters of their favorite local artists. Although they consider wearing accessories something that enhances their appearance, they do not actively engage themselves in producing artful objects to wear, that is, just for the sake of art. Lately, however, many young ones have acquired clothing and toiletries, revealing the changes and expectations they are accommodating from their Uta neighbors.

It could therefore be said that their aesthetic sense is more integrated into the natural conduct of life because of their nomadic past. Art forms desired by tourists in search of sophisticated representations of reality are more associated with people who have built a complex interpretation of their world. Thus, for the Ati, themes, meanings, and symbolisms are all merged in the simplicity of their approach to life. There has never been a need for one to emerge as a culture specialist since each of them is part of a whole that sustains an unpretentious culture—a culture that at this time is fully threatened with extinction and which is further generally discriminated against by a bigger society that worships progress defined by a never-ending quest for material wealth.

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4.2.15. Contemporary Society

Just like any small-scale society in the world, the Ati communities in Guimaras Island Province are increasingly absorbed into mainstream society through mechanisms that almost imperceptibly undermine their cultural heritage. Starting with the office of the NCIP, one of its aims is to assist the Ati in obtaining ancestral land, while their goal is unquestionably noble, as it is assumed to ensure their security and survival, this presupposes, however, that the Ati are adjusted to a settled life, or that a settled life is far superior or the only valid way to live. At worst, there is a hidden attempt to settle them down. In a sense, there is logic here since those who have the power to define their destiny came from settled communities. Thus, with this position, it is almost natural to use one's paradigm of life as a valid framework over those who wish to remain in the old ways.



It is believed that Ati people can cast a spell on someone they like with the use of a potion. But for them, there is nothing more powerful than its simplicity, naturalness, and grace. (Sansait, 2009).

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As for the Ati, although they recognize a sense of bond to the land where they are located, on the other hand, they remain partially restive as to the economic viability given their felt

confinements in such settlements. Their life before was one of symbiosis with agricultural communities; that is, at regular intervals or as customarily agreed upon times or seasons, they exchanged their harvested forest goods with the products of people in a farming village. Commonly, too, they offer labor in exchange for carbohydrates at certain times, but all of these were conducted without sacrificing their autonomy.

As their territories are encroached upon, they become more restricted in obtaining enough resources for exchange. Thus, rather than both remaining equal partners in trade with village people, they are now becoming beggars on the street or objects of disdain in urban settings. All these were brought about in part by the long colonial history of the Philippines, in which attitudes, values, and behavior are increasingly defined in economic terms, heightened by man's alienation to his natural world through the private ownership of land.



A motorcycle represents how people are now very involved in the life and activities of the province. Almost all households own at least one motorcycle, which provides them access to the wider market and to various events in the province. (Sansait, 2009).

In their new circumstances, discriminated against and almost totally left behind in poverty by their more clever and greedy neighbors, institutions and concerned groups came to appease their plight. This is most represented by nuns, who specifically put up a school and a convent to assist the Ati community in raising their status in life. This presumes that the only way to put

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dignity into their lives is to civilize them through literacy and familiarization with the skills necessary to compete against their fair-skinned neighbors.

Although the nuns do not aim to make the Ati Christians directly, their comforting and caring presence does reveal so much as it validates their values, which ultimately will confront if not undermine the Ati culture. To protect the Ati, to give their dignity back, to help them, to teach them, and to save them are all noble visions of missionaries, but in a sense, they speak of an assumed cultural superiority, and so they conspire to weaken further the status of the Ati. In the end, a new kind of patron-client relationship is established, if not dependency, which in this case is based on religious pretext.



These are some of the crafts produced by the community, mainly as souvenirs demanded by visitors. Indirectly, these reveal their participation in the island's economy, but only at a minimal level. (Sansait, 2009).

The life of the Ati in Guimaras is indeed beguiling. Relying on their millennia-old tradition, they remain to fulfill their life's demands against the many enticements of greed and luxury that, for them, the world is possessed with. In them lies in part the history of mankind, which is no less sophisticated and complex, exploiting a world that they wish to understand and harmonize rather than control and manipulate, and to live in and make peace with rather than

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strain and antagonize. For the generations of Ati to come, it will be up to them how they will consciously cherish not only their past but likewise hold steadfast to their rich culture side by side with the extent of their own struggle to regain the land where the enjoyment of their lives, autonomy, dignity, identity, and respect for their heritage and history could be ensured.

4.2.16. Retained and valued traditional rituals and beliefs

4.2.16.1. Courtship and Marriage as Narrated by Tay Floro. As far as Tay Floro could recall, he narrated that from his parents' generation, there was no strict regulation as regards the choice of marriage partners. "*Pwede ang pakaisa, basta magka-intiyendehanay lang sila*" (individuals may marry their first cousins so long as they are agreeable to each other). As regards the age of marriage, teens as young as fifteen or earlier have been reported to engage in sexual relations without incurring any negative social sanctions. At present, it has been observed that although many Uta marry late in life, this case is simply taken as part of a myriad of choices in an Ati teen's life rather than an outstanding preference to abide by. To the community, the most compelling behavior that leads to a marriage decision is when a male has built a hut and his mate modestly gets inside it.



This area has been identified as an excellent place to show love by chasing a lover at a distance. (Sansait, 2009).

Towards marriage, the initial step is "*luyagay*," or when both male and female have come to be fond of each other (after some acquaintances). When this has become obvious or

noticeable to the community, a parent, after being alarmed by neighbors who have observed the unusual intimacy between the two, will approach the lovers to confirm the relationship ("*mamangkot ang mal-am*" – parents will inquire). If their response is affirmative, they will then advance to "*pamaan*" or "*pabagti*," (to announce or to declare) wherein they will be counseled to inform their parents, especially their father, about the relationship ("*ti, kun galuyagay kamo, kun-on mo si tatay mo*" – if you love each other, inform your father about this). At this stage, it is expected for a male's parents to initiate the first move by informing the girl about their intention of visiting her parents ("*kun-on mo si tatay kag si nanay mo nga maagto kami jan*" – tell your parents that we will be visiting them there). This phase is called "*kagon*" and is aimed primarily at setting the final date or arrangement so that the two can formally declare their union.

When the parents of both parties have agreed on the date, any available relatives are likewise informed and invited to witness the event ("*tipunon ang mga mal-am*" – gather the elders). In the past, Tiyo Floro said that it was the parents who would just converse about and agree on the forthcoming relationship ("*ang ginikanan lang ang ga-istorya*"). Today, however, both partners are being made to confirm their intention and commitment before their parents. Each will be asked if they indeed like to live together ("*pamangkuton kun luyagay gid sila*"), and their affirmation will seal the occasion ("*ti, tapos run ra*"). With that, no one will ever bother them or probe once again about their relationship since their decisions have already been confirmed by their parents ("*ma-imaw run sanda kara, bahala run ra kananda*" – they will now live together as a couple, and their fates are now up to them).

But interestingly, Tiyo Floro likewise could recall how males and females in the past were expected to act to publicly confirm their union. The fiancé, with a cooked meal set on a bamboo pole on his shoulder, would walk or appear to run over a hill or at any open field ("*ang linuto ginatuwang-tuwang kang nobyo sa bungsod ukon sa patag man*"). Then, with the urging of those present, the fiancée would run after him. Their relationship is confirmed once she gets hold of him ("*kun malab-ot, ti, kasal na*" – If she catches him, then that will seal their marriage.).

Tiyo Floro made it clear that the marriage ceremony that is accompanied by rhythmic dance with bolos (traditional bladed weapon, like a machete) at hand is not theirs ("*ang ga-saut ka sinulog kag ga-kumpas ka binangon kag talibong, sa mga Uta ra tana*" – The religious marriage dance ceremony with bladed weapons at hand is for the lowlanders only.). This was erroneously attributed to them since their lifestyle has been arbitrarily associated with the cultural practices

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of other known indigenous groups in the country. But for him, their marriage ritual has always been this way, and in fact, in the past, it could have been simpler with fewer neighbors around to bother about anybody's conduct in finding a mate.

4.2.16.2. The *Panagda* and the *Panul-ong* as Narrated by Tay Floro.

These rituals are expressions of gratitude and generosity and of affirmation of their bonds to each other, to their ancestors, and to nature in general. These are done to recognize and celebrate each other's presence and contribution to the cohesiveness and intimate link of the people to their world and to their community. The old folks who possess knowledge about the procedure and ceremony are usually sought to initiate or preside over these rituals.

4.2.16.2.1. *Panagda* happens usually as a form of Thanksgiving, although literally it means to invite people around over a meal. The family or community that sponsors this generally concedes that while they are happy about their harvest or being reunited once again with the folks who had been away for some time, they must likewise recognize the dead whose souls are just around and who likewise want to partake in the celebration. This means that although it is the living who do this commemoration, the souls of their dead relatives, who are thought to inhabit the area, are similarly given due recognition.

It is customarily held or done when rice or any crop is ready for harvesting ("*sa tig-ani*"), starting with the folks who would go to the rice field to manually cut a bundle of rice stalks ("*bu-ol kaw kang paray*"). This act, which signals that the harvest period or season has started, is taken as special since this first harvest is meant to be offered (as a profound token) to the souls of their bereaved relatives.

To separate the grains from the stalks of the harvested rice, they will first thresh it with their feet ("*linason*"), and then they will heat the grains on an iron pan ("*sanlagon*"). Next, it will be pounded on a wooden pestle ("*bayohon*") to separate the hulls, and later, it will be winnowed ("taphan") using a wide bamboo woven tray to whisk off the separated hulls. Such rice without hulls will have to be manually cleaned off of dirt or pebbles ("*sisigon*"), and later on will be ground to bits ("*dikdikon*") using the same wooden mortar and pestle.

This ritually prepared rice is now ready for cooking but should be separated from the rice collected and processed through conventional means ("*tig-angon ti lain*"). When cooked, it will be manually shaped into small, inverted cones and placed on a plate. The number of these cones

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depends on the number of souls decided to be offered or invited upon. Together with other available cooked meats (chicken, pork, or beef), as well as coconut wine or any drinks around, it will be placed on a bamboo tray ("*sa kararaw*"). It would be furthermore considered complete if a turtle's ("*bao*") and a monitor lizard's ("*halo*") meat were present, for they are said to be their unquestionably gratifying delicacies, relished in their community as far as they could remember.



Nay Dolores performs a *panagda* ritual in front of her visitors to thank them for their presence. As you recite the appropriate words, she moves the plates accordingly. (Sansait, 2009).

As the bamboo tray is ready, hot charcoal is set up on a pot ("*bagahan*") that will soon be sprinkled with bits of tree resin (either from *Cinnamomum camphora, Dryobalanops aromatica,* or *Styrax benzoin*), resulting in an aromatic smell from the smoke produced. The ceremony usually happens in a spacious space outside the house so that a few relatives can be accommodated. With everybody now seated around the offering, the designated leader will pick each food and recite:

"_____ (name of the person), *ari ang bao, ari ang halo, ari ang kan-on, ang tuba, ang tabako, ang mama, kag ang karne. Kauna ninyo, kay inyo ni*." (Here is the turtle's

meat, here is the lizard's meat, here is the rice, here is the coco wine, here is the tobacco, here is a betel leaf paste, and here is the rest of the meat. Do get and eat these; these are yours.)

Immediately after reciting these words, the leader will pick up the bamboo tray and move clockwise around the group seven times. He would repeat the same procedure (invitation and walk) for each name or soul being invited. The community considers this very serious and sacred, so as not to desecrate the whole ritual. Everybody is prohibited from tasting or eating the food offering until the whole ceremony has ended, with the strong admonition that anyone who forgets to observe this runs the risk of having their teeth knocked off ("*kay mabingaw ang unto mo*").

2.2.16.2.2 ***Panul-ong***, on the other hand, can be done after the *panagda* or can be accomplished solely as the occasion may require. Typically, before or after a hunt or planting season, people may opt to hold this ritual wherein a designated folk will bring tobacco wrapped in a leaf (any large leaf as of a banana) to a forested or cleared lot or to an open paddy.

While in a motion of pushing the tobacco away, he or she will declare, "*Itulod ko ang malain*" (I will push away any evil).

Then, in a motion of pulling or drawing to himself or herself the wrapped tobacco, he or she will declare: "*Butungon ko naman ang mayad*" (Then, I will pull the good).

After the performance of this ritual, the material offerings are left on the ground, and the rest of the community just resumes any activity or chores they are into now. The main motive of the *panul-ong* is to appease other spirits with the hope that they will intervene favorably in whatever venture the community wishes to accomplish.

4.2.17. Significant Food Gathering Practices

4.2.17.1. ***Pang-ranso***. This is a generic form of finding food, for it involves families moving out in a new temporary location to hunt, to gather food, or at present, to look for temporary employment that could be supplemented by selling of their herbal/medicinal kits or by begging. *Pang-ranso* is an essential tradition to the Ati identity and history, for through it they have successfully survived up to the present. This behavior allowed them to disperse in a particular region, which in part mitigated any environmental stress to the surrounding area of their occupied territory through over-consumption and exploitation of resources. Likewise, this

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enabled them to open up new frontiers for their group to explore as well as create opportunities to gain new experiences and knowledge about their subsequent surroundings. It is thought that those who have been gone, no matter for how long, will at length return, but it is understood that one or two families may eventually opt to stay for a long time. When done through generations, they would soon come to realize that they were on the move or would find it difficult to remember where they had come from without noticing how *pang-ranso* had played a significant role in it.



This apparently abandoned hut is the temporary result of the *pang-ranso*. Hungry families may camp temporarily in some places to sell their goods, find temporary employment, or beg, which necessarily leaves their huts unattended. But after a few months, when they return, they will repair their huts or build a new one nearby. (Sansait, 2009).

For the Uta, who had built a strong convention of owning a piece of land, *pang-ranso* could be thought of as a temporary undertaking only, but for the Ati, this mode of exploring a vicinity is an open venture were settling for long and being separated from one's kin is likely a possibility. However, as the Uta are determined to appropriate any terrain available, the call for *pang-ranso* that will lead to the opening of new settlements is most likely becoming a venture of the past.

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4.2.17.2. *Pang-ngayam*. This is a well-specified food gathering behavior that aims mainly at obtaining protein by hunting or trapping animals in the wild. Since this involves a long walk and being away for at least three days, males (who are traditionally associated, although not exclusively, with this task) generally do have to make good judgment when to go as well as negotiate for each other's availability since many are now employed among the Uta. Although they do not have any preference as to the kind of species caught, they nonetheless are keen to hunt only those animals that are not perceived to be pregnant or still juvenile. Recently, however, they noticed that they become less selective with their kind of catch to compensate the length of the trek they have to do and the limited space available for them to exploit. On the other hand, as to their traditionally specialized hunted species, the "*halo*" (monitor lizard, *Varanus indicu*s), the "*ibid*" (a kind of iguana, *Hydrosaurus pustulatus*), the "*magkal*" (a kind of snake, *Python reticulatus*), and the "*ba-o*" (a kind of turtle, *Heosemys leytensis*), they remain confident that these species are still abundant, having fully known the reproductive capacity of these reptiles, as they lay dozens of eggs at a time.

On a cultural level, *pang-ngayam* is associated with *pang-ranso*, as both connote mobility. They played a significant role not only in providing protein but also in defining their identity as this enable them to continually commune with nature. Presently, as it is with *pang-ranso*, the viability of this hunting habit is becoming irregular given that the land available for exploitation is getting constricted, in addition to the fact that many males have learned to work on Uta's farms or industry on a regular basis.

4.2.17.3. *Pang-ngilimos*. Commonly, begging is frowned upon as it indicates an unproductive state of life. As one puts himself in the position of being the object of embarrassment, disdain, or pity, it is seen as a social aberration. From the Uta's perspective, there is nothing unusual for Ati to beg, having defined and accepted that such behavior is corollary to their values and lifestyle. However, this behavior could be better appraised in the context of Ati history and practices rather than to appraise them as victims of economic disparity. This means that traditionally, their visits to their relatives to ask for food or their desire to establish exchange relations with the Uta are perfectly part of their traditional strategy of not only redistributing goods but also reinforcing social ties.

In asking for food (now called begging) or in giving away one's excess, the difference is very thin, for in their own perspective, both are the same—only that they happen in different

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periods of time. In both, they are altogether involved in the negotiation of relationships, the working out of compromises, and the maintenance of trust. Their asking for food or money today is the other side of their eagerness to share on their times of abundance. Given their cultural past, *pang-limos* could hardly be understood then as totally new or without cultural significance in their own worldview. Within their group, they euphemistically refer to their fellows' begging in the city as "*ga-kolekta bayad*" (on the path to collect payment), for in their mind, the Uta have not yet paid off the land and resources they have unkindly taken away from the Ati.



Usually, in the months of August to September, when food was scarce, an Ati family or an individual may be found wandering to solicit any food or money. While pang-limos is not totally frowned upon since this is only a temporary activity, an Ati is wary of being caught since ordinances were passed prohibiting mendicancy. (Sansait, personal).

4.2.17.4. *Pang-pamunit*. This is their term for fishing in general and it involves the use of a hook and line attached to a long pole. Although many now use nylon string and iron hooks available in the market, however, in cases when these are not brought along, many are still capable of using any tree or plant fiber as their lines and a shaped and sharpened branch or bamboo as their hook. This activity is not discreet but rather it always includes other modes of obtaining sea or river products like the installation, the inspection, and the collection a catch from bamboo traps, small seine, and bagnets.

4.2.17.5. *Pang-panulo* is their term for fishing at night using their improvised harpoons (iron-tipped poles) to catch fish that became visually disoriented due to the light coming from their powerful torchlights. While, recently, they claimed to have used illegal chemicals that stun fish, but nonetheless they are quick to maintain that the Uta were the ones who introduced these substances to them.

4.2.17.6. *Pang-nginhas*. This is a purposive collection of shells, snails, and crabs at the tidal zone (*sisi*, *bagungon*, *arikumo*, *talaba*, *suso*, and *kalampay*). Usually, this is done when they are close to or happen to visit the shore in conjunction with *pamunit*, or it may even supplant fishing in cases when their catch is few that day.



The photo shows the preparation of a python's skin for drying after removing the meat for consumption. Although in most cases, captured reptiles are sold to increase their income, however, since they also crave meat regularly, some of their captured animals are consumed. In this case, they still make sure that the skin and bones are processed for the market. (Sansait, 2009).

4.2.17.7. *Pang-ngali*. Although associated with diverse and abundant forest vegetation (which Guimaras is now losing), digging root crops is seen as truly a major means of acquiring starch or carbohydrates. On a given day, they would initially scour an area and look for the familiar vines indicative of root crops they consider edible. Then they would estimate the maturity and even the size of the tuber hidden beneath the soil by inspecting the size, length, and color of the vines and leaves relative to the soil type where the vine is found. The tuber is either "*rabo*" (ripe for cooking) or "*ganas*" (less starchy), and only the root crop that is *rabo* is

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pulled out and taken home while the rest are left for another week. A simple way of determining or predicting the maturity of the root crop is by observing whether the main trunk is stiff, brittle, or has dried ("*kung patay na ang lawas, kag laya na ang dahon*"). Having found one, they would focus their digging where that dead vine of a tuber has sprouted—not immediately over it, but about a foot in diameter or more around it; and careful as one's tool hit the soil deeper—so as not to wound or stab the root crop with their stick. The targeted crops are "*banayan*," "*ube*," *tam-is*," "*singkamas*," "*kamote*," and "*bakwit*."



Nang Violeta arrives shortly before nightfall with her forage, which includes tubers, fruits, leaves, roots, and branches of well-known medicinal plants collected a few kilometers from her home. After being cut into pieces and dried in the sun, these branches, vines, and twigs will be passed on to relatives and other vendors, who will trade them at one of the stalls adjacent to the central market of Iloilo City. (Sansait, 2009).

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4.2.17.8. ***Pang-kaingin***. This is a set of activities common among horticulturalists involve the preparation of the field and the planting of crops on it. It would usually happen during the

dry season ("*tag-irinit*") that after having chosen a field due to the perceived fertility of the soil, shrubs and juvenile trees are felled ("*tapson ang gagmay nga kahoy*"). Then, after the debris has been collected ("*tumpukon*") and left for at least a week to dry further, it will be burned ("*tutdan*"). Once the leaves and branches have been burned, planting ("*panggas*") would start with the use of a digging stick. Species recalled as being planted include rice, corn, beans, potatoes, and cassava.

4.2.17.9. *Pang-nguling*. Charcoal making entails the existence of a strong demand for its production and is thus generally associated with the Uta community, who are predisposed to cook a host of menus and delicacies. This task, therefore, for the Ati partially defines his venture into an economic relationship, for it involves a payment by the Uta for the labor he had invested. On their own, the Ati are not inclined to get into the charcoal-making enterprise except when commissioned by the Uta ("*kung suguon lang*"). The Ati, out of the task assigned or contracted to him, will receive two-thirds of the earnings ("*tersya ang parte*").

Of interest, the Ati further distinguish themselves from the Uta in this task by the manner and choice of the part of the tree to cut and process. For them, they will only cut those branches that are bent or crooked and those they consider the end parts of a tree ("*ang mga tiko, kang ang mga punta lang*"). They avoid cutting the straight parts because of their foreseeable use in the future ("*indi ang mga tanos kay magamit pa*").

4.2.17.10. *Pang-buhat Habon-habon*. This category is purely an economic enterprise, for they are now tied to a contract to produce a native purse handicraft. After having been provided with initial training by a religious organization (in Kati-kati) and having been given capital by sales agents who have contact with them, they are now made to respond to the market demand for their produce. For many, to have food on their table or kerosene on their lamp, they have to obtain credit from their neighbor, who expects a payment upon the next visit of a sales agent, who would grant them additional capital to stimulate further production.

4.2.17.11. *Pang-trabaho* o ***Pang-nguma sa Bisaya***. Being paid laborers in a household or on the farm of their Uta neighbors is held as another means to obtain food, though indirectly. This is not only plain work for a pay since the contact usually results in the Ati learning the values and expectations of their masters. Oftentimes, they would receive, uncalled for

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prejudicial remarks as "itum," "baho, or "tamad" (black, smelly, or lazy) by their neighbor, but over time they were able to live by or ignore them and so able to move ahead with their life.

This form of employment is never a full-time job, though. On the surface, it seems it is the Uta who dictates when to hire and when to end the job, and likely so because he has the resources and money. On the other hand, Ati likewise has a sense of limit in his work. Most often, when discontented with the treatment of the Uta or the kind of job he has, he will either complain or simply leave early from the task at hand. To the Uta, this is plain laziness, but for the Ati, this is part of his search for a far better source of contentment in life.



The photo shows that behind the open patch the residents of Sirum identify as a kaingin area, a place where the previous year they had cleared manually (and the remains were dried and burned) and is now ready for planting with the help of digging sticks. (Sansait, 2009).

4.3. Land and Wellbeing of the Ati People

Being slowly restricted in their traditional space and way of life, the obvious signs of anxiety and stress may not be visible in their daily encounters with the Uta, as their perception of themselves as resilient and self-reliant is strong. No negative or unusual behavior in the open could be observed if one's mind is conditioned to think that what they were in the past is like what they are today. Their destitute huts, meager food resources, low-income status, lack of opportunities for regular labor employment, limited education, and precarious food and water

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resources could only be glossed over as part of their choice or tradition, thus easily dismissed as matters of no urgency. Worse, if their present condition is seen as of their own choice alone or just brought about by fate, all that is required is simple acceptance of life and a resolve to compete in skills and competence with the Uta for a better life.

There is no escape from self-blame if events and circumstances are understood as recent phenomena rather than realizing that all these disparate manifestations of poverty are products of historical dispossession, cultural trauma, stigma, and prejudices universal to all small peripheral indigenous groups. Ordinarily, it is tempting and feels good to see them as people who have the utmost optimism in life, full vigor, and innocence, and thus have all the cultural and psychological advantages compared to their rich neighbors in terms of life satisfaction. This attitude, however, points to the narrowness of understanding of the general fate of indigenous peoples nowadays as well as endorses ignorance and tolerance toward the subtle and blatant injustices and sufferings that they are undergoing. Without a fair appraisal of their status and condition as people displaced by market forces and historical events, neglected in the social, political, and educational spheres, and curtailed in their cultural expressions based on land and identity, any good thoughts about them would simply be another form of consenting to a form of violence to their existence and identity.

Mental health issues could not be reduced to a listing of recommendations, receipts, or diagnoses for those who fit into the medical categories, but rather attempts should be made to make those efforts holistic, sustainable, and meaningful to their lives. The understanding that since these people have been used to endure their fate in the past, they can most likely endure it in the present and in the future is totally vicious and unacceptable. These people are not just things that come and go in society; rather, they are part of it, and so their needs based on their own cultural experiences and identities must be respected. But respect could not come about without knowledge of the intricate connections of their lives, thoughts, and practices to their land. At this instance, it would be worthwhile to dissect the following statements expressed on the webpage of the Province of Guimaras, Philippines:

> Security of land tenure is still a problem for the Aetas, particularly in Kati-Kati, San Miguel, Jordan, and Maabay, Sibunag. They still live on private lands, which they cannot call their own. There is no identified ancestral domain in the province. They still have to accomplish several documentary requirements for the processing of land titles before they can have a claim on them. Thus, most of them have not yet transferred to the settlement areas. There are also some non-Aetas who are tilling and planting crops in the proposed settlement area. For those who have lived in the settlement or CARP areas, they find their backyards too limited for planting and animal raising.
>
> The other challenges of IPs include a low level of family income, the prevalence of out-of-school youth (23 percent of the total children), malnutrition, a lack of farming equipment, inadequately sealed

> toilets, a potable water supply, and personal hygiene. Discrimination and bullying at school are still experienced by IP children. Interventions for persons with disabilities and senior citizens are also given priority in the province (Guimaras Profile, 2018).

The statements above are not simply descriptions of the Ati people in their midst; each sentence or phrase reveals perspectives, attitudes, and levels of awareness as to the plight and needs of the indigenous peoples. Each of those sticks out messages to be analyzed or examined so that equal views are presented to enhance recognition that the problem is not only upon the indigenous peoples but likewise in the prevailing knowledge and conventional view from a privilege position of the government. Thus, those sentences always beg: from whose point of view should the analysis be made? This then could open understanding to the voices or grumblings from the Ati themselves, for the truth about life is not always monopolized by those enjoying privileges in the political, economic, and educational spheres.

While in the next section, extensive and detailed analysis will be presented based on the underlying and overarching factors consistently observed by researchers that define indigenous people's mental health problems, a short commentary will be made here about the statements quoted above. The first is on the phrase "security of land tenure is still a problem for the Aetas..." Foremost, it is a generous and honest recognition that there is a problem, and this is about land tenure. With this, there is hope for a broader dialogue since the acknowledgment itself that there is a problem reveals a window of humility and recognition of the task ahead.

Nonetheless, by reducing the problem to a land tenure problem, the Ati people are as well reduced to being mere peasants of a bigger society rather than a people enshrined with the right to self-determination. As peasants, they could be rightfully classified as belonging to the lower stage of the assimilation efforts of the government and thus are expected to be capable of improving themselves based on how they participate and compete with the rest of the people in society. This perspective could indeed be encouraging since there was a recognition that they are part of a democratic society, and with their patience, positive reforms will happen in their lives. Nonetheless, this reduction of their status to peasantry does not do due justice to their inherent rights and historical trauma since colonial times.

Second, "They still live in private lands, which they cannot call their own. There is no identified ancestral domain in the province." It must be emphasized that before the birth of the nation and before the coming of the current dominant Austronesian immigrants to the archipelago, their ancestry was already in the country. It could be argued that they might have come late or simultaneously with other types of indigenous groups, but nonetheless, across

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these centuries or millennia, they have never ceased to be less than what they understand as who they are as the Ati people among other early settlers in the archipelago.

The statements therefore reveal similar things: that their enjoyment of land is to be "granted" by the state under a new land system of ownership. With this choice of word and attitude, the question of ancestral domain could easily be reduced to a question of "giving" them lands to be owned privately rather than culturally based on their inherent right to ancestral domain. As of their current land status, the Ati people are promised separate land pieces in five community locations, about 70 to 100 hectares in all, which until now remain elusive due to bureaucratic processes. Given this overdue act of justice, the tentativeness in political will probably due to some level of ignorance and prejudices, the once promised wider land space becomes in actual account to be only about 10 hectares in total.

Calculated against the total land area of Guimaras, which is about 60,000 hectares, 10 hectares is only about 0.014%, and so the claim that "there is no ancestral domain identified" for the Ati is very dismissive of what is due to the Ati people. Further, recognizing that Guimaras is undergoing economic progress driven by tourism and housing development, most likely the Ati people will be out of luck other than to be relegated to a peripheral location.

In this instance, therefore, there is something wrong with the claim that the province has no identified ancestral domain since, in the first place, the role of identification belongs to the Ati people. All it takes is a simple dialogue and a recognition that the Ati people have a unique past and present conditions and that, ever since, their cultural life has always been integral to the lives of the province or to the country. This implies that acknowledging a wider space for the Ati is also a form of appreciation of the legacy of mutuality, generosity, and humanity that is inherent across cultural groups in the country. In the development of the country or of the province, the Ati has never been a threat nor an obstacle. On the other hand, the Ati people are part of the treasures of the Ilonggo community and identity known for its generosity, ingenuity, and industriousness driven by diverse sources of beauty, creativity, and identity.

Third, "They still have to accomplish several documentary requirements for the processing of land titles before they can have a claim in them." It is correct that their level of (il)literacy in addition to low esteem loaded with discrimination, would have undermined their self-confidence, and thus cannot complete processes without specific help from those in power. In this circumstance, the National Commission for the Indigenous Peoples (NCIP) has the prominent role of guiding or providing support for attaining the requirements necessary to enjoy

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their ancestral lands. But across these years, although these Ati people are a small group only seeking simple help from the government, their existence described by their continued land insecurity is truly bewildering.

Knowing that the NCIP is directly under the office of the President of the country, much could be accomplished, as the agency could have expedited processes only if priorities were set. The case of the Ati people, however, is not unique, as their fate is shared by almost all marginalized groups all over the world, where governments become successful in keeping indigenous peoples insecure by keeping them dependent upon the initiatives and pity of those in power. Equally, this is not the sole responsibility of all NCIP personnel who do their office work eight hours a day diligently, with each having their own economic needs to fulfill for their respective families. In other words, as regards the urgency of realizing land for the Ati, it must start with a sense of awakening to the great injustice on them. One way that could drum up a healthy appreciation, respect, and protection to their existence is through a realization of their cultural and ecological contribution to the world's natural resource's diversity.

Fourth, "Thus, most of them have not yet transferred to the settlement areas." There is no doubt that what this statement intends to say is that the Ati are to be housed and to thrive in a resettlement area. This, however, does not sound humane at all at this century and at he current level of understanding based on the UNDRIP and IPRA documents, for these people deserve more given their cultural identity in relation to the local community. Recalling the experiences of North American Indians and other indigenous groups in New Zealand and Australia, putting indigenous peoples into resettlement areas requires justification for why they should be resettled in the first place. These people are neither animals nor criminals nor people without history who could simply be reduced to merely settlers in a land.

Fifth, "There are also some non-Aetas who are tilling or planting crops in the proposed settlement area. For those (Ati) who have lived in the settlement or CARP areas, they find their backyard too limited for planting and animal raising." This happens when the Ati people's inherent welfare is compromised or confused with other laws like the CARP (Comprehensive Agrarian Reform Program). Again, the CARP might be suitable for the non-Ati, but that does not mean that political will cannot find wisdom in the IPRA law, which could further be expedited since its implementation is under the Office of the President.

This attitude unnecessarily deflects the real issue, which is that the Ati people, who are not cognizant of their inherent rights and favorable laws, will likely end up likewise confused and

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unable to analyze and find the correct action to uplift their condition. Sadly, this also pits non-Ati against the Ati people, as they are made to contest the land on the pretext that both have the same rights under the same and fair law. This will likely translate to unnecessary animosity, placing the Ati in an unfavorable condition given their history of trauma, stigma, and discrimination. On the other hand, the statements likewise reveal the unspoken consequences of the delayed implementation of the long overdue CARP law, which victimizes both the Ati and the non-Ati people and further compromises their mutual respect and beneficial relationships.

Lastly, the statements above enumerate the negative conditions of the Ati, including "low level of family income, prevalence of out-of-school youths, malnutrition, lack of farming equipment, inadequate water sealed toilets, potable water supply, and personal hygiene," plus incessant "discrimination and bullying at school." At first glance, given the fluidity of words in the descriptions, it seems it has become conventional to associate these negative outcomes with the Ati people as their normal attributes. It appears it is inconceivable to think of them as being in a better position other than from a prejudiced perspective. The verbal projections in this frame may look like a badge of accomplishment—that these people have been described to be so, and so the actions of delay, indecisiveness, and uncertainty are justified in freeing the general populace and institutions from accountability and blame.

With all sincerity and desire to ameliorate lives and relationships in Guimaras and the archipelago, there is no need to go any deeper into the game of blame vs. guilt, for the immediate demand now is on how to make this information renew commitments to the better future of the Ati people. Thus, by reexamining the context, position, and embedded meanings in the statements, many concepts and confusions have been put into perspective. One of which is the view that land is immensely important to the maintenance and protection of the wellbeing, identity, and culture not only of the Ati people but also of the good name and future ecology of the region.

4.4. The (mis)representation of the Ati image in the region

In the desire to boost the tourism industry in various provinces of Western Visayas Region (Region VI), annual dance festivals are celebrated in each urban center in Bacolod, Antique, Aklan, Capiz, and Iloilo. Besides looking at these as sources of revenues, these are likewise seen to reinforce the sense of belonging or attachment of the people to their home province. On

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the street scene, one can expect choreographed dance presentations of different groups called tribes in colorful native motifs, including headgear, tights, earrings, necklaces, anklets, and bracelets. With the synchronous beats of the drums, bamboo flutes, and xylophones, and further aided by loudspeakers, the spectacle on the final day of the week-long celebration, starting from early morning till afternoon, becomes psychedelic as each group performs their depiction of a specific narrative about their respective province's immediate glorious past.

In Iloilo, one such famous event is called Dinagyang, and the dominant narrative is that of a celebration to commemorate a successful harvest, a warding off imagined invaders, or a restoration of health. Often, however, each culminates with the affirmation of conversion to Christian faith with the unveiling and raising of the image of a child Jesus accompanied by chanting: *Viva, Viva, Viva, Señor Santo Niño*!" There is no doubt how convinced and earnest the producers and participants are about the cultural roots of their festivity, but these alone do not guarantee the truth or authenticity of the narratives.



Ati-Atihan, Dinagyang, and Binirayan are colorful carnival-like events every January in the provinces of Aklan, Iloilo, and Antique. While variations in choreography, spiele, or emphasis do exist, they still share a common theme peeled off from the cultural imagery of the Ati people. (Explore Iloilo. 2020. Dinagyang Festival. From: exploreiloilo.com)

Since each celebration is aimed at providing a venue to sustain the tourism industry, entrepreneurial spirit, and the promotion of local pride, truth and fiction could readily be mixed up or easily justified in the sphere of creativity and entertainment. In Antique, for example, the

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Binirayan festival is marketed as a celebration of the successful sale or barter of the Panay Island, with a large golden hat and a long, heavy golden necklace as the means of exchange, from the powerful Ati clan to the southern, fair-skinned immigrants who eventually became the dominant group on the island or elsewhere in the Philippines.

In Aklan, they have the Ati-atihan festival, and by the name, the festival prides itself on being purely a celebration for the Ati people with motifs and themes, and participants earnestly attempt to depict the Ati features from skin color to curly hair props dancing at the synchronous fast drummers' beats. In Iloilo, the same narrative depicted in Antique and in Aklan reappears, but the festival in the city is far more glamorous given the budget support provided by the local government and by the local business owners. Besides the usual Ati conversion highlight, other folk themes like mystical-religious-nature healing are incorporated, reflecting the pre-colonial beliefs and practices of the Tumandok group and of the dominant Ilonggo society. Meanwhile, in Bacolod, they have the Maskara festival, which portrays the province's resilience Despite poverty, thus the popularization and marketing of ornamented smiling masks worn in group performances or to adorn commercial buildings during the week.

While the Maskara in Bacolod does not have any direct portrayal of the Ati, major elements of their parade overlap with the themes of those in Antique, Aklan, and Iloilo as found in their choreography, drumbeats, and the infatuation of painting or decorating their arms, necks, legs, and faces with colorful paints or glazes over black skin canvas. Further, while they are all commercially funded, nonetheless they are packaged as a cultural celebration, and so the event would officially start with a Catholic mass, signifying that the province's cultural heritage is inseparable from their colonial religious hopes and imagination.

The nostalgia, infatuation, sincerity, sense of euphoria, and aggressive marketing, however, do not guarantee that the content of the narratives is correct and dignified. Themes, creativity, and imagination may be fluid and engaging, but when these are not regularly scrutinized, they may end up being shortsighted if not harmful to people who might be misrepresented if not deprived of their correct cultural and historical experience and identity. In the province, however, to produce a valid continuity or justification of their present life in relation to their imagined glorious past, the people somehow need to construct cultural and social events and narratives within the purview of their selective memory. Inventing, modifying, and re-imagining cultural identities and traditions are healthy habits for people, as these may provide security and direction in their future lives. Often, fictive stories are merged with facts to

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construct a worldview that would become unassailable across time given the ideological strength rooted in both action and imagination.



By fusing color, music, pageantry, and indigenous themes, festivals like this are being marketed to tourists as authentic and exotic, even to the dismay of the disenfranchised Ati people. (Photo by: Nelson Rondan, 2020.
From: https://newsinfo.inquirer.net/1219620/dinagyang-returns-to-its-roots)

These provincial festivities may therefore be good for reinforcing social and cultural ties to the local communities, in addition to the income generated out of them. But nothing in here could justify the continued neglect to scrutinize how fiction has denigrated the truth and weaponized the celebration to misappropriate the cultural and biological identities of people long since discriminated against. While the Ati people are generally accommodating, kind, and forgiving of the circumstantial uneven relations they have with the general society, however, when among themselves, they too feel the anxiety, frustration, and discomfort of the ongoing festival's displacement of their role through their silence, indifference, and grumblings. The pain of the dichotomy is clear: while the province profits as it makes use of the Ati name, features, and fictive cultural history these people have not in any way had direct participation in the performances or economic benefits from this charade.

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In Iloilo, the Ati people are not physically visible in the main artery of the celebration. In contrast, it is the general populace itself, in their alter-fictive selves, who wrestled and owned, re-imagined, repackaged, re-presented, and disseminated the Ati identity by the Ilonggo performers with consent from the political, social, and religious structures. In Dinagyang, there are so many dehumanizing aspects, starting with the adherence to false narratives. While it has already been shown to be false that an Ati chief once sold the island to the migrant chieftain, the province's persistence in espousing this fiction undermines Ati's history and welfare. This puts the Ati people at a psychological disadvantage since this justified, by default, their land dispossession, and by extension, it became acceptable to relegate them to remote and marginal locations.

Further, this narrative also blurs the nature of relationships among all migrants in the archipelago thousands of years ago, whom the Ati had never done wrong except to be their neighbor, friend, ally, and partner in the use of the land. They might have different biological features or cultural patterns, but in deep analysis, all humans belong to the same genetic background, and the current cultural traits are products of the mutual and warm interaction between the Ati and the general populace, both in adaptation to their natural world. While there might be prejudices out of ignorance and miscommunication, none is more harmful than maintaining a narrative that encourages denial of the Ati people’s shared access to land as well as their beneficial economic and social connections and exchanges with society in general.

The second distressing portion of the Dinagyang celebration is that in every culminating part of each performance, the Ati are depicted to be as if, after having been enlightened, they would heartily shout, sing, and dance in adoration and acceptance of the Catholic representation of the Holy Child Jesus. At this moment, the performers and the crowd become emotionally one in affirming their common bond through the elevation of the image in frenzy to the hardest beat of all drums, accompanied by the pitch-black voices of the performers shouting: *Viva, viva, viva! Señor Santo Niño*! Everybody would give their applause and openly cheer up the performance as an act of affirmation of their own devotion or expression of faith in the name of spiritual comfort and culture at the expense of the truth and good name of the Ati. This imagery in the minds of participants and audience alike postulates the triumph of faith and civilization, the submission of old culture, and the conversion of what is from the past and old life to a new one, which deserves memorialization, recognition, and continued passion, and so essentially validates Dinagyang as a celebration of what it means to be an Ilonggo.

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The last morally injurious portion of the Dinagyang is the appropriation of the name, color, and identity of the Ati in the whole festivity itself. While probably less than half of their cultural identity is used in the whole celebration, given the misrepresentations above, it is no wonder why it was easy to keep them invisible in the whole event itself. Rather than a recognition through some affirmative act to their welfare, during the Dinagyang event, they could be found further away from the staging areas yet become visible anyhow, as they too would like to become active audience or witnesses likewise to an event that makes use of their name and culture. There is, in a sense, a tentative attitude in them about whether to push themselves among the crowd, risking discrimination, or stay some distance away while still being in touch with the celebration. Individually, few would venture to beg or sell their handicrafts or medicinal kits and wander into the crowds, but at the end of the day, they would return to their identified temporary refuge or street corner for the week.

This cultural misappropriation, in the form of using their identities in the marketing and performance of the Dinangyang without fair compensation to them, makes the erasure of their cultural status as indigenous peoples possible or normalized. It is really a curious reality how participants and celebrants of Dinagyang become culturally narcissistic to take joy in appropriating someone else's identity and physical appearance to represent an alter-self to produce a successful performance. Much worse is to take joy in transmitting and celebrating narratives that are false and discriminatory. These Ilonggo people and the rest who misappropriate and distort history for their own benefit and self-need for profit or to appear exotic are most likely also the people in need of greater awareness to transform their indifference into kindness and fruitful dialogue with the Ati people.

Meanwhile, it could be said that in Antique Binirayan and in Aklan Ati-atihan, the Ati people are better off since they are encouraged to perform as a tribe in their respective provinces. Nonetheless, this is still far from empowering them or giving them what is due to them. This same thing goes with the regular performances of Ati groups in some towns in Iloilo. Although they participate in them or take pride in them, their performances are not for them, and their choreography is not innate to their culture or tradition. The steps, appearances, and costumes are all reinterpretations by some self-proclaimed Ati cultural experts. Though unquestionably sincere these organizers might be, their eagerness to retain these imagined narratives over these discriminated indigenous peoples does not serve well towards the need for respect and promotion of identity, land, and culture in the first place. The most one can

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appreciate in these performances is that the Ati are willing to entertain people and are eager to take any opportunity to present their skills or artistic talents, however often within the acculturative design of the majority populace. Overall, however, this utilitarian view of the Ati culture with sincere motivations perhaps on the side of the promoters does not in the long run benefit the stigmatized status of this group unless efforts are premised on their rights to self-determination and ancestral domain claim.

4.5. The faces of mental health and wellbeing among the Ati people

This paper is conscious of raising understanding about the wellbeing needs of the Ati people and refuses to reduce the issue to a medical problem alone. This endeavor aspires to or advocates a holistic, comprehensive view of mental health programs centered upon their land, identity, and culture. This means further that mental health is just one of the many challenges they face in life, which are interwoven by their experiences of land dispossession, nonrecognition of their ancestral rights to land, and forms of stigma and discrimination, along with poverty, unemployment, and illiteracy. The following are short narratives of the contexts, experiences, and views of four selected Ati septuagenarians, which touch on issues about their wellbeing and mental health. Through the narratives they have, common concerns and worries could be indicative of deeper insecurities, anxieties, and vulnerabilities. It is hoped that serious attention will be given to them not only as individuals but as members of a group capable of reinvigorating identity and culture; thus, long- and short-term approaches could be figured out and implemented, integrating medical and cultural themes on healing and illness prevention.

4.5.1. Nay Loling. As with many older Ati people, given their limited mobility, they are usually left in their houses. Nay Loling is not like the rest, however, for she used to love visiting her children in another location in the province, but due to her illness, she was kept alone in her bamboo hut. For the past month, she has had bouts of fever, fatigue, heart palpitations, indigestion, and headaches. She was brought by her daughter twice to a nearby hospital and was given medicines, but after a month after each visist, she would again experience the same body malaise. She likewise visited known local folk herbalists and healers, and this is shown by her wearing a red scarf, indicating how enthusiastically she cooperated with what was

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recommended for her recovery. Besides having one or two small amulets pinned behind her clothing, she too had some other medicinal leaves and roots inside her room, ready to be boiled for her drink or for body rub.

When her daughter arrived, she readily sat atop the wooden stairs framed by bamboo walls at the entrance to her room. Her daughter too shared her story about some causes of her illness through a mixture of medical and local interpretations. While preparing herself to go to see a medical doctor, her daughter reminded her to bring along some medicinal pouches that would protect her from evil influence or energy along the way. This day was the most anticipated moment for Nay Loling since only at this time her daughter was able to come up with enough to hire a tricycle to bring her to the nearby hospital.



After months of seclusion, depression, and recurring fever, Nay Loling becomes the face of resilience, acceptance of fate, and hope for recovery. (Sansait, personal).

Had she had good savings earlier, she could have visited the clinic much earlier rather than spend more than a month alone in the hut in stress and agony. Now this photo was taken, her enthusiasm was visible, but at the same time, her mental and body movements appeared to have

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already weakened a bit. While she was so willing to narrate her life and feelings to the researcher, from time to time she ended in gibberish and repeated the same narratives about her longing for her children repeatedly. Since their house is about a half-kilometer from the dirt road, she was obliged to walk to the hired tricycle parked nearby. Regularly, with her bent knees and back, she would sit on the ground to rest and take a good breath before proceeding again. Her optimism to get better was visible by her forward strides towards the road. While their initial plan was to go to the hospital, this time they agreed to pass by the house of a local folk healer first.

4.5.2. Nay Sara. Her case is the most unusual among the Ati, for seldom or never can you see one languishing for a longer period in the city. But Nay Sara is such a regular sight in the southeastern district of Iloilo City that from dawn to dusk she would just be found sitting or lying on the pavement in front of commercial buildings. Literally, she might be cited for begging, but because of her status as an Ati, this gives her a sense of privilege from concerned local traders who understand the pitiable condition attached to her identity. In a sense, her being an Ati, while considered deplorable, likewise provides an opportunity for the people around her to show their kindness by regularly providing her with regular meal for her sustenance.

Her position, though, could not be fully categorized as begging, for she had paraphernalia to sell: her medicinal kits, displayed in front of her. This distinguish her from other beggars, for she had something to offer that was integral to the needs of the people around her. While she could not earn much, her position as having something to offer gave her a sense of purpose in being around. However, one thing that people worry about is her daily consumption of hard liquor, which makes her doze off most of the time if not by her drunkenness would regularly shout insults at imagined beings surrounding her.

From her appearance, much could be said about her health, from her hygiene and to her obesity. Since Ati people, no matter where they are, would return to their community at the end of the day, the story of Nay Sara however reveals so much more about her cultural background than her individuality. When asked about her family, while she could readily recount a number of them and the places or communities to which they were connected, but it was most likely that her alcoholism had brought her to this condition. Rather than seek regular protection and warmth from her own community, she had now absorbed and accepted her miserable condition in front of passersby, whom she equally ignored. But again, what distinguishes her from other

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beggars is her alertness to sell her goods, her ability to recognize her regular buyers, her ability to identify the place as a spot to sell or to doze off, and her willingness to converse with people eager to listen to her personal story.

Upon checking with other Ati in nearby communities, they unanimously recognized Nay Sara but simply dismissed any idea of helping her on the pretext that her plight in the city was her choice. Her status is a reminder of how Ati people behave or react to their fellow members, which makes their group viable and resilient. Their community is willing to accommodate anyone so long as each is willing to maintain respectable behavior with the neighbors through sharing of goods and food, kindness to help, and accommodation of time and attention. Most likely, in the case of Nay Sara, her alcoholism and impulsive nature when intoxicated made her group or family members let go of her as she wished. This was their group's justification: as much as they care for her, they cannot have any means to help her alcoholism. They also recognize that Nay Sara's decision was her own and for her own good.



Nay Sara seems to be sober in her favorite place. (Sansait, personal collection).

It is not that they are not willing to re-accept Nay Sara; they are just waiting for the right moment and the right person to initiate her reintegration. This, of course, may require rehabilitation, but in whatever communities, it has been proven that people are always willing to accommodate their own kind so long as they show some deference to their neighbors' standards. Also, proof that they have not totally abandoned Nay Sara is that they regularly

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supply her with the medicinal kits for sale. This was also confirmed by Nay Sara, as she could readily recognize the persons who visited her to deliver the goods and to whom she could request specific messages be sent to her immediate relatives. This means that she was not totally disconnected from her family, but rather that there is still an underlying thread that keeps their sense of identity and support for each other, revealing their staunchness and resiliency in life. Overall, while Nay Sara was able to go beyond self-acceptance of her condition, her life is a daily reminder of the obvious needs of the Ati people for a wider, comprehensive program to address their wellbeing needs.

4.5.3. Tay Floro. He was the face of conscientiousness in the Ati community because of his willingness to assist in whatever needs neighbors may have, from carpentry to farming to giving advice, as well as to accommodate visitors with his hospitality in his simple open hut. As with any person of his age left in their community, with little material resources at hand, he has ample time to sit and let time pass in reflection and be entertained by his memories of the past in connection to his present condition. From time to time, he would recognize universality in his ideas as he referred to his poverty as common among their group as well as in contrast to the abundance of their neighbors. From him, the author learned that Ati people given their poverty may survive a day with only one meal or a week without a regular mealtime. Being away from the gaze of the general populace, all one can do without something to eat is to keep a minimal movement thus conserving body energy expenditure.

For Tay Floro, by simply being in a squatted or lying position he could allow a day pass while waiting for his wife, nephews, or grandchildren to bring him food ready to eat or for him to cook. He has some deep questions about his life and the fate of his community in poverty and insecurity, but across the years he learned to ignore these and be happier instead entertaining visitors. His acceptance of his condition allowed him to share his thoughts willingly and sincerely about his past experiences and his imaginations of life if given that the Ati people would be provided with a bigger land area to manage and improve.

Regularly, people would visit him to seek his advice in maintaining the farm and even in identifying plants and trees as sources of medicines or materials for hut construction. His hands appear to have a memory of their own, as he said that whatever he could hold, there was something he could do with it, either as functional wood crafts, baskets and bags for twigs, or decorative house roofs or walls for grasses and fibers. Also, as he was fond of recollecting and

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talking about his life way back in the forest, infused by the observations he obtained from their parents, he was a good resource for people wanting to know more about their past. Young ones would be regularly entertained as he would start his recollection of the past given the opportunity, especially when he was offered a share in alcohol. "Basta pa-imnun lang ako, madamu gid ako ti ma-istorya, bisan masaut kag makanta pa." (So long as they would provide me with alcohol, I would be more willing to grant a conversation, even to dance or to sing.) - he would often quip to reinforce personal connection with people who wish him to share his life story and views about his community.



Tay Floro always takes any curiosity about their lives seriously and has a propensity to be thoughtful and contemplative before answering a question. (Sansait, personal collection).

As expected, to the author, a bottle of his favorite local whiskey or rhum was his only request to warm up his mood for a conversation, in which he would soon dwell upon his nostalgia for how his life was bearable then enjoying the resources, and comfort provided by the forest. It might not be a jungle, but a simple space with trees and other vegetation where he could spend time was more than enough for him and the rest of his community to bring relief from their emotional burdens. He has the sincerity and honesty to tell without being led on topics that stress their community, which he himself admitted that he could not fully understand

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why they are now in the present miserable condition in a restricted space. While he was not really bothered by the apparent poverty they have, for people can share goods and food anyhow, yet, what disturbed him most was that there is no forested space for the community to enjoy anymore. To him, the forest was a complete world where everything necessary and meaningful for them to survive could be obtained.

As the author reminds him of the soothing effect of alcohol, he nonetheless dismisses it as nothing compared to the forest ("lati". Alcohol may relieve pain for a night, but it cannot replace a forest's resources in the form of wild crops, small mammals, birds, reptiles, mushrooms, fruits, honey, and other medicinal plants. But the most important thing for him, which he continually recounts to the younger ones and to visitors, is that for him, the forest has life and has the capacity to renew life. He would confess: "*Sa pirme ka beses kun daw gapanulum na panulok ko kag nagapananig-a na ang akon ulo sa mga ginabatyag ko nga mga problema, ini tanan madula kun magkadto lang ako sa lati. Bisan mag pungko lang ako, ang hangin daw naga istorya sa akon kag mabatyagan ko ang akon mga katigulangan nga naga gaistorya sa akon. Pagkatapos sina dugay-dugay, mauli na ako nga daw wala lang ako problema*." (Oftentimes in the past, when I felt dizzy and my head ached, these symptoms would go away once I visited the forest. By just sitting for a while, the wind would seem to talk to me, and I could also perceive my ancestors conversing with me. Later on, I would gladly return home feeling relieved from my problems.) The "lati" was a place where he could connect to his ancestors, and so he was at home conversing with them in and through it. The forest or the moment he goes to the forest probably was a cathartic period or space, but each time he was in it, his mind became clearer to would arrive at a better solution or answer to problems he might have long wished to resolve.

4.5.4. Lola Dolores. Although the Ati people do not have matriarchy, nonetheless, Lola Dolores seems to appear to be a recognized strong and influential person in their community. She too had a lot of knowledge of the past, but she would dwell more on caring for her grandchildren and teaching them simple tasks at their huts. Practically, given the limited household materials, all she could impart were basic responsibilities like fetching water and cooking, besides reminding them to wash their hands or take a bath regularly and clean their surroundings when needed. The beauty of life with them is that there is no pressure as to what task to do each day. Used plates and pots will only be cleaned when they are about to be used.

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This goes on their bamboo floors with scattered toys, clothes, pillows, blankets, or an unfolded dress and towels. There is nothing negative about these appearances, so there is nothing to hurt the feelings of children or offend adults, as everyone seems to be accepting of doing things responsibly one at a time. Promptness and industriousness are not defined by the space and immediacy of time but based on need and cooperative value. Thus, they are a people willing to extend kindness and cooperation but untied to the stringent idea of obligation and duty on things that are not directly related to the maintenance of a good relationship.

Lola Dolores is likewise one of those who are happy not only to remind the younger ones to care for their hygiene and eating habits, but also to appreciate respect and responsibility without pressure. She would do this by recollecting her life and the lives of her friends and neighbors in relation to their housework expectations. Most often, however, the action to maintain cleanliness is prompted by the presence of visitors. There is in them the tacit desire to please or to appear upright and neat before outsiders who happen to drop by their charities or from government agencies to monitor some projects or to announce forthcoming meetings. It is not that they wanted to appear like the Uta, but that most often, being aware of the negative stigma attached to their identity, they became careful so as not to trigger any further unlikely feedback about them.

With many of the children wanting to imitate what the Uta would wear, including bags, shirts, shoes, and pants, as well as make-up and lotion, parents become anxious to remind them that these are unnecessary expenses. This admonition stems from the view that they do not reflect the needs of the Ati, and it is also a financial burden once a child is caught in the field of imitation. Lola Dolores is much more alert to correct these tendencies in children by keeping them busy besides her. By frequently calling each other to help her with some chores or her personal craft work, children are nonetheless willing to obey, but soon afterwards they would again disappear called by their fellow children nearby to play chase, hide and seek, jump rope, and many more games in an open field and nearby hills, or go to some wooded area and look for tubers or fruits to eat.

At her age, without a reliable source of income, her food is usually supplied by her two married children nearby. In this community, people love their autonomy; even parents of old age still prefer to have a separate hut where they can be alone doing their chores. By keeping distance, they could free themselves from thinking of the burden of their children and grandchildren while at the same time willing to entertain any children who would visit them.

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Children are fond of going to their grandmother since they have a lot of stories to hear and, at the same time, opportunities to try working on the handicrafts woven or produced in her hut. Bracelets, armbands, necklaces, and small pouches are usually meticulously handcrafted for sale to traders in the town area, who themselves will resell them somewhere, even to Boracay and Manila.



Nay Dolores' preference and habit of staying busy and productive keeps her depression and anxiety at bay in the face of prevailing discrimination and poverty. (Sansait, personal collection).

Overall, the stress and anxiety that are felt differently by different Ati are likewise experienced by Lola Dolores. She was just lucky, though, as she would narrate her case that she did not feel burden by any mental problem since she made sure she seldom got out of the community. She was aware of the stigma and discrimination, as well as the insecurity of their community given a land that is too small to make a living. She would rationalize that by staying in her hut she could advise well her grandchildren and other children who she hoped would be

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able to face reality with stronger resolve and capacity when they grew up. Every day, in many ways, she would always know each case of discrimination experienced by a member of her community, either as a student, a worker, a trader, or a passenger in the space dominated by the Uta.

Regularly, she would hear how some Ati children were called in derogatory terms as black, curly-haired, flat-nosed, smelly, or slow learners. She would hear how a worker was shortchanged or accused of trespassing on property. She would likewise hear how Ati passengers or traders would be commented on negatively, even as a joke. These are some of the things that, at a personal level, she was aware of that create daily anxieties in her and their lives. But the longer and more difficult narratives, however, in which she was often deeply moved into silence, were on their land tenure case. For her, self-pity seems to be the immediate reaction, as a kind of habit of acceptance about their fate as black, uneducated, and unappreciated by society.

In a practical world, they have nothing to defend. Furthermore, they are aware that that there are positive laws in the country, but these are way beyond their capacity to realize. They are unorganized, and they have no empowered community organization to begin with. There is also no advocacy group willing to gamble with them. Practically, no one would invest in them in terms of time and money. Even the local government units (LGUs) and other government agencies (CHED, DOH, DA, etc.) that could have incessantly worked in their favor seem powerless as well. The most common reason is that these offices have certain priorities too, and the personnel likewise have competing needs for their lives and their families. In this scenario, everybody would appear to be victims of their own fate and an inability to realize their capacity to work as human beings, side by side.

Lola Dolores is aware of all these misfortunes in society, although she could not enumerate each. In every conversation where some topics became unbearable to her emotionally, she just shifted her attention to her work. She would sigh some words in exasperation but readily admit that so long as she is in her hut busy with her work and regularly cheered up by grandchildren around, she could easily pass the day without being anxious about the looming future of her community. By keeping herself busy, she could parry any negative mental thoughts she might be hearing from her neighbors.

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4.6. Parallel stories of dispossession and transformation at different locations

Though relatively far from the province, the fates of the Batak of Palawan and the Agta of Casiguran are presented here as a recognition of the commonality of the external and internal processes and pressures across these communities, having shared the same colonial and present political and socioeconomic processes of the country. Place is only an accident, but as to their fate, they share the same tragedy of dispossession, trauma, discrimination, and poverty. The detailed portrayal of the Batak by Eder demonstrated the necessity of some kind of urgency in actions with respect to their inherent rights to autonomy, health, and dignity. The same goes with the Agta of Palanan, which makes the inclusion of Cultural Survival's mental health advocacy relevant. All this knowledge will be reflected in the proposed mental health plan for the Ati people in the subsequent sections.

4.6.1. Eder's Batak of Palawan

The narratives and analysis of the fate of the Batak people in Palawan, who shared with the Ati the same phenotypical features and cultural tradition as a former forager and are now living precariously in designated parcels of land, could be a great resource to illustrate the similar fates these people are undergoing along the political, economic, and social development of the Filipino nation. In a book written by James F. Eder (1987) entitled "On the Road to Tribal Extinction: Depopulation, Deculturation, and Adaptive Well-Being among the Batak of the Philippines," the not-so-distant realities of the Ati and the Batak are easily understood. Eder's recorded notes and regular presence that span almost two decades in the central part of the third largest island in the Philippines are undoubtedly a record of transformations among the indigenous peoples of the country, especially those of the same cultural tradition as the Batak. Dissecting his thoughts necessarily leads us to comprehend the likely parallel experiences and cultural trauma these two groups share.

The Panay and Guimaras islands, where the Ati resides, are to the east of Palawan, divided by the Sulu Sea. To get to these islands, one has to detour by boat through a series of islands to the north of Panay Island. In all these islands, the lowland communities, or generally, the people who have adopted the colonial legacy, dominate the scene in politics and culture. While there

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are a handful of indigenous groups distributed as well in other parts of the country, those sharing the same cultural past and phenotypes as those of the Batak and the Ati are generally found at the margins or in remote places. They become visible only when they have to trade or have a spin in the city as mendicant vendors of folk medicines and could often be categorized as beggars, for occasionally they beg and are eager to receive goods or a penny given to them.

For Eder, this dismal condition that the Philippine former foragers are now facing is the product of both process modernization and detribalization—the two sides of the same coin. These are not overnight processes, for as subtle as they are, they slowly eroded the cultural fabric and social stability of the Batak, leading to "social stress" that manifests in many ways in their lives, especially in their psycho-emotional states or mental health. Of interest to the ethnography of Eder is that he is not only theorizing the effects of modernization on tribal communities, but he was also able to record empirical data that could account for the changes and experiences of the Batak people. With these, his notes and thoughts could likely cover all the other tribal communities in the country, though the pace of change, transformations, and effects may not be uniform among them. Similarly, as with other ethnographers and ethnologists, like Bodley, observing other tribal groups in the world, there seems nothing new in the narratives of Eder, for everywhere, indigenous peoples are victims of progress.

Eder's postulate on Batak's mental state is totally logical and existential as an outcome of sociocultural malfunction leading to social stress, which are by-products of the bigger processes stated above, detribalization and modernization. The face of modernization has many elements, including the lowlander's continuing agricultural and settlement expansion, illegal logging, continuous dependency on labor contracting with lowlanders, the introduction of processed and prepacked foods, and worst of all, forced resettlement in the name of park preservation. For the lowlanders, these are natural processes and events that could be seen as good because they promote economic activity and profit. On the other hand, these had some deleterious effects on the cultural life of the Batak, as these meant that they became incorporated more and more into a bigger capitalist enterprise, and they ended up becoming marginally poor, having lost their cultural fabric rooted on land, which could be translated further into their losing their sense of wellness and dignity.

The Lowlanders' hegemony could not be understated given their monopoly of the political and economic spheres as well as having a solid ideological and religious base in Christianity. With their education, wider kinship network, and material capital, the expanding agriculturist

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settler communities have a solid base and upper hand in whatever relations they have with the Batak. With the routine and frequent contact and the subsequent incursion of new modes of life, as well as the disruption of cultural habits in relation to the traditional sphere of their cultural life, the forest, their cognitive and noncognitive capacities were likewise negatively weakened.

It is not that the lowlanders alone were the cause of their cultural disruption or that they were to be portrayed as having a perfect life before the contact, for just like any social group, there are always external and internal challenges and problems each must face. The case of the Batak or the Ati is that the manner and speed of incorporation have not prepared them, nor have they been equipped to ride atop the changes that are happening in their lives. Seasonal lack of rain, fruits, or wild animals could be explained in many ways in their traditional life as they have built adaptive belief systems and explanatory modes to deal with their daily problems, but to be in a context where they could not move places in search of forest food, where they have to seek money to pay for their food, and to be in a labor-debt relation with the lowlanders does not give them greater liberty to work out their problems at their own pace using their cherished explanatory frame and cultural references as before.

At present, the Batak, and by extension, the Ati people living in their settlements or prescribed parcels of land, have a marginal mode of existence that becomes the tenacious face of both detribalization and modernization. Their sociocultural disruption becomes manifested in their cognitive and noncognitive loss of capacities to live and survive as a distinct ethnic group, other than in name or in books. The ecological disruptions brought by logging and overuse of resources in settled communities further accelerated culture change towards erosion of cultural practices and beliefs, leading further to the weakening of individuals' capacity to find meaning within their own traditional world view.

The consequential ecological, social, psychological, and cultural disintegration that Eder posits as the Batak's cause of sociocultural disruption now extends its mode to become a social malfunction as a whole and so defines the group's experience of social stress. For Eder, this web of interacting forces leading to stress defines the mental status or health of Batak and any other cultural groups that have undergone this disintegration of their traditional frame of living. In the resettlement areas, therefore, psychological, cultural, and biological (dis)stresses became the norm, and these are not in linear mode, for they continually interact, which would further heighten the tension already occurring in the lives of these people.

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In their daily lives, distress or malfunction becomes the overarching force behind the failure of the Batak to enable their distinct group to thrive just as before. Proof of this was Eder's data on the poor level of nutritional status and the regressive demographic structure of the group. The varied diet enjoyed before is now being replaced by the restricted and economically limited diet of the lowlanders based on rice and other processed foods. With husbands frequently at the service of or in trading with the lowlanders, and with the availability of alcohol, family stability and relationships are redefined along with the occurrence of crimes not experienced before. Further, the Batak could not in any way keep up with the lowlanders, for according to Eder, they lack the necessary wherewithal in the political, social, and economic fields. In other words, they might meet and greet each day in their trade or work agreement, but at the end of the day, it was the lowlander who dictated the price, how much to buy or the labor needed, and when to meet or deliver the requested good.

Thus, every time one sees a Batak articulating less interest in work, having poor diet selection, and delivering inadequate infant care, these are manifestations of a deeper psychological stress, a state of mental health, where their quality of life is affected due to weakened or depleted self-esteem because of limited ego resources and dependable social networks. This Batak's status for Eder is a serious one, given that their interest in surviving is weakened and the group's replacement level to keep their population viable is poor. Seen from this view, the Batak's bleak mental health or stressful world could be of their own making, only if it was their choice to get into the gambit of the lowlanders socio-economic and cultural lifestyle. On the other hand, according to Eder, the ultimate cause of their cultural and psychological insecurities rests upon the growing articulation of the capitalist world into their lives, which dominates and incorporates their habitat and will towards their detribalization.

From Eder's contention, the incorporation and the lack of wherewithal necessarily lead to a list of heartaches from the economic, political, material/spatial, cultural, and psychological spheres. At the economic level, the Batak's capital is almost nonexistent as regards selling any products or their employment of labor. Added to this is their land tenure insecurity, with only a parcel of land to occupy and till, with the view that in the coming future their access to other spaces will be limited when landowners and the government reclassify these areas as reserved for other economic purposes. On the political front, they remain without any representation at any level of government bodies or agencies, much less a respectable organization that could say no as a collective voice. In other words, the legal system has been very silent about their

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situation, either by design or by neglect. At the material level, this is well connected to their economic status, for in their settlements and as a landless populace, the resources for adequate provisioning for their necessities in water, food, housing, and clothing are yet to be conceptualized.

Looking at their cultural adaptation in the settlement areas, their language and lifestyle are not appreciated or fit well with the lowlanders' preferences. The more they look at the differences, the more they feel discriminated against, pushing further down their self-esteem. In the first place, there was not even an adaptation, for in Eder's estimation, there is nothing that is culturally or economically sustainable in their status. The color of their skin and their unique hair patterns, even though they are externals in life, became their badge, signifying their irreconcilable difference and status in society. As for their psychological sphere, there is nothing more deplorable than having to live with anxiety, low self-esteem, and depression. Pride, which is important in daily living and accompanies confidence to pursue one's goals, is missing. To this end, Eder sympathetically aspires that one day, this people, as well as other indigenous communities having the same fate as Batak, will regain their sense of purpose and meaning in life.

As with the Ati community, it is good to follow Eder's questioning: what is there in the Batak's settlement area that makes it the face of a culturally disrupted, dislocated community? At the same time, how could this be of use in understanding the mental health of the Ati community? Undoubtedly, if sincerity is the measure of success in treating indigenous peoples, it is impossible to doubt the altruistic motive of the agencies that resettled the Batak. But as various ethnographic resources attest, sincerity is not enough and could even be dangerous, especially if the lives, health, dignity, and future of a community are at stake. In their settled communities, Eder saw a bleak life for the Batak, where malnutrition, disease, collective trauma, alcoholism, role strain, discrimination, and longer episodes of anxiety and depression exist.

With limited land to explore and land limited to a few crops, the variety of forest fruits and meats that were readily available in the past are now gone. Further, in a resettled community where there is no defined water course or sanitary system, garbage and human litter at nearby sites became breeding grounds for diseases and flies. Used to simple living and without further budget for a better housing unit, their abode confirms their destitute situation. With children learning the lifeways of the lowlanders, they would start to demonstrate an autonomous outlook

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and behavior, disregarding certain roles they were supposed to play in and for the community. But for adult men, the presence of small stores that sell liquor became their site to spend their time, hoping that in the coming hours a new request for labor from a lowlander would be made of him. But at any moment of opportunity, the liquor could have gotten a part of him, and so the cycle of despair and drinking came full circle.

The resettlement is therefore a site of depression and anxiety where their socio-psychological makeup is put under stress, which Eder saw as producing a collective trauma for the Batak. But for outsiders and aid agencies, these behaviors are manifestations of a lack of education for the Batak, who are simply misguided, backward, and have not yet appreciated the life of an urbanized citizen of the country. But for Eder, this impression has something to be corrected by having a good narrative of the Batak circumstances so as not to fall into further paralyzing discrimination, for such an altruistic view may simply be a rationalization for their further subordination.

For Eder, it would be inhuman not to detect how this demeaning crisis produces mental anxieties and depression in the Batak people. But to address the mental health issues of the Batak and other indigenous peoples like the Ati, they require more than clinical interventions. Rather, Eder outlines important topics that are embedded in the process of restoring cultural meanings among these indigenous groups. These are not exhaustive but having these in mind now and becoming part of the conversation in the open, better collaborative and respectful efforts could be initiated to favor the survival and maintenance of self-autonomy of these affected indigenous peoples.

These are not discrete concepts, but they do overlap, and they are not complete, but they are itemized to emphasize their importance in the web of actions that might be taken before these cultural groups. First, their settlements should take into consideration the security of land and be extended to various resources of their traditional diet and lifestyle. Second, they need a trustworthy and reliable agency that can explain and assist them with consistency and as regards their needs in their land. Third, their traditional mobility must not only be tolerated but also appreciated within the bounds of their needs, so that they might have some hold on their traditional consumption patterns. Fourth, their health and curing methods must be allowed to thrive so long as these give them functional explanatory models and confidence in their lives. Fifth, their ego resources and political potency must be provided with sufficient support to allow them to recover their self-esteem, self-efficacy, and capacity to participate in any decision-

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making activities. Lastly, their language and their rituals must be supported as well for them to keep the integrity of their nurtured, meaningful view of their culture.

These ideas of Eder may not be as provocative as to vanquish any capitalist enterprise that might come into their territory, but nonetheless, with sufficient space and support, the Batak, the Ati, and the rest of indigenous peoples undergoing cultural stress may still have ways to keep up with their meaningful lives and integrity with their mental health.

> *States shall provide reparation through effective mechanisms, which may include restitution, developed in conjunction with indigenous peoples, in respect of their cultural, intellectual, religious, and spiritual property taken without their free, prior, and informed consent or in violation of their laws. traditions and customs.*
>
> (UNDRIP, Art 11, no. 2, 2

4.6.2. Headland's Agta of Casiguran

In the northeastern part of Luzon is Isabela Province, where the Agta populace used to live in relative isolation (Headland, 2010). These are the same seminomadic people identified as the Batak in Palawan or as the Ati in Panay and Guimaras islands, who, by their common darker appearance, are conventionally labeled as Negritos, or the little Negroes. Of similar fates, Headland saw their future bleak with the same socio-cultural, political, and economic forces affecting their demographic and ecological sources of well-being.

As for the Agta, with the coming of loggers and homesteaders and the presence of land-hungry politicians together with their security entourage, they saw their land encroached upon, and the dirt road created by one logging company became the conduit for further intrusion by lowlanders. Within twenty years, Headland witnessed how the encroachment had transformed the Agta into landless squatters, which he noted was very traumatic to the group. The change is visible, with more families now tending their swiddens for carbohydrates rather than trading them for meat. Further, with regular contact with homesteaders and some security personnel, men acquired or were given rifles to expedite hunting; in fishing on rivers, pesticides and dynamite became available; and at the end of the day, homesteaders have stores selling liquor on credit. The result is the eventual collapse of the meat-resource base of the Agta.

But the design to settle them or for them to cease their nomadic life is not new. In the early period of American occupation, men were even chain-ganged to clear the forest for them to plant crops. In the 1970s, they were rounded up by government forces and placed on reservations, but they resisted. Other enticements by government agencies (the Commission of

National Integration, the Panamin Foundation, and the Department of Education) were made, but with little or no subsequent support, all programs to transform them into agriculturists or farmers failed.

The effect of this cultural trauma is inevitably distressing, with mortality on the rise, women's fertility low, and life expectancy at birth at only 22 years. With alcoholism and other diseases such as tuberculosis and pneumonia, plus malnutrition and poverty, both their biological and cultural survival are in peril. In this similar context, the need to attend to the mental health issues of the Batak, the Ati, the Agta, and the rest of the indigenous peoples comes into order by providing policymakers with a critical view of the realities affecting these groups, starting with the recognition of the interplay of psychological conditions with other forces affecting their cultural, social, political, and economic lives.

4.6.3. Cultural Survival and Mental Health

Given their proven unassailable commitment to the well-being and a secured future for indigenous peoples across regions of the world, Cultural Survival's voice concerning IPs mental health resonates solidly across the academic field, government agencies, and world policy-making bodies. With the IPs' spaces and integrated cognition of their world being besieged by dislocations and trauma, they most likely suffer enumerable neuropsychiatric and behavioral problems manifesting in depression, anxiety, suicide, and alcoholism, among others.

Consistent with their data at hand, Cultural Survival asserts that this IP's experience of psychosocial stress and their vulnerabilities are linked to their economic marginalization, which defines their subjection to discrimination wherever they are. This overwhelming tide of misfortunes reflects similar patterns across IP communities, starting with colonization, then confiscation of lands, imposition of a singular economic system driven by profit and capital, introduction of diseases, and subsequent repression of their cultural expressions and neglect by colonial states.

As of today, their dislocation stands among other distressing conditions to which they are being subjected, including violence and poverty. Despite these, IPs mental health could still be addressed positively by having a clear view of what defines their sense of meaning. In other words, in comprehending this concept and working with the IP's conception of what gives them happiness and purpose in life, they would at least be provided with a psychosocial intervention ameliorating their confidence, esteem, and pride in their society. While this endeavor or

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intervention might look promising, the realization would be such a total challenge given that mental health is "enmeshed with economic and political concerns such as poverty, hunger, and malnutrition," among others.

Second, there is still so much to know about the "mental health status and treatment needs of indigenous peoples". This is a real obstacle, realizing that even in settled communities whose social networks, education, and access are well defined, there remains a huge gap in addressing their mental health issues. Thus, for indigenous peoples, the difficulty is magnified: whose memories, experiences, and trauma are not generally and equally shared by the wider society? Compounding this is that their dislocation and threats to their land, culture, and life remain looming ahead, undermining whatever remains valuable to them.

Third, there is likewise a challenge in generating "effective guidelines for its treatment" among these populations, for the cultural expectations and treatment frame may not be sustainable in the indigenous people's circumstances. In other words, alcoholism or depression cannot simply be remedied by taking a pill or by undergoing psychiatric treatment without delving into the causes of despair, unemployment, poverty, landlessness, and discrimination. Thus, according to Culture Survival, any prudent and sensible intervention when addressing the mental health of indigenous peoples must always be "within the wider frameworks of social justice and better living environments."



This selling of herbal/folk medicines at the side of the street has been a trademark associated with the Ati people. Without a clear path that is rooted in their identity, land, and culture, these people will remain at the periphery of a society whose structure and supporting ideologies are mostly out of reach, or, if not, less accommodating to a different view of life. (Sansait, 2009).

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5. THE LAND, CULTURE, IDENTITY, AND MENTAL HEALTH NEXUS IN LITERATURE

> *Humanity has not woven the web of life. We are but one thread within it. Whatever we do to the web, we do to ourselves. All things are bound together. All things connect.*
>
> Chief Seattle

In section 4, the ethnography of the Ati was presented as people living in four dispersed communities in Guimaras, Island, Philippines. While they tend to keep their identity separate from that of the lowlanders, their locations, limited land area, poverty, and other social variables do not bode well for them. Their numerous incapacities from lack of employment and income opportunities and their state of unkempt houses reveal so much of their state of well-being, which at the same time could negatively affect their esteem and decision-making abilities. In this context, section 5 is conceived to further emphasize the general understanding, view, and approaches reached by ethnographers, anthropologists, and other social scientists in addressing the mental health of indigenous peoples. In enumerating and analyzing each variable or factor affecting mental health, policymakers will have the opportunity to realize that indigenous peoples' relation to land is inextricable and has been fraught with trauma since colonial times. The following subtopics below will illustrate the interconnections of history with the on-going experiences of displacement, dispossession, stigma, discrimination, and neglect as a living nexus between land and the mental health of indigenous peoples. Rather than simply mention the key concepts in passing, each theme or topic below is given a comprehensive analysis so that important contextual lessons can be emphasized that are significant and equally shared in the fates of indigenous peoples.

While the United Nations, through the World Health Organization, is calling attention and concrete action to global mental health needs, anthropologists who are exposed to varied communities and experiences, primarily in remote locations far from direct attention from the government, have always been attentive to this phenomenon as well. Long before any medical mapping of mental illness, anthropologists were already interpreting world processes through the concepts of world systems and their economic and psychosocial effects, as well as in the production of meaning. In other words, from the anthropological discipline, research shows how mental health is produced and sustained to the extent that communities are linked to global

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economic and political systems, as well as how these people interpret or adapt to changes through changes in meanings and behaviors.

However, anthropological data or inputs do not have the direct potential to make a difference in people's lives. Ethnography has always relied on government funding or political support to carry out the necessary programs on issues affecting tribal welfare and protection. In this regard, it is important to acknowledge support for the WHO CMHAP 2013-2030, as it is designed to encompass various states and cultural groups. Anthropological data could be used to provide key information at various stages of any intervention program that may be implemented in local communities. However, this does not deny anthropology's separate and robust contribution to mental health problems. Therefore, the following topics are intended to present the paramount positions of anthropology based on field experiences or in-depth reflections on world events that affect mental health. In line with this, the research articles are thus grouped and analyzed based on certain categories so that they can be aligned with the WHO CMHAP 2013-2030 blueprint.

5.1. Global capitalism, social murder, and the accessibility of social movements

In this first sub-theme, the articles consider health in general from a macro perspective, with the perspective that local health experiences are now all connected to the broader sociopolitical and economic relationships around the world under the banner of capitalism. While this is a reality, states therefore have a unique role to address the negative impacts of indifference that can lead to condoning many unnecessary deaths, revealing a case of social murder. As in the experience of oppression, participation in resistance is essential, which is why it also highlights the need to recognize and provide space for those who suffer from mental health problems or a disability to exercise their right to be heard.

Flynn's (2021) article, entitled "Global Capitalism as a Social Determinant of Health: A Conceptual Framework," argues that the WHO has not fully emphasized or is silent on the social determinants of health, especially how imbalanced power structures have negatively affected culture, education, and health. health, among others. These inequalities are established by social determinants throughout history in the forms of colonialism, imperialism, militarism, and patriarchy. With globalism, capitalism ensures that the system of accumulation of labor and

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exploited resources is sustained in the economic, political, and cultural spheres. Therefore, according to the author, with the rise of neoliberal policies, health outcomes require an analysis of the roles of transnational classes and the states that shape them.

Under this critical position, there is no genuine discussion about health without linking it to the Marxist concepts of commodification, proletarianization, exploitation, endless accumulation, and social contradiction. These concepts see how health moves away from the natural inclination of capital to commodify resources and relationships that lead to a surplus to reinvest from the exploitation and proletarianization of workers. This eventual reality resulted from colonial and economic expansion that placed some countries on the periphery through unequal trade relations, capital exports, and the dominance of multinational corporations. When cash flow dictates policymaking and market operation through neoliberal strategies advocating austerity, liberalization, deregulation, and privatization, the health vulnerability of the exploited global proletariat is expanded and sustained. The power of this global capitalism is in the hands of the World Trade Organization (WTO), the International Monetary Fund (IMF), the World Bank, the G-7/8, the G-20, and the World Economic Forum and their similar

Through this theory of global capitalism, the state of health around the world can have a conceptual and integrated framework for analysis since it can analyze and synthesizing "the various pathways through which global capitalism leads to unfair health outcomes and inequities." The relevant processes and concepts that dominate the macro-functioning of capitalism are transnational corporations, financialization, consumerism, transnational social classes, and the transnational state. With transnational corporations penetrating different corners of the world, they often marginalize societies and communities as well as environmental conditions due to their extractive capabilities at a higher rate in the name of income. Agriculture also suffers from the conversion of land to industrial parks and subdivisions and the substitution of a healthier diet for mass-produced food, leading not only to the displacement of farmers but also to lower agricultural productivity and a diet of poor quality. Worse is when these corporations take over indigenous lands, which can result in the literal expulsion and annihilation of many communities.

Universities and research institutions, under the guise of science, forgot ethical concerns and became paid researchers for health industries that monopolized the rights for their production and distribution. This usurping capacity of transnational corporations has adversely affected working conditions, the prices of medical supplies and medicines, and the natural

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environments in many regions. This dominant power structure and the control of the international capitalist corporations, together with their network in the global financial system, through their control of products and work for the accumulation of wealth, necessarily put health in a vulnerable situation. This could happen when countries without sufficient protection suffer an international economic recession that leads to cuts and unemployment, a drop in remittances and foreign aid, higher prices for food and medicines, and reduced health budgets.

With effective advertising investments, transnational companies were able to transform people's appetites and imaginations by defining their desires and not their needs. This leads to consumer habits that are harmful not only to health but also to the environment. In the name of the free market economy, non-nutritious foods and drinks abound, private clinics are becoming the modern definition of healthcare provision, and public transportation is giving way to private cars, among other impacts. negative health and could feel in poor countries with the increase in malnutrition, obesity, and diabetes, among others, in addition to the effect of a greater emission of carbon into the environment.

The rise of the transnational middle class further entrenched consumerism in the exploitation and dominance of the market and social services such as health, favoring the interests of those with wealth far from the real needs of ordinary citizens. With minimal social support, quality of life and mental health are especially limited for the poorest sections of society, especially women and children. These practices occur because, under the capitalist mode, while independent governments exist, their economic and economic lives are dictated by linkages under the superstructure of cumulative drive and the myth of free market trade.

Through trade deals and loan agreements, neoliberal policies easily overwhelmed local political autonomy, leading to further social inequalities. In the field of medicine, international pharmaceutical corporate interests embedded in international financial institutions control "obligations of the state, such as patent term extensions, patent linkage, data exclusivity, the lowest criteria of patent capacity, restrictions on the use of compulsory licenses, and guaranteed marketing exclusivity". Even charitable acts by wealthy individuals become a form of "philanthrocapitalism," as they possess the capital to lobby decision-making away from the interests of those in need of equitable care.

In general, the article showed how health is directly and indirectly within the structure of capitalist companies, which are highly organized and efficiently operating, leaving less access to the proletarian class that is continuously exploited. But these are not without dissent, as this

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unequal position is continuously challenged in different fields through protests from Wall Street to Peru and other parts of the world and literary criticism that exposes the inhumane side of policies that see health as less than a right.

Meanwhile, given the previous context of domination by the capitalist system, Medvedyuk, Govender, and Raphael (2021) published a seething article titled "The reemergence of Engels' concept of social murder in response to growing social and health inequalities." These authors sought to examine whether the term "social murder" as used by Engels is gaining space in the academic literature. The term refers to the conscious neglect of the authorities in the face of the plight of the marginal sectors of society, causing their deaths. Given this scenario, since the ruling class controls political power, can enact policies, and has the key to the treasury, it becomes the guilty bourgeoisie.

There are four components that define murder, as is implicit in Engels's formulation: that someone died due to working or living conditions; that these conditions are exploitative to the extent that the capitalist system is produced and fed; that the ruling class, the bourgeoisie, benefits from this exploitation; and that, being conscious and doing nothing to avoid death, the bourgeoisie becomes the main culprit of the social murder. The authors further identified that even the World Health Organization is on the same page in pointing the blame at those in power by saying, "The combination of bad policies...is responsible" for the neglect of the quality of health of people around the world. Meanwhile, in academia, social determinants also describe very well the living and working conditions of Engels workers that affect their lives and health.

The authors also pointed to the abundance of other terms that attempted to deflect the tone of social murder, such as "health inequalities," "health inequalities," "health disparities," "premature mortality," "excess deaths," and "disparities." in morbidity and health". mortality between groups. Convinced that the term has greater utility in generating genuine change in health outcomes, their review of journal articles published in the 20th century aimed to examine the frequency and context of use of the concept of social murder, as well as how the term is expanded. your acceptance. The result of his scoping review showed that the concept of social murder was "rarely used," that when used, it contained the basic elements implicit in Engels's formulation, and that it is increasingly used in academic journals.

In the data they accumulated and coded, they found that the dominant domains studied as associated with capitalist exploitation are issues of living and working conditions, housing, poverty, and health inequalities. However, important domains, although recently recognized by

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researchers but of equal importance, were austerity, neoliberalism, social services, and deregulation. In general, while the authors were horrified by the paucity of use of social murder in academic literature, these journals were consistent with Engels's formulation that in those "adverse living and working conditions brought about by capitalist exploitation, those who benefit from it are morally guilty."

While the researchers noted that the term social murder carries a very strong emotional tone, they are still convinced that this concept alone has the potential to expose policies and practices that undermine the integrity of people's health and could have great appeal to unify affected groups. in highlighting the exploitation and neglect that are occurring. Part of the reason few make use of the concept is that in the West, there is a history of aversion to anything that makes use of the Marxist interpretation of the human condition. However, world news shows that Engels's ideas are still valid, and his polemic is gaining acceptance among young people around the world. Thus, to win the battle for better health, aggressive approaches must be employed, and one of them is the use of a highly emotional and provocative term, with all its intensity: social murder.

To persuade the state or those in power to make their policies inclusive, it is necessary to listen to people with disabilities. This can only happen if the roles and spaces are modified or structured so that the idea of full participation in rights can be exercised, especially under the helm of freedom of expression. In Reed's (2022) article, "Mental health, availability to participate in social change, and social movement accessibility," the importance of accessibility is emphasized, not only in name but in practice, to participate in the activism of social movements as a fundamental part of the democratic right. However, for people with disabilities (marginalized, stigmatized, etc.), mental or physical, this backbone, along with other human rights, is severed.

Nonetheless, it is argued here that their inability to participate is equally the result not only of individual limitations but also of being deprived of "the structure and cultures of movements" and obsessed "with the capacity-focused image of the 'ideal activist,", among others. In other words, personal shortcomings have not only social significance but also political implications, since actual lived experience and adherent/participant survival are vital components in sustaining movements. Thus, the notion of biographical availability is expanded in the political sphere by accommodating the voices and experiences, together with the notions of health, illness, and disability, of psychologically marginalized people.

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The author claims that since "social movements can create opportunities for psychological well-being", examining what constitutes availability and accessibility would not only further the goals of social movements but would also inform well-being studies. Through participation, you not only get a positive feeling but also the satisfaction of contributing to society through volunteering or activism, among others. Logically, if participation in the mass movement does indeed have a form of social contribution and is at the same time psychologically rewarding, the next question would be, "What makes activism more accessible? Specifically, for those who self-identify as having episodic and/or ongoing mental disabilities, how would you harness these positive mental effects through activism?

Discussing biographical restrictions and biographical unavailability, Reed asserts that personal impairments alone do not necessarily affect broad participation in social movements, but also their "inaccessibility to access the movement contexts themselves." This means that "the actual experience of disability, and by extension well-being, can also shape one's political functioning", such that "the interplay of biographical availability and movement accessibility" can empower or "disempower people in the political space.

The findings revealed important lessons for biographical availability in terms of how personal, environmental, and social factors impacted or challenged people with neurodivergent conditions. Within movements, while psychological differences can affect energy levels, especially those limited by mental disorders, their political functioning can be accommodated well with adjustments within and beyond the social construction of the organization. On the material and environmental levels, the prospect of being in a crowd, on the street, or in a space that is not congruent with one's neural and physical control can and does aggravate any existing psychological anxiety.

Additionally, stigma is documented as a form of barrier to activism, undermining its credibility as participants are often stereotyped as lacking emotional self-control. But these could be addressed by promoting a culture of acceptance and patience in support of neurodiversity. Another condition that requires adjustment is the expectation of productivity, which neurodivergent individuals may not live up to. Their restrictions can lead to guilt and further devalue their participation in the protest culture. This pressure can be resolved by allowing for role diversity in participation as well as finding creative ways in which your activism-embodied self can contribute, such as backstage, providing essential functions for the

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group. For this reason, the culture of "slowing down" allows activism to recognize the productivity of each capacity and the relationality of its objectives.

Likewise, the ideal image of an activist, being up front and fully active, could become inaccessible, and therefore neurodivergent and physically limited participants "could face inequality in maintaining participation in the social movement." This can lead to further stigma by viewing them as an exception rather than part of the movement. In this case, organizational value must respond with greater recognition of the potential of these differences for activism as well as appreciation of their ability to represent their values in the movement.

Ultimately, in any protest movement, the "cowboy mentality" must give way to the accommodation of those who cannot keep up with the rest but can nonetheless provide proportionate momentum and validity to the cause. From this point of view, the availability and accessibility of the actors at different levels "have a dynamic and dialogical relationship in the configuration of the work available for the survival of the movement". Therefore, through the acceptance and adaptation of diverse circumstances and needs by the embodied participants, the defense and advancement of democratic principles will gain highly empathetic and participatory adherents.

Like any indigenous population, their advocacy and defense of rights and identity may also require sustained visibility. Although stigmatized, they could take inspiration from the article by renegotiating their position so as not to diminish their value and potential. Their involvement should also be seen as positive in advancing democratic ideals, and therefore advocacy groups can fully accommodate them and allow them to take on some roles that suit their abilities.

> *Indigenous peoples have the right to establish and control their educationalsystems and institutions providing education in their own languages, in a manner appropriate to their cultural methods of teaching and learning.*
>
> (Article 14, no. 1, UNDRIP, 2007)

5.2. Healing journeys, ecosocial self, traditional model of health, and critical local involvement in well-being

This sub-theme will have four reviews illustrating the richness of knowledge and experiences of indigenous peoples in relation to their environment, which are all functional to their health and culture. It would start with a characterization of Native American healing

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movements that are infused with meaning in their specific cultural space. The second review is all about the remarkable efforts made to enable local communities in the Peruvian Amazon to co-participate in the production and analysis of their projects in support of their wellbeing. The third is about the Maasai women in Tanzania, as they reveal themselves and their communities as components of a singular dynamic self, and so challenges can only be approached by addressing multiple relationships in nature. The last review demonstrates the efficacy of an alternative non-Western model or approach to mental health issues in Hong Kong, which has a strong traditional and cultural appeal to the people.

One way of showing how cultural groups have their structures to deal with their tragedies in life was documented by Waddell et al. (2021) in an article entitled "Healing Journeys: Indigenous Men's Reflections on Resources and Barriers to Mental Wellness," who emphasized the concept of a forward movement or journey in the healing process. This attempt to make use of the voices of indigenous men and their traditional way of expressing themselves could be useful in the search for a culturally sensitive or relevant strategy to address mental health problems among the Ati people as well. The researchers looked at how health disparities exist between Metis, First Nations, and Inuit, and how their pain is exacerbated by the effect of the reservation system on them. Although they were provided with ways to resolve inequities, they are often partial and fragmented, revealing the pervasive influence of the Western medical framework. Given this scenario and in response to the Truth and Reconciliation Commission of Canada (TRC), the authors sought to highlight the appropriate mental health needs of indigenous people and culturally appropriate ways to address them.

Their sources of grief included dislocation, colonial schools, and a lack of appreciation for their traditional healing practices, such as talking in circles, pipe ceremonies, and sweat lodges, among others. Often in the research, the views of men were also ignored, preferring young people, children, and women. Therefore, with men as subjects, healing journeys were described, and barriers and challenges to healing were explored. Sensitive to the interests of these men, not only was their prior consent obtained, but the research also recognized them as co-developers of the research questions, approaches, and results. In effect, participants were assured of ownership, control, access, and possession of the research process and results.

The setting was a sharing circle, and the healing journey involves sharing, listening, participating, and discussing their experiences, such as dealing with colonialism, dealing with politics that made them feel disconnected, as well as dealing with and resisting harmful racial

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stereotypes. While they all share the damaging internal effects of racism, they recognize the importance of spaces and spiritual leaders in boosting their confidence to get healthy. Their experience of having to live in two worlds, that of the colonizers and their own, is seen as a barrier, especially since they feel daily pressure to live according to Western standards.

In addition to having the confidence to talk in circles, they consistently state that losing relationships is a difficult process on healing journeys, as well as being subject to racial stereotyping. But they also recognize time and rhythm in healing, especially out of fear of losing their identity as members of their community. Their sharing circles allowed them to grieve, listen, and tell their stories, and they consistently state that losing relationships is a difficult process on healing journeys as well as being subject to racial stereotyping. But they also recognize time and rhythm in healing, especially out of fear of losing their identity as members of their community. They also express the positive healing effect of becoming parents, as they become cultural role models in addition to their commitment to their religious ceremonies and connection to their land.

Overall, the research shows how clinicians are attuned to the needs of indigenous peoples by engaging with their well-being, values, and aspirations for healing. These include sensitivity to their ongoing experiences of systemic racism, oppression, and inequities, calling for the mitigation of continued colonization when their knowledge and terminology are suppressed in favor of the Western medical framework. The lesson is that healing journeys are an important mechanism for recognizing only these traditional modes of healing and achieving the necessary confidence to maximize opportunities to combat anxieties and stress in their lives.

In another ethnographic study, the practice of centralizing the mechanism, symbolism, collaboration, and interpretation of indigenous mental illness-related experiences was examined to clearly inform health workers and policymakers about the importance of the local health economy. The article by Bussalleu et al. (2021), entitled "Nuya kankantawa (we feel healthy): Understandings of Health and Well-Being among the Shawi of the Peruvian Amazon," is noteworthy due to its awareness of defending indigenous well-being throughout the entire course of investigation, from the choice of site and samples to the selection of the appropriate methodologies and mode of analysis. This could very well become a template for any research on communities like the Ati people in the Philippines. Although both are remote, the Shawi are very numerous and have a high degree of autonomy in their cultural practices. Unlike the Shawi,

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who are on their traditional land, the Ati are now hunkered down on a parcel of donated land on various outskirts of the city.

The study, through in-depth and context-specific analysis of the data obtained, was conducted to enable Shawi to access healthcare that fits his worldview. Appropriate protocols were followed, including obtaining written or oral consents as well as awareness to respect and abide by cultural practices, indigenous knowledge, community requests, and pre-existing power dynamics. Therefore, to characterize local beliefs about health and disease, a community-based participatory approach was used to "engage communities as partners, share control and responsibilities in decision-making, work collaboratively to effectively respond to research questions, give research participants a voice, and promote ownership in the research process and results."

The researchers ensured that "at all stages of the study, including study protocol design and data analysis," community members were involved. They established parameters for interviewer eligibility, used focus group discussions in a pilot data collection with heads of household, and administered semi-structured in-depth interviews, followed by an open-ended interview guide and further validated through informal one-on-one interviews. or group conversations with community members. Through interactions with the community, they learned behaviors appropriate to social norms and were able to keep in touch with herbalists and other women responsible for maintaining medicinal plant gardens.

They make use of research journals for formal observation and are supplemented by separate notebooks for additional comments from the day. Audio recordings and notes were initially transcribed manually and later digitally after creating a codebook. The coded data were then compared, and discrepancies discussed to speed up or simplify the codes where necessary. Again, true to his community-based participatory research approach, "community members were asked to participate in data analysis, including clarifying, validating, and commenting on preliminary findings during general assemblies and, in some cases, in individual meetings." In addition, triangulation was carried out along with spending more time in the community to allow for more exposure of their observation time. During data collection, a member check was performed to ensure a consistent procedure was followed, and after each interview process, a peer report was conducted.

The result revealed that Shawi associate's health with emotional, collective, and environmental well-being and less with physical well-being. The strong associate their well-

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being with their ability to care for their family and others, followed by having a good relationship with the community, valuing their traditions, and being well in tune with nature. They would get upset when work capacity decreased, as you would with a "feeling of worthlessness". Some gender specifics are in the ability to hunt for males and in the ability to grow cassava and make masato for females. The elaboration of masato (from fermented cassava) is unique in promoting well-being since it plays a central role in maintaining social reciprocity since the act of sharing generates a feeling of happiness and security.

With a view that social networks promote emotional, instrumental, and informational functions, any "inability to participate in family and community activities generated feelings of frustration." While health is perceived to be negatively affected by the decline in forest abundance, they view disease more as a "disturbance of body, mind, or spirit, caused by the introduction of a harmful agent, whether by witchcraft, forest spirits, or by accident." In undesirable social interactions, one may suffer harm (sorcery) because of negative feelings, including envy, which can only be remedied by a traditional healer or shaman. In addition, they recognize natural elements, such as animals, that can negatively affect one's vital energy. Sometimes, diseases can also be caused by inanimate elements that surround them, but events such as "susto" (fright) for them can lead to disease. They also recognize that some diseases do not have remedies like those that come from outside their communities, and except for the latter, tobacco is the shaman's favorite means of curing illnesses.

To guide health professionals and policymakers, the research emphasizes a holistic view of the Shawi's emotional, collective, and environmental well-being, especially in maintaining a healthy relationship with their family as well as their world. social and natural. With their growing concern about more exposure of their youth to the outside world, it is still important to pay due attention to their values that promote community cohesion, along with their appreciation and respect for forests and the natural elements of their environment.

With the increasing awareness that mental health is not a simple personal, subjective, and ego-centered illness for which an intervention can just be acquired through a regular paid visit to a clinician, a new paradigm addressing this problem is being forwarded that is rooted in the basic relation of humanity to nature. This view is advanced by Myers in her article entitled, "The ecosocial self, place, and well-being: An ethnographic case study with Maasai women from northern Tanzania." Even from the evolutionary perspective, human senses and minds are all molded through interaction and adaptation with nature, and so the ecosocial self-proposed

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by another article to frame approaches to mental health is given extra space here. This becomes relevant when the subjects are not individuals in the urban setting who get used to their built autonomous world but seminomadic or pastoralist groups whose lives, livelihoods, and lifestyles are very much connected with the natural landscape.

The ecosocial self sees humans as deeply embedded in and interdependent with their environment, or as living in an ecological niche, and through intimate interactions and relationships with other non-humans, be they animals, plants, or other meaningful objects that surround them, they obtain their sense of self, their self-identity, and their worth. These continuous and complex lived experiences of people in their natural and social worlds construct their sense of self as good and morally valuable persons, as well as being their source of pathology and healing. In other words, their vulnerability to mental health problems hinges upon their nurtured relationships, such that when their niche and connections are impaired, their capabilities to live a meaningful life are likewise affected, leading to stress. Happiness therefore lies in their healthy living in their natural world in mutual relations with plants, animals, and the natural landscape surrounding them.

The example presented is the Masai women in Ethiopia, who are increasingly under threat from both socially and naturally driven changes and threats. As they have been well-known pastoralists for centuries, their culture is built upon tending animals, from goats to cattle, and these animals became not only their source of meat and milk but also a source of satisfaction and pride in the political, social, and personal spheres. Thus, when periodic drought and floods attributed to climate change diminish their herds, the people not only experience economic difficulties, but their psycho-emotional well-being suffers as well.

The most affected are the women, since with displacement and poverty, men started to leave homes and work in cities, and so much regular housework, including tending the animals, was saddled with their wives. Hunger, since they are used to this, is not really the one that burdens them, but the periodic droughts, locust attacks, and flooding, which slowly kill their beloved animals due to starvation, thus upsetting their psychological and emotional worth and producing stress, anxiety, and mental problems. Compounding this is their shrinking space to pasture their livestock, much of which is identified as game reserve parks by the state. For these women, their sources of happiness are being threatened, which include their children, husbands, and animals.

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Given this context, the ecosocial self takes its form as a product of intimate communication with land and livestock, and through their nurtured interaction, they obtain meaningful mental nourishment and healing. Thus, ecosocial advocates see the need for nonclinical intervention based on meaningful relationships on land by looking at what puts people's ecological niche at risk so as not to diminish their esteemed selves. This land- and animal-based therapy has a restorative value since it reconnects people to a healthy relation to land against dispossession, colonization, and capitalist valuation of relationships. This non-stigmatizing approach is truly meaningful for it "focuseson what mattered to people in their place of living, based on their ideas about what it meant to have moral worth and the ecosocial relationships that mattered to them."

With strong ambivalence toward the western medical approach to mental health because of its problematical status in approach and explanatory predicates, the Health Hexagon Model offers a more optimistic alternative that is more meaningful for communities with strong ties to their traditional medicinal practices. The relevance of this position is pointed out by Chan and Hazan (2022) in their article entitled, "The Health Hexagon Model: Postulating a Holistic Lifestyle Approach to Mental Health for Times and Places of Uncertainty." The need for acceptance and utilization of this model was highlighted during the COVID-19 pandemic, wherein the people of Hong Kong had to grapple with their lock-down status, and with limited medically trained psychiatrists, much of the people's depression and anxieties were left unaddressed. Besides this treatment gap, or the need for and availability of help, there is also a cultural gap, since Chinese were used to dealing with anxieties and personal tensions in life through lifestyle modifications rather than looking analytically into the diseases embedded in their minds.

The Hexagon Model holds that the cause of the disease and the treatment are singularly related in a balance in the body, just as the cause and the consequences of behaviors are part of a larger reality. By recognizing and meeting the seven elements of the model, these reciprocating elements will produce a sustainable outlook by unifying the material, cultural, and spiritual needs of a person. In this outlook, this model would likely have greater acceptability, as it has been centuries-old in China with its functional, remedial, and protective mechanisms of care against mental stress.

Thus, rather than seeing patients as having deviant mental or behavioral status, the model has the capacity to offer warm encouragement to cope with problems not by labeling or

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stigmatizing individuals but by restoring closeness with nature, social relationships, and a sense of purpose, meaning, and sacredness. In the end, this model is seen as appropriate in third-world countries since most communities possess values that seek the holistic health of the person using culturally meaningful explanations of disease that resonate with their values and beliefs. Individuals are then made to understand that they are part of the whole and that their health is a cultivation of their relationships and habits by responsibly balancing the forces or elements that support the integrity of the wholeness of their body-environment-society identity.

> *Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.*
>
> (Article 23, UNDRIP, 2007)

5.3. The flourishing, health, and protective effects of well-being and flourishing

To many researchers, the concept of mental health appears to be very medically focused, if not overly conservative, in representing the human desire for a positive health experience. Here, the better term is said to be "flourishing," which implies a fulfillment beyond the attainment of health that is in continuous flux. Willen's (2022) article entitled "Flourishing and Health in Critical Perspective: An Invitation to Interdisciplinary Dialogue" begins by asking how the idea of "flourishing" becomes relevant to health care and universal mental policy influencing human development. He then presents a series of studies to show that the concept of flourishing has been widely examined across disciplines and contexts. He then gives two main reasons for health and mental health researchers to participate in this burgeoning enterprise: that it "is rapidly emerging as a leading paradigm for research and policy" and that there is "massive philanthropic investment" waiting in this field.

In promoting this concept, the author cautioned that any conversation about flourishing will lead to "multiple and divergent viewpoints, often running in parallel and with limited cross-fertilization," requiring a "call for interdisciplinary and interdisciplinary discussion." open-minded about what we want. "Collectively, we do and do not signify what we are and are not talking about". In addition, researchers must be willing to "juxtapose disparate lines of inquiry;

highlight notable points of convergence, tension, and disagreement; and lay the groundwork for a broader conversation... to sharpen our collective understanding" of flourishing.

The concept of being a "borderline object" carries with it fundamental and deeper "defining differences" in explaining why some people thrive and others do not. However, when it comes to critical public health studies, the main accompanying concepts are always the dynamics of "structure, power, and the dynamics of social (in)justice." Consequently, research in this field is considered necessary to further explore how inequality and material circumstances affect individual psychology and how this effort might strengthen the promotion of health justice.

In the pursuit of flourishing research, three main considerations are offered: One is that the concept implies polyvalence, which requires clarification regarding its meaning and use in evolution over time. Second, while there is no definite consensus on the main approach to be used, its utility can enrich the analysis of flourishing in different domains. Finally, it asks how policies in the fields of health and mental health would be changed or improved with flourishing as a focal point of analysis. How might the research resolve policy tensions, and how might its outcome be locally and culturally realizable?

In the current popular usage of flourish, the author sees four main research themes. The first is on topics that seek to investigate and capture the functional use of flourishing in the fields of social sciences that promote positive aspects of health. Second, the bloom had been used to integrate studies in the biological, medical, and social fields. Third, flourishing enters into the philosophical and religious rationalization of virtue and character. Finally, there is an emerging use of the concept in the critical social sciences of health that questions power and structures. In all of these, they had a common vision that flourishing is an integral part of health as well as a flexible and interdisciplinary concept.

How, then, is flourishing relevant to mental health? First, flourishing involves an emic view, so it can generate insights from the genuine experiences of people that could inform policymakers. Second, flourishing could capture people's entrenched values and commitments in their local terminologies and thus enhance intersecting relationships, including with the natural world. Third, it has a positive view of what is good, right, and moral in its various forms in societies, so it has the potential to unite ecumenical movements and critical approaches to inquiry.

Flourishing in its abstract form cannot escape its Aristotelian lineage, so while "eudaimonia" may connote a good life, it does not necessarily equate to flourishing since it has

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yet to resolve moral obligation. While eudaimonia is in process and being carried out, the question remains about the obligation and human capacity to achieve it, knowing that social structures go beyond human will. Although flourishing shares with eudaimonia the realization of one's own happiness, they diverge in the way to achieve it. Aristotle agrees that it is achieved when individuals want it, but in a flourishing context, structures can create obstacles, thus requiring more than the separate intentions and acts of an individual. In general, the burgeoning field offers concrete opportunities for collaboration in all fields of research for those who are willing to invest in understanding the bases as well as confronting congruent external constructs that determine human well-being.

Finally, the article by Burns et al. (2022), entitled "The protective effects of well-being and flourishing on long-term mental health risk," examines the concept of flourishing from a psychological mode of inquiry that establishes the functional use of the concept in clinical practice. The same goes for other concepts such as wellness and mental health; blossoming takes its meaning from its relative function, whether it leads to a positive experience or provides a buffer against mental illness. To investigate this further, two traditional models were used: subjective well-being (SWB), which measures the hedonic experience, and psychological well-being (PWB), in combination with social well-being (SoWB), which operationalizes the eudaimonic domains of well-being. Using the scales of these paradigms, two defined states were identified: flourishing and languishing. Although the first is attributed to a high level of well-being, through psychological measures, there is no consistency with the real meaning in different research works.

To remedy the need to clarify the functional use of flourishing, a longitudinal study is proposed to evaluate its relationship with well-being indicators. The first task they performed was to review all the associated meanings of well-being through different standard psychological measurement tools. They then draw their data from a large longitudinal study of well-being at different parts of the life course of people in three narrow age cohorts for comparison purposes. Finally, they use the SWB, PWB, and SoWB indicators to compare the meaning and benefits of the well-being categories against their protective contributions in relation to the concepts of flourishing and languishing.

Regarding the findings, the most important thing is that public and clinical interventions and programs have a preventive effect on improving mental health conditions as an experience of well-being in general. This is confirmed by data on growth, which is associated with high

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well-being indicators and therefore has a protective contribution against poor mental health outcomes. This points to the need for relevant projects with reliable funding provisions that address general wellbeing rather than just selective aspects of health.

> *Planning, organizing and financing health systems is a complex undertaking involving multiple stakeholders and different administrative levels. As the ultimate guardian of a population's mental health, governments have the lead responsibility to put in place appropriate institutional, legal, financing and service arrangements to ensure that needs are met and the mental health of the whole population is promoted. Governance is not just about government but extends to its relationship with nongovernmental organizations and civil society. A strong civil society, particularly organizations of people with mental disorders and psychosocial disabilities and families and carers, can help to create more effective and accountable policies, laws, and services for mental health in a manner consistent with international and regional human rights instruments.*
>
> (Objective 1, no. 28 & 29, CMHAP 2013–2030, 2021)

5.4. Political will, debt servitude, and cultural trauma

This subtopic starts by illustrating the case of Maori health inequalities as a product of colonization and the fact that it takes political will and cultural sensitivity to obtain a measure of assurance and hope. This will be followed by relating the dominance of colonial power over time and space, characterizing their deep influence as a sort of terrifying shapeshifter. Next, the case of Africa's desultory health care is presented as an outcome of overreliance on external funders and internal strife. Lastly, the concept of cultural trauma is presented to underscore the need to address the core causes of health disparities.

For indigenous peoples, the actions of political parties and the programs initiated by the government can have a strong impact on their wellbeing. In New Zealand, the Maori people's history of colonization impacted their health conditions until subsequent increased awareness and activism paved the way for some promising reforms. In this article by Brown & Bryder (n.d.), entitled "Universal healthcare for all? Maori health inequalities in Aotearoa New Zealand 1975–2000," they traced the tensions and lessons of the Maori people as regards the promotion of their health, especially afforded by the Labor Party.

While there were studies that raised the health vulnerabilities of the Maori, it was Mason Durie's published works that captured the complete picture of the tribe's wellbeing. By

emphasizing relations of land culture, he was able to outline the need for greater self-determination provision among the Maori. The backdrop of the narrative is shared among other minority groups in Australia, Canada, and the United States, where the white settlers took hold of their resources, leading to their displacement for a longer period. Also, while there were notable differences in the degree and kind of treatment tribal groups received from their colonizers, they share the same health vulnerabilities as a result. Nonetheless, this paper reemphasizes the necessary connections between policies and health by identifying structural problems and insensitivity to cultural differences that need to be acknowledged and remedied.

Upon the start of colonization in 1852, the Maori were basically displaced from the government's view given that voting rights were only reserved to those who owned land. With their displacements, their health status is, however, opposite the rate at which their population increased decades later. After more than half a century of neglect, they saw the light of recognition of their plight in 1938 with the election of the first Labor government and its thrust on a universal health system. Meanwhile, with all its promises, this program had not contributed much to Maori's health since, basically, their concepts of wellbeing and health were ignored. Being exposed as a program designed for whites that was seen to be institutionally racist, the demand for sovereignty and justice came to be heard.

Meanwhile, the second world war interlude brought a major change in Maori demography, with many starting an exodus towards urban centers; in the 1980s, almost 80 percent of them were in cities. With economic inflation in the 1970s, the main casualties were the Maori, who found themselves at the bottom of the socio-economic scale. Nonetheless, at this later period, the Maori mobilized themselves along with the international civil rights movement and so started to articulate on the streets their rights for self-determination and to seek redress for what they lost through colonization, especially their land. Along with their demands, they aspired for cultural revival by gaining confidence in asserting their identity.

One remarkable achievement in their movement was the institutionalization of the Waitangi Tribunal to address the breaches of the principles spelled out in the 1840 Treaty of Waitanga between the British Crown and the Maori chiefs. This treaty guaranteed Maori the right to self-determination, the right to citizenship, and the right to design and deliver healthcare according to their cultural preferences. Consequently, by 2000, the government had abolished moribund health agencies and replaced them with the Maori Health Authority, which had funding and a mandate to address Maori health inequalities. Also, by 2021, the Maori would

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have been given an appropriate legal mandate to monitor the performance and implementation of these changes. While all these reforms or achievements were seen as timely, they did not happen without the political will of those in government.

Recognizably, these efforts to redress Maori land, identity, and health started in 1938 with the first election of a Labor government that espoused free, complete, and accessible universal healthcare to all, which resulted in big subsidies for general practitioner fees and consultation. But with inflation in the 1970s and 1980s, patients were increasingly carrying the medical costs versus the proportion of the subsidy received. Thus, it appears that in these years, health access has been inversely related to the needs of the Maori. Given that the GPs recommend specialist care, Maori who cannot afford the GP likely cannot avail of the latter. While hospital boards received funding in the long run, they were forced to streamline their expenditures given the decreasing funding appropriated for health.

In the 1960s, while many Maori in urban low-income households could not afford health care, those who could afford it had to pay for the services designed for white settlers, which further marginalized them. This blind approach could be understood since the goal of the government this time was for the Maori to integrate and so assimilate with the white people, who saw health as a privilege rather than a right. In effect, since the health system ignored the appropriateness of the services offered, Maori death rates were observed to be almost double that of the white population during the 1955–1975 period under 65 years of age.

By 1972, after twelve years in opposition, the Labor government was again in office and envisioned a renewed health care system that was more efficient and equitable. Since in practice the aim was mainly focused on infant mortality while forgetting other widespread health concerns, and as much as it attempted to make GPs salaried employees of the state, thus reducing the role of private-led health care, the party lost in the 1975 election. The new conservative government, by establishing the Special Advisory Committee on Health Services Organization (SACHSO) without any Maori on the board, predicted a change in health approach. As a result, the ever-increasing payments for GPs were solidified along with the promotion and dominance of private insurance and the neglect of Maori voices in the design and monitoring of health programs.

Meanwhile, in an urban context, the Maori became increasingly aware of the disparity between wealth and wellbeing, which in part motivated them to assert their rights and cultural identity. In concrete form, they organized themselves into clubs and established urban marae

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and community centers to promote their culture and address their health concerns. In 1970, for example, a university-based group, Nga Tamatoa, to counter racism reversed the burden by pointing out that the problem was not with the Maori but with the settlers and declared Waitangi Day a day of mourning over the loss of land due to colonization. With an 80-year-old Whina Cooper leading the march in 1975 with land as the central theme, the protest was seen as multi-generational activism. This resulted in the Treaty of Waitanga Act, which established the quasi-judicial body, the Waitanga Tribunal, to redress the unfavorable consequences of the 1840 Waitanga Treaty. Further, a decade later, in 1985, the Tribunal was given authority to include breaches of the treaty retrospectively.

Examining the treaty, three articles were seen to be supportive of Maori health, such as the provisions for good government, the control and retention of resources and treasures, and the enjoyment of rights and equal citizenship. These realizations led to the modeling of Maori health conceptions to be like a four-sided house—physical, spiritual, family, and mental—to make programs and approaches to health easily improved and measured. The Maori movement was further given a solid boost with the passing of the World Health Organization's Alma-Ata Declaration in 1978, which emphasizes that wellbeing is a human right. A decade later, the New Zealand Board of Health, given these new conceptions of health, advocated five principles in its national health policy reflective of the lessons learned from the Maori: "holism, empowerment, social and cultural determination, equity of access and devolution, and equitable and effective resource use."

These positive changes that made governments receptive to health concerns that benefited the Maori were the result of the Maori's increasing awareness and determination to regain their rights, culture, and identity. While the fourth Labour Government elected in 1984 adhered to a neo-liberal or free-market path, it retained progressive principles supportive of anti-nuclear, feminism, and Maori rights movements. In effect, in 1979, a Maori political party was founded, and later, in 1983, the National Council of Maori Nurses was established, followed by the creation of Maori-led healthcare programs and initiatives in 1984. Further, along this momentum, Maori were again given substantial representation in the Area Health Board; in medical and nursing programs, Maori language and culture became mandatory; marae-based health initiatives were recognized and supported; and more Maori were hired in health services. Overall, this happened due to the increasing acknowledgment of the need to integrate Maori views into health provisions.

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In 1984, various studies pointed out that much of Maori mortality "was not attributable to socio-economic factors alone" and instead was due to environmental factors. By doing so, the setting up of marae health centers, previously thought to be preventive, was now seen as the solution to the problem. With the establishment of mental health services in 1984 in secondary care programs and by supporting community-based initiatives, the link between local communities and government health centers was facilitated, but this did not prevent them from insisting that they be identified separately from other Pacific native groups. These notable changes were all consequences of the growing awareness and recognition of the government about the needs and conditions of the Maori, mainly due to their activism, supported by a growing body of research.

One of the reforms under the neo-liberal directives in the 1980s, although under the fourth Labor government, was the prioritization of spending for those over the age of 60, which again acted against the Maori since many of them were younger in that category. Further, the corporateization and privatization of state assets exacerbated Maori's unemployment rate, which was almost three times as high as that of non-Maori. In the 1986 and 1988 commissioned health reports, no Maori was ever consulted, and the texts endorsed a free market system in healthcare. With expressed support for the private sector's participation in financing healthcare, the internal response was the "purchaser-provider split" and charges for secondary care in public hospitals." Soon, the traditional health boards were replaced by four regional health authorities with no guaranteed representation from the Maori.

Although Maori representatives were soon appointed to many of these boards, the constant restructuring of health systems created a strong strain on health delivery since partnerships were always reworked and negotiated, which might lead to indifference. Further, the lack of consistent policy and the one-year contracts given to providers over Maori healthcare created further strain in negotiating contracts. Nonetheless, the positive side was that by 1994–5, there were 23 health initiatives providing health support, mostly in primary care.

While the purchaser-provider split mechanism may become an opportunity to access funds for healthcare, the competitive pricing has produced tensions and divisions among providers. Given this scenario, rather than creating efficient services, the competition led to a "multiplicity of poorly funded, under-resourced" health structures. Further, with urbanization, the challenge was how to organize a new framework of services that would address different background groups of Maori. In 1992, more concrete efforts were introduced by the New Zealand Nursing

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Council to make health practitioners conscious of cultural safety requirements in health delivery. The training involved a process of introspection and deciphering one's background culture so that each person may attend holistically to the health needs of the community.

In 1996, a new election mechanism emphasized a mixed member proportional (MMP) voting structure, which the New Zealand First Party won, headed by Winston Peters. Unhappy about the neo-liberal policies, he pushed for reforms like "free GP visits and prescriptions for children under six years old, abolishing the extremely unpopular remaining hospital user charges, the establishment of a Maori Provider Development Programme and a Maori Health Commission, and an increase in baseline funding for the Ministry of Health." Further, from 16 Maori MPs in 1993, the number increased to 120 in 1996, revealing the greater importance of providing a strong voice to their community. While the worst health trends might be over, in the 2000s, however, health disparities were still observed as regards cases of renal failure and diabetes-related mortality.

With the election of the fifth Labour Government in 1999, the issue of health disparities remained, and despite restructuring the initiatives towards "social equity," the opposition party continued to criticize the privileges afforded to the Maori. But the most significant was in relation to the Waitangi Tribunal, which was able to attend to over 200 claims over breaches involving three phases: the primary health care system, Maori mental health, and historical claims. The latter is seen as highlighting so many grievances since it has a restorative justice character over the lands taken from the Maori. Overall, the whole history of the Maori health care system is interwoven with political system policies, starting with colonization towards acknowledgment and restitution. Under the shadow of neo-liberal policies, the failures were mainly due to constant changes in policies and structures of health delivery, underfunding of primary health organizations, and underrepresentation of Maori across health governing bodies. Nonetheless, given Maori's greater participation in politics and legacy of activism along their revitalized community-based (hui and marae) programs, their progress towards better health outcomes may bear better promises in the future.

Meanwhile, indigenous people's state of health, despite various reconciliation and acknowledgment acts along the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), remains to reflect disparate outcomes. On efforts to refocus health services to be culturally sensitive without contextualizing the efforts within systems of power dominance, much of it would simply end up privileging white perspective and control.

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Furthermore, when initiatives are centered only on health outcomes, health inequalities will always remain underpinned by forms of racism and settler colonialism.

The article entitled "Shapeshifters, systems thinking, and settler colonial logic: Expanding the framework of analysis of Indigenous health equity" by Ray, Wylie, and Corrado (2022) posits that policies and practices in health, since they are framed within a colonial imprint, become sites of racism and discrimination. Further, since they embed interrelated structures of inequality and factors that perpetuate inequality, such as poverty and land dispossession, they demand approaches that integrate anti-colonial and anti-racist theories and methodologies. Through this, the subtle path or logic of the erasure of indigenous identity and the legitimacy of occupation and control of indigenous lands will be questioned or examined. Thus, dominance behind poor health outcomes, the power and domination expressed through norms and standard health protocols should be accounted for not on how consistent they are with clinical demands but on how they continue to promote and subtly perpetuate the structural violence that undermines indigenous peoples' self-determination and access to quality health care.

Rather than focusing on health care alone, health systems analysis is proposed as a "conceptual toolkit to interrogate health system interactions with the histories of discrimination and disenfranchisement that underpin determinants of vulnerability, risks, and poor health outcomes." Further, through this analysis, rather than fitting the indigenous peoples into the colonial structure and practice, the understanding of positions in the structure of inequality can reveal failures in the health practices and so can encourage changes.

The authors espoused the complex adaptive system (CAS) analysis, taking note of the concepts used in critical theories to understand the interacting collective agents and forms that move along complex, non-linear, and unpredictable adaptive paths that define the colonial logic in health performance. It is adaptive since it could transform itself to appear valid in different contexts while maintaining its intention to control and define processes and outcomes in health. This then allowed the researchers to call the process of entanglement and analysis in the metaphor of shapeshifting, which would separate and identify the indigenous systems of knowing, classifying, and interpreting the world.

The importance of social system analysis is further highlighted as it demands accountability from researchers to confront inequality and colonial logic by attuning their theoretical frame towards justice and recognizing the cultural capability of indigenous peoples to transform health care. This complexity theory was mainly drawn from Walby (2007) in an article entitled

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"Complexity Theory, Systems Theory, and Multiple Intersecting social inequalities," who posits about a broad living non-linear interactive system embedded in institutions, politics, processes, and thinking that structures and sustains social relations and hierarchies. By the capacity of networks to overlap, it is self-organizing and could lead to spontaneous order and stability capable of reinforcing and energizing patterns of privilege, and, as it is capable of co-evolution with other systems, it could magnify further inequalities. The most important nodes in this system are the concepts of constraints and attunement, signifying that it can create barriers to options and creativity against conditions of control and dominance while also being capable of awareness and adjustments in support of the system.

As a concept, shapeshifters are commonly found in the stories and imaginations of indigenous peoples, referring to people or animals capable of transforming themselves into something else and could transport themselves into places, thus capable of informing, communicating, and accomplishing their goals or purpose. This depiction of mutable identity, existence, and force reflects the indigenous worldview as multi-dimensional, complex, holistic, circular, and interacting with living and nonliving entities. This dynamism and fluidity, which are beyond good and evil categories, pose a challenge to the western construct of a linear, singular logic of life and relationships in the universe.

This fluidity of shapeshifters allowed them to move beyond "compartmentalization and reductionism and continue to emerge beyond economic conditions, ethnicity, and biological status. Thus, in the case of indigenous people's health, the optimal character of colonialism has the face of a shapeshifter, in which, by the logic of power and networks of domination, minority groups become entangled in a complex manner, and everything they own, including knowledge, culture, and land, is subordinated, and appropriated through various controls of institutions, agencies, and domains. Having organized both the institutions and the relations in a spatial and temporal matrix, it is capable of saturating, adapting, co-evolving, and manifesting in health inequalities.

In historical context, the power of colonialism as a shapeshifter is embodied in the performance of capitalism and racism, which look upon indigenous people as inferior and property to be enslaved and owned, including their lands, identity, and culture. By dichotomizing relationships between the settlers and the dispossessed, the shapeshifter was able to enforce segregation, marginalization, and dehumanization in the form of violence, loss of land, and health inequities. It further justifies assimilation, which in appearance grants status to

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indigenous peoples but possesses and categorizes them according to their degree of similarity to white values and appearance.

To illustrate how this shapeshifter concept operated within complex constraints and attunement processes, see the story of Brian Sinclair, who was made to stay outside the emergency room for 34 hours until his death without having been properly attended due to miscues and misinterpretations due to stereotypes about his behavior and identity as an indigenous person. In the process of availing of medical care, from admission to medication, Sinclair's case demonstrated that not only an indigenous person has to navigate protocols outside his cultural system but also has the burden to demonstrate his degree of conformity to assimilation expectations. Thus, while each staff member—from guards to nursing assistants—should perform not only the roles they were taught to play in an urban, white-dominated hospital, interwoven in their functions are their learned cognitive views as stereotypes normalized in dealing with indigenous persons. These protocols and patterns of behavior and thinking that lead to the denial of proper care to Sinclair not only predict negative health outcomes for indigenous peoples but likewise validate the shapeshifter's capacity to normalize violence against indigenous peoples.

Nonetheless, against the backdrop of the ambitious goals of the World Health Organization (WHO) since 1948 and its universal "Health for All" program, the authors (Gorsky & Manton, 2022) in their pre-published article entitled, "The political economy of 'strengthening health services': The view from WHO AFRO, 1951-c.1985," reflected how the Regional Office for Africa (AFRO) performed in providing equitable access to all in the region. Beginning with a critical look at WHO's initial preference for 'vertical' programming, the initial focus was on single disease campaigns, which limit building necessary health services as defined by technocrats designing externally conceived projects. Thus, rather than make sensible improvements, much of the work was a matter for individual states, many of which were at war either within or among their neighbors. The 1978 Alma-Ata Declaration, however, reinspired efforts for a sustained health program through primary health care (PHC) initiatives. This nonetheless was soon disenfranchised with the rising international debts, with foreign banks insisting on focusing instead on selected health projects. During this period, the WHO's dominance was replaced by the World Bank, which dictated numerous structural conditions, including the introduction of pluralistic, private sector-driven development.

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By examining the achievements of WHO AFRO, they revealed how the organization's overall mechanism was at the start dominated by western constructs that supported dominant powers despite decolonization. This contrasted with other regional organizations found in the Americas and Asia, where they already have clear traction on health services that reflect vertical organizational management rather than horizontally driven. Through historical examination of the allocation of resources, African health realizations were always tied to fractious support and shifting programs affecting management and delivery of services. In the 1950s and 1960s, despite being a big continent, only three regional public offices were initiated, with one country-level program allotted only to South Africa, in contrast again to massive investments already taking place in the Americas, South Asia, and Pacific regions. This lack of implementing policy-making agencies in sub-Saharan Africa generally reflected its colonial status and relied upon external funding and programs that were vertically managed.

With limited funds, staffing and administration lagged until the 1960s, when countries started to gain independence and so came to hear promises in the form of practical commitments. Technical advisers were placed but were distributed disproportionately among countries. So far, the biggest recipient was Congo and later Eastern Nigeria, with 700 health workers trained, followed by the entrance of USAID's pilot projects in Gabon, Liberia, Mali, Niger, and Sierra Leone. During this period, a realization emerged of the lack of well-articulated national health and sanitary service investments, and so studies were commissioned among 14 countries to understand disease prevalence, spread, and control. Also, out of the USAID experience, they started to plan projects with measurable results.

In the mid-60s to early 70s, bureaucratic organization and training across the continent experienced a great boost, but funding remains constrained, so African projects remain at a basic level of consultation rather than building diversity and capacity. In response, USAID set up monitoring and evaluation mechanisms, while the UN established a planning institute in Senegal to refine methodologies. With project demonstrations, the budget was increased across member states, and symposia and seminars followed, generating consultants and experts. Overall, however, at this period, much of the plan was unrealized, especially in providing sufficient personnel and adequate training on a larger scale.

By the 1980s, Africa was again beset by internal wars and violence, which prompted migrations to cities and other places, escalating vulnerability to disease. The overemphasis on vertical management weakened the cultural and technological capacities of the local leaders in

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addressing their own local health-specific concerns. With the introduction of the WHO Tropical Diseases Research Programme, a new budget increase was provided, yet the Alma-Ata vision was still far beyond reach given the appearance of a global financial crisis and the increasing national debts of countries. To motivate greater focus on the health goals, workshops and national plans were held in various countries, including a study trip to China and specific training on family health care funded by the European Development Fund.

Out of these experiences emerged the realization that AFRO "lacked the consolidated power to implement and fund national policies and programs" and that "the management training approach was flawed, over-emphasizing sophisticated techniques for hospital and vertical disease program administrators rather than supporting indigenous development of management education throughout member states." In this context, a new management training program was envisioned to build self-reliant leadership among the African states. This emphasis paved the way for the coming of the Catholic Relief Services besides the World Food Programme, together with the involvement of local universities and the setting up of non-governmental organizations in many districts.

With political instability, structural adjustment recommendations by the World Bank, and selective primary health care provisions, Health for All was criticized for administrative vertical bureaucracy, financial limitations, and dependency on donors and loans. From the WHO perspective, at all management levels, "the complexities of allocation, financial responsibility, existing health system structures, and staffing" were seen as serious problems and so "necessitated continual refinement of feasibility and evaluation mechanisms." This goes along with the "history of inefficiency, inadequate coverage, inappropriate service design, a lack of useful statistics, and largely weak management" observed by the Nigerian government in the late 1980s. In this condition, there was fear of looming fund constraints, which would again translate into selective health programs.

The article’s main lesson here points out that health dependent on changing policies as well as on vertical management styles will often lead to mistrust and unnecessary illnesses among poor countries. Instead, national countries should be involved in the planning and design of projects to better reflect their needs and priorities. Further, without recognizing and overcoming the colonial past, the continued dominance of European capitalist enterprise will certainly become a new force that structures health inequalities over finite resources.

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Inevitably, any historical wounds to the lives and memories of indigenous people will end up as cultural trauma. Cultural trauma is a new concept developed in constructing another theory to account for health disparities other than those due to personal (perceptions, habits, and choices) and social (health policies and programs). According to Subica and Link (2022), in their article entitled "Cultural Trauma as a Fundamental Cause of Health Disparities," health iniquities are a product of powerful social factors like poverty, stigma, and racism, which are in themselves the output of cultural traumas (colonization, genocide, and hate crimes). The effect of these processes on disadvantaged groups like the indigenous peoples is a greater risk for illness and death, and interventions that do not address the root problems are mere short-term actions.

This new theoretical perspective attempts to link health disparities from a resource deprivation or loss perspective and a social disadvantage perspective. In other words, by understanding cultural trauma as an effect of collective negative events affecting the whole culture, disadvantage groups' health-protective resources would likely be deleted, and so health status becomes a casualty. Culture here is conventionally defined as an integral whole that includes the shared material, conceptual, behavioral, and experiential characteristics of a group that allow them to adapt and become resilient across time. Trauma refers to an ongoing, overwhelming assault on the culture by a dominant group with the aim of subjugating the weaker ones.

Thus, cultural trauma is differentiated from other trauma since the former encompasses the historical, psychological, and collective trauma of a group. This cultural trauma has the capacity to perpetuate its effects intergenerationally since the impairment affects the whole shared resources of the group's life and health. It is also differentiated from interpersonal trauma since, while the latter affects only individuals, cultural trauma goes beyond the individual. In other words, colonial empires, hate crimes, and genocides affect individuals, but the target is the group's identity, safety, and future. In addition, integral to this novel theory is that the dominant group is not only up to the destruction of the weaker culture but rather aims to transform the latter into a new subjugated and weak form, thus producing health disparities.

The need for conceptualizing this theory is based on the unique condition of minority or disadvantaged groups that experience "ongoing persecution, discrimination, and retraumatization," and that explaining health disparities on clinical terms is short of understanding their genuine circumstances in life. In this regard, this model has a unifying

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perspective since it sees health as a construct of collective, historical, and intergenerational experiences. It is also a form of critique of those powerful groups who might be unaware of the true context of health conditions not enjoyed by many.

In explaining health disparities, cultural trauma borrows the template of fundamental cause theory, which posits three criteria for the use and access of flexible resources affecting the health of disadvantaged groups. First, given the nature of the cause, it must be able to produce multiple health risks and effects, not only a singular symptom or health indicator. Second, it must control access to flexible resources being affected, through which power can be wielded (knowledge, money, power, prestige, social connections, etc.). Lastly, the factors that sustain health must be replaceable to sustain the dominance that goes along with health disparities among disadvantaged groups. Overall, these harms weaken the basic health support systems of minority groups, leading to health inequalities.

Since culture is the unifying resource of any group, it has three flexible modes (cultural modes, institutions, and lands), which, when disrupted, "may trigger an intergenerational cascade of negative health outcomes." The modes are the basic patterns of a group's life guided by their values, norms, languages, and orientations. Since these are the ones that give meaning to group and interpersonal life, this has a protective contribution against personal levels of anxiety and stress. Thus, with colonization and displacement, which suppress language, rituals, and traditional living, cultural modes shift to confusion and trauma.

Institutions, on the other hand, refer to policies and systems that provide order to thinking and doing, which are found in the economic, political, and religious spheres. With the traditional meaningful linkages and hierarchy, it is likely that the surviving group performing in a new role with a different status will experience discrimination and racism. Disease, unemployment, and poverty will likely produce acculturative stress, which is a product of deprivation, segregation, and unequal access to health resources.

The dispossession of material resources, especially land and other properties related to it, will likely destroy their cultural resources, leading to psychological stress and a loss of protective factors for future insecurities. It is not only restricting their opportunities, but often, by resettling these people, dispossession is aggravated, leading to genocide in many cases. The problem with land loss is not only displacement but also resettling people in areas with poor access to resources among themselves, who are necessarily forced to pay for their own resettling.

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Following subjugation, new mechanisms will be implemented and maintained over flexible resources, thus allowing the dominant group to maintain the domination and exploitation. The ways of gaining control and transforming flexible resources can be structural, interpersonal, hierarchical, or by simply doing nothing. While structural control happened through policies imposed like living in boarding schools and reservations. Interpersonal assault is through direct assault verbally or physically. Meanwhile, hierarchical mechanisms make conscious efforts to replace the old system to facilitate subjugation, thus limiting the ability of the subjugated to resist inequalities in privileges and resources. Doing nothing is passive or a practice of indifference over the plight of marginalized people by downgrading the conditions of the poor as of no importance, if not an irritant.

Cultural loss and wounding could happen directly, which could weaken protective factors by hurting cultural identity and pride, healing practices, and community and family networks. While this has a physical and emotional destructive effect, the trauma can be passed on as an intergenerational wound, affecting individuals and nagging them daily about the misery they are in. Indirectly, stigmatization and limited access to flexible resources happen through policies found in employment, housing, and education, with minorities labeled with words signifying inferiority. These, in turn, not only denigrate status but also put the blame on the victims.

The intergenerational effects of exclusion, stigma, and violence lead many minority groups to have impaired parental models, with the latter being in a maladaptive situation given their trauma. Besides the absence of a contextual guide and model, the narratives of displacement and genocide haunt children about their optimal and fair status in society. Likewise, when resources are disrupted, even physical illnesses are transmitted, and the different strands of vulnerability may have a cumulative effect on the health of the young.

Interventions have been found to remedy health disparities either by directly addressing the cultural trauma or through relevant policies. Going to the culture itself, projects, and initiatives like reviving traditional practices involving the use of language, ritual, and land that are participated in by everyone in the community may increase confidence and pride and allow cultural healing. Further, people can likewise organize themselves to increase awareness and empowerment in health and political matters, which could be extended as an advocacy group aimed at correcting inequities.

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This effort, however, is seen as one-sided and puts the burden on the victims to provide solutions rather than "challenge the systems of domination/power that maintain health disparities through the suppression of cultural and other flexible resources." Thus, policies should be lobbied for and so that displaced minority groups will again have access to land or obtain necessary reparations for the trauma done. But one important venue highlighted is through direct public actions, through protests in various ways, so that those in power will seriously reflect upon the inequalities and gaps in policies and practices, especially those that perpetuate cultural trauma.

> *Indigenous peoples have the right to determine their own identity or membership in accordance with their customs and traditions. This does not impair the right of indigenous individuals to obtain citizenship of the States in which they live.*
>
> (Article 33, no. 1, UNDRIP, 2007)

5.5. Land alienation, environmental repossession, gathering places, and decolonizing health

Following the previous topic on colonization and dispossession, the next theme informs us about the cycle of trauma that needs acknowledgment towards healing. Through this, indigenous local initiatives are recounted in pursuit of their desire to reconnect to their land culture through environmental repossession or by holding on to their gathering places. Also, their resurgence to recapture the old cultural paths of healing, which include generating their own community-led research, validates movements supportive of critical decolonization.

The precariousness of the well-being and health of indigenous peoples is always pinned to the integrity of their culture and fundamentally to their land. In history, this happens because colonization leading to the loss of land has an intergenerational effect on their sense of identity, confidence, and overall health. In line with this, Thom & Grimes (2022), in their article entitled "Land loss and the intergenerational transmission of wellbeing: The experience of iwi in Aotearoa New Zealand," narrated how various processes of land dispossession due to colonization impacted the health of the indigenous people of New Zealand.

At their current state, the Maori people are depicted to have the worst health outcomes, with a life expectancy gap of 7 years compared to those of European origins. One explanation

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is that the health system in New Zealand was designed for westerners; thus, rather than accommodating the cultural needs of the indigenous peoples ("iwi"), it resulted in further disparities. In contrast, Maori leaders identified four pillars for their health: the spiritual component, the psychic-mental-emotional component, the physical component, and the family-social component. But in all these, the spiritual component is at the top, always connected to the land. In other words, poor health conditions will always reflect something that is related to the land.

The traditional concept of the Maori is contrasted with that of the colonizers since, prior to their arrival, land was communally owned. Since land is connected to their other facets of life and health, it is highly treasured, and so everyone considered themselves guardians of their treasure. Thus, unlike the Maori's view of occupation and use of land, westerners see land as property owned by individuals through deeds. In the latter view, the cultural aspect of land is downgraded in favor of its economic value.

The land question among the Maori has been very depressing since colonization produced mechanisms that disenfranchised the Maori from their land. These are Crown purchases under pre-emption rights, land confiscation through the New Zealand Settlements Act of 1863, land title individualization, and private acquisitions through the Native Land Court. Thus, it is of no surprise that Maori's land, with a status of freehold rather than as ancestral land, now only comprises 5 percent, or 1.4 million hectares, in New Zealand.

Through the Treaty of Waitangi, represented by a local chief, the British crown was given the sole right to purchase land held under customary title, and so this paved the way to losing most of New Zealand. While the most vicious manner happened through the New Zealand Settlements Act and the Suppression of Rebellion Act, both of 1863, wherein lands were confiscated for those who "deemed" themselves to have participated in and supported the rebellion. This act could even be extended to those lands by the loyal subjects when thought to be "absolutely necessary for the security of the country" without any compensation. While some of these lands were returned, proportionately, they were of lesser economic value since they were not arable. In addition, rather than reverting to their customary title, the returned lands were instead given a new classification as freehold land.

Besides reclassifying lands that weaken Maori cultural ties to their land, the Native Lands Act of 1862 also gave the settlers the power to purchase land directly from the Maori. Along with this, the Native Land Court legislated further that owners of land blocks should not be

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more than 10 people and that clan representatives whose names appear on land claims were recognized as sole owners. While this was later reverted to customary lands, the effect rather ended up being further fragmentation (splitting) of lands through family inheritance.

Given that land is connected to the cultural life of the Maori, this land loss undermined their overall well-being by depriving them of access to rivers, forests, and food sources. But the most important loss is the loss of their burial grounds, which provided them with connections with their ancestors and supported the integrity of their spiritual life. This land and cultural loss have an intergenerational effect on the economic aspect of their lives. While they too are losing grip on the value of their lineage and heritage connections, their language transmission too suffered a great setback, with only eight to eleven percent of the young generation able to speak it.

These assaults on the culture, health, and language of the Maori are not different from those of other subjugated groups around the globe. Starting with colonization, land alienation, and historical trauma, which cumulatively debilitated the emotional and psychological backbone of society and were transmitted across generations, In other words, the alienation from older connections to land, animals, trees, rivers, and sacred sites produces unquantifiable distress, anxiety, and dysfunctional behavior as a consequence of historical trauma. As a new system took hold, exploitative structures were sustained by the dominant group by controlling access to agencies and institutions unfavorable to the natives. In other words, as the Maori people had been segregated, dispossessed, or displaced, deprived, and subjugated economically, physically, culturally, and emotionally by a dominant and alien power, their capacity to revive, participate, and even assimilate to the new society was greatly reduced as their protective source of health and wellbeing was weakened and their opportunities to thrive were limited.

The study is therefore illustrative not only of how the dominant group controlled the Maori but also of how the latter, because of their unique conditions, became vulnerable or unable to respond to the new structures imposed on them. While responses are varied, by examining the processes involved along with the intensity of exposure of Maori groups to colonization, the amount of land affected, the method through which land was appropriated, and the way these are resisted collectively and individually, their health and wellbeing could therefore be accounted for. The key elements here are the effects of colonization on their collective identity and connection to land and culture by marginalizing and interrupting the flow of unity and meaning, which greatly diminished the most important protective factors for their health.

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The result of the analysis shows a relationship between the intergenerational loss and the amount of land alienated. In this instance, the earlier land loss experience resulted in a greater experience of interruption to transmission and proficiency in cultural knowledge. Similarly, those who suffered greater losses of land through confiscation in moving to urban centers had, in effect, experienced spiritual disconnection from land. Meanwhile, even those who remained near confiscated lands still show high anxiety since they are constantly reminded of the historical trauma.

Meanwhile, in the search for healing from this trauma, the Maori's collective memory is deemed helpful as the narratives of resilience could strengthen collective identity. While alienation could not be removed from history, the process of acknowledging, recognizing, and validating experiences brought about by colonization could help in the healing process. Actions and programs regarding this are indeed very important, which include education and visitation to sacred sites or lands where, in a ritual, young ones may be exposed to the deep connections and spirituality of the Maori people. The visitation and the attendance themselves at funeral rites can provide space for interaction where they can sustain their esteemed values of social support, honor, and respect for their ancestors, culture, and identity.

On the other hand, formal apologies, financial recompense, and partial return of the lands, especially the sacred sites, could be very helpful. Furthermore, the provision of culturally sensitive health services with staff well informed about the historical past of the group could likewise support healing. Overall, the research thus provides an overall perspective on health affecting indigenous peoples, which involves being connected to their land, history, and spirituality.

Meanwhile, to develop healthy communities, especially for indigenous peoples who were victims of land alienation, the repossession of lands has become a global alternative movement. By revitalizing knowledge systems, identities, and relationships to land, health protective mechanisms could be highlighted. This case was described by Nightingale and Richmond (2021) in an article entitled, "Reclaiming Mountain Lake: Applying Environmental Repossession in Biigtigong Nishnaabeg Territory, Canada." It narrated concrete efforts to remedy the forces of dispossession in Biigtigong Nishnaabeg affecting the Anishinaabe people. By constructing two cabins, the Chief and Council of Biigtigong desired to reintroduce the community back to their place, where they could once again reconnect their thoughts and history, as well as transfer their heritage to the younger generation.

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This pursuit of reclaiming land has become common among indigenous peoples in recent decades who want to make cultural connections to their heritage and tradition. The foundational thought that runs behind this is the recognition that land is intricately linked to their identity and good health and that this land has an active agency in their wellbeing as a provider, teacher, and mother to whom they have a mutual responsibility to care. In other words, the historical experiences of indigenous peoples are intricately linked to their land, and knowing these connections is part of the "complex knowledge systems and holds the teachings that sustain physical, mental, emotional, and spiritual wellness."

Getting access to these lands requires strategies that are context-specific and unique to each group, but nonetheless, the aim is to "explore active processes to reclaim, reoccupy, and reconnect to land." The experience, therefore, of the Biigtigong Nishnaabeg becomes an illustrative document of how the repossession of Mountain Lake, Ontario, becomes meaningful through strategic enactment from development to implementation. As expected, tensions were also encountered, especially among settlers who thought the land was empty and alienable.

This initiative is justifiably part of the overall meaning of health for indigenous peoples, where land, place, culture, and other elements are recognized to be intricately linked. This place-based view of wellbeing reinforces the concepts espoused by health geography, where health has multidimensional connections and people have reciprocal relations in the form of "ethical and spiritual responsibilities" to land, the giver, and the resource of their lives and health. Land here is not only the provider or basis of their culture but likewise their teacher, guide, and facilitator of knowledge, emotions, spirituality, values, and relationships that cut across generations and affect their health. On the legal front, it is one of their protected rights to self-determination with regards to their lands.

As expected, the historical event leading to their dispossession of their land has always been recognized as the major event causing their mental, social, and physical illnesses. By limiting their access to land, they become disconnected from the intimate connections they must everything on the land. A recognized example happened in 1876 through Canada’s Indian Act, which created a reserve system that "systematically displaced communities from their ancestral territories and contained them on small plots of undesirable land." With this, almost all tragedies that happened among the indigenous peoples in Canada or elsewhere can be traced to this form of displacement, from diabetes to substance issues and suicide, to socio-economic disadvantages, to high rates of missing and murdered women, and to genocide. Far worse is the

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establishment of "residential school systems, Sixties Scoop, child welfare, and resource extraction." Until now, the conditions of separation, culture shock, and depression created trauma for the surviving people.

This struggle to rebuild their identities through the repossession of their lands means a lot to them. For the youths wanting a concrete engagement to fully connect to their history and culture, they need the guidance of their elders about how land has nurtured their lives in the past in an intricate fashion. This land-based activity has been found to be instructive to the youth wanting to learn and practice the teachings from elders that sustain Anishinaabe identity and ways of life. This repossession from a community approach inspired by the Ontario First Nation was envisioned to realize four goals: re-establishing relationships between elders and youth; increasing time spent on traditional lands; improving physical health; and fostering community pride. It was even noted in a different study that a community "canoe trip to reclaim, rename, and restore cultural meaning to significant places along the Pic River" had impacted the youths as regards connections to land and relationships to their culture. Thus, access is highlighted to preserve their historical journey, which makes repossession and active engagement with land meaningful.

The need for repossession is rooted in the Anishinaabe's claim that Lake Superior, Canada, has since time immemorial been occupied and utilized by their ancestors. Despite the current development infrastructure built along with it, it could not be erased that this indigenous group had established meaningful and reciprocal ties with the land. This relation, however, was severed through colonial laws, starting with the 1850 Robinson-Superior Treaty, under which, along with the Indian Act, the land was transferred to the state along with the transfer of the tribal group into a 332.7-hectare territory and being supervised by an agent. Besides, harsher realities further befell them with their children being moved to residential schools, underfunding community infrastructure, and outlawing spiritual practices. Lately, their land has been subjected to natural resource industries that have destroyed or contaminated the physical landscape.

The overall strategy in repossession was informed by the principle of mino-bimaadiziwin, which means "living in a good way," which emphasized nurturing relationships with people, animals, and things. This relationship is sustained by prioritizing group experiences, reciprocity and accountability, respect for protocols and the sacredness of cultural knowledge, and willingness to support other communities' cultural goals. The pillars and goals of these are the

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core Anishinaabe teachings of "wisdom, love, respect, bravery, honesty, humility, and truth," which anchor their struggle for self-determination.

The effort to construct two cabins and camp at Mountain Lake had three aims: to reclaim access, to reintroduce the community, and to reestablish community relations with Mountain Lake. At the camp, elders recount how they used to camp, hunt, fish, trap, and travel through the area but were cut short with the resettlement and the introduction of trap ground systems imposing quotas, seasons, and access for non-indigenous members to intrude in the fur trade in the area. Thus, by their presence, they are now reclaiming their access, and the cabin acts as a physical marker of the area, further expressing their right to self-determination.

While settlers or cottagers put up some initial face-off, eventually the elders simply ignored them, asserting their preeminent claim to the area. This demonstrated a positive attitude toward the young by reminding them of their inner strength based on their identity and courage to reestablish connections to their land. This access therefore ensures that future members of the group will have a wider space to develop themselves and continue their precious heritage. However, the only way that this access can be sustained is when members continue to actively and regularly use the area. This shifted to the need for the younger ones to be initiated by their parents and elders, although at first many of them were tentative about this strange place and never thought that the Mountain Lake was theirs. Thus, by engaging the whole family, motivation could be enhanced given the cultural meanings and community history narrated by the elders.

Furthermore, this reconnection demands reciprocal responsibility, accountability, and respect for the land, heritage, and culture, which can only be nurtured by the subsequent stories of the young to their subsequent children. In this view, the cabin could act as a place where a continuous dialogue of history and culture takes place as new stories are incorporated into the older ones. Further, when memories are continually shared, the ongoing history and relationship are sustained, making the youths' participation relevant, especially if they start to realize or claim that their connections are not only at the group level but at their personal level as well.

On the other hand, indigenous people, who are usually away from the main government infrastructure for health, have to rely on their own resources and capacities to address this. In an article written by Kingsley et al. (2021) entitled "Developing a Framework Identifying the Outcomes, Principles, and Enablers of "Gathering Places": Perspectives from Aboriginal People in Victoria, Australia," the importance of meaningful cultural spaces for various

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indigenous groups that might encourage further support is highlighted. By adding successful cases of gathering places to the literature, better health outcomes for indigenous peoples through well-channeled practices could be achieved.

Using a strength-based approach, government policies or programs informed by gathering-place utilization could help close the gap in health disparities among indigenous groups. This involves a conceptualization that places wellbeing and health as outcomes of the activities done by participants and the principles of gathering places. In Australia, the research covers Aboriginal people of Australia, Tasmania, and Torres Strait, who, although they might prefer their own designated names as First Peoples or First Nations, shared the same aspiration of better health away from the trauma of colonization. In this instance, community centers become the primary functioning safe place where, if given due attention and proper support, they could likely promote meaningful protective mechanisms for health.

Although it is merely a space, the term "gathering" provides a notion of activities, thus connoting further that something culturally meaningful could be carried out, from simple rituals, ceremonies, food sharing, art making to storytelling. With these potential activities that could be carried out, it could likely become one of the determinants of health. Further, the term "place" designates a specific use of space or activities or a provision of access where people can relate to one another's cultural constructions and meanings of their experiences and aspirations as a people. Thus, with a range of activities and possibilities that could be done, gathering places possess a multi-layered capacity to produce positive outcomes for community members.

In addition, given the holistic view of health sustained by the indigenous peoples, the availability of these gathering places makes them a preferred site to promote wellbeing. This is further attested by the interplay of connections along social, cultural, and political factors being reinforced in gathering places. In many circumstances, this could be understood as community hubs, but whatever the terms used, given that it allows a nurturing experience as well as connects community members to each other, a holistic need of each member could be well addressed.

As site-specific hubs, gathering places allow strong community engagement and become a significant partner of mainstream health services, which could be staffed and owned by community members. As a functional space, it could be in various contexts where activities and services could be delivered, which makes it function as an activity-based outreach network.

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Thus, in the multi-location feature, various categories in the communities can share resources for specific activities and resources. As an important determinant of health, thirteen different gathering sites were identified in Victoria, Australia, to identify strong contributions to community and wellbeing using a socio-ecological approach. This approach sees health as a product of a complex interplay of reciprocal systems in the physical or social spheres affecting health and so reflects likewise the living system theory.

Overall, gathering places as sites reinforce a sense of belonging and being connected to community members in a web of support networks for health. As such, it facilitates healing therapies and becomes an alternative to health centers located far away from the community. Furthermore, gathering places provide opportunities for learning and better awareness about the community, which can improve confidence and pride as well as allow mentoring towards leadership. Since it is inclusive, the space can reduce isolation and increase a sense of community. Likewise, appropriate government support for this through appropriate funding can further enhance indigenous peoples' aspirations for self-determination.

Furthermore, since the process of healing has always been dominated by western constructs, among many victims of colonization, this creates constraints as it neglects cultural aspects that make healing meaningful. Among the Innu, their healing practices deserve recognition given their unique views and practices that could complement western medicines. This compilation and analysis of indigenous healing was reported by Ward et al. (2021) in an article entitled, "A process of healing for the Labrador Innu: Improving health and wellbeing in the context of historical and contemporary colonialism," which highlights initiatives that seek re-incorporation or re-activation of cultural knowledge as a protective mechanism for their group's wellbeing.

For indigenous peoples, healing is rooted in the knowledge and culture of the group, which encompasses their spiritual, physical, mental, and emotional aspects of life. Healing practices, which include traditional teachings, sweat lodges, ceremonies, and community-organized events, have been practiced for millennia, but with colonization, much or all of these were outlawed. But still, the idea of healing as a transformative process as a journey across life conditions has been recognized to provide remedy, restoration, if not alleviation of suffering.

Among indigenous groups, however, there is not one healing practice, nor do they have a common practice; rather, each one has its own unique process given their circumstances, views, and history. Despite these differences, they share the core value that healing involves

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connections and relationships with community members and the environment that form a coherent and well-integrated system. In view of these, it is no surprise that the western model is recognized to possess limitations since the context of indigenous peoples often leads to misunderstanding and is therefore seen as a barrier to their health.

Their lack of confidence, or probably their recognized misunderstanding, is revealed by their limited utilization of services afforded by the government. This may also reveal their deep wounds from historical trauma and the asymmetry of power in healthcare provision. In effect, experienced racism and discrimination can likewise serve as another barrier to accessing health services, which, when unresolved, may further add to the cycle of mental health burden.

Nonetheless, it has been equally noted how indigenous peoples increasingly rely on their traditional healing practices, which require documentation. Towards this need, the authors partnered with local leaders to conduct community-based participatory research and so allowed each participant to be recognized as a co-designer and co-author, contributing their important views in the process. By having this team, healing practices are recognized as a cultural system anchored on indigenous epistemology and ontology that are sustained by relational value in the process of "becoming, emerging from relations among people, stories, and non-human beings."

In the view that life is intertwined with other entities in the community, affliction and pain are therefore outcomes of a ruptured relationship found in the ecological context. Thus, inevitably, colonial trauma is counted as resulting in "social suffering" since it produced cultural loss affecting their identity, language, and spirituality. While there is disconnection in relationships, there has been a recent movement to revitalize cultural healing. This sense of awakening, which partly inspired this research, involved several activities with the aim of developing and revitalizing community cultural and spiritual values. The movement is generally recognized as "pan-indigenous" since across the American continent, there are sustained events that seek to restore traditional modes of healing by "strengthening and renewing culture, social relations, and the healing of the broken spirit caused by colonialism'."

By recognizing the need of the community, which could be partly addressed by taking responsibility to renew the old cultural meanings and practices, healing becomes holistic as it involves reconnecting people to nature and to their heritage. In many studies, these healing practices and movements are often characterized as "journeys," since they involve transformation in "collective identity, purpose, and meaning-making."

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There is no homogeneity, however, in the practices since the context, material base, and interpretation are different from one group to another. This calls for a specific exploration of each group's cultural position and needs from an emic point of view. While all indigenous peoples consider reviving spirituality as regards healing important, there is no singular spiritual frame shared by everyone. While this demands that researchers and health providers always be sensitive to each cultural group's unique conception of spirituality, the idea of having recognized a cherished pathway to healing means that this new model could become a meaningful alternative in the approach to restoring wellbeing.

As a historical note, the Innu were nomadic hunters made up of small family groups who gathered on trading posts a few times a year. In the mid-twentieth century, with the aim of assimilating them, they were resettled and made hunting illegal, while schooling was mandatory. While this disrupted their traditional life, they became exposed to further destituteness by being housed poorly without running water. Their land eventually was flooded for a hydroelectric project, and it also became a military training ground. Not long after, however, they started to become politically aware of their condition and started to exert effort to assert their rights. Besides letter-writing and seeking sustained media attention, their movement was further articulated in a protest. Their continuous activity allowed them to increase their confidence to assert their rights, which eventually caught the public's empathy over their bleak health conditions, "including excessive use of alcohol causing drunkenness, violence, family breakdown, suicide, and accidents." While they have access to health care, it is distant and can be accessed only by air or sea, as the clinics are staffed by non-Innu nurses.

Along with their demand for higher funding for their health infrastructures, they also recognized the need to reconnect to their tradition of healing and negotiated the reestablishment of gathering sites. In 2014, they articulated in a book, Innu Nation, their Healing Strategy, which incorporates their vision "not as a return to the past but as a new way-of-being where Innu ways and ideas are maintained in their original meaning and practiced in a contemporary manner within Innu contexts." Along with the idea of self-determination expressed "through activism, writing, filming, or hunting," they are confident of improving their health conditions given their high knowledge of language (90%) and cultural tradition.

Through this research, they identified five stages in the process of healing: being "under the blanket"; finding spiritual These stages, although not experienced by all, generally depict various phases according to their vision of a state of wellbeing. First, being sick is like being

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covered and immobilized under a blanket; one feels hopeless, in misery, and alone. Second, in finding spiritual strength, one conceives of themselves as connected to their ancestors, environment, and community in a dream, which gives them a boost in their strength to overcome illness. This rediscovered strength allowed them to proceed to the third stage, extending hands out, wherein one emerges above his condition and can gaze around in confidence, capable of extending a hand for others.

Furthermore, this active movement in the vision solidifies their relational status, leading to the fourth stage, finding strength and power, which means that healing happens when one participates in helping others, as through this one's identity is recognized and enhanced. Further, in this stage, one utilizes the connections to the ancestors' instructive teachings in stories and legends, along with understanding and resisting negative influences on their lives like discrimination and other stereotypes. Lastly, in the helping others stage, the third stage is connected by emphasizing the purpose of healing, which is to contribute to the welfare of the group. Thus, supporting each other's conditions and sharing personal stories allowed them to practice this stage.

These stages are separate from their continuous recognition and respect for their local medicine man (Tshenut), who continues to act as "counsellors, spiritual advisors, and intermediaries" who could "communicate with and act as intermediaries between animal spirits and ancestors' spirits." Given this role, he remained the repository and source of knowledge and could alleviate the tensions felt, especially by the younger Innu, in their contemporary lives.

Overall, for the Innu, healing is a journey with five phases and could be depicted by a person looking at a rising sun over the sacred mountains, assisted by the four winds (spiritual, emotional, mental, and physical guides), with a walking stick and snowshoes (depicting family and community support). Further, on this trail, one carries a bag containing the tradition and knowledge of the ancestors, including a special connection with the caribou. Thus, healing for the Innu reflects their worldview, which involves recognition of their tradition, culture, language, identity, land, and interconnections with living and nonliving beings around them.

Lastly, it must be noted how the biomedical model in healthcare has not only been negatively felt by indigenous groups but has also been unconsciously endorsed by health practitioners unaware of their potential to contribute to health disparities in health-disadvantaged communities. In this article by Haynes et al. (2021), entitled "Decolonizing Indigenous Health: Generating a Productive Dialogue to Eliminate Rheumatic Heart Disease in

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Australia," they highlighted the need to explore and utilize alternative mechanisms wherein better health outcomes can be meaningfully achieved by engaging local communities in them. The focus, however, is on the key roles of health providers since they can become agents in bridging dialogue given their critical role in health delivery. In addressing the higher disease burden among indigenous peoples brought about by colonial legacies, health practitioners' creative and conscious participation in health delivery is crucial to bringing about improvements in community health status.

Health inequality in Australia has for decades disadvantaged Aboriginal communities, especially in the incidence of rheumatic heart disease (RHD), with 60% of them more likely to suffer compared to the dominant citizens of the country. Since this disease has been reported to increase morbidity and mortality, including in children, it becomes a potent marker of health inequity and a health burden across the individual, family, community, and society. Despite persistent efforts to address the prevalence of this disease, strategies have not substantially reduced the incidence of RHD. With these concerns, the authors sought to use a critical lens in analyzing the views and experiences of RHD practitioners to identify factors effective towards RHD prevention and care, besides interrogating the processes and structures through which they operate. Through these limitations, the biomedical and western health discourses could be informed or restructured to improve the delivery of health care.

By emphasizing the impacts of the dominant biomedical discourse in the RHD in the health context of the Aboriginals in Australia, along with the challenges experienced by the health practitioners, the macro-level forces brought about by poverty, racism, and an imbalance in communication can be addressed. Using the critical medical approach, the dominant western approach to health is evaluated to "both sustain health inequity and impede positive, systemic transformation, revealing a gap or contradiction in participants' discourse and practice." This allowed them to identify and realize racism and power differences, which generate disempowerment, oppression, and trauma in Aboriginal people's beliefs and practices. Rather than externalize these constructs, the participants critical understanding of their role allowed them to obtain a reflexive view of the ongoing effects of colonization.

Thus, through having an "insider" perspective, the blaming of the system and the patients is remedied by realizing alternative approaches to understanding their own capacity and participation in sustaining inequities. The first step towards achieving wider consciousness about health disparities is the identification of cases and events where the dominant biomedical

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discourse becomes the enforced conventional belief and practice. Second is the exploration of the practitioners' sense of lack of control and feelings of inadequacy within the biomedical system. Lastly, opportunities are sought to empower initiatives that restructure the impacts of the dominant biomedical system of care.

The interviews with the practitioners revealed how the dominant view structured their orientations, which sustain racism and misunderstanding reflective of what they learned within their biomedical function. Expectedly, this leads them to see RHD as a disease of poverty and a problem associated with Aboriginal beliefs and values, easily faulting the indigenous peoples rather than seeing a bigger issue. Others are even reluctant to connect health disparities to colonial trauma and so easily problematize indigenous behaviors that they project marginalized groups along a normalized deficit discourse. By focusing solely on the narrative of deficits, the dominant structure that sustains it is often ignored, and the cultural alternatives are often seen as different or undervalued.

The problematization and othering of indigenous peoples' experiences and views further reinforces the view that these people are indifferent and incapable of grasping the recommended care for them. These further feeds the normalization of the deficit view and marginalization since the biomedical field has the power to control, define, and enforce relations and decisions related to health. In the end, this narrative helped in enabling indigenous peoples to accept the blame or internalize their health disparity as part of being fated to be poor and discriminated against, which could be seen as institutionalizing racism.

Furthermore, noting the practitioners' emotions and sense of agency, they exhibit a kind of dissonance out of their feelings of hopelessness and powerlessness to initiate or accomplish beyond their limitations in the delivery of health care. This could be further understood as a kind of contradiction between the demands of their work to care and their being unable to fully remedy the limitations of the biomedical systems of which they are part. By keeping with the bureaucratic processes along with structured reporting requirements through computerization, they observed a greater weakening of interaction and loosening of networks necessary for a productive discourse. All these tied the practitioners into a loss of sense of agency to contribute to change in as much as they were unable to correct their deficit discourse about indigenous cultures.

Although they recognized their need to integrate their roles and responsibilities, their sense of helplessness against the external dominant system put them in a limited status. This

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hopelessness and frustration reflect their position in a biomedical structure that narrows opportunities to learn critical and analytical skills necessary to increase awareness and advocacy for change. Thus, despite their competency, they often feel as though they are complacent, if not contributing to the system that enforces health disparity. Therefore, to broaden their sense of agency, they must likewise appreciate their potential to collaborate meaningfully by addressing their "lack of training in management, cultural safety, reflexivity, and trauma-informed care, combined with a lack of institutional support, workforce shortages, and funding for primordial prevention, health literacy, and advocacy."

To bring about productive health systems, fuller recognition of the roles of the practitioners and the communities must be actively integrated, not only in the delivery phases of medical treatment but in the whole system of care through a reflexive mode. This means that in a productive dialogue where each voice is valued, differences and solutions can be identified and negotiated, affecting the organization and delivery of care. The lack of space to bring about dialogue can be remedied by recognizing the unique indigenous worldview that emphasizes collective relationships integrated and shared through their history, language, and value system.

Against the individualized biomedical approaches, indigenous culture must be given consideration, which is consistent with the health protocols of the government and aligned with their right to self-determination. This can be adequately addressed by providing funds for the training of health workers and community workers so that they may integrate their own voices and needs into the structure of health provisions. Similarly, by having a paradigm shift, health practitioners may empower their sense of agency and capacity to support and advocate alternative approaches.

To operationalize the lessons learned, three mechanisms were offered to remedy the gap: 1). Small-scale, strength-based, community-led local changes; 2). Community-led research focused on action that uses critical, decolonizing social science approaches; and 3). Cultural safety training, including reflexivity regarding power dynamics. By getting into the community, the people become empowered, which will lead to better participation and a recognition that they are co-creators of a program based on mutual respect and the mutuality of help against illnesses. Through a critical social science approach, collaboration could lead to the recognition of evidence of what works, appraised in a manner that is mutually recognized as critical to health and has the capacity to help communities gain confidence in the process of decolonizing medical structures. Lastly, with culture respected, power dynamics are recognized and

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moderated through reflexivity, which could transform relationships and structures against marginalization and normalize deficit narratives affecting indigenous conditions.

Thus, the participation of the community will remedy the biomedical template's cultural blindness and enable practitioners to become productive outside their comfort zones, capable of recognizing and resisting power imbalances. Likewise, their skills will be enhanced as facilitators committed to social justice. Their sense of weakness will be transformed into strength since, through reflexive dialogue, they will become conscious agents and participants in delivering a culturally sensitive, holistic, and transformative health care system.

> *Indigenous peoples have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired.Indigenous peoples have the right to own, use, develop and control the lands, territories and resources that they possess by reason of traditional ownership or other traditional occupation or use, as well as those which they have otherwise acquired.States shall give legal recognition and protection to these lands, territories and resources. Such recognition shall be conducted with due respect to the customs, traditions and land tenure systems of the indigenous peoples concerned.*
>
> (Article 26, no. 1, 2 & 3, UNDRIP, 2007)

5.6. Cultural identity, indigenous voices and representation, and co-production in health

Towards recovery and healing, the notions of cultural identity, indigenous voices and representation, and co-production in health are often recounted in literature to be effective in demonstrating the local system's efficiency. This holistic view that models' indigenous health always challenges stigmatizing and disparate mechanical approaches and thus needs to be corrected. Thus, the following reviews will illustrate how models rooted in ethnicity and culture are important in any intervention program. Similarly, if given the chance, indigenous peoples are likewise capable of producing valid and reliable research tools capable of capturing their voices and equally valuing the role of their women. Lastly, an example of an integrated view of health is presented through a case study looking at how human-animal mutuality enhances life and makes the integrity of health meaningful to indigenous peoples.

For indigenous peoples and other minority groups, going to a mental health clinic is least favored since it carries with it events and ideas that are foreign to their cultural background. In

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the case of the UK migrants, those coming from the Caribbean identified that high levels of police involvement in their cases as well as compulsory treatment created tensions in their search for care. Lawrence et al. (2021), in the article entitled "Navigating the mental health system: Narratives of identity and recovery among people with psychosis across ethnic groups," analyzed the narratives of Caribbeans in contrast to the narratives of white British to explore the interplay of personal, social, and cultural factors that moderate mental health recovery.

Psychosis being prevalent among the UK Caribbean population, this is often associated with inequalities and a lack of access to care. Yet, as is often the case, the medical model in identifying the sickness often involves more than is necessary, which can create further anxiety and distress. This happens when police are involved to enforce medication as well as the compulsory admission to health centers, where cultural context and personal needs are given less attention in favor of enumerating symptoms. This "static, one-dimensional model of pathways to care" does not consider alternative pathways to care as well as the dynamic social processes involved in the experiences and life of a person.

Rather, based on Kleinman's Health Care System model, there is a need for health care to be informed by a cultural framework to understand how people make sense of their experiences. In understanding the fluidity of human cognition and personality formation, psychosocial and cultural contexts can impede recovery. With this background, people create narratives, and by understanding the genre of these in the conception of illness and health, a coherent view of life could be understood. These narratives, while reflecting their identities, likewise restructure them in the context of the social condition. One genre is 'restitution,' 'chaos,' and 'quest,' which could help explore ways to encourage individuals to recover.

The restitution narrative looks upon the role of medical doctors, while chaos depicts the self-enveloped in suffering, and the quest narrative emphasizes the will and determination to recover. While there is no discrete experience that could be isolated into one of these constructs, they are helpful in allowing individuals to reflect upon their conditions and so contextualize their illness. Often, however, without considering cultural variability, the language of the biomedical model may suppress personal representations but instead force categories that may be outside of one's experiences. By assuming prior categories, it marginalizes experiences as well as suppresses understanding of the context, which further increases one's vulnerabilities.

Rather than sticking to medical categories, the method of recognizing illnesses through narratives could be empowering since it takes into consideration conditions that shape them, as

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shown by sharing personal stories. Stories like recovery narratives may be outside the biomedical structure, yet they give a clue about the role of interpersonal and social factors, which could also be applied to narratives of psychosis and psychological distress. In line with this, in consideration of unique personal experiences, seeking mental health treatment could thus be seen as a "journey," although in a different field of experience.

Using the three narrative themes, 'losing the self within the system' was seen to be most common among Caribbean groups. This means they possess a high level of self-stigma, and this distress could be associated with frequent police involvement and compulsory treatment. This narrative likewise reveals a strong desire to avoid discrimination since being a member of a minority group can lead to many social disadvantages. Without taking this into consideration, their situation may lead further into greater vulnerability, and their forced treatment could be interpreted further as a form of oppression.

In the 'losing self' narratives, a few participants revealed how their emotional conditions are generally ignored in the medical field due to their poor living conditions brought about by power inequalities. Often, because of financial difficulties, they ignore or deny help, not recognizing their need for clinical help. Both showed indifference to their medical treatment as well as recognition of their "profound sense of hopelessness," which they could hardly escape. Given that they are in a socially disadvantageous position, other events and circumstances may further compound their anguish, which calls for a critical examination of their structural circumstances that put them in a disadvantageous position.

Lastly, in the 'steadying self through the system' narrative, this was adhered to more by the British participants, whom they claim to associate with being part of their genetic makeup triggered by adverse circumstances. This easily fits into the medical frame given the confidence towards recovery through medication away from self-pity. Given the strategy, which includes self-management, participants show how they overcome stress by accessing the system of care.

Overall, the participants revealed several lessons since the limitations of health care revealed the gap in the delivery of psychiatric help, which must likewise be sensitive to other manifestations outside the medical language. Also, personal accounts, though varied, still show a sense of control that, when supported, could help in the recovery process. Medical personnel thus need to become sensitive to personal narratives, for they carry meaning and notions of health as well as clues as to how their social and personal factors can modify their wellbeing. Also, being in a marginal group, one resource for healing that could be integrated is recognizing

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the role of spirituality by connecting the participants to their family networks and culturally constructed meanings in their lives.

Meanwhile, the use of cultural concepts in the medical field affecting indigenous peoples has been debated, including "if and how local community or population differences ought to inform changes to conventional clinical practice." In the article written by Hartmann et al. (2021) entitled "Conceptualizing culture in (global) mental health: Lessons from an urban American Indian behavioral health clinic," this has further implications on the issue of extending colonization and on the predicaments of health professionals for effective and ethical interventions based on cultural competence and evidence-based practice. The debate can be rooted in the need to balance the idiographic and nomothetic knowledge constructs between medical-centric cultures and the need for diversification based on cultural differences. Thus, although much of the funding and design are from the Global North, the fear of a colonial imprint can be tamed through collaborative efforts where there are bidirectional relationships involved in health knowledge and practice.

With little guidance on how this dialogue would take form, mental health programs may continue to reflect settler colonialism, which validates activism and research revealing how discrimination affects indigenous life and health. Seen as a tool of colonization, eurocentric medical practice has been met with resistance through rejection of the framework and looking forward to negotiating for alternative health services at the community level. By enabling active agents and stakeholders in the dialogue and being supportive of self-determination goals, experiences in health care settings could shed light on how this promise can lead to a better understanding and response.

The culture concept, being an added dimension in health care demands, stands at the intersection of mental health needs for American Indian communities, and thus, by clarifying this, empowerment may be felt in engendering trust and viable meanings in the clinical setting. By modifying the binary views of health and illness attuned inside medical clinics, the top-down impositions can be moderated by recognizing available traditional healers through referrals of their expertise. Meanwhile, it is observed as well that local healers might have cultural competence, yet there is no single American Native category lifestyle that questions the persistence of essentialism in the face of alternative and contextual views favoring local differences in approaches. This continued association of cultural concepts with minority groups

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has, in effect, pushed mental health practices to adapt to new initiatives in interventions for these diverse groups.

In effect, interventions based on group values have been tailored by incorporating community practices to address medical needs, making them sources of valuable lessons in negotiating power and informing debates on mental health provisions. In doing this, the importance of indigenous healing processes and the need for "flexible, pragmatic, and eclectic" models could be explained through descriptions of both the treatment activities and the recipient communities' points of view. By incorporating further, the symbolism, tradition, and orientation, a complex interplay of cultural concepts in each setting, researchers can uncover "sociopolitical questions about agency" that are sustaining the tensions between self-determination aspiration and the legacy of colonialism.

The study revealed that by incorporating indigenous forms of healing in the clinical setting, local practices become "reconfigured as decontextualized symbols" in a "client-centered" approach. This client-oriented strength-based approach emphasizes a holistic understanding of illness rather than looking at each as a deficit or a result of maladaptive behavior in a psychotherapy setting. Further, this shift in engagements by integrating local symbols has become popular in healing practices given the accepted "assumptions, the clinic structure, and popular culture concepts." However, since the burden is on the therapists since they carry "an unrecognized predicament" given the tendency to displace their medical training in favor of traditional cultural demands, Nonetheless, they too may innovate, revise, or reformulate their learned medical template to accommodate indigenous values and needs.

For the therapist, while they may sincerely observe the required approach, they could not do much unless they became fully immersed in indigenous community life, and so the most they could do was "repackage" or "tweak" the medical protocol to reflect the differences in values and practices. Given the strict medical regimen and reporting, the process of integrating indigenous symbols and meanings could constrain their skill and practice at the same time as it was observed that some activities were ignored in many sessions. In the medical setting, in the process of accommodation, two activities were operationalized rather than pursuing a holistic and integrative approach, which could potentially create a discontinuous application of cultural symbols and meanings.

This reconfiguration may lead to disassociation and blending in a short period of time, which may result in a "merely performative" session that could undermine the expectations of

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indigenous clients. In part, this risk is a product of emphasizing cultural differences and traditions with the aim of improving health delivery to people harmed by colonialism. These efforts of reimagining, tailoring, reflecting, adding, and repackaging therapeutic approaches to mental health to make them appealing may also lead to tensions among people who resist misappropriation of their cultures. Therefore, to avoid misleading communities, health professionals can work along the "cultural commensurability" frame as a viable alternative, which could happen when American Indian healers themselves lead in their curing practice. This working together in a commensurate fashion may not only free health practitioners to pursue their learned approach but at the same time allow local communities to pursue their self-determination aspirations in a mutually reinforcing setting of knowledge exchange and respectful accommodation of cultural meanings.

Overall, this "model of medical and epistemic pluralism" could work well across common concerns for healing, although it should be repackaged and avoid performative acts that could challenge colonialism's imprint and ideology. Rather than incorporating indigenous practice into western norms of health, a collaborative effort could lead to fruitful discussion and dialogue within clinical ethnography that avoids essentialism and generalization in medicine about cultural concepts and differences.

On the other hand, one of the sources of anxiety and depression for indigenous peoples is not only the dispossession of their lands but also the usual practice of destruction and pollution of their resources. One of the affected communities is the Mi'kmaw in Canada, who, according to Lewis et al. (2021), in their article entitled, "If only they had accessed the data: Governmental failure to monitor pulp mill impacts on human health in Pictou Landing First Nation (PLFN)," the dumping by Boat Harbour Effluent Treatment Facility (BHETF) of 85 million gallons of industrial effluent per day had not been fairly quantified as to their health. In consequence, the estuary, which was culturally the source of their food, medicine, and varied activities, became "a place of disease and death."

This disaster became possible through the British North America Act (1867), which subjected all Indian lands to federal control and allowed local negotiations leading to the 1966 agreement that gave a permit to an industry to dump effluent on the riparian zones. To seek redress, a court ruling decided that the PLFN should receive $35 million aside from conducting regular health monitoring. However, despite the establishment of the Joint Environmental Health Monitoring Committee (JEHMC), no serious monitoring was done, and contrary to their

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lived experience, a health assessment commissioned by the state agency even claimed that BHETF has not negatively impacted the PLFN's health.

As a response to this denial and cold attitude toward their health status, the Pictou Landing Native Women's Group (NWG) started to mobilize in 2010 to demonstrate how the BHETF "has in fact impacted" their health and that "the JEHMC failed in their obligation to monitor the health of the community." In this, the authors lamented that not even baseline data was collected so that at least cases of cancer could be given an early diagnosis. The study then demonstrated through a bio-political theory how settler colonialism has displaced, marginalized, and distorted the images and capacities of indigenous peoples under the frame of dominance.

The case in point is the conduct of surveys, which are in the control of the colonizers as to when and how, as well as the purpose, language, and analysis. Thus, the effluent was presented as not a threat because it is located remotely and has not impacted the lives of the Mi'kmaw. This further justified the NWG's decision to "change the narrative" by "collecting their own data" in comparison with the settler's account. By making their studies inclusive of the physical, mental, cultural, and spiritual aspects of their lives, they hoped to disrupt the bio-political frame by interrogating the power of dominance and control. This could further serve indigenous pursuits for balance and harmony by integrating "distal determinants of health" that may seem remote from personal life yet are relevant to sustaining community life.

Another strategy employed was the "Two-Eyed Seeing" (Etauptmumk) principle, which organizes views, analysis, and interpretations from both the local and western perspectives. Thus, it advances the idea that there is more than one way to look at things, and so the contribution of the indigenous peoples is integral to the overall assessment and decision-making process. Further, since this principle emphasizes integral relations, the central theme of all relations is making land or place the center of linkages.

By observing the Etauptmumk principle, the use of settler's language is guaranteed not to decontextualize indigenous knowledge. Also, by using Mi'kmaw categories and language frames, the research initiative can come up with standard variables that can be measured without committing "epistemic violence." With participants as co-researchers in the community-based research, the framework thus makes sure that they remain focused on "the consequences of land displacement and environmental dispossession on the health of the PLFN community." Lastly,

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the NWG was keen and confident that they were able to formulate "the questions they wanted answered."

To bring about a local understanding of health, four outcomes were sought as variables: physical, mental, emotional, and spiritual. Unlike western self-rating surveys, a general concept was sought instead that depicts health in the local context. In contrast again to the medical psychiatric definition of mental health, the indigenous notion was pursued, which includes the capacity to achieve full potential, the capacity to cope with normal pressures in life, and the capacity to make meaningful contributions in the community. To avoid downplaying experiences of stress, the question was rather framed as "has the person had an experience of stress "in the last year?"

Whereas emotional health was conceptualized on the level of connection to land and culture, spiritual health was determined in terms of purpose, meaning, and the ability to engage in traditional activities and take care of the earth. While measures of income and employment were utilized to explore social determinants of health, health and well-being were framed to reflect the consequences of land displacement on their physical, spiritual, mental, and emotional needs. Lastly, other historical sources of trauma were explored, like having any member of the family attend residential schools, which could enlighten the level and extent of racism and discrimination felt in the community.

The study thus demonstrated how the biopolitical mode attempted to dominate the narrative and put the oppressed indigenous peoples into silence. In the face of the legal need to examine the effects of dumping the effluent, government agencies refused to do research, claiming that it was time-consuming and expensive. But resistance was advanced by drawing up research that was framed from the local perspectives and cognitions that challenged the controlling power. In the end, by focusing on land and the effects of displacement and environmental dispossession, Mi'kmaw were able to develop and assess their own health vulnerabilities, which were structured by colonialism, apathy, and racism.

Meanwhile, another great lesson or model to be learned from successful intervention is the use of community health workers. The article by Grant et al. (2021) was titled "The Development of a Community Mental Health Education and Detection (CMED) Tool in South Africa." As in any indigenous community, the sub-Saharan region is likewise beset with mental health illiteracy, stigma, and a lack of available health services. But while this may be the case, something is still forgotten on the demand side. This means that while programs may be

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conceived and implemented, success may still depend on the response, cooperation, or eagerness of those affected to avail themselves of the initiatives at hand.

In this instructive article, the authors outline their steps in developing a tool called Community Mental Health Education and Detection (CMED) to enhance positive attitudes toward the health programs to be delivered by local health workers. To ensure that it was in line with the government's health program, the development of the tool took four steps: 1. Continuous interaction (1) Ongoing engagement with the KwaZulu-Natal Department of Health (KZN DoH) to ensure co-creation of the CMED tool and alignment with routine community health team activities; (2) Adaptation of the CMED tool from the Community Informant Detection Tool (CIDT), used to promote help-seeking of people with mental health problems in Nepal; (3) Review of the CMED vignettes and illustrations by a panel of local and international mental health care experts to establish accuracy and contextual and cultural relevance; (4) Process mapping and focus group discussions (FGDs) with community health teams in one district to establish cultural and contextual appropriateness as well as coherence and compatibility with existing community-based services.

The 75% treatment gap in the sub-Saharan region is equally shared in the third-world countries (76.3% and 85.4% gaps). While there is an increase in mental health services, the demand is low, revealing that many do not seek care due to poor literacy and information, a lack of awareness, or the stigma associated with the disease. But in many cultural groups, these attributes are shared, so any misconceptions could be a symptom rooted in each community. While increasing awareness may be helpful, sensitivity to context must be taken into account. This refers to the potential of health workers who live and have specific roles in communities. By integrating the intervention into the work of health workers, there is a greater possibility that more people will avail themselves of the mental health services offered.

This collaborative care package, known as the Mental Health Integration (MhINT), is operationalized so that, through this learning health system approach, people will improve their recognition and detection of mental health problems. In the case of South Africa, the existing Brief Mental Health Screening Tool was reengineered yet was seen as ineffective because of its checklist approach, which could potentially lead to labeling and stigmatization of people who screened positive at a community level. In effect, the SMhINT team, upon request, developed and validated a mental health tool that could be used at the community level by

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community health teams to identify community members with possible mental health conditions during their routine household visits.

In response to the low levels of mental health literacy in South African communities, the Community Mental Health Education and Detection (CMED) tool was thus developed to provide psychoeducation on mental health conditions. Further, given the screening and health promotion roles of community health teams, it was agreed that this tool would likewise raise mental health awareness and identify people with potential mental health problems at a household level. This is very informative for the Ati context, to help them develop their own tool for detection and education against mental health. Soon, if they were given a program and if identification and education were a necessity, this tool could be adopted.

The Normalization Process Theory (NPT) was used to guide the creation of a tool that is in line with the health workers' roles. Such a tool, to be effective, must be both meaningful and agreeable to participants, as well as compatible and capable of monitoring the cost and benefits of the intervention. The tool is like a mini-comic strip that identifies mental illness by depicting it in a story. Such a prototype approach allows diagnosis since patients or family members are made to match the story with their observed mental health issues and, in effect, leads to a referral for those having symptoms of depression, anxiety, harmful alcohol and drug use, and psychosis reflective of MhGAP recommendations. Meanwhile, local idioms of mental health problems were incorporated into the development of the vignettes based on the literature.

The vignettes production was undertaken by a team of experts, and they were illustrated by a graphic artist, keeping in mind their translational aspect, which ensures their content equivalence and semantic and conceptual equivalence. Translation being important in communicating the message, it was done here by two bilingual clinical psychologists and a bilingual research psychologist. Subsequently, an expert panel reviewed the CMED tool to determine the appropriateness of the vignettes and illustrations in the South African context.

Lastly, the health workers' comprehension of the vignettes was likewise assessed since they are the ones to implement them on the field, which involves process mapping and focus group discussion. The process mapping is important to understand how health workers operate daily, from planning, home visits, linking patients for referral, follow-up, and administration. This will ensure coherence and compatibility between their expected duties and their actual lives in communities.

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For this purpose, the community health teams were made to create a visual map of their daily activities for the whole week. Besides, they were also passively observed while they were in the community to assess to what extent they observed their expected tasks. A focus group discussion was done to assess their understanding and perceptions to understand the appropriateness of the meaning, idiom, and illustration used in the vignettes.

Important lessons include an appreciation of an achieved psycho-educational and detection tool that is functional in the hands of health workers not only for screening, assessing, and diagnosis but also for mental health literacy. Such strength came about because the vignettes made use of the local custom of oral storytelling using local idioms. Besides, this task being close to the goals of health workers, their effectiveness is further enhanced because of their closeness to the community, and with the broadening of their skills, other illnesses could likewise be included in the referrals. Overall, the normalization process theory has been shown to strategically help in the design of the intervention by following its principles of coherence, meaning, and relevance of the tools. With focus group discussion, health workers become co-creators of a tool that is invaluable in bringing about the context and required design through an iterative process of a culturally sensitive tool to increase literacy and recognition of mental health needs and referrals.

Following through on the idea above, research done with or without the participation of indigenous peoples is often suspected to lack authenticity and genuine connections to the local conditions and experiences. This could be in the form of incomplete data or in choosing a topic or interpretation that is of less importance to the local group's needs and worldview. In an article by Patterson et al. (2022) entitled "Are Indigenous research principles incorporated into maternal health research? Through a scoping review of the global literature," they highlighted the need to widen the representation and involvement of indigenous peoples to make research meaningful and relevant.

The high incidence of maternal mortality and morbidity has always been found among women in poor countries, but generally among indigenous women, which cannot be detached from their experience of historical colonization, land dispossession, and discrimination. These traumatic backgrounds manifest in their nonavailability of antenatal care and skilled birth attendance, leading to adverse perinatal, neonatal, and infant care and support. Despite this, there is still a widespread lack of recognition and acknowledgment of their need by their respective governments, or they are underrepresented in research. Given their heterogeneous

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identities, some are neglected, while others are over-researched, adding further to the widespread confusion and misappropriation of intervention programs for them. One of the best solutions to this is to enable them to collaborate in research by recognizing their capacity to lead and interpret results reflecting their conditions. Through this, the gap in priorities could be identified, as their contribution forms part of high-quality data that is critical to policymaking.

By collaborating, researchers not only promote trust and validity in data but also acknowledge the historical trauma that is critical to the design and understanding of the worldview of indigenous peoples, which can frame accountability and improvement in health programs. Further, the active involvement of indigenous peoples does ensure that relevant research principles are integrated or embedded that would allow intersecting domains—social, economic, political, cultural, and geographical—to be investigated. By further highlighting intersectionality and heterogeneity, researchers could responsibly account for poverty, exclusion, discrimination, oppression, and colonialism. In practice, indigenous participation has to be defined as integral by providing them with leadership roles in setting up research agendas and identifying needs. This inclusion acts as centralizing the roles of indigenous peoples through community-based participatory research, which would likely then ensure sustainable solutions by making visible the identities, voices, and aspirations of indigenous peoples.

In this instance, to make healthcare responsive to indigenous peoples, Mwangi (2022), in his article entitled "Institutional one health and animal-human health connections in Nthongoni, Eastern Kenya," pointed out the need to integrate the practice of traditional healing along the lived connections of people, animals, and the environment. This comes as a realization that with human expansion and activity, communities further encroach on natural spaces, which exposes people to new animal-borne diseases. However, rather than look at this in a competitive mode, the author looks at this as an opportunity for active collaboration of professionals motivated by integrating the networks of benefits from animal and human relations to bring about strategies to promote health through a One Health agenda.

Given the broad framework of this view, it was questioned as to its feasibility and practicability given the fear of disease spread and budgeting. Nonetheless, there were already practices that, when done in a particular situation, could benefit the health of communities, animals, and the environment, like the culling of certain animals, caring for pets, and managing livestock, although each may bring about some moral questions as to their equal importance. However, rather than seeing them as separate, One Health studies may encourage integration

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as a strategy of the biomedical system with indigenous health systems to make health responsive to cultural needs. This also touches on the multi-species approach to life and health that humans share with different species of plants and animals that construct, constitute, and co-produce health.

This new approach began as the "One Medicine' program in 1984, emphasizing the human and animal linkages to health. But a decade later, challenged by viral epidemics like the severe acute respiratory syndrome (SARS), 'One Health' evolved that incorporates new but significant agents for health: the natural space along the infrastructure of medical care. At this time also, parallel initiatives grew like "eco health, comparative medicine, environmental health, and "veterinary public health, conservation medicine, ecosystem approaches to health, environmental medicine, global health, public health, and population health." Since the project sees that health is co-produced by providing support to people, animals, and the environment, an interdisciplinary and collaborative agenda is pushed for an optimal result. With this orientation, the OH can be adapted to different needs and topics like hazard mapping, disease risk detection, impact assessment of diseases or human actions on environmental health and informing the epidemiology and etiology of diseases.

In traditional medicine, these interconnections, in contrast to the practice of western biomedical approaches, are always integrated in the explanatory view and treatment of diseases. This active inclusion of the natural world, including animal welfare, enables traditional medicine to exemplify the basic practice called lay one" as opposed to the medical One Health health service. In the case of Kenya, this often involved using the same healing practices of diagnosis and medication among humans and animals alike. In using the same concoction, the healer recognizes that there is more in common between animals and humans and that this interconnection is further linked with the environment where the materials were obtained. In other words, traditional healers have always been interdisciplinary practitioners, and in the act of their homogenizing practice, they become collaborators in promoting health in all spheres of life.

Like health professionals, local healers similarly view that many human illnesses are related to animals (animal-borne), and the main culprit is in the interconnections of personal and socio-economic factors. For them, human greed and dishonesty plus ignorance made them slaughter dead or sickly animals for the market and so pass the disease to the human community. Nonetheless, they too recognized that these behaviors were also products of poverty and

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corruption in the government, which pushed people to despair and become numb about welfare. This odd materialism was introduced by colonialism, leading to the displacement, and "squeezing" of people in small villages in "historical, social, and politico-economic complexities" that accelerate disease occurrence and transmission.

This adherence to medical pluralism, of modern and traditional healing, is not new in Africa, and although there is more than one option in seeking remedy, for Nthongoni of Kenya, the first and last institution to approach in need of a cure will always be the traditional practitioners. This preference is dictated by feelings of trust and respect as well as by the accessibility and affordability of the services provided, which make a person's health practical and fulfilling. Further, given the proximity of people to their animals, it is easily understood that animals and humans co-produce their health.

One Nthongoni healer narrated his observation that baboons and squirrels too could heal themselves by utilizing various food resources available around them. By identifying these leaves, roots, soil, and barks, he has gained confidence from experience that the healing properties of these materials could similarly restore health to humans or other animals. Similarly, by observing what these animals avoid, he too prohibits them for his human clients. This narrative showed that health is not arbitrary but likewise a result of careful observation and logical reasoning, and so it has a great role in sustaining health in a resource-poor region. This entwining in ongoing interactions and encounters of the natural world, animals, and humans along with health concerns about human sharing and respecting space with animals would become meaningful. On the contrary, western biomedical practice with a reductionist outlook sees animals as sources of contagion, and so for indigenous peoples, this could not only deny them of the valuable lessons and interactions but also aggravate their anxieties as their connections to nature are severed.

Besides having a deep knowledge of animal behaviors, the Nthongoni also have the advantage of obtaining, processing, and consuming animal products as ingredients to counter diseases. With new diseases continually emerging in various communities, these local resources and meanings as interconnected realities could provide greater assurances against their anxiety and vulnerability. Since everything in nature is believed to possess medicinal properties, lay one health inform or enhance one health implementation in the local setting. This integrative view of health possesses the potential to sustain health through respect for the knowledge and

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experiences of local healers as well as the recognition of the functional properties of local values and beliefs.

5.7. Gardening, nature adventure, and land-based connections as sources of holistic wellbeing

Having been introduced to the importance of indigenous peoples' health and identity connections to their land above, the current topic will relate how active experiences centered on land can empower them against threats from climate change to personal anxieties and depressions. The significance of this to the Ati becomes obvious when they realize that even land connections alone are more than enough to restore their esteem. In subsequent reviews, when given the chance or liberty over a landscape, most likely, they too will experience not only therapeutic experiences but also positive healing, which could act as protective factors in their lives. This position is depicted by the narratives of communities involved in gardening, which, when extended to connect to their heritage, land, and other rituals, gardens, gardening as a process, and plants as living bodies, would likely become genuine elements of healing.

As observed, the indigenous peoples, being in marginal places, although they are the least contributors to climate change, are predicted to mostly suffer from its consequences. In an article entitled, "Land is everything, land is us": Exploring the connections between climate change, land, and health in Fort William First Nation," Galway, Esquega, and Jones-Casey (2022) narrated this issue, highlighting Anishinaabe perspectives on and direct and indirect impacts of climate change on health and land. In this study, their voices are contextualized by social and historical forces, starting with colonialism, which disproportionately structured their experiences of vulnerability to climate change. Nonetheless, it could not be discounted that their adaptive efforts in the form of "movements for climate action and justice" may define their resiliency.

In the northern part of Canada, the annual increase in temperature was documented, and the thawing of permafrost, which leads to the displacement of plants and animals, affected the Anishinaabe's access to resources, thus undermining their knowledge, health, identity, and culture. Since their connection to land goes beyond territories as it includes living and non-living entities, the interaction of these in a reciprocal fashion for millennia nurtures their

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physical, emotional, and spiritual needs. Seen from a relational perspective, these resources of life, culture, and identity could likewise be their strength against climate change.

To understand these connections and their resilience, collaborative, culturally specific, and place-based research was conducted "drawing on the perspectives of elders, knowledge keepers, and community members with close ties to the land in Fort William First Nation." The whole project, from conception to analysis and sharing, was guided by Two-Eyed Seeing (Etuaptmumk) and the Medicine Wheel commonly used by the Mi'kmaw Elders. The former refers to looking at a phenomenon from two or more perspectives so that it is easier to arrive at compromises while at the same time being able to grasp opportunities in life. Further, since it encourages reconciling views, it thus leads people to healthy cooperative efforts in solving problems. In addition, the Medicine Wheel guided their interviews, emphasizing the interconnections, the movements of ideas and activities, and the linkages to health, environment, and community life in relation to climate change.

Using visuals in the analysis and interpretation, the Two-Eyed Seeing and the Medicine Wheel led to the production of quilts that embody their interpretation, fears, hopes, anxieties, interconnections, and strength found among themselves and their environment. The first theme revolved around their observations and experiences of change on land; they described their noted changes to the flora and fauna as well as to the natural landscape and wildlife. They saw how extraction and pollution undermine the goodness of the land, and likewise how climate change weakens the integrity of the connections. Climate change was experienced by observing rather than through texts, through their acts of listening, watching, and experiencing the land. Because of their "complete dependence" on land, a place-based perspective revealed how climate change impacted their health through the tensions and degradation they observed around them.

The second theme identified the root cause of climate change, which was a lack of care for and respect for nature. Besides recognition of the ongoing effects of colonialism through "the Indian Act, the residential school system, forced relocation, and land dispossession," displacing them disrupted relationships to land and so undermined the traditional care and respect for the natural world. Due to the incursion of external investors, their lands became a space of greed through resource extraction in the name of money and profit. In this view, climate change intensified or compounded the disempowering effects of colonialism, and this crisis has been long overdue.

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Theme three emphasized how healthy land promotes healthy lives. With lands considered kin members together with the rest of the natural world, any degradation would likely affect other integral members. Humans being only part of these connections with roles to care for, their love and appreciation of the health of the land will likely lead to better health for all. However, with resource extraction and pollution, this land becomes sick and so negatively affects its integrity, which sustains other life forms, including man. These could be observed in the loss of flora and fauna diversity, the loss of livelihoods, and the loss of connectedness that impacted and exacerbated the mental, emotional, and spiritual conditions of people. This loss and pain are expressed as ecological grief, or solastalgia, which is common among indigenous peoples upon perceiving and anticipating ecological loss and destruction. Overall, by looking at the effects of climate change, people come to align their views and beliefs, protecting the integrity of and connections to their land, where healing is obtained.

The fourth theme highlights the importance of youth and future generations. The recurrent view is that all efforts and lessons must involve the youth since they are the ones to carry on the tradition and care for the land. There was a strong need to inspire the youth by imparting knowledge through activities in response to climate change, so they could develop protective measures for their physical, mental, emotional, and spiritual wellbeing. In Anishinaabe, this connecting with the youths is part of their "looking back and looking forward seven generations" philosophy, which considers the care of the earth by recognizing their long interdependent connections to their kin. With youth voices regularly being heard in meetings and activities, recognizing the importance of the future generation, a sense of hope is therefore truly assuring.

Theme five is about (re)connecting with land and culture, which could mean a return to their traditional life or way of life involving retreats, teachings, ceremonies, and the use of traditional healings and medicines. By recognizing this, they emphasized their life and culture as stewards of these connections, which required reciprocity with the land. Some related ideas to this are the practice of their indigenous language and stories rooted on land, as well as their involvement in environmental repossession by asserting their rights. Since land is seen as a mother and teacher, reciprocity requires giving back, honoring, and respecting the different spheres of relations that respond to the pressure of climate change.

Overall, by examining the messages embedded in the quilts, the community expressed their holistic view of the relationships between people and land. Such connections are comparable to

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the thread that weaves through the design; the interconnections, relationships, reciprocity, and relationality can inspire and ground analysis in response to climate change and health issues. Thus, by centering on land, the Two-Eyed Seeing and the Medicine Wheel underscore the lived experiences, wisdom, and stories of Fort William First Nation. By "relationship-building and co-learning," the simultaneous and generative learning and caring of the land "reduces binary and hierarchical thinking" that undermines relationships and connections with the land.

Meanwhile, noting that one of the concerns of place-based or landscape research is how to identify the mechanisms through which land can promote health, Milligan et al. (2022), in an article titled "Wilderness as Therapeutic Landscape in Later Life: Towards an Understanding of Place-Based Mechanisms for Wellbeing through Nature-Adventure Activity," held that the activity that one is involved with could have an instrumental effect on health. The fundamental idea behind this is espoused by the importance of outdoor environments in support of health, which is expressed today through various modes of activities in nature like wilderness-based therapies, nature-based encounters such as forest schools, and nature-adventure activities including mountaineering, rock climbing, mountain biking, and surfing. Either they may be called outdoor adventure or alternative sports, yet they possess some degree of risk and danger and so create "uncertainty and the emotional response to fear," although for the practitioner those could be their source of fun and thrill and so could further reinforce their motivation. This could then probably explain that engagement with nature embodies an experience that promotes wellbeing.

In later stages of life, the beneficial effects of nature could be found in the therapeutic impacts of engaging in nature. The euphoria gained can substantially improve their resilience in their mental, physical, and social health, allowing them to improve their sense of self and identity of "what it means to be old." Thus, by exploring their engagement in wilderness and nature, mechanisms could be outlined as to how exactly outdoor activities promote wellbeing.

By exploring activities in nature through attention restoration theory (ART), the authors would like to explore how healing could be derived from interaction with nature through voluntary and involuntary means. Voluntary engagements mean a well-planned involvement focusing on the output of the act, in contrast to involuntary involvement, where nature is allowed to spontaneously effect positive results. In either of these settings, beneficial emotional experiences could support recovery, either in a rural natural setting or in structured urban conditions, if interaction involved the physical body and place.

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One view of restorative engagement is to go beyond nature-individual tandem by incorporating relationality, cultural aspects, and the symbolic effects of the interactions. As an ideographic study, engagements in remote areas may involve cultural narratives since they involve encounters with wilderness, which reinvigorate personal kin connections and awareness and identity with nature. By defining wilderness as peaceful and harmonious, subjective experience and perception could reinforce the personal need for a therapeutic relationship.

Embodied experiences with nature therefore involved specific activities, emotional responses, and the interactive presence of nature in the form of fatigue, muscle aches, and skin sores. Meanwhile, community gardens may be a moderate source of engagement, yet, as in the wilderness, "what people do is as significant as where these activities take place." In accomplishing this, "the entities, processes, and structures" of events could become conducive spaces or embodiments of therapeutic absorption by the body in a relational action with nature.

Wilderness as a source of healing is often contrasted with the conventional urban setting, where there are people, impersonal built spaces and structures, and a complex of technology. It is beyond a rural setting where there is quietness, beauty, and wildlife that "engender feelings of wonder, aloneness, excitement, fear, and terror." Different people have different kinds and levels of engagement or proclivity with wilderness depending on their 1) formative childhood or youth experience; 2) work or volunteer activity experience while young; 3) supportive and encouraging friends or relatives; and 4) experience of critical moments in their life course.

Despite the challenges, stress, and dangers of outdoor engagement, older people continue to engage due to a sense of euphoria with all the adventure, risk, and fun involved. Ageing bodies may be relieved through the experience of excitement and pleasure through a nature adventure activity, so this could be counted as very therapeutic. In other words, rather than withdrawing, the gentler form of stressing the body can provide relief and confidence over perceived limitations. If varied activities were presented, the meeting of new challenges could be both enhancing and enabling, extending further their confidence and self-acceptance of their capacity to complete other tasks.

Thresholds of activity for older people may eventually affect their self-esteem, and they may disregard additional challenges and engagements. This comes when some of my younger friends are demonstrably becoming more skilled and have grabbed front row status. Similarly, this could also be felt when one realizes they are the only person who can no longer keep pace with the group. Both of these could signal for a person to self-reflect and reassess his or her

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capacity, which would likely lead to a withdrawal from further engagements. While wild spaces may not have the accessibility and fitness of structures found in built environments like fitness centers or gyms, the combination of visual and sensory experiences facilitates unique interactions leading to wellbeing. By forcing the participants to focus on a different topic, they become challenged to successfully complete their activities.

Overall, the study revealed how immediate context in the wilderness creates an immediate response to stimuli such as awareness of the space and its reassuring effects on the beholder. Through the demand to shift the focus to the current reality, the self allows a rest from the former mental burden, which can lower anxiety and enhance productivity in life. While this could be about mental level conditioning, others take on outdoor challenges because of their demand for immediate physical risk. This does not simply require a simple cognitive shift but rather a complete setting aside of other competing demands, which requires an understanding of the direct risks involved in the engagement, the extent of personal responsibility for the risks involved, and the extent to which the landscape poses itself as a challenge.

The mechanism that involves engaging people in outdoor engagements has something to do with learned orientation and thus could have been influenced by the life course, where previous experiences in the outdoor environment are rehearsed with new meanings achieved in later years of life. The other factor involves the in-built attitude of focusing the mind on the immediate risks and challenges, which could affect overall resilience in life. On aging bodies, it became a matter of time before one readily accepted the need to shift towards less challenging and less risky activities, with the mind finding relaxation that enhances wellbeing, and so one may still find wilderness therapeutic.

To further support therapeutic needs, gardening as a public health tool has been promoted to enhance wellbeing, but according to McGuire, Morris, and Pollard (2022), in an article entitled, "Community gardening and wellbeing: The understandings of organizers and their implications for gardening for health," there is far more to it than simple planting and harvesting vegetables or fruits. Basically, community gardening involves space, plants, intentions, and willing bodies. With broad purposes like food production, engaging in therapeutic activity, group identity reinforcement, demonstration, and education, this could be found just anywhere, from pots to benches to parks, besides on lawns. Besides, for health and biodiversity goals, gardening was also seen as facilitating activism against some perceived socioeconomic injustices against some business interests associated with farm produce.

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Interestingly, gardens can also be a place where obesity concerns are played out and so promoted as an alternative lifestyle that, while it is free, it can likewise make fruits and vegetables available at hand. No wonder health professionals encourage this to promote health consciousness along with psychological benefits that reduce stress and anxieties as participants become carers of each other and carers of the earth. While gardening may just be the simple tending of patches of vegetables, with the new trend to look for alternative lifestyles, such activities have become almost an extension of medical requirements for some illnesses. With health associated with land and plants, people tending to this notion can use gardening as an advocacy and a form of resistance against the increasing demand of a neoliberal market for conscripting land for profit and trapping people solely in employment work.

Meanwhile, gardens are seen to promote health by emphasizing meaningful links to land and plants. People can utilize their cultural backgrounds to further their identities, leading to effective therapeutic effects. Thus, gardens become spaces where opportunities exist to establish good health and consolidate cultural identities, embodied in a bigger role in human social and emotional needs. It could likewise become a facilitator for healthy interaction with a symbolic meaning as the caring heart of the community.

Besides, therapeutic gardens support relational values where plants, land, and people become co-producers of a healthy lifestyle, and each reinforces the value of each element through the life course. Since it affords meaning to participants, the space becomes a source of pleasure as each generates life as an active agent in the web of relations. Further, while gardens may offer a holistic experience where people obtain a flourishing life in the community, they could also become exclusionary away from their benign or philanthropic function by defining who has access to them.

In the study, most organizers had vivid memories and experiences about gardening, connecting their skills and passion from previous generations. This made them enculturated to the rhythm and routine, as well as to the skills and knowledge of gardening. On the other hand, with new trends that seek to live a simpler lifestyle away from processed foods, activism may develop, bringing about a new advocacy for health. The act of tending a garden may also reflect actions towards mitigating the effects of climate change, while others look at it as rehabilitating untended patches in urban settings and so can promote spaces for contemplation, or the act itself can promote calmness in each of the participants.

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Overall, while much of the gardens reflect the positioning, skills, and advocacy of the organizers, participants may still carry their conception of gardening as having a spiritual or magical influence, confirming relations with nature, promoting ethics of care, and being a space that enhances self-worth and attains emotional satisfaction. Eventually, being in constant care of plants across seasons, the transformation going on in plants could offer an astonishing sight that could reflect a sort of spiritual realization of one's agency in making nature productive.

The routine and the patience gained in gardening likewise enabled a dimension of time for reflection, thus allowing a eudaimonic interpretation of life and wellbeing over a period of difficulties. Likewise, since each one takes part in the tending, everyone can position themselves as co-owners, which is non-hierarchical and allows for shared and equal self-esteem for all. The health effect could not only be on activity and meaning in relation to plants, but likewise through the promotion of resilience as gardening involves processes and movements reinforcing the purpose of patience and optimism in the work.

Meanwhile, gardening may be a lifestyle in an urban setting that serves the biomedical need to manage illnesses, and so the space becomes a challenge to overcome laziness and become fit. Likewise, it could also become another option in the process of transitioning from work to retirement and thus provide another set of community experiences that could support any emotional disturbance. This is aligned with using gardens as a venue to enact social change since it offers a chance to improve the lives of those who are socially disillusioned and disadvantaged. By motivating them to develop skills and confidence, gardens could become a space to demonstrate valuable behavior against undesirable policies. Thus, when leaders connect social and political events to the meaning of gardening as a space to promote human dignity, the space and the process could likewise become sources of developing awareness and consciousness against social inequalities.

Activism can also be enhanced by encouraging people to pursue higher visions of life in society and by providing "welcoming, inclusive, and non-judgmental social spaces." Through this, gardens can further remedy discriminatory attitudes by educating people through engagement about the negative effects of social exclusion. Simple activities like talking on fair and equal terms, as well as sharing snacks in the garden, can exemplify socially acceptable behavior towards tolerance, respect, and mutual trust. Thus, besides a simple biomedical view and reductionist understanding of community gardens, the respondents presented varied but promising functions of the garden, which include mental and emotional healing and a space for

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personal and social goals filled with relational meanings connected to land, health, culture, and social and political constructions. If this is the case, appropriate funding towards the realization of this bricolage of functions and meanings can truly promote a cohesive and health- and life-supporting community.

On the other hand, given the close affinity of indigenous peoples to land, most likely any initiative that could make them come closer to it would be beneficial. In Aotearoa, New Zealand, gardening as an activity is explored to see how it could improve the wellbeing of older people belonging to the Maori tribe. This was reported by Wiles et al. (2021) in an article, "Gardens as Resources in Advanced Age in Aotearoa NZ: More than Therapeutic," positing that gardens possess multiple roles that could grant support to the wellbeing of people of advanced age. Whatever their motivations, the overall effects, from mental to physical, have been well noted, which makes it a site for meaningful connections to culture, identity, and the community. While it may not have commercial purposes yet since it facilitates intergenerational legacies, the early life introduction and experiences with this activity help people lead meaningful and satisfying lives.

By infusing pride in the activity and by accommodating different people of different backgrounds, gardens could lower stress and anxiety as well as promote harmony across relationships. Thus, by being involved in the planning and nurturing of gardens, participants are not only challenged but also allow for continuity in cognitive functions, which are known to be therapeutic as well. Further, through adaptation and flexibility towards problems and challenges, gardens possess a performative capacity for creating meaning through narratives and speech acts. In other words, the interactive engagements in a garden produce power shifts reflective of dynamic shifts of positions that are continually negotiated as part of the rhythms of life. The discursive meanings and experiences obtained in the activity could enable participants to generate new realizations that could replenish their cultural, personal, and affective resources in life.

The study revealed that participants overall obtained high satisfaction and self-esteem from the gardens, not only because of what they produced but also because they recognized their abilities Despite their perceived physical limitations. By becoming familiar with their plants, their topics of conversation become further sources of connections as they exchange observations and notes about their success. Likewise, as they recollected their past experiences, they were able to reinforce their sense of identity associated with their language use and the

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crops they cultivate. Further, as they recounted their dedication and hard work, they were able to affirm their nurtured values and so share moral status through sharing, kindness, care, and self-sufficiency.

Gardens too revived their memories and connections to their ancestral lands through their rituals and rites, as well as their experiences of dislocation. This gives further meaning to their understanding of sharing, as through it, they were able to help themselves survive during those times when their lands were confiscated. Their sharing with others, therefore, gives them pride, for this shows the continuity of the lessons they learned from their parents. For some, gardening becomes a site of connection with their past and to other Maori people, and so they develop a longing for a wider participation or production to bring about greater happiness for all. As they recall their past, each phase of gardening generates memories that impart lessons to their children, besides producing nutritious and chemical-free produce.

In their symbolic world, any form of sharing is healing, and gardening links experiences to good practices and health by emphasizing the medicinal properties of plants as well as recognizing the place as a source of therapy. While gardening becomes an opportunity to demonstrate the ability to do active work, it is also a source of concrete reminders for self-control, moderation, optimism, and gratitude for life and others. Further, gardens also facilitate acceptance of changes in life and so demand a balanced attitude as well as creative adaptations to circumstances like the use of wheelbarrows, walkers, or stools. This shows that even in old age, resourcefulness and becoming a team player can still be achieved. Meanwhile, although they lamented about the indifference of their children to gardening, overall, at their personal level, they were able to realize their significant contribution to their culture and identity, which this younger generation can fill in when they too become older, needing a template to find life meaningful. Finally, recognizing the benefits of gardening beyond personal pleasures, the research thus supports any initiatives that would allocate funding to this type of gardening given its multiple roles and material and cultural contributions to society.

As for indigenous peoples who are attuned to the natural world, plants are necessarily not only part of but also meaningfully associated with their culture and health. Elton (2021), in an article entitled "Relational health: Theorizing plants as health-supporting actors," emphasized that the proposed "relational health" concept is rooted in the idea that plants do not only produce food but also health in a complex relation with other cultural and social dimensions of life.

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Ignorance of this is called 'plant blindness," and it becomes acute when one cannot see the broader connections.

While plants produce oxygen, fiber, and nutrition, they are also fed by soil as products of previous life forms. This emphasis on relationships recognizes the view that plants have agency and are therefore capable of initiating and collaborating with humans to produce the proportionately desired effects. This exploration of concepts regarding plant roles could be linked to other theoretical frames like "one health, ecohealth, ecological public health, planetary health, and ecological determinants of health. While there is a proliferation of versions of this human-plant interactive relation, in the actual medico-political sphere of public health, it has only received marginal attention.

Using a post-humanist theory, the author assessed how human-plant interaction produces health in the context of gardening as an adjunct to an ecologically and health-supportive social housing infrastructure. It started with the realization that nature and plants are more than simply sources of contagion and diseases; everything in them, from microorganisms to plants, animals, and climate, affects and supports human health. This relationship dissipates the binary view of the world, which excludes or makes humans unique among the rest. At the same time, while it sees man as part of an ever-changing environment, and so its health is co-produced, the meanings nonetheless come out as a product of analysis and cognitive representations expressed in language.

With humans described as simply one among the many interacting elements, this view thus adheres to a decentering approach or "flat ontology," for it promotes the "we" identity beyond the "us vs. not us" view. From this perspective, the conventional dualistic view of human health and diseases is disrupted by citing how viruses, rather than threats, become instrumental in elevating the human immune system. The same is true with hookworms; careful ingestion of them could have a therapeutic effect on the body. This means that rather than being against nature, humans should learn to collaborate with it, thus recognizing that nature too has its own agency in shaping human health. As co-participants with capacities, humans and non-humans are then both co-responsible for producing and sustaining the wellbeing of each other on this planet.

Human agency, however, is differentiated from nonhuman agency since, although both are co-participants, only the former can define motives and intentions. In contrast, nonhuman agency is in its achievements, which are readily reflected in the health of humans as outcomes

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in the relationship. This view has always been ignored since it does not benefit pharmaceuticals and market politics' partiality to laboratory drugs in promoting health. Looking at the experiences of indigenous peoples, one of the reasons for their miserable health could likewise be traced to colonization, which disrupted and erased their links to their land, culture, and tradition and instead imposed a dualist view of wellbeing. Thus, health is not only medical or cultural but also political.

In Toronto, Canada, prior to the construction of a condominium to remedy the housing gap along Regent Park, the neighborhood was surveyed as to their main interests and concerns that might be included in the design of the building. While the plan was set to prioritize social cohesion to promote healthy and meaningful relations, garden spaces were limited in favor of growing food, which could be located on rooftops. In this circumstance, people who could not have access to rotational use of rooftops for gardening make use of alleyways and other open spaces in the park and elsewhere, including the church and plant boxes. It turned out, however, that new condominiums provided less space for gardening, and so people transformed "scraggly lawns" to be called "guerrilla gardens" since they were utilized without permission.

From the participants' perspective, two main themes emerged: that gardens provide an affordable supply of vegetables and likewise enhance wellbeing and mental health. Since most participants came from low socioeconomic backgrounds, the availability of fresh and pesticide-free vegetables allowed many to stretch their budgets. Likewise, the therapeutic effect of gardening was appreciated since the interaction and the space increase social cohesion and the sharing of experiences. They too feel a strong sense of interdependency with plants since, while they are the ones who provide water, other factors like sun and air are also important and allow plants to produce the fruits people desire.

Looking at the posthumanism view, plants in gardens were recognized to have the capacity to influence people, especially in the way the building was designed or constructed. This capacity of plants to influence ideas and motives is demonstrated by the outcomes or consequences in the form of benefits and opportunities to realize emotional, social, and physical needs. By having relationships daily negotiated in relation to plants, plants too were able to initiate community lore that made others become vocal advocates for gardens. This movement, to an extent, becomes political through the creation of "guerrilla gardens" in recognition of the collective relational benefits of gardening, making plants "protest placards" visible on streets. In other words, plants become actors as well, not only providing health benefits but also

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becoming facilitators in producing collective actions that would support a stronger bond between humans and nature.

5.8. Finding strength and recovery through the family, community, and cultural networks

Having identified the need to challenge cultural trauma and understood the importance of land, gardening, and plant connections, this subtopic addresses the enduring community microstructures that sustain their culture and identity. Indigenous peoples, who often value tradition, community life, and heritage, are most likely to rely on emotional support from their social networks. When these are revitalized, most likely any psychosocial disruptions like stress and anxieties will be reduced. This is the theme that the following reviews below will highlight, as each connection is endowed with meaning and becomes another resource of protection against mental illness.

For this subtopic, it has been documented that problems with mental health and substance abuse exist among indigenous peoples in Canada and elsewhere as a direct result of colonization's resettlement project. This forced removal abruptly disconnected these indigenous people from their source of cultural meaning, and so it was recognized that understanding their health systems as well as reconnecting them to their land could eventually facilitate their healing. This was the view of Ninomiya et al. (2022) in an article entitled, "Anishinabek sources of strength: Learning from First Nations people who have experienced mental health and substance use challenges." Through local partnerships, their interviews and photovoice records allowed them to conduct a thematic content analysis to identify the Anishinabek's system of care and sources of strength and resilience over health issues because of colonization.

They recognized that besides the mental burden, indigenous peoples could likewise demonstrate strength and perseverance in congruence with their cultural resources of meaning and connections with their environment. This pursuit to facilitate cultural empowerment is one of the thrusts of the Truth and Reconciliation Commission of Health Canada in 2015 as part of the process of reconciliation, supporting the integrity of their culture. With the prevalence of mental health issues and substance abuse among these people, it was seen that a clinical approach alone is not sufficient given the depth of the trauma suffered by their group. Much

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more, in the design to assimilate them, much of their traditional knowledge was suppressed or denied to them, underestimating the traditional value rooted in their culture.

Thus, part of the effort to revitalize their culture is to provide inputs to healthcare services so knowledge could generate positive results for indigenous health. This way their tradition is described through diverse viewpoints could help identify pathways to healing along with their increasing demand for self-determination. There is then the need to describe the system of care and sources of strength and resilience from the perspective of those who have lived experiences with mental health and substance abuse, not only to inform health services but also to be able to conceptualize how indigenous peoples sustain their health.

The first data source of the study is through interviews with those who had issues with mental health, substance use, or violence (MSV0) and those with lived experience (PWLE) and their family members. Together with secondary data analysis, the goal was to identify how their received health services function to serve their needs directly or indirectly. The second strategy was called photovoice," wherein members of the Aamjiwnaang First Nation were asked to take photos of their conventional lives and have them discuss the captured image based on their perspective. The narrative resulting from these will allow us to explore the group's sources of strength and resilience in the face of their health challenges.

The study revealed that participants highly recognize the bonds they share with their family and friends. These connections were highlighted because they promote trust, openness, and confidentiality, which opened avenues towards wellness and feelings of hope, self-worth, and pride that positively affect them in their daily lives. These illustrate the importance of family members and friends since, through them, critical confidentiality and encouragement could be sustained, especially in times of need. Extending this, the kin members became relevant because, through them, multiple lines of support could be obtained and reconnected. Given this view, it becomes important to note that formal health services are challenged to incorporate trust, openness, and confidentiality in the provision of services.

The overall lesson is to see culture and land itself as sources of healing and participation, and the use of their traditional medicines can reinforce their worth and confidence in their communities. Further, the integration of these traditional systems gave them empowerment as they reclaimed what had been suppressed among them. Thus, given this recognition, support, and opportunity to reconnect and activate their holistic approach to health, their renewed identity became open to exploring and availing themselves of opportunities offered by the

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government, especially in education and employment. Health recovery as a journey therefore becomes meaningful in the context of a relational, trustworthy, and non-judgmental cultural and kin support system.

Meanwhile, if safe spaces and access to social resources are important to health, then enjoyment of land is undeniably important to sustain a positive lifestyle. This article, though focused on LGBTQ2+ people, remains a lucid reminder that could be equally applicable to indigenous peoples. This paper by Aghedu, et al. (2022), entitled "Social resource patterns and health outcomes among Canadian LGBTQ2+ adults: A latent class analysis," emphasizes how access to social resources could improve coping needs over stress and threats to wellbeing.

It has been observed how social support or access to it directly or indirectly promotes social integration, such that even a perception of it could enhance a sense of belonging as it assures connectedness to the family or society. The benefit might not be material, but the closeness of ties can become a capital to gain more confidence and improve one's sense of identity. Thus, access to this becomes crucial, which is oftentimes contested and unevenly enjoyed by marginalized groups like indigenous peoples.

Historically, people assigned identities by their differences due to physical characteristics or by birth were not only emotionally subjected to discrimination but also denied important connections. While caring family and community members are around, the linkages and opportunities are often unavailable due to some held prejudices. Thus, while supports could be protective factors, they could be compromised due to some personal or social circumstances that are withholding their availability or access.

In further analysis, social connections could likewise be seen to sustain cohesion, which supports meaningful relationships. This suggests, therefore, that upon looking at these linkages and access to relationships as resources, their availability in multiple forms could be beneficial to mental health and growth. For this study, five resources were identified—family of origin, friends, partner, neighborhood, and LGBTQ2+ community—as sources in association with loneliness, mental health, and self-rated overall health. Thus, this study could remind us how minority groups experience limited access to important social resources and how these in turn affect their health outcomes.

Overall, the research revealed the intersectional challenges of minority groups given their biographies, and so access to support also requires multiple resources, both from type (family, relatives, and friends) and level (frequency of quality time) to ensure optimum health outcomes.

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In many cases, though, one good but nurturing connection can be more than many but have less effect on emotional needs. Finally, the authors emphasized that behind this lack of access to social and emotional supports and compromised relationships and resources are the products of colonial extended structures, which likewise need to be amended to realize a favorable space for respect and growth.

A further example of the importance of social connections is illustrated in an article entitled "Labeling, causal attributions, and social network ties to people with mental illness," by Pullen et al. (2022), which explained that social contact has a remedial effect on stigma in people with mental illness as well as facilitates identification of the symptom. They made use of egocentric network theory in the 2018 General Social Survey (N = 1173) upon recognition that mental illness stigma (MIS) "remains among the most serious impediments to recovery from mental illness." Their analysis of the effects of interpersonal contact on individuals' perceptions and beliefs about mental illness assumed that contacts with people with mental illness have been repeatedly associated with "less stigma endorsement, such as beliefs about personal responsibility, dangerousness, and desire for social distance." In effect, this could lead to positive understanding and responses to mental health problems as well as improve mental health literacy, which means it could influence "endorsement of mental illness labels and scientific versus moral attributions."

Among indigenous populations, contacts are an essential part of their daily lives. This research, though made under a sociological lens, is worth emphasizing. Particularly, the study reported that those who have friends with mental illness are more likely to have a better estimate of the condition rather than trivialize the symptom, thus lessening their negative attitude. Those who have contact with mentally ill family members are more likely to tolerate a negative attitude or see the patient as a burden or a threat. Thus, overall, the study related how contacts become an opportunity to lessen, if not remove, stereotypes about individuals with mental illness.

Further, the study pointed out the importance of looking at stigma and not only focusing on individuals and their traits, which make each prone to prejudice and discrimination. Rather, to establish a better frame, stigma is evaluated in the social network frame, by which the authors could "identify, measure, and evaluate the association of mental illness network characteristics with stigmatizing attitudes." Thus, through the latter approach, contacts are recognized to have

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"an important influence on both labeling and causal attributions of mental health problems described in vignettes."

The findings contend that the number of family members and friends with mental health problems is likely to endorse the view that mental illness is a character problem, and that meaningful connections may lessen the view that mental illness is a personal responsibility alone. Meanwhile, connections to friends with mental health problems are less likely to result in downplaying the symptom as ordinary, and connections to family with mental health problems are likely to help understand the neurobiological connections of mental illness. Moreover, the "frequency and intensity of interactions" between family and friends would become opportunities for learning about mental illness as well. In contrast, those who have distant experience with mentally ill people appear to have a higher level of stigma and discrimination.

Further, those with intimate connections with people who have mental illness have "lower desire for social distance from" the latter, and that contact with individuals with mental health problems does not necessarily free many from attributing mental illness "to poor upbringing and bad character." They also regard personal contact as most effective at reducing negative attitudes against stereotypes (rather than relationships alone), along with the claim that women have better mental health literacy compared to men as they are less likely to associate mental illness with poor character. Compared to whites, indigenous groups are predisposed to view mental illness as a part of life and linked to personal responsibility. Also, it was learned that social network methods are useful at analyzing stigma and contacts since they have the potential to describe how social contact "matters and under what circumstances." Lastly, through analysis of contacts, the research reinforces the importance of "network structure and culture as avenues for dismantling stigma," which points out that not only interpersonal contact but rather "interventions that foster meaningful connections" can be useful in preventing the negative effect of poor mental health literacy.

Furthermore, the idea that social participation as a lived experience of social networks is beneficial to mental health is generally understood as it affects a sense of belonging and confidence in the emotional and social fields. In the article written by Ang (2021), entitled "Your friends, my friends, and our family: Informal social participation and mental health through the lens of linked lives," she highlighted how this participation becomes more relevant in the marriage context, wherein husbands and wives expand their kin network and so also their

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social sources of participation. Since wives and husbands carry different characteristics, their gender-specific experiences are also examined beyond the assumption that they share predictable health outcomes. Further, binge drinking together with other depressive symptoms is likewise noted to equally understand the negative pathways of participation and its effect on mental health.

The study proceeds from literature that infers social ties promote health given their capacity to sustain confidence and acceptance. The frequent interaction solidifies this relationship, and over time, this relationship can prove helpful. One important connection is through marriage, which is seen to be more sustaining and meaningful in practical and emotional terms to partners than those who are unmarried. Besides the psychological and financial assurances, marriage likewise connects spouses to wider kin groups, so social contacts may be expanded. However, given that time is limited, a spouse may simply select with whom to socialize; thus, it is likely that the type of socialization can influence mental health as a covariate variable. Furthermore, gender differences may also be significant in sustaining social contacts since males and females have different expected social and domestic roles, which can influence mental health. This study would thus like to illustrate how the social participation of one's spouse can affect one's own mental health and whether gender differences exist in these associations.

The principle of "linked lives" holds that individual behaviors are non-autonomous but rather co-produced as "linked lives" with other recognized associates as friends or kin-members. Marriage, as a mechanism and a state, establishes connections and provides additional resources for social connections, which may favor mental health under the self-selection view. However, given the traditional role of women, it was thought that men possess more advantage over women as regards relating marriage to mental health. Given that women are often expected to fulfill further home duties, the overall benefits for men are greater as regards mental health experiences. Furthermore, while women might eventually earn more than men in the later part of marriage life and there might be an increase in contact with relatives, it is still not known how women's contact is relevant to men's mental health and vice versa. Thus, given that marriage alters the scope and frequency of contacts, it could affect mental health as it offers additional sources for emotional support.

The result revealed that the informal social participation of one's spouse is related to one's experience of positive mental health, although there was no clear data as to whether males or females benefit more. In the dyadic model, however, time matters, which shows that depressive

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symptoms may occur later with contacts on the husband's side. While this shows some kind of imbalance, it could still be understood that as time goes on, a spouse tends to narrow down relationships, which could influence perceptions of emotional support.

As regards binge drinking as an indicator of emotional distress, wives reported this more in association with their husbands' friends later. Rather than see this negatively, it is shown that this behavior could reflect the drinking behavior of the husband's friends. Nonetheless, while this is reported on the side of the husband, it is not shown on the side of the woman. The partner effects for both depressive symptoms and binge drinking are substantively large, which revealed that informal social participation is just as important as actor effects and individual-level effects from informal for mental health outcomes.

Overall, it appears that the mental health of both husbands and wives is broadly associated with their own informal social participation in similar ways. Nonetheless, women's binge drinking is associated with their husbands' contact with friends, but their contact with their own friends does not seem to affect their husbands' binge drinking in the same way. On the other hand, the positive association between within-dyad imbalances in contact with friends and depressive symptoms is statistically significant for wives but not for husbands. Further, while the negative contact effects may be beneficial with friends for wives but not for their husbands, women's mental health may seem to benefit less from the overall marriage relationship. This could be explained by the fact that men and women are more likely to benefit equally from increased informal social participation, which includes kin-keeping experiences.

To realize social connections, the case of community-level intervention in mental illness is reported by Fong et al. (2021) in an article entitled "Evidence that loneliness can be reduced by a whole-of-community intervention to increase neighborhood identification." It was built on the idea that social identification has a protective effect on mental health, which means that, through or by it, people's needs for trust and support are satisfied. In a longitudinal study with 437 participants, the Neighbor Day initiative in 2019 in Australia, which was aimed to motivate people to connect with their neighbors, was found to effect "increased social cohesion, reduced loneliness, and improved wellbeing." Given that one of the challenges among indigenous people in an urbanized area where their mobility is curtailed is loneliness, this research examined immigrants and those living in middle-class neighborhoods who face the burden of it and require intervention. As such, the experience of indigenous peoples in their basic

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community life could inform any policymakers that meaningful interactions and positive perceptions of a functioning neighborhood have an intervening effect on people's mental lives.

All in all, the study confirms the literature regarding the importance of neighborhood identification in addressing loneliness and supporting social cohesion and wellbeing. While the exact connections between these have yet to be explored, social identity interventions, especially the role of neighborhood identity, do improve emotional ties among people. Also, it highlights the effectiveness of community-based intervention to improve neighborhood identification and, in effect, creates a venue for positive experiences for the individual and the community. Meanwhile, it brought to light those specific activities like hosting activities, leaving cards in neighbors' letterboxes, and connecting to Facebook or social networks, among others, could increase meaningful neighborhood engagements.

Lastly, the researchers recognized that while strong neighborhood identification may overcome barriers to social connections, programs that promote these initiatives can necessarily have a positive contribution to health-related outcomes. This also strengthens the importance of community- and place-based efforts in intervention efforts targeting mental health and wellbeing, as they are "delivered by locals for locals, rather than by outsiders." Thus, the study clarifies the importance of strengthening positive cultural identity as a protective mechanism against stigma and loneliness.

One good example is how sleep is moderated by having some assurances of kinship ties, given that as machines do require rest or a reset, so, too, do humans. In this perspective, Palimaru et al. (2022), in research entitled "Mental health, family functioning, and sleep in cultural context among American Indian and Alaska Native urban youth: A mixed methods analysis," explore the relation of sleep to the mental health of indigenous adolescents. This is welcome research since these youths, who are often neglected yet are crucial in the maintenance of their culture, Furthermore, it is noted that even if they experience anxieties, their conditions are often associated with the biological phase of their lives rather than some cultural contexts or their family life.

The study utilized two methods—the survey (N = 142) and the interview (N = 26)—that would capture actigraphy-measured sleep and narratives about their experiences and patterns of sleep. Besides describing variables affecting sleep relations and other behaviors in the family, the narratives opened the subjects of family cohesion and traditional practices. Further, a path analysis would provide a picture of how quality sleep is moderated by family support and levels

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of anxiety that would inform intervention appropriate to this cultural group. The research reiterated that most mental health problems have their origins during the adolescent period and that sleep is a major factor. While there is a biological basis for sleep disturbances due to brain development, it was also noted how poverty, urban setting, and emotional ties in the family can affect a young person's ability to rest. Within the family context, adolescents can be provided with successful interventions that would prevent the onset of mental health issues.

Besides the role of family, cultural connections may also affect, directly or indirectly, the relations and contexts of the family and the adolescents' need for quality sleep. In this view, culture can be a protective factor through the promotion of good sleep for indigenous people's mental health. In relation to this, some of the findings are: First, a family sense of belonging can lead to less family conflict and, therefore, increase the emotional states of everyone, favoring sleep. Second, extended family members presence as cohabitants may at times improve cultural awareness, but in an urban setting, adolescents may feel constrained by their presence and so may create anxiety. Lastly, a warm and supportive family atmosphere leads to fewer sleep disturbances. Thus, lessons lead to the following: interventions should be family-based, focusing on specific family functions like family cohesion and togetherness as well as cultural integration to lessen the adolescents experience of anxiety and improve their sleep patterns and mental health.

Furthermore, immigrants like indigenous peoples or Ati in a new environment surrounded by a larger group or in a new nation in the process of learning a new life must encounter a host of anxiety, depression, and discrimination. Unlike immigrants, who might have an accommodating host country, indigenous peoples, once they are displaced, are usually left on their own, thus their experience of mental stress would likely be magnified. A good resource on how these stressful conditions is experienced was narrated by Abdulhamed, et al. (2022) in the article entitled, "Anxiety and depression symptoms and their association with discrimination and a lack of social support among first- and second-generation immigrant adolescents." Two migrant groups are being evaluated as to their experiences of acculturation in Finland: first- and second-generation immigrants and adolescents. To describe their experiences, the factors being examined are their experience of discrimination, their capacity to discuss personal matters with parents, and having someone to discuss personal worries with. It is expected that with favorable access to these relational variables, anxiety and depression would be lessened.

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Results showed that, as expected, migrants revealed high levels of depressive and anxiety symptoms, which are more pronounced among first-generation immigrants. This group likewise experiences discrimination, often compared to second-generation migrants. Also, the first-generation migrants are said to rarely be able to discuss personal worries with someone or personal matters with their parents, unlike the second-generation migrants. The gap is associated with the limited time for parents to adjust to their environment, which affects their acculturation and makes them unable to provide timely attention to their children. But once they are settled, the younger ones, when they become parents, can establish comforting relationships with their children. Like migrants in a new, circumscribed plot, they must navigate their lives surrounded by a dominant culture.

Besides these parental factors, immigrants also experience discrimination, and despite the proactive policies of Finland, tensions still exist among the populace, who are less welcoming to the newcomers in the area. While this might be a bigger social phenomenon to overcome, it is still possible to provide protective mechanisms for adolescents experiencing stress and anxiety. School and community intervention can include pedagogy that makes everyone culturally knowledgeable about differences and encourages supportive behavior. Thus, while encouraging parents to accommodate their children's personal needs, it is possible to promote a sense of belongingness and relatedness starting at the school level.

Going back to the Ati people, this points to the need to address key variables that affect the mental health of youth: anxiety, depression, and discrimination. Especially in an environment detached from their wider ecological and cultural space, it is expected that adults will have difficulty communicating positive thoughts to the young members of their society without assistance and assurances from the government. Unlike in Finland, which has resources to accommodate the social and economic needs of migrants, these dislocated Ati people have to contend with the limitations and poverty in their lives. Nonetheless, what is important is that there must be a realization that the mental health of the youth is associated likewise with the emotional support of parents, only if the latter are likewise capable of doing so. In a community where everyone else is vulnerable to discrimination, poverty, and anxiety, any efforts or support given to the Ati people must equally address their insecurities and other modifying conditions that threaten their relational connections with each other.

Lastly, in sub-Saharan Africa, Demissie et al. (2021) wrote in an article "Why doesn't God say "enough"? Experiences of living with bipolar disorder in rural Ethiopia," reported their

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study about how indigenous peoples experience and cope with bipolar disorder. By seeking out related data regarding these goals, they hoped to provide input for medical interventions appropriate to the community. Although they made use of phenomenological and thematic analysis, their in-depth qualitative approach nevertheless speaks more of their etic orientation when working in the health field. Yet, rather than see this as a limitation, it nonetheless highlighted deeper challenges that require cultural sensitivity and awareness in providing support to people experiencing bipolar illness.

Bipolar disorder is recognized as one of the major mental health burdens in the world (39.1%, mhGAP), and thus those who suffer this depressive-manic mood swing become a grave issue since it affects not only the individual but also the surrounding family members economically, emotionally, and culturally. Since there is little knowledge about this care system and support in low and middle-income countries (LMICs), this research attempted to address this gap, as modified further by culture.

Among poor nations, while social cohesion is considered the most prominent source of help, stigma and a lack of knowledge are high, which often results in blaming the patient or the family for the illness. In consequence, besides developing low self-esteem, they often hide and move farther away from social spheres, which would aggravate their situation further. As family members often lack capacities to help, it is foreseen that without proper addressing the bipolar mental illness, a large portion of society would likely suffer as well.

In the biomedical field, there is an urgency to address this illness, which is listed as a major world health threat, because neglecting people with this problem is a human rights issue. In this regard, the context of the region demands that the expression of this illness be understood since there is a variation in views, experiences, and knowledge about what it means to be affected by this problem. While the gap in knowledge may lead to high relapse rates, it was noted likewise that participation in religious activities or other culturally meaningful activities does improve healing. This led to the understanding that to have a successful health intervention in low-resource settings, modifiable factors need to be identified, as well as recognition of their significant experiences and beliefs about the illness in the context of interacting relationships in the community.

Given that the interviewees selected are in a unique situation of having access to health services compared to those living on the outskirts, their use of health still begs for additional investigation of what further culturally appropriate strategies need to be implemented. The

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result shows that people with bipolar disorder generally situate their problem as being connected to other elements in society that would result in social exclusion. This means that interventions should also address economic and social pressures like family and cultural supports to lessen the stress on the patients and their families, leading to self-valuation and increased trust in health treatments.

In a society where there is much unemployment and stigma, the presence of bipolar disorder can lead to self-denial, antagonistic relationships, hostility, and social exclusion. In effect, without intervention, the vicious cycle is sustained, leading further to poor health and social alienation of patients. These negative consequences can lead to another layer of stigma affecting families and households, restricting their opportunities and capacities to improve their social and economic lives.

On the cultural side, many reported to include in their healing strategies their visits to religious places or to traditional healers on the view that their illness was caused by some evil forces in their environment or community. This affirms the common worldview in sub-Saharan Africa that demands connection and harmony with living and nonliving entities that, when not respected, will cause harm. Similarly, participants also mentioned taking the local herbal drug (khat) that helps relieve mental stress.

The implications of the study reveal that people are generally willing to obtain medical help, but with consideration for other factors attuned to their culture. Besides improving their knowledge, they too could be assisted with their medication by being introduced to alternative drugs that are nonaddictive. Likewise, health is seen as a collaborative effort to be participated in by family and health services, which includes the recognition of the role of local healers and activities and rituals that promote healing and connections that are meaningful in their worldview.

> *Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, interalia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.*
>
> (Article 21, no. 1, UNDRIP, 2007)

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5.9. Health insurance, stigma internalization, exposure to discrimination, and other psycho-structural elements to healing

It is not fair to look at indigenous peoples as resistant to or incapable of change. Thus, programs like health insurance can likewise be meaningful if they become reliable and consistent with their needs. Further, contrary to prejudices, indigenous peoples themselves would like to be well dressed or appear clean to their neighbors. In many instances, however, their continued experience of stigma can have a deleterious effect if it ends up being internalized and integrated into their self-view. However, the attribution of prejudices in the reviews that follow here is seen to be culturally constructed even though processed by the brain, which points to the importance of positive education and appreciation of indigenous lives and experiences. Along with this are the experiences of refugees who, like the indigenous peoples, are away from the safety of their cultural context; they too desire and make use of state health care yet still aspire to use community-meaning approaches that are less stigmatizing to mental illness.

In one of the above topics, the youth are given special focus since the prevalence of mental health issues affects this group, which is likewise prone to suicide. In relation to this, all the UN WHO mental health plans always recommend the expansion of health coverage, recognizing the burden mental health places on families and individuals. In this study by Hamersma & Ye (2021), entitled "The Effect of Public Health Insurance Expansions on the Mental and Behavioral Health of Girls and Boys," they reviewed how the provision of public health insurance that includes 6 to 17-year-old children benefited this group.

The paper reminds us how this coverage is relevant given that 13%–20% of children and 49.5% of adolescents have experienced various forms of mental disorders, with 22.2% of the latter being chronic. While there is an urgency to address this problem, there is nonetheless a lack of affordable care as well as information and appropriate services to mitigate mental health problems. While interventions are badly needed, the availability of public health insurance, especially for the poor, is likewise noted as important. In this regard, as the biggest provider, Medicaid's role is highlighted as part of an innovative scheme to provide health insurance to children and adolescents.

The first observed result of this expansion is that there was an increase in the participation of eligible families relative to Medicaid coverage. Utilization, however, does not mean fair outcomes for boys and girls alike, although adolescents were recorded to benefit, especially the

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boys with a 20% score. As for the girls, a lower utilization was observed, although this did not negatively affect their overall level of mental health. Partly, this gender gap, with boys having been recorded as having greatly benefited, could be explained by health visitation programs targeting girls. In other words, girls felt no need to get further mental health assistance since, on a regular basis, there were already regular health visits targeting them. Underutilization for girls here does not mean a reduction in mental health.

Overall, expanding health insurance coverage and access not only ensures quality life, but also supports other specialized needs for optimum health. The lower utilization of girls, however, does not undermine the value of the insurance but rather could open for "an improvement in efficiency of care modality." Meanwhile, one of the consequential benefits of expanded health care is that parents themselves experience less stress and anxiety over the prospect of financial burdens associated with the mental health of their children.

Meanwhile, the conversation and understanding about mental illness never happen without processes involving perception, interpretation, and meaning construction. Though examination of these processes could be understood to be continually renewed and sustained as people remain unaware of how these words carry messages that they themselves help to create, In other words, information about mental illness is shaped and transmitted through the cognitive abilities of people who inadvertently pass on the burden of stigma. While narratives about mental illness are about the observed events, they are packaged through mental structures so that individuals' biases may further modify the message. Since people are living in communities, the influence of cultural perspective likely structures further this interpretation, nurturing further bias.

In this study by Jacobs and Quinn (2022), entitled "Cultural reproduction of mental illness stigma and stereotypes," they forwarded the term "cultural schemas" to denote how people map out ideas—subconsciously learned—that transmit biases, especially on mental illness. Since this happens among those who share language and values, the biases could be further extended and reproduced. To demonstrate how this cultural schema operates, the researchers demonstrated how, in a case of schizophrenia, prejudices could be sustained or learned through cognitive operations among individuals.

Schizophrenia became prominent as one of the stigmatized mental illnesses due to public indifference about it as well as the fact that it is often associated with multiple negative outcomes like hostility and violence. Further, besides looking at stigma as a subjective experience, there were few interests in modifying attitudes about it by examining prejudices

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and beliefs. This points to the idea that prejudices are representations of how one interprets reality in as much as they are an idea produced in cognition with a template drawn from culture. Thus, the idea that attitudes are outward manifestations of mental schemas could be further elaborated as an output that continues to reshape and reproduce stereotypes.

There is nothing new to this given that second-hand information always carries diluted views and information since the message has been processed subjectively and unconsciously. The retelling therefore of stories carries with it the influence of a mental schema either deliberately or unconsciously done. In either case, given the effect of culture, these cognitive states become manifestations of cultural lenses. The awareness and knowledge being expressed therefore do not only appear as representations of reality but themselves reflect the fundamental view of society.

This mode of cultural transmission, which operates subconsciously, manifests itself through consistency bias as the "tendency to remember and transmit information that is consistent with one's cultural schema." In explaining bias transmission, cognitive expectation becomes evident as people of the same culture are most likely to end up producing and extending ideas that are found to be within the preferred meaning found in society. To test this view, the authors made use of the "affect control theory (ACT)" to empirically evaluate how much culture influences the transmission of prejudices as regards schizophrenia. This required constructing a narrative to be communicated across a series of participants, with the resulting narrative to be evaluated according to its consistency or inconsistency with the cultural-cognitive schema. Knowing this, interventions affecting mental illness and prejudices can likewise be extended to modify cognitive spheres.

Prejudices are often baseless given that either stigma is achieved or is born of a particular condition, thus clarifying them based on capacity to become responsible demands a reappraisal of the forms of ideas produced in cognition. Despite this, stigma based on birth is still persistent, and it continues to affect individuals who have no control over their conditions. Further, while additional information from biological studies has been shown to provide a good explanation of mental illness, it is not enough to correct prejudices and biases. Thus, biases and stereotypes are serious health concerns, for they may lead people to experience further isolation, depression, and reduced self-esteem.

Stigma further can be endorsed by the public or internalized through acceptance. In either case, with little effort to remedy this context, it will lead either to a sustained reproduction of

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ill feelings in the open or within the person. There is then a need to understand the cultural pathways of stigma reproduction and transmission by examining not only the sources or reactions to them but also how they are processed culturally. To elucidate this, a "serial transmission study framework" explains how various factors and biases are structured. With individual-level cognitive biases, individuals actively select and communicate preferred ideas over others, reflecting stereotype-consistent paths along communication-based processes. This reveals that prejudice proliferation and maintenance are not simply passive realities but are actively played out in the cultural frame and the cognitive schema of society.

It must be remembered, however, that most information transmission occurs through resonance or indirectly through secondhand knowledge acquired through news outlets or through neighbors and close friends. Whether they are deliberate or not, the conceptualization and processing of biases appear to be a default cognitive function given the operations of culture entrenched in beliefs, values, and motivations that allow people to evaluate others. Thus, stigma might simply be a representation of a reality in its symbolic form, making use of the culturally learned schemas operating in cognition.

Overall, the study revealed how the transmission of schizophrenia follows the process of the schema-consistency bias, meaning that while individuals might simply think to reflect what they have absorbed, their cognitive constructs, as instructed by culture, reproduce biases. In other words, reality is secondary to the mental construct’s capacity to omit or alter "the story to become more consistent with known stereotypes about individuals with schizophrenia." Thus, bias or prejudices are not just about the victim and the offender but also about the cultural constructions being processed or transformed at the cognitive level that shape and transmit the stereotypes learned.

Furthermore, among minority groups, with marginalization comes discrimination, which would likely lead to a decrease in the quality of life and health, leading to further vulnerabilities in life. In the article written by Mullany et al. (2022), "Who is our real enemy?" internalized racism in the Puerto Rican diaspora and the role of political education within community health intervention," they qualitatively examined the tensions that cut across the Puerto Ricans and the Mexicans. On their own, they tend to compete and see each other as threats, although both share the same historical colonization and subjugation and are currently subjected to racism in the US.

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The irony of this infighting among the Latinx living in the US is that while they fault themselves, they too recognize the effects of racism and long for a better, more harmonious future. Despite this animosity, their shared beliefs, and perceptions on health, causes of stress, and coping strategies revealed a dissonance: that while they accepted their discriminated inferior status, they too shared pride, hope, and a desire for unity. This contrary attitude was analyzed using W.E.B. Du Bois' theory of double consciousness, which explains that white dominance and racial oppression created a "double consciousness" for those subjugated that led to the internalization of racism.

Dubois talked about the veil that keeps people from seeing each other, thus continually distorting relationships and views of oneself. The separation of views was extended to two conditions that might put the person in a vulnerable position, leading further to maintaining a double identity, one towards the community and the other towards the powerful racial group. This "double consciousness" produced a "double self," which could be nurtured to become a force by engaging the self in a collective act to remedy the historical trauma experienced by the group. Thus, the theory was said to be able to explain the source and nature of discrimination as well as elucidate ways of restructuring relationships leading to political liberation. If this happens, there will be an awakening of the subjugated self against white supremacy by getting through the veil and understanding how and why racism was internalized along the diaspora brought about by colonization.

As psychological distress affects physical health or vice versa, discrimination likewise can be felt at the community level or indirectly as a shared, learned, and anticipated stress by individuals. Without social support, acts of racism against the community ultimately create a sense of powerlessness among individuals, affecting their esteem and confidence, leading to further vulnerabilities or a sense of isolation. This internalization of racism creates "hidden injuries," often overlooked, that could lead to "self-hatred and self-destructive behaviors." All in all, internalized racism has been documented to produce negative mental and physical consequences as it likewise weakens social solidarity. In effect, among the interventions sought is the examination of different roles in affecting the collective and structural contexts of vulnerable communities.

One major analysis leads to an understanding of internal racism, which "contributes to the maintenance and reproduction of the white status quo. By undervaluing minority groups' identities and cultures, alternative views become dominant, like white supremacy, and this

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reproduces subordination among colonized people. With minorities internalizing their low self-esteem, they help ensure and maintain dominance as well as allow the endorsement of stigma and stereotypes about them. This simultaneous uneven transformation of identities would soon allow the subjugated to accept and internalize the dominant view that they are responsible for their fate and failure. Thus, those in power may not need to exert additional force against racism, for "marginalized groups enforce it within and amongst themselves."

In the case of Puerto Ricans, though they share a common generic colonization history with the Mexicans, but because of their unique experience, they receive different and unique group stereotypes. One is their visible acceptance of inferiority and acceptance of the colonizing culture even though they have high rates of mental illness and poor health among the various Latinxs groups. Such incidence are not accidental but rather it a consequence of the colonial extraction of resources that impoverished the island economically, affecting diet, food, health, and the mental states of the people. Despite this, because they had taken the view of their colonizers, they looked upon themselves as solely to blame. This is further justified by the exodus of many to the US, where migrants dissociate themselves from their past and accept the new culture, thus disrupting further any possibility of resolving the cause of racism as well as ensuring divisions based on internalized and accepted cultural and material attainment.

Analysis of their conditions and perceptions of racism and health disparities showed an incongruity between acceptance of negative stereotypes and a positive hope of reclaiming unity. Understanding, therefore, the interplay of forces that drive people to poverty and mental illness could reveal factors that comprise the etiology of the disease and need a positive response from those who have a fuller grasp of the situation. It is interesting then to note how they subscribe to the pervasive view "that Latinx immigrants are lazy, engage in criminal activity, refuse to learn English, and are a drain on the welfare system." This, however, is no surprise given their pervasive acceptance of hierarchical status based on language competency, possession of Eurocentric values, and citizenship in a new territory. Despite disparaging stereotypes, they felt they had eluded the discrimination through a distorted and uncritical acceptance of subjugation, thus allowing the reproduction of invisible structures that sustain the identity in question.

On the other hand, even though Puerto Ricans hold US citizenship, they still cannot escape anti-immigrant racism. Thus, often their way to cope is by keeping distance with the Latinx, but this simply endorses division among themselves. The interplay of languages likewise created dominance and doubt over their status, as they themselves longed to be identified with

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a new culture and refused to speak the language that they all shared. The contradictory forces are leading them to experience tensions as they are caught between two worlds: a world of meritocracy and individualism vs. the world of having a shared community spirit found in heritage, language, and identity. Despite this scenario, however, there are still those who genuinely aspire for the cohesion, love, and respect of all Latinx disparate groups.

Towards resolving this "double self," there is a sort of "awakening of critical consciousness through political education," which would open the "second eye" toward liberation from discrimination. This revolutionary initiative was started by "the Yong Lords, mostly composed of first and second generation poor working-class Pueto Rican youths" who espoused education, reflection, and activism, thus forming a praxis. In the face of a destitute condition, a sense of racism could be overcome by a positive movement that seeks to engage everyone to understand the material cause of health disparities. One example of the Yong Lords action was their community health programs, which include food for poor children, a free medical clinic, free classes, especially in history, and celebrating cultural festivals.

Furthermore, their approach to addiction was through political education concerning the origins and the capitalist connections of the heroin trade. This insightful project enforces an awakened solidarity and conscience that provide a positive reason for many to get out of addiction. Thus, the concept of liberation, which is rooted in their shared history of oppression that is affecting their daily lives, is seen as a movement that fights off oppressive conditions affecting their health and wellbeing. By combining education, health issues, and political activism, people increase their confidence in their capacity to make change rather than simply remaining divided and coerced by their accepted notion of depreciated identity. Through education, they disentangle the causes of their health disparities by reclaiming their capacity and identity away from the enforced trauma of colonialism and poverty.

On the other hand, while it is common knowledge that discrimination does produce anxiety, there are few studies exploring the effects of this from a stress and coping perspective. This is especially true for vicarious exposure and its mental health consequences, along with the utilization of mental health facilities. The interest in this is partly the result of the continuous threats experienced by black people in the US, as highlighted in the Black Lives Matter movement. This narrative is discussed by Moody et al. (n.d.) in an article entitled, "Vicarious experiences of major discrimination, anxiety symptoms, and mental health care utilization among black adults." Through this paper, the upsetting events were seen to create racism-related

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stress, brought about by shared perceived discrimination across the sociocultural, interpersonal, and sociopolitical identities of black American people.

This racism-related stressor has been found to be significantly associated with poor mental health, which further produces anxiety problems. Lately, however, vicarious exposure to discrimination has likewise received attention, as this too may elicit anxiety and affect the mental health and sense of well-being of black people. Vicarious exposure is distinguished from personal or direct experience because its source is the experience of family members or close friends. This indirect perception of vulnerability might not be relevant to other people, but to blacks who have had historical exposure to racism, their shared identity allowed them to find commonality and sympathy in the experiences of others.

The inclusion of vicarious exposure is within the full spectrum of racism-related stress experiences, and so underestimating this may ignore other important factors affecting experience of fear or anxiety. The need for this is to avoid further mental health consequences being endured in a lifespan by people belonging to racial and ethnic minorities. Besides the anxiety causing circumstances are resources that members of a discriminated group can utilize, which include confidence, level of esteem, social support, and other culturally available avenues and cues. In other words, given these resources, people could likewise be assisted by moderating the stresses they encounter by utilizing these positive resources.

There are studies that show how self-esteem and confidence do lessen the effect of discrimination, but there is still a need to explore how the effects of discrimination and vicarious experiences could be lessened by these positive psychosocial resources. Further, there was a sort of irony observed along this line, such as the lower rates of reported psychiatric disorders Despite high exposures to stress. One reason for this is a sort of learned underreporting of severe psychiatric symptoms Despite enduring them for a long time. In effect, since these mental disorders may compound chronic health diseases, black Americans are often reported to "consistently experience earlier onset of illness, more severe progression of disease, and lower life expectancy relative to their white counterparts."

Upon reviewing mental health care as an institutional resource, it has been found that it is less utilized by black adults due to several reasons associated with stigma and structural factors. This becomes then another reason why actual utilization was examined to understand health care's moderating effect on the experiences of stress and anxiety. Overall, the results of the study showed that vicarious exposures to major episodes of discrimination are associated with

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symptoms of anxiety. On the other hand, despite barriers such as distance, financial limitations, and mistrust in health centers, the use of health care facilities does lessen the effects of discrimination or symptoms of anxiety. While low utilization may be a challenge, it was found that the most important factor is that one-time treatment over the course of one's life significantly reduces symptoms.

Lastly, indigenous peoples and minority groups everywhere, while many of them were survivors of wars and conflicts, still, in the current times, their vulnerabilities have not been abated by ongoing suppression, displacement, and misrepresentation of their conditions. Eritreans have found themselves safe in Israel, but with their status as refugees, much of their holistic life has been curtailed, which defines their conditions of restlessness over their uncertainty and insecurity. No wonder in this condition, while mental health issues affect many, there is no clear-cut way to manage their needs. In this regard, Fennig & Denov (2022), in their article entitled, "The impact of trauma, flight, and protracted displacement on the mental health of Eritrean refugees living in Israel: An exploratory study of coping strategies," describe the liminal condition of Eritrean refugees in Israel, where they struggle with the paradox of being in a society yet outside the structure of its rights and privileges.

The 21,690 Eritrean refugees in Israel are a result of a civil war in their country, and because of their status, they are excluded from any social and political privileges in Israel. Their ordeal in coming into Israel involved a perilous journey through the hands of traffickers and kidnappers. All these agonizing events and circumstances they underwent likely resulted in high levels of health-related problems, including mental health. Often, due to their insecure conditions, seeking help often comes late when the symptom becomes severe, and thus, diagnosis and treatment are further compromised. In addition to these, their experiences of trauma, poverty, language barriers, and cultural differences put them in a discriminatory condition that further defined their barriers to health.

Coping strategies may be looked upon in terms of their cultural capital and background, but within the Israel context, many still felt in a limbo of powerlessness. Nonetheless, it was still hoped that a modicum of strategy could be identified to complement the medical care afforded in Israel and be meaningful to the patients. These require identifying the sources of their trauma and recognizing their explanatory models based on their cultural capital and meanings rooted in their rich tradition of healing and spirituality.

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All these refugees are undoubtedly not only survivors but also witnesses of violence, murder, kidnapping, rape, and abuse in their home country, reinforced by their equally perilous journey. The trauma brought about by cruelty, torture, heat, hunger, and the deaths of loved ones defined their vulnerability as refugees from Israel. Their memories of past brutalities and their current state of hopelessness construct their feeling of being lost or out of their minds and present selves. One of the outcomes of these are somatic diseases manifesting in dizziness, poor sleep, and forgetfulness.

From their folk cultural knowledge, unseen spiritual forces endowed with agency use an "evil eye" to poison or possess individuals. Besides Debtera, Diablos, or Saytan, there is Buda, who controls the evil eye that could cast illness on people. In combination with their trauma, fears, insecurities, and hunger, any small incident can trigger paranoia, anxiety, and depression.

Four basic themes were identified that described their coping behaviors against health threats. The first is by silence and forgetting, which is a natural response since being identified as mentally ill can bring stigma to the self and to the family. By denying and withdrawing, silence is kept, even though such may result in further violence. The next is seeking treatment through spiritual beliefs and practices, usually through prayers and invocations of faith in the church. This may produce calmness and reduce stress, and with hope, a sense of recovery can be attained, although limited by their refugee status. Third, by invoking their traditional cultural beliefs in curing mental illness, which include the use of maychelot, or holy water, to get rid of Buda possession. In cases of persistent malignant conditions, patients are even sent home to Eritrea to undergo ritual baths beneath waterfalls.

This folk healing is utilized since the medical model is seen as dangerous, unreliable, and may even cause death. But this attitude, however, is seen because of their difficult status, which limits their access to standard healthcare besides the financial demands of medicines and regular treatment needs. Furthermore, by using the traditional approach, less stigma is felt since the community sees the problem not as personal but as something to be overcome by community spiritual cohesion. Furthermore, using the folk approach, broader emotional support and cultural connections are reenacted and reemphasized, which, although not articulated yet, allow the community's sense of responsibility and identity to become alive. In a precarious situation like the one within the Israel camps, this affirmation of support and emotional ties would mean a lot to the patients.

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Meanwhile, it is noted that almost half of the patients sought formal medical care, which may involve long bureaucratic processes starting with the referral of a general practitioner, yet many confirmed the effectiveness of this approach since it allowed them to share their specific thoughts with someone professional. Meanwhile, given the structural barriers, there is so much suspicion and fear that many would prefer to remain silent and deny their condition. Given the strength of the appeal to tradition, where they could find safety and control, the potential of integrating or involving these practices in medical care may be rewarding. In this regard, by acknowledging that their mental health has been aggravated through the loss of their cultural, traditional, and community cohesiveness and meaning, most likely by utilizing meaningful practices, rituals, and beliefs, their recovery may be more pleasing to their desired hope in life. Thus, over their experience of protracted structural discrimination, detention, uncertainty, and the activation of their beliefs and cultural networks and support, it is likely they would be able to manage their trauma and mental illnesses in a meaningful way.

> *Indigenous peoples have the right to maintain and strengthen their distinctive spiritual relationship with their traditionally owned or otherwise occupied and used lands, territories, waters and coastal seas and other resources and to uphold their responsibilities to future generations in this regard.*
>
> (Article 25, UNDRIP, 2007)

5.10. Multidimensional sources of poverty, inequality, and other webs of barriers to mental health

In the previous themes, the historical consequences of colonization have been documented to produce enumerable effects on indigenous peoples, including dispossession and displacement. Those who survived genocidal policies ended up living in poverty. In this view, intervention programs such as those generally endorsed by health agencies, including those found in the UN WHO health documents, are likely to fail given that inequality and poverty remain. These barriers to health are scrutinized in the following reviews, which include, among others, their housing and transportation privileges. Using an intersectional approach, conditions of inequality become illustrative of various dimensions of poverty in the lives of indigenous peoples.

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In the lives of indigenous peoples, old people may get over their mental health problems and poverty by dying early, but this does not solve the ongoing trauma of their group. One strategy is to find ways to prevent young people or adolescents from experiencing mental health issues that could have debilitating effects on their lives. Compounded by poverty, their anxiety and depression could be further exacerbated. In the article by Daz, et al. (2022) entitled "Multidimensional poverty and adolescent mental health: Unpacking the relationship," they explored poverty and its dimensions among Colombian youths to identify ways interventions could improve their social confidence and identity. Thus, it is not only that the youths are to be seen suffering from poverty, but they also indirectly suffer from the other dimensions conditioned by poverty, although they have a different category and measure.

One of the barriers to the brighter future of the youth is their current experience of depression and anxiety, with many located in poor countries, which heightens their vulnerabilities and puts limits on their productivity. Once caught in this nexus of poverty and depression, the youth would likely be trapped in a cycle of frustration and marginalization. In other words, as mental health weakens the youths' ability and access to resources needed to accumulate capital, their impoverished status can affect their mood and confidence, increasing their levels of anxiety and depression. In many instances, poverty itself may not be directly observed to cause mental problems, but the related dimensions of poverty, such as poor education and social status, are undoubtedly upsetting. In some instances, even parents' socioeconomic status and educational attainment can likewise be associated with mental health, as limitations on these may have impacted their lives, and in turn, their attention and care in nurturing their children may have been limited.

Without intervention, this cycle of unfavorable conditions would likely be passed on to the next generation, perpetuating a life of anxiety and insecurity. One favorable approach is to go beyond the unidimensional concept of poverty and recognize the noneconomic conditions that define the functions and capacities of each person, like health, education, and standard of living. With this focus, it is possible to understand and highlight modifying conditions related to anxiety and depression that would eventually help adolescents lead confident lives. More specifically, this could be carried out by distinguishing different deprivations (education deprivation, adolescent condition, labor market participation, health, and access to housing and utilities) as well as the household members directly affected (child, adolescent, or adult).

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In the study with Colombian youths, it was found that both direct and indirect deprivations were strongly linked to their mental health. While schoolwork, health insurance, and employment were cited as relevant, the material condition of the household was found to be unrelated. Further, it was found out that it was not poverty in general but rather only a subset of those who experience poverty that could be related to mental health issues. On the other hand, adolescents' mental health is directly related to their poverty experiences rather than through those observed by household members. Also, those students who work at the same time are likely to suffer anxiety, which could point to the heightened experiences of being in two demanding situations.

Likewise, lack of access to insurance or health care is associated with their level of anxiety since this condition reveals insecurities about keeping up with their health in times of need. Limiting their full confidence to accumulate capital can be further heightened by the circumstances experienced by other members of the family, such as no childcare support for younger siblings and no secure work for an adult member of the household. These show that while conditions of family members that are related to poverty can affect adolescents in their growing-up years as they locate support for their sources of confidence in the hope of a better future,

Meanwhile, an intersectional approach has been proposed in research to understand mental issues, as this allows recognition of unpredictable inequality patterns in society. This works by looking at the multidimensionality of a phenomenon rather than through the traditional unidimensional lens. According to Trygg, Mansdotter, and Gustafsson (2021), in their article entitled "Intersectional inequalities in mental health across multiple dimensions of inequality in the Swedish adult population," disentangling multiple intersecting dimensions would be able to confront disempowering discourses and so allow multiple positions and voices to be heard. Accordingly, by recognizing the influence of ontologies, epistemologies, and methodologies on how they conceptualize and operate as well as how terminologies shape research, health outcomes could be well analyzed as an interactive map in a set of complex strata and population dynamics. Therefore, dualistic views and other homogenous categories that obscure health inequalities may be avoided to notice nuances of power, opportunities, and needs in various domains, contexts, and processes towards successful health promotion.

In the face of social identities and power structures, intersectional inequality is observed along inter-, intra-, and anti-categorical research assumptions that could be employed beyond

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quality and quantity measures and descriptions. With this view, stratified intersections across multiple strata could identify social inequality and hierarchies of positions to highlight the range and estimates of health conditions, needs, and outcomes. This can then deconstruct irrelevant categories along the implementation of interventions, preventing unnecessary stigmatization. Regarding mental health inequalities in Sweden, dimensions of income, sexual orientation, and education, when leveraged along intersectional space, can result in better mental health. This means that while high income has a protective role for white women and a risk factor for African American men, education is the protective factor for African American women. This implied that while the health agencies need to implement context-specific strategies, they also must promote programs targeting the whole population to reduce discrimination and stigma.

On the other hand, when Indigenous people's mobility is hampered, other sustaining connections to their lives and wellbeing could be put under strain. This is what happened when the Saskatchewan Transportation Company's (STC) publicly subsidized bus system in Canada was discontinued to realize austerity measures. In an article by Alhassan, et al. (2021) entitled "It feels like somebody cut my legs off": Austerity, transportation, and the 'web of dispossession' in Saskatchewan, Canada," they explored how this neoliberal policy had put strain on the various and interconnected aspects of Saskatchewan lives. This transport system, which started in 1946 as a legacy of a democratic political tradition and employed 224 workers, has been of service to 253 communities, benefiting around 200,000 commuters daily. But the government, aiming to save around 9% to remedy its budget deficit Despite the evidence against health, saw this as necessary to implement.

Public transportation in relation to climate change is the friendliest, as energy is maximized, and carbon emissions are minimized. Likewise, because of its construction and professional standard, it is also seen as the safest. Meanwhile, given these advantages, public transportation is on the side of health. Furthermore, by providing access to anyone at the minimum fare, it becomes a symbol of a social equity program. In this context, the termination of this infrastructure would likewise entail direct and indirect negative consequences as a web of dispossession not only for the users but also across the different phases of community living.

Since the closure affected commuters in need of medical care, it was seen as a barrier to such access, which could be experienced through missed or canceled hospital appointments or not seeking care anymore. By relying on or being dependent upon others for transportation, people inevitably feel shame, which could limit other social activities with respect to a friend's

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schedule, leading to loneliness. One of those important cultural activities put under strain is the visit to ancestral land, which inevitably makes this an extended aspect of negative memories and consequences of colonialism. By inhibiting their movements, this limitation further puts them in a vulnerable condition, especially during the winter, either as a driver under medication during the bleak period or left alone in the house. Hitchhiking was likewise seen as unfavorable, being associated with harassment and physical attacks. Also, the burden of buying and maintaining a car or staying in hotels and eating out when away from home upsets their budget.

With family members stepping in to fill the gap in transportation, the effect becomes convoluted, as when divorced partners had to ensure the safety of their kids moving from one family to another. Meanwhile, many families had to relocate or rent to lessen the effect of the STC closure, and so they had to make additional loans. Further, to facilitate the transport needs of extended family members multiple times, the burden of driving results in fatigue and stress.

At the community level, the transportation limitations affected their participation in tribal events, and so their identity could be weakened as smaller communities or individual lives became further isolated. This isolation due to a structural deficit was likewise seen to weaken their tribal unity and fervor as well as isolate them from regular interaction. At the educational and social level, their correspondence with libraries became impaired, as did their participation in or attendance at concerts and events in museums and art galleries.

At the macrosocial level, health workers efficiency was disrupted by the new mode of long lines and lists of patients and overcrowding at lodges with unpredictable patients arriving dictated by the convenience of those transporting them. Under this unpredictable condition, medications and blood could expire and must be discarded. Meanwhile, since budget cuts likewise affected healthcare, uncertainty further created a shift toward the clogging of emergency services generated by tentative decisions to seek medical help over uncertainty of care provisions.

Given the financial constraints of clients, hospital staff were often made to spend time and money to support their patients. Often, the staff were the ones to arrange transport and pay other fees that the clients had not foreseen. These subsequent consequences revealed how a closure in the transport system revealed and impacted individual and social experiences of limitations in health, cultural, and political spheres, which, when mapped out, become a dense network like a web of dispossession. While this might be the design of a neoliberal policy, the historical,

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cultural, and contested meanings of the public transport system as it is sustained by the people should always be defined within the rights of the citizens.

Furthermore, it is widely agreed that financial barriers limit access to primary health care. However, even though New Zealand has favorable health structures, reduced health inequities, and fewer avoidable hospitalization records, it still must consistently demonstrate its capacity "to provide universal and accessible care that is determined by the needs of patients rather than their ability to pay." In a published study by Jatrana & Crampton (2021), entitled "Do financial barriers to access to primary health care increase the risk of poor health? Longitudinal Evidence from New Zealand," they wanted to explore the observation that, despite a functional primary health system, many still postpone care in the country. In many studies, common barriers besides financial are cultural and geographical. The exploration of this postponement is significant since it can lead to further negative health outcomes and complications. While there is a need to understand the link between postponement of primary care and health, there have been limited randomized trials and longitudinal studies with repeated measures done to demonstrate causal relations. In the case of this study, the focus included both general practitioners and dentists in terms of their impact on health.

In New Zealand, while tax-funded health services started in the 1930s allowed low or zero charges for many aspects of health care, there are now co-payment schemes, and recently among those that are not part of government support is dental care for adults. The result revealed that overall, based on their personal, physical, and mental health concerns, postponement of a dental visit was their most important concern. With this, males were found to defer most of their dental needs, which signifies that they are highly mentally affected, besides having a lower self-rated health assessment than females. On the other hand, females see their general practitioners and dentists more frequently and take their prescribed drugs regularly.

One conventional explanation of this discrepancy is that men usually visit their GPs at a late stage of their illness, even though at the household level, it is thought men are prioritized over women as regards health care utilization. Besides the stigma associated with being sick, this observation then raises the question of why men are not visiting their doctors or dentists despite their need. One clue came from the elderly, who did not show any postponement to their doctor's visit, likely because their status is provided with special health packages. This partly confirms that the deferment of younger males was due to financial barriers. On the other hand, deferral to dentists was more associated with Pacific Islanders and minority groups and linked

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to poorer self-rated health status. Thus, to avoid far more serious health complications and extended financial expenditures, timely intervention in the form of financial packages for physical and dental care must be provided.

Also, it is recognized that the social and mental consequences of homelessness for individuals are really a big challenge, especially since they are associated with stigma and discrimination. Especially if these affects those with mental health problems, policies uninformed by their trajectories may mean further personal pain, expenditures, and social exclusion. To obtain a bigger picture of this, Mejia-Lancheros et al. (2021) estimated these relationships using 274 participants in Canada and reported their findings in the article, "Longitudinal interrelationships of mental health discrimination and stigma with housing and well-being outcomes in adults with mental illness and recent experience of homelessness." Using the group-based trajectory model, they depicted intersections, identified vulnerable groups for discrimination and stigma, located interrelationships, and indicated necessary interventions that would address discrimination and stigma for those who suffer mental illness.

This research is relevant to indigenous peoples given that their experiences of stigma and discrimination are events in their social lives. Even in a larger society, these negative stereotypes and attitudes are equally detrimental to healthy living since they sustain inequalities based on negative labeling of skin color, economic positions, gender, lifestyle, and mental health conditions. Since these stratify and limit recognition for people in society, they further suppress rights and opportunities and so become barriers to productive living.

Studies about stigma and discrimination consistently reveal that they lead to mental disorders and emotional pain up to adulthood. On the contrary, this can be reversed if appropriate interventions through medication and social support are provided. In society, while marginalized groups are often seen to "disproportionately suffer stigma, discrimination, and their associated adverse health, economic, and social effects," their circumstances do intersect with other social attributes like gender, race, sexual orientation, substance abuse, and mental illness. As stigmatized groups, accounts are abundant relating to the unfair treatment they received in their access to health and social services by those who unfairly stereotyped them as dangerous, fraught with mental illness, or associated with criminalities.

These denials of basic services are therefore seen as further blaming the victims and punitive, thus likely to reproduce further social exclusion and poor health outcomes for many. Worse, given this sustained treatment, people who needed help will likely internalize stigma,

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leading further to the lowering of their esteem and sense of empowerment. These complex interrelationships of mental health, stigma, discrimination, lack of access and provision, and other social, structural, and systemic factors need to be understood by exploring how they intersect and follow certain trajectories. In other words, by examining the links and patterns of stigma and other personal and social realities, informed intervention could be conceptualized.

Overall, the research supported the related trajectories of mental health discrimination and stigma with housing stability, recovery, quality of life, and community functioning over a two-year study period. This connection was likewise observed among individuals with mental illness who experienced recent homelessness. Meanwhile, the housing intervention program was seen to ameliorate the trajectory paths of those in the moderate-to-high stigma groups. Conversely, those who received low housing support had the worst discriminatory and stigmatizing experiences. These point to the lesson that both housing instability and poor mental health are major factors influencing stigma and discrimination from the personal to the social and structural levels.

Without intervention, these experiences of negative factors can act as barriers to personal development and reduce their opportunity to access housing, leading to insecure outcomes in "family stability, social support, income stability, and social inclusion." On the other hand, while access to housing was seen as positive since this provides an avenue to a wider "social exposure or interpersonal interactions," some remained to suffer stigma due to continued social exclusion and marginalization because of their poverty and mental illness. While internalization of stigma and discrimination happens to those with low income and those homeless and having mental illness, this can be moderated by better context like housing access, which could be a protective factor towards successful social functioning and integration.

Going further, the importance of access to housing as a source of physical as well as mental security is indirectly examined by Moschion & van Ours (2021) in the article entitled, "Do transitions in and out of homelessness relate to mental health episodes? A longitudinal analysis in an extremely disadvantaged population." The idea that homelessness could be causally linked to mental health episodes (bipolar affective disorder, schizophrenia, and post-traumatic stress disorder) is relevant to understand how exactly depression could lead to homelessness. This study is premised on other studies revealing the association between mental health problems and homelessness and how mental disorders are correlated with costly social problems such as homelessness. The relevance of this to indigenous peoples' research, especially the Ati, is that

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both homelessness and mental health issues are realities they face in their daily lives. Thus, any information derived from this can be a source for policymakers in the provision of intervention programs required to ameliorate both negative conditions.

In this research, homelessness is understood in an Australian context, which includes those in temporary and emergency accommodations. Some studies noted that in other countries with a strong social safety net, mental disorders may be associated with homelessness, but in other contexts, individual or institutional factors may be important. Further, the term "precariously housed" is introduced to accommodate other experiences or modes of being without proper access to home care. This then allows analysis of whether homelessness affects mental disorders or the other way around.

The actual contribution of this research was its exploration of a possible causal effect of mental health episodes on homelessness and vice versa. Also, the strategy of using information based on diagnosed cases of mental health conditions other than self-diagnosis makes the research less subjective. Lastly, the interconnected and complex relations between mental health and homelessness are given an expanded analysis by incorporating the support services factor.

Interesting results revealed that episodes of depression, among others under the form of mental illness, increase the possibility of "homelessness in the next 6–12 months, and in particular becoming precariously housed." While this might not be the case for other mental conditions, depressed people nonetheless do not automatically need housing services. Thus, while health services do not account for precarious housing needs, the coordination of support services needs to be reinforced so that those vulnerable may not further increase their vulnerabilities in life. In addition to this, while homelessness is found to have no significant effect on mental health episodes, cases of depression decrease when individuals have access to housing. This observation is seen as an adaptive consequence when one is housed, giving a person a sense of security in life.

The bigger picture confirms that there are overlapping and confounding factors that may explain relationships between mental health episodes and homelessness, like "homeless people are usually poor, but most poor people are not homeless." While this confirms that there are multiple ways to be homeless, such as through drug and alcohol abuse, trauma, psychological problems, and family problems, it is not yet clear whether mental problems are one of the causes of homelessness. On the other hand, while ways to become homeless can likewise be due to

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"housing crises, family breakdowns, substance abuse, and mental health issues," the experience of long-term homelessness could also be due to losing social connections like parental support (among young people) and the death or incapacity of loved ones (for older people). This means antecedent and confounding conditions like drug abuse may lead to homelessness, but the risk is greater for those with negative childhood experiences and those with a lack of social support.

For economic intervention purposes, it was even asked which treatment mentally ill people should receive first: treatment or housing. In this case, while housing was seen as addressing homelessness, it did not support mental health outcomes. In other words, the causality between homelessness and mental health issues has not been fully established. One promising related study found that for males, the experience of anxiety, stress, and depression decreases with the availability of housing but not for females. Evaluating the health seeking of women, it was found that women are likely to use emergency services as well as "young respondents and those with a history of abuse or violence as children." This minimal use of mental services by women, older respondents, and those with a history of abuse or violence could be explained by adaptation theory as an effect of having been at least precariously housed.

The overall analysis of the data for those with diagnosed depression shows that while depression may not be an effect of housing services yet, housing per se decreases depression, which reveals further that limited housing services do not limit respondents from seeking alternative sources of help. Thus, while those with depression might likely become homeless within six to a year, it is only due to precarious housing circumstances, and they are far from being without any social support. Further, once depression episodes are accounted for, other mental health conditions like anxiety disorders are found to have a weak link to homelessness. Likely, then, rather than mental health, homelessness could be better explained by "family breakdown, labor market opportunities, and affordable housing." Finally, while depression and precarious housing are not linked to mental health services, given the risk factors presented, it is more viable as a preventive policy to make housing services available to citizens before they experience any onset of symptoms.

Thus, acknowledging that the housing crisis affects health becomes more significant and urgent when analyzed using an intersectoral approach. Phipps et al. (2021), in an article entitled "Lessons from a Rural Housing Crisis: Grounded Insights for Intersectoral Action on Health Inequities," narrated the need to explore this issue using a novel methodology called Equity-focused Intersectoral Practice (EquiP) that is grounded in the lived experience of people in rural

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Canada. The approach is apt since, besides indigenous people's homelessness, homelessness as a whole is rising along with the deterioration or lack of repair of many houses in Canada. This condition creates chronic housing insecurity, which pushes people to either live without a house or live in a degraded house that does not support their health.

Housing adequacy is enshrined as one of the human rights that is "affordable, habitable, accessible, sufficiently proximate to employment and services, culturally appropriate, and with security of tenure." To realize this, regular research and support must be undertaken to reflect the actual needs and experiences of the citizens with respect to their intersecting spheres in society. The intersecting collaboration recognizes the ever-shifting landscape, contentions, and relationships that contribute to an inclusive call for social justice and equity in health concerns. The practice involves sustained and integrated engagements along multi-directional and relational knowledge, avoiding hierarchical valuation through a critical, relational, and reflexive approach. The praxis inherent in the analysis, while doing away with the privileging of expert knowledge, recognizes the marginalized as responsible agents. By conceptualizing this pedagogy, it highlights the stigma of the neoliberal frame, which structures inequity in housing and health.

Housing as a basic right must go beyond class-based privileges that value profit over the functional needs of the people of Canada. Rather than look at issues separately, it must be recognized that everyone from public officers and agents to ordinary citizens, by espousing a holistic concern, becomes a catalyst and co-creator of knowledge and praxis, overcoming inequalities, racism, and discrimination in the housing and health domains. By enabling each to converse back, the process becomes a movement enacting intersectoral diagnostic and lens-shifting possibilities that can mutually reinforce and influence structures, perceptions, and beliefs towards systemic change.

Thus, equipped with knowledge and provided with space to examine inequities, framed by beliefs and practices, advocacy becomes inclusive and collective. In this new position, assumptions are made that trapped individuals, implementors, agents, and institutions, based on their narrow job descriptions, will be able to leverage support so that trust and empathy can promote respect and collegiality based on lived experiences. Thus, sustained collaboration through regular meetings could further strengthen relationships that could overcome further fear and reluctance and thus transform into an opportunity to realize housing and health equity for everyone, not only as a need but as a right.

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5.11. Embodiment of stress and insecurity through water, food, and other resources for wellbeing

One of the best strategies to highlight the colonial effect on the lives of indigenous peoples is their contextual deprivation of basic food and water resources. Given their marginal locations, it is narrated through the reviews below how these deprivations affect not only their bodies but also their mental states, which pushes them further into experiencing stigma and higher levels of stress and anxiety. It is interesting, however, how these inequalities are perceived as well as how they sustain their esteem and optimism as these resources are embodied in their lives.

In many poor districts of poor countries, indigenous peoples experience water insecurity, which undermines their daily needs for hygiene and health. Among the Tsimane's forager-horticulturalists, this insecurity can be embodied in the quality of their food and the risks of obtaining it, which form part of their body image. Contrary to the conventional imagination that indigenous peoples are living in pristine environments, due to their continuous marginalization, dispossession, and neglect by governments and the effects of climate change, many of them are living in precarious environments. The most persistent is their need to efficiently procure safe water since the usual circumstance is that either the water sources are located far away or that their waters are polluted. In lowland Bolivia, Rosinger et al. (2021) in an article entitled, "The embodiment of water insecurity: injuries and chronic stress in lowland Bolivia," assessed all the interacting circumstances that define a community’s experience of water insecurity to have a better focus on how such could be addressed.

Challenges to the provisioning of food at home include the question of access to sufficient clean water, which could be compromised by water-borne diseases, a lack of reliable clean sources, and injuries associated with its acquisition. With climate change, such a need may be further aggravated by intermittent floods and droughts that disrupt the reliability of water sources and so define the indigenous people's water insecurity. As in many parts of Africa, the community in Colombia relies in part on surface waters from rivers and ponds, which can be turbid and contaminated, which may further limit the community’s full benefit of water. Water insecurity therefore reflects the circumstances where water procurement and benefits over accessibility, availability, and quality are hampered.

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As water insecurity becomes a lived experience affecting the body's function and integrity, it becomes embodied, which could be shown in stress, anxieties, back pains, and scars. Other than these personal manifestations of water insecurity, another biomarker for stress is the hair cortisol concentration (HCC), which could be tested objectively. Thus, through both subjective and objective methods, water insecurity's pathway to embodiment could be assessed empirically.

The study revealed that those experiencing better water services (tap) have less water insecurity experience, while those experiencing "bad water" intake and those who had high daily water fetching trips have high water insecurity experience. Further, high water insecurity is associated with higher injury experience, and those who received service water have less injury experience than those who procured surface water for consumption. In addition, subjective experiences of insecurity were not detected in hair cortisol, but related injuries were registered in hair cortisol for women but not for men. Lastly, it was found that water services, as they are found to affect high cortisol levels in the hair, pointed to the insecurities of users about the quality or safety of the water provided in their house.

One prominent finding is that household water insecurity was low even though families have limited access to clean drinking water, which makes them often resort to relying on turbid and unhygienic surface water. This could be due to their having normalized this condition or because they are more interested in water availability. On the other hand, while handpump availability is associated with lower insecurity, the bad smell, taste, and look of water are associated with high insecurity. The study therefore supported the need for improving water sources in the community.

On the embodiment of water insecurity, it could be identified through scars, bone breaks, bruises, and pains in the arms and lower backs while fetching water. While there was evidence that these injuries were underreported, since they are again normalized as part of life, it is seen that the availability of hand pumps can reduce the injuries. On the other hand, there is the invisible injury in the form of chronic stress, which was associated more with women than men through falls while fetching water. This could be explained by the traditional role of women as the ones to fetch water, which means that while they are not only required to do so, but they are also daily exposed to the perils of injury in accomplishing their task.

Although some families may have access to water services, the unimproved condition led to stress, as found in high cortisol levels. The explanation could be found when Tsimane'

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realized the existence of piped water in adjacent communities and clear bottled water in the market, which elicited in them a realization of inequity, having been deprived of these amenities. This sense of dissatisfaction, distress, fatigue, and inequality could be remedied if they were given favorable projects in the form of pumps that would make their procurement efficient in addition to protecting the quality of their water source.

Meanwhile, water insecurity may have many features in their experiences, yet this is often symbolized or associated with their cultural tradition and basic needs in life. In Canada, Duignan, Moffat, and Martin-Hill (2022), in an article entitled, "Be like the running water: Assessing gendered and age-based water insecurity experiences with Six Nations First Nation," explored how frustration with water availability is linked to the group's cultural life and expectations. Background data revealed that almost 90 percent of indigenous households are without running water, which frames their water insecurity. Relying only on official advisory about their water quality, their condition likely diminishes there, as individuals and as a community, cultural links that relate to water. Compounding this is their racial experience of structural inequality through water contamination and poor plumbing and housing conditions.

Besides recognizing the direct impact of dispossession and exploitation of natural resources, including water, on the health of indigenous peoples, many of their current insecurities are a result of colonization. Through dispossession of their lands, their access to basic resources was reduced, along with environmental contamination, resource extraction, forced assimilations, and land rights disregarded. While maintaining relationships with land improves health and self-esteem, their experience of dispossession likely leads to limited productivity and frustration.

The root of this dispossession goes back to the promulgation of the Indian Act of 1876, which gave the Canadian government jurisdiction over all indigenous lands, overriding the previous Crown agreement and privileges. In effect, the Indigenous Nations were forced to assimilate, which paved the way for the notorious residential school system. Furthermore, with this colonial control, indigenous peoples lose their right to govern their waters and are unable to protect their resources from extraction and contamination, which makes them vulnerable to mental health issues, including suicide. With the dissolution of traditional confederacies and councils, including women's important authority and roles, the government now has the sole monopoly to design policies affecting the health outcomes of these people.

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The Six Nations, found on the southern Ontario reservation, were traditionally governed through a confederacy under matrilineal governance, and having allied with the British Crown, they were rewarded with money and recognition of their vast tract of traditional lands. But unknown to them, the British and Canadian powers proceed to dispossess the Six Nations of its water and creeks, which make these available to almost a million Ontario residents as water sources and wastewater. Thus, while traditional water is now used for irrigation, fishing, recreation, and waste, it also receives agricultural runoff and landfill waste that contribute to its contamination. In addition, water mining irreversibly affected the integrity of the ecological and hydrological conditions of the land, including its aquifer.

Culturally, water is held sacred as it is integral to their teachings, ceremonies, and language. They see it as the primary resource of life as well as the source of energy for all living things. In their Grand River, although a treatment plant was built, this did not dissipate anxiety over contamination and access to it for hunting, recreation, or ritual purposes. The negative view on health implications is supported given that only almost 17% of the tribe has access to it, leaving the rest to rely on wells, cisterns, or bulk water delivery and pick-up. A water test found that 21.2% of water samples were contaminated with E. coli, exposing the 57% of households that used this water for making beverages and washing produce. Further, traditionally, the tribe's Haudenosaunee women used to have authority over this water resource, but with the colonial policy dispossessing them of their role, their capacity to protect the integrity was reduced, as was their ability to pass the responsibility on to the next generation.

Using the standard water insecurity experience evaluation tool, household income was found to be not related to water insecurity, although many households plumbing is incomplete, which further makes them pay for their own water delivery and treatment. This surprising result calls for a better, more appropriate tool to capture the detrimental effects of contamination and limited access to their water resource. However, while the presence of diverse water resources has been linked to water insecurity, interviews illustrate how they understand this through access, affordability, and quality of water in relation to the integrity concerns of the environment and the health of the community. In other words, it is not the availability per se, but the presence of multiple sources that are suspected to be contaminated that creates anxiety among them.

As for the younger generation, they do not generally share their elders' interpretation of "good" water, which reflects a generational divide in values and perceptions due to the influence

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of dominant culture over their tradition. While the older generation emphasizes the natural state of rivers, the younger generation emphasizes the availability of clean water. Overall, given the limitations of reliable and clean water, water sharing has been found to be helpful, which not only allows them to save or share expenses but also reinforces their sense of community. Water sharing has been found to be common among many communities worldwide. Further, the younger generations' interest in access to water, which is connected to making medicine, supporting language, and sustaining gardens, was seen as positive as it decreased distress and promoted unity and spiritual health. This shows how preserving their land-based healing tradition, which includes caring for water, requires that they protect their land. Likewise, this attitude opens the possibility that they become co-creators with government agencies in establishing reliable water treatment facilities at the community level.

Women, however, were more negatively affected by this state of water supply given their traditional role in their tribe. Being caretakers of their families, which involves household chores, water contamination, and shortages, may limit their functions, adding further burden to their physical and emotional conditions. In more particular cases, their traditional postpartum practices to keep their health are affected, as is their fear of dehydration while breastfeeding, which includes their fear of using contaminated water on feeding bottles. Overall, these barriers could be embodied across their physical and emotional experiences, especially for women, making this insecurity a gender issue as well. In the context of neoliberal dominance, one of the challenges they see to keep alive their rituals, health, spirituality, language, and tradition is raising the consciousness of their community towards reclaiming their control over their sacred resources.

On the other hand, food insecurity, where access to a sufficient nutritious diet is limited, has been consistently noted to have debilitating effects physically, emotionally, and mentally. Among indigenous groups, the chronic experience of this, either in the form of anxiety about where to get food or skipping meals, can further increase their vulnerability to stigma and discrimination. In an article by Elgar, et al. (2021) entitled "Relative food insecurity, mental health, and wellbeing in 160 countries," they held that this debilitating food insecurity has to be understood as to the pathways that affect the integrity of society's mental and physical wellbeing.

Besides the physical function of food, it too has social dimensions that limit its use, which may hamper relationships, participation in social functions, playing roles, and fulfilling

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traditional rites and routines in the community. Thus, any lack of proper nutrients or any denial of access to important resources of the body in the form of poverty becomes a threat to wellbeing. Meanwhile, though the procurement, processing, and consumption of food may be a universal need, the manner in which these processes are fulfilled depends on the historical, cultural, and geographic conditions of people. Meanwhile, within certain groups of communities, some or many of the citizens, including the indigenous peoples, may not share the same food items as expected given their limited social status or income capacity.

While the negative experience of deprivation can be physical, this may not readily be translated at the perceptual level since each person has subjective perceptions as well as levels of expectations when desiring certain food types. In other words, people may not be affected by the difference in food type given their level of experience with access and deprivation. If they have learned to internalize and accept their inability and become content with their limitations, the affluence of some cannot persist and affect them. In contrast, in rich countries, where access is possible, any form of limitation to the enjoyment of their food could have a negative mental effect since certain expectations have not been met. Meanwhile, this anxiety can also be felt if one perceives the relative deprivation of the present condition compared with the past.

The possibility that food insecurity becomes a mental health issue for indigenous peoples arises when they come to realize their depravity compared to their affluent neighbors or by examining their current miseries in contrast to their nostalgic past. On the other hand, these differences can be normalized when experiences can be perceived as part of the cycle of events by referring to insecurities in the past or of community members. By understanding the mechanisms of food insecurity, policies for food equity can be integrated at the community level so that extreme experiences of food availability can be avoided.

The result of the study revealed that food insecurity is not directly related to income, which means psychological distress may be the result of other subjective perceptions in certain contexts other than people's capacity to buy food. Further analysis showed that people become mentally distressed not because they are physically in need of food but because of their perceived need relative to the observed affluence of their neighbors. In contexts where food insecurity is prevalent and generally shared, mental distress may not be similarly observed. This means that the scarcity may not be good for their physical health, but the fact that it is indifferently perceived makes it positive in preventing anxiety.

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While food deprivation may be coped with by provisioning or making it available, mental anxiety could hardly be remedied if it was due to a perceived unfavorable comparison of the affluence of others. This means that unfavorable social comparisons could lead to mental anxiety in a context where food insecurity is high and there are fewer unfavorable comparisons. In other words, as insecurity increases, there is less tendency for people to compare themselves with others, which may affect their perceptions of wellbeing.

In the real world, however, food insecurity and mental health are just a few of the many threats people experience, "including poverty, inequality, natural disasters, armed conflict, forced migration, economic turmoil or collapse, or hyperinflation." In other words, since the personal and social consequences of food insecurity may be complex and abundance itself may not be the answer, social inequality through access to food should be pursued in policy practice.

Further, since the study likewise identified females as showing mental health symptoms, they too have higher life satisfaction. This could be explained in their traditional role: despite their being involved in many household tasks, their challenges may create anxiety, but their regular sense of accomplishment against odds could likewise produce a sense of personal achievement. Lastly, those in older age groups, those in lower income groups, and those in rural settings have more anxieties, which could reveal their perceived subjective limitations and frustrations as they compare themselves to those having the privilege and luxury of time and material abundance.

Furthermore, it is widely known that food quality and quantity could have a tremendous effect on the body as well as on the mind, so any food insufficiency could become food insecurity. This connection of food to mental health was examined by Weaver et al. (2022) in an article entitled "Unpacking the "black box" of global food insecurity and mental health," on the claim that any food depravity could lead to stress and anxiety. The prevalence of food insecurity is reflected in the 2019 Food and Agricultural Organization report, with more than 820 million people suffering from it, referring to those who do not know where to get their next meal from. Consequently, people may switch their preferred diet or food to meals that offer fewer calories to cope with the burden.

The cost of this malnutrition may appear to be physical, but the harm could as well be mental, as in the cases of Ethiopia and Brazil, where food insecurity leads to high levels of anxiety and depression. Meanwhile, in some wealthy cities like Quebec and New York, the experience of food insecurity itself, though not necessarily equated to less nutrition, still leads

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to mental stress as the thought of limited options creates some form of anxiety. For the authors, an assessment of this link between food insecurity and the body and mind can lead to a better intervention program and advance understanding of how poverty affects the experience of wellbeing.

There are two proposed modes of explanation for how food insecurity could lead to mental illness. One is the direct and indirect effect of micronutrient (specific vitamins and minerals) deficiencies on the body and the brain through their effects on hormones, the gut microbiome, and nueral integrity. On the other hand, this too has been downplayed since there are families in high-income states who are food insecure but have robust bodies, whereas in low-income cities the association has been found statistically negligible when some socio-economic variables are controlled.

The second proposed explanation is suggested by the social sciences, which claim that the psychological experience of food insecurity itself triggers mental anxiety and depression. This is broadly understood, with food not only understood as a material entity but also having a symbolic status endowed with meanings that are integrated into social life. Thus, it is no surprise to understand that food procurement, preparation, and consumption may reflect social class and status motivated by beliefs and culture. Regardless of the nutritional value, the type of food sought or preferred, as directed by social expectations, norms, and values, must be procured. In other words, the inability to obtain the food desired becomes stressful not because of the lack or abundance of calories and nutrients but because cultural norms have been violated.

Two hypotheses were generated to reflect these factors or linkages, though they are seen as non-mutually exclusive variables. Furthermore, to accommodate other intervening variables, a third hypothesis was given, which says that the prevalence of food insecurity has been so pervasive that it cannot be isolated among other social constructs and experiences of deprivation in society. This could then provide an additional clue as to how societies give meaning to their food-getting and consuming behaviors as well as how they negotiate these deprivations in their lives within their cultural expectations and values. To test the hypotheses, in two communities found in Ethiopia and Brazil, indicators of nutritional status (upper arm fat area and symptoms of anemia) were assessed to see if they modified the link between food insecurity (access to food desired) and mental health.

The result revealed that in both countries, corroborating partly previous studies, a high level of food insecurity (not a moderate level) is associated with common mental illnesses. This

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negative outcome of food insecurity on the body and mind calls therefore for states to address this concern as a unified policy issue in their intervention programs. Furthermore, food insecurity, as expected, was not associated with nutritional variables as well as food insecurity, depression, and anxiety. Similarly, social variables and cultural meanings are not related to experiences of food insecurity and mental health. Reinterpreting these results beyond the limitations of the study could likewise lead to an alternative view pointing to various ways food insecurity might affect the body and the mind. In this case, rather than going through cultural symbolism, the regular experience of food insecurity may simply have a direct effect that is captured in the variables of the study. This means that the respondents might have already had the symptoms but did not recognize them since they were attuned to them. In other words, cultural buffering might have allowed this harm given the prevalence of poverty, which could create physiological, neurological, and emotional setbacks that could be potentially passed across generations. Thus, this direct and broad effect of food insecurity calls for intervention that is broad enough to support both the nutritional and mental needs of the people addressing their anxiety, shame, or frustration in procuring food or their basic needs in life.

> *Indigenous peoples have the right to determine and develop priorities and strategies for the development or use of their lands or territories and other resources. States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions to obtain their free and informed consent prior to the approval of any project affecting their lands or territories and other resources, particularly in connection with the development, utilization or exploitation of mineral, water, or other resources.*
>
> (Article 32, no. 1 & 2, UNDRIP, 2007)

5.12. Culturally sensitive health delivery, seeking help and predictors of health, and access to health care

This last subtopic illustrates how individual medical staff or aids may, in the process of providing care, overlook specific practices sensitive to the cultural background of patients. This often happens because concepts by themselves contain abstract ideas and are therefore open to interpretation. In the case of health settings, any mistranslation may lead to insecurity and a lack of trust from clients. On the other hand, help-seeking behavior, however, is not automatic

but could be modified by circumstances like economic deprivations, which may trap those in need of assistance in a cycle of deprivation of care and poverty. Further, a good attempt to map out strategies for addressing mental illness like dementia risk is most productive if quality education is used as a measure. Lastly, mental health seeking behavior could be enhanced if access is widened and it is ensured that it is available, feasible, and meaningfully connected to culture.

Indigenous peoples, as the recipients of health policies, must contend with budget limitations, cultural gaps, and mistranslation by hospital staff, whether implementors or practitioners. The relevance of this to the Ati people is that the lessons could help clarify, if not prevent, circumstances leading to better attention to their health care. The study of Lee et al. (2021), entitled "Blurred in Translation: The Influence of Subjectivities and Positionalities on the Translation of Health Equity and Inclusion Policy Initiatives in Aotearoa New Zealand," presents the case of the Maori people, who, contrary to the dictate of a treaty, are having their health care treatment affected by the reinterpreted meanings by hospital staff. This reduction of health equity into simple cultural sensitivity and competence blurs obligations and responsibilities as well as trust in health care.

In New Zealand, the District Health Board was set up to oversee an inclusive health system to remedy the health disparities because of colonization and the subsequent influx of migrants the world over. To understand how the concept of equity and inclusion is played in hospital settings, the authors examined policy translation as a mechanism where the subjectivities and experiences of staff may blur the intended purpose of the aspired health policy. The problem with the meaning of the treaty starts with it having two versions: one in the local Maori language and the other in English. At its core, it questions the commitment to partnership expressed since rights and obligations have been interpreted inconsistently given the language barrier. Given this gap, the long-term effect of remedying the question of equity could be downplayed if, in hospital settings, staff workers maintain a loose view of the treaty.

Interestingly, health workers were given training on cultural safety and cultural competency, which are distinct terms, yet when not given details for their rationale, the difference and the intended goals could be convoluted. The first refers to efforts that are associated with power structures so that, in the long run, the Maori people will be given what is due to them in their own land. The second refers to the informed attitude required to address the health needs of everyone else coming from different backgrounds. Thus, there is a need to

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understand how these policies are translated in the actual hospital settings by staff members who have their own set of practices and meanings brought about by "personal biographies, subjective social identities, and professional positions within organizations" that could affect the delivery of services. The distinction "between policy translation and traditional framings of policy transfer, diffusion, and implementation" is basic and could be further complicated "across multiple sites and actors."

The researchers obtained their data by interviewing hospital staff with emphasis on their "personal subjectivities and positionalities" to explore how these might influence, compromise, or blur the expressed goals of policies and programs affecting the Maori people. It is understood that these staff workers are likewise embodied agents, and so their practice or translation of health policies in their own setting may be impacted by their own orientations and other social or institutional limitations. Translation in the context of medical care does not only involve mental or verbal comprehension but also takes into consideration actions and processes between agents who co-produce meanings in the process of interaction.

The movement of ideas and actions in response to policy requirements is more than the act of transferring or diffusing. In other words, the policy provision is not just a transfer of packaged measures or simply a matter of influencing change. The latter measures are seen as very "mechanistic" and "linear" and ignore the dynamic roles of the actors and agents, with a measure of success limited to the "binary opposition" either from top to bottom or fitting or not fitting. On the other hand, translation includes "constructivist understandings of policy knowledge" and is therefore capable of creating and recreating "meanings and relationships." Thus, providers, agents, and recipients alike become participants in the translation processes as "mutations, transformations, new practices, the remaking of new social worlds, new enactments of relationships and power, and new performativity's and practices are all part of the process." Further, since there is a recognition that in the act of translation new meanings and practices are possible, these should not be seen as reproductions but rather in their "mosaic" fashion that "emerges" along the process. Necessarily, those lost or blurred accounts being part of meaning-making would signal lessons for future possible engagements.

In delivering health provisions or the process of translating policies itself, the key elements are the rational actors, the heterogeneous context, the disparate meanings with polysemous characters, and the presence of resistance. Because of the micro biographies given by the distinct personal histories of each of these actors, their rationality and irrationality are aspects

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that construct meaning in different ways. Also, since each "text" is different from each other as "objects, matter, contexts, sites, and spaces," their discourse and relationships do not follow linear, dialogical, or multilateral paths; their meanings may therefore take on infinite possibilities. Further, since participants have different roles as "brokers, experts, facilitators, consultants, and so on," ideas and practices will have consequences in assigning meanings to texts within an open and discursive space where everything is becoming. Lastly, since translation carries with it contesting actions, it should be expected that projects, actions, and sites become political spaces as expressions of power that may inhibit or reflect various structures and limits of meaning.

The result of their analysis revealed that hospital employees do not act mechanically, for each has intentions, an agenda, and distinct expectations in the workplace. Since employees carry these "differential subjectivities," their statements thus include ideas of uneven views of roles, duties, and responsibilities. Their position in the organization may act in a complex manner, affecting their narratives and so retaining meanings different from the expected policy agenda. In other words, the distinct equity agenda was blurred, interpreted, or subsumed into generalized cultural competency practices. While it sees the effects of power differentials, the authors see the "distortions of equity goals by individual actors" in their daily delivery of their duties. This therefore reveals that power is not only retained in the historical colonization and institutional gap in health but is also interplayed by the actors who have agency in the translation of services. These actors, who themselves are migrants and come from distinct backgrounds, may have blurred the distinction between the long-term equity goals with cultural competency and the risk of downgrading the potential of the program into something else.

Thus, it is not only in the delivery but also in the acknowledgment of differences in "subjectivities and positionalities of staff and patients" that health disparities may be accounted for. One remedy as regards staff positioning in this agenda translation is by aligning training that includes broader knowledge about health care and power differentials and cultural knowledge based on history and on the distinct cultural health goals of the Maori people.

On the other hand, institutional assistance to prevent mental illness is crucial to health care programs. In the USA, the 911 number is associated with all emergencies, including suicide prevention, which could likewise apply to mental health needs. The study of O'Connell et al. (2022), entitled "Association between race and socioeconomic factors and suicide-related 911 call rate," revealed interesting information like the association between access to private

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insurance and low education with a decreased 911 call rate. On the other hand, the findings that those with public insurance are associated with fewer calls may reveal bigger needs for those with limited health options, including those vulnerable to mental health issues.

The availability of 911 calls is a protective mechanism for any emergencies like acute suicidal thoughts and behaviors that are associated with psychosis, with trained personnel to facilitate temporary relief, including referral and transportation of patients. Despite these, while the majority of people do experience mental illness in their lifetime, few seek medical help, which, for those in serious condition, may escalate to suicide. Further, it was also observed that disadvantaged groups, though equally or far more often experiencing mental illness, may not utilize mental health facilities. The consequence, if left untreated, would be death or self-harm.

This underutilization of the 911 call by some groups could be due to mistrust, but it is interesting to note some patterns among black neighborhoods or those with low incomes or a lack of options in health insurance. Public insurance, for example, is always contrasted with private insurance because of the perceived reliability and adequacy of the availability of treatment. Overall, it was seen that race, health, insurance, and education levels are related to the rate of seeking help through a 911 call.

Lessons from this research include the need to increase the availability of intervention at community levels for those who are affected by mental problems, which includes the need for more responders, especially from disadvantageous localities. Also, those involved must increase their sensitivity when recognizing multiple and overlapping signs of mental health with other health concerns. Along with this, data collection must likewise be a part of the effort so that researchers will continually be informed of further efforts to be implemented to address the health of everyone.

For the Ati people, this reminds policymakers of things to be accomplished or to be accomplished about preventing the mental health of this indigenous group given the current health gap in the country. One is to incorporate them into a health insurance plan through which their anxiety about their financial limitations to seek help could partly be addressed. This supports the idea that mental health programs must involve trained personnel from their community so that cultural barriers might be lessened, thus overcoming the experience of stigma or discrimination.

Meanwhile, one risk faced by marginalized groups is dementia, which is often undiagnosed and left unattended due to poverty and stigma. Intervening on this, however, requires a clear

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understanding that the prevalence of this group could have been prevented if education quality was incorporated as part of the overall program for mitigating mental health illnesses. This was the contribution of Liu et al. (2022) in the article entitled, "Eliminating racial disparities in dementia risk by equalizing education quality: A sensitivity analysis," in which educational attainment alone as an indicator is not sufficient in remedying the mental health needs of people. In other words, for them, there is a relationship between race, dementia, and quality education, and thus studies must be sensitive enough to go beyond simply reporting about educational attainment as mere background information. They argued in effect that "if education quality were equalized across groups by race without changing disparities in attainment, racial disparities in dementia would be reduced by about half."

The burden of pain on people with dementia has been well represented in literature, and its association with minority groups is likewise linked to an array of negative consequences in life, like failure to achieve economic, social, health, and personal welfare and success. These are seen as the products of policies and practices that structurally support racism since they create barriers to quality education. Further, the congregation of houses based on racial profile as an output of policies in the past sustains the current segregation and discrimination as it allows people's continuous exposure to conditions and structures of poverty. The cycle and the downward spiral of their lives are said to be the result of low cognitive reserve and economic opportunities.

The study thus sought to find out how education is operationalized in relation to measuring mental capacities, with an emphasis on quality. Also, it analyzed the disparities in dementia incidence if education quality is considered along with educational attainment. Using extant literature about dementia in the adult population, a sensitivity analysis allowed the researchers to have comparative data that led to the realization that disparities are decreased if education quality is emphasized. In other words, the importance of quality early-life education was held relevant to preventing dementia. This further supported the campaign for social justice and public health through the provision of quality education. In addition, in developing criteria for screening mental capacities, instruments must not only record educational attainment but also the quality of education received.

This intervention is likewise relevant among children since quality education may allow them to sustain life's challenges better and so face the future less burdensome. In making this happen, family and school conditions must be critically examined, especially the quality of time

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to study at home, the ratio of students per classroom, and the availability of books, which may affect quality education. The knowledge brought about by this study has a potential contribution to confronting racism as it shows that dementia is not an outcome of fictitious biological essentialism but rather of "historically constructed, systemically unequal opportunities for racial and ethnic minorities in the U.S. Lastly, it should likewise motivate policymakers to address the critical periods of learning, where interventions through quality education can be enforced and so can remedy or prevent future inequalities, the experience of severe dementia, and further discrimination among marginalized groups.

In connection to subtopic 2 above, it could be recalled that indigenous peoples' mental health is culturally, socially, and politically tied to their land, and specifically, for the American Indians, in 2010, the Affordable Care Act was passed to accommodate their health care insurance needs. While this may sound promising, in a study by Jaramillo et al. (2021), entitled "Producing insecurity: Healthcare access, health insurance, and wellbeing among American Indian elders", they observed tensions in the implementation, and it was met with skepticism that rather than create a venue for security, the recipients in turn become further troubled with fear and uncertainty. The relevance of this article for the Ati people is clear, given that in the long run they might too be provided with health care insurance, and so policymakers may be forewarned of the pitfalls of this approach.

The intention of the program was viewed as productive and helpful, for it seeks to address the overdue health needs of the Indian people as victims of racial prejudices. It is also seen as an opportunity to remedy the underfunded and under resourced health care system affecting the Indian people. This is seen, therefore, as making health support closer to tribal communities; overall, the program can be evaluated as having imperfect and uneven consequences for Indian health needs. The observed issues identified by the interviewed elders are:

a. While it allows individual tribal members to enroll and avail healthcare and health insurance, the accompanying new processes become another complex reality for the elders to tackle, which they are not prepared to undergo given their cultural background. Likewise, this does not allay the fear of provider shortages and scarcity of care at their own tribal facilities. Thus, this is simply seen as a repackaged old system, filled with horror stories about system failures. This does sustain the elder's continued insecurity about the system.

b. Besides the need to burden the elders with providing financial capital, such insecurity has such a deterring effect. The condition that is continually missed is that these people have

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etched in their memories their experience of historical discrimination and inequality, and so there is no guarantee that, given their fears, they may end up further marginalized.

c. The perception that this initiative is confusing, unreliable, and responsive to their needs has not been resolved in the first place. There must be a justification for this, given the experience of many elders being treated less than to their satisfaction. The effect is disempowering and could be seen further as an extension of colonial structures over them, which includes frustration and doubt about the health care system. This mistrust, therefore, when ignored, would simply mirror the prevalent structural failures that affect the position of American Indians within the control of a dominating American government.

d. This perception of unreliability could further be connected to the past negative experiences of the elders, which were seen to outweigh any promises and improvements the program promised. Like their experience of scarcity of food and water, the health care system would likely be no different from the unreliability and insecurity they experienced in accessing those vital resources in their lives.

e. Further, the idea of privatizing health care is seen as another attempt to undermine the political structure of tribal communities and so strengthen their experience of exclusion and marginalization. The bureaucratic processes that cater to private individual concerns only may signal emotional frustration as though they are blind to the experiences of the marginalized population. Thus, this sense of insecurity must be addressed in a culturally appropriate way.

f. The repeated experience of fear of unanticipated change in provider, which is common among health companies, bureaucratic complexity, and uncertainty over costs likely would produce a sense of helplessness, exhaustion, and resignation. This is a genuine concern for any marginalized tribal elderly, for the thought itself of the inadequacies of health systems in accommodating cultural circumstances can be seen as a failure of the health and insurance systems.

g. While the program may be seen again to improve health gaps, by being focused on individual, subjective individuals, it likely fails to understand the social dimension of health. Thus, this effort can be construed as health illiteracy, which favors in the long run insurance companies since it sees the elders as clients only. The basic orientation, however, is that this program is constructed and connected to a subtle goal of profit controlled by stockholders. This privately driven structure at the expense of public individuals runs contrary to the ideals of indigenous peoples and so undermines their cultural integrity.

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h. The current neoliberal policy is evident in this practice by imposing the narrative that health is a personal responsibility, so clients must establish a new level of loyalty to their provider. This, however, is seen as eroding community integrity and threatening cultural living, which has been destabilized many times through the prejudices and marginalization policies of the state. This therefore requires another approach that is long-term, communitarian, and encourages trust and confidence through emphasizing connections to patients' holistic concerns. In other words, policymakers must recognize indigenous social ties and shared experiences by being transparent in their processes and involving the elders and clients in closer interaction with the providers. In short, for indigenous peoples, health systems that work are those that recognize health as a collective right.

In line with the above observation, it is interesting to note that even in the medical health structure, caregivers' dispositions and examples are critical in the implementation of mental health programs. However, in many former colonized poor countries, other local folk healing practices were observed to remain functional in parallel to health programs. In Nigeria, Kang et al. (2021), in an article entitled, "If we build it, they will come: caregiver decision to use an accessible outpatient psychiatric service for children and adolescents in Nigeria," acknowledged such circumstances needing further clarification. In other words, they are interested in exploring how these caregivers trained to promote medical programs are likely to utilize alternative healing paths if the concerned patients are their own family members.

In Nigeria, one medical project available that is equally accessible, although only in urban settings, is the child and adult mental health (CAMH) service. The overall picture, however, is that because of a lack of political will or inadequate training of providers, these facilities were underutilized, and so a gap was observed between needs and resource availability. One explanatory idea is that parents' beliefs may have a strong influence on utilizing accessible mental health clinics. This idea is rooted in the prevailing local belief in the etiology of the disease, which could predominate over the biomedical constructs. Although supposedly both models could be fused as one, in Nigeria, etiology could mean their rooted understanding of how diseases emerged or were caused, which is thus identified from the formal medical explanation.

Caregivers, being natives of the community and having grown up with their folk beliefs, would likely carry with them their local views and so may utilize this as part of their decision-making. Encoded in the local beliefs and attitudes is the stigma associated with those with

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mental illness, which would reflect on the family or parents. Thus, having a mental illness could be locally understood as divine retribution or something done by supernatural elements, or worse, as an effect of addictive drug and alcohol use. With the spreading of stigma to parents as "courtesy stigma", the attitude usually leads to self-blame and may limit help seeking since this could lead to admission of an illness that could invite unkind reactions from neighbors.

Caregivers' attitudes, however, are also affected by their circumstances like poverty and social beliefs and expectations. Often, their accumulated work-related stress may further compound their confidence, which could affect their decisions to seek medical care for their children. Overall, caregivers are generally willing to avail themselves of outpatient psychiatric services, and their decision is not associated with personal problems or stigma; like the rest, they avail themselves of any strategy that may be helpful to their children. There was no observed ambivalence on their part since religious and folk beliefs were equally recognized as effective in restoring health to their children.

Their undeterred attitude to exploit various local resources shows how their understanding is a product of intersections of influences that see healing as a fluid and heuristic understanding of illness in their community. In other words, health is a continuous negotiation in the social, spiritual, and biological worlds, and a more pragmatic approach is to not rely on one fixed model proposed by health professionals. Thus, aside from explaining the mental health conditions through one lens, the perceived needs of patients are likewise understood to be complex products of social, educational, and economic forces. In this regard, rather than seeing mental states as either healthy or ill in a binary, it is recommended to look at each case within the spectrum of experiences and conditions so appropriate interventions may be recommended.

From the caregivers' responses, the etiology over symptoms became prominent as beliefs rather than actual conditions determined the actions taken by them for their children. This means that while caregivers recognize mental facilities as helpful, since for them mental health is not a brain phenomenon alone, they thus make use of other means that they think are best to address the illnesses of their loved ones. This explains the perceived dissonance between the nature of their profession and the actual practice for their children, which in effect dissipates further the effect of stigma. Nevertheless, given other competing issues in their society, including colonialism, poverty, and discrimination, collaborative campaigns that would eradicate these, including literacy about health, would certainly be of great help.

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If innocence is to be taken as the basis of success, certainly the Ati people will reap all the benefits of it. But, in a competitive society, laws must likewise be sensitive to differences due to cultural history and context, which necessitates protection and support for these children's culture, land, and identity. (Sansait, 2009).

States shall take measures, together with indigenous peoples, to ensure that indigenous women and children enjoy full protection and guarantees against all forms of violence and discrimination.
(UNDRIP, Art. 22, nos. 2, 2007)
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6. POLICY RECOMMENDATIONS

The previous sections are significant sources of information through which the current discussion will proceed. In those narratives, the Ati context, experiences, and worldview were presented, along with the need to look at their mental health requirements guided by the World Health Organization's Comprehensive Mental Health Action Plan 2013–2030 (WHO CMHAP 2013-2030) and other relevant health documents on indigenous peoples. These "global instruments, ranging from joint action plans to legally binding conventions, are critical to guiding action on mental health and providing an enabling context for transformation" (WHO CMHAP 2013-2030). To construct meaningful connections between their lived experiences, needs, and strategies for a mental health framework, a wealth of updated literature about indigenous peoples was initially presented in the last section (McGuire, Morris, and Pollard, 2022; Subica and Link 2022; Wiles et al., 2021). In consequence, given the unique condition of the Ati people as a marginalized minority group, displaced, and almost invisible in the prioritization of health care in the country, important concepts, frameworks, and variables will therefore be given priority or emphasis here (Fennig & Denov, 2022; Hartmann et al., 2021).

This section will have four main themes. The first reiterates the core health measures that policymakers and concerned agencies should be aware of and adopt and implement (Jaramillo et al., 2021). In line with these, the benefits as a form of incentive and analogous justifications when Ati people's health needs are met Equally, recognized barriers in implementing health plans, derived from the experiences of other communities, were recognized to point out that, despite the difficulties, solutions are widely available (Jatrana and Crampton, 2021; Waddell et al., (2021). The second identifies and relates the significance of the core principles of the Ati mental health plan (Fong et al., 2021). The third formulates the main characteristics of the Ati community mental health centers as a flexible, multi-sectoral, and culturally sensitive space and mechanisms where health is holistically linked to other competing issues and capacities in the community (Phipps et al., 2021; Wiles et al., 2021; Walby, 2007; Ang, 2021; Duignan, Moffat, and Martin-Hill, 2022). For the last theme, two important notes will be briefly examined: the geopolitical drivers and the role of advocacy movements in a community that seeks a comprehensive framework for health (Gorsky and Manton, 2022; Mullany et al., 2022).

To start with, this policy recommendation acknowledges the need to provide significant information to the local government in compliance with the expected output of CMHAP 2013–

2030. The Ati status as indigenous peoples make them fit to belong to the priority group that obliges states to comply with this plan (Medvedyuk, Govender, and Raphael, 2021; Brown and Bryder, n. d.). In this regard, selected themes of this mental health plan will be identified and supplied with necessary inputs reflective of local needs. It could be recalled that in 2001, the UN document entitled "World Health Report 2001: Mental Health: New Understanding, New Hope" had already enumerated the core mental health themes and that each had to be addressed by each country. These are to provide treatment in primary care; make psychotropic medicines available; provide care in the community; educate the public; involve communities, families, and consumers; establish national policies, programs, and legislation; develop human resources; link with other sectors; monitor community mental health; and support more research.



Sometimes men and women form their own groups to discuss important issues that affect them. This mechanism shows that policies could also be meaningful if their views and collaboration are sought. (Sansait, 2009).

In the case of indigenous peoples like the Ati people, with respect to their rights, they must thus be included in the country's health care system (Thom and Grimes, 2022; Lee et al., 2021). In this paper, concrete actions in response to selected themes will be articulated given the need to continuously monitor, keep relevant, transmit, sustain, and improve capacities and responses to health programs for Ati people (Trygg, Mansdotter, and Gustafsson, 2021; Kang et al., 2021).

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Thus, rather than simply agreeing to "support more research," this paper argues that all data, from medical, cultural, personal, and economic to social and political spheres, must be meticulously recorded given that awareness of the potential contribution of each theme will have a bearing on future projects (Moody et al., n. d.; Ninomiya et al., 2022; Gorsky and Manton, 2022).

Several benefits are identified by advocating for mental health for all. The first general benefit includes a reduction in suffering and an improvement in mental health and well-being as it promotes, protects, and restores health in general (Fong et al., 2021). Second, as the program or intervention grants equity of access to all people with mental illnesses, it likewise promotes and protects human rights (Demissie et al., 2021; Jaramillo et al., 2021). Third, given that quality care is provided, the program would likely be a strong mechanism to stop stigma and discrimination (Pullen et al., 2022; Abdulhamed et al., 2022). Fourth, given that this program is created and collaborated on by different sectors in the Ati community, it carries with it a message and novelty of empowerment (Ninomiya et al., 2022; Phipps et al., 2021). This sense of ownership will further be expressed in their sense of autonomy and confidence, which could further open the way to their social and economic improvement (Moody et al., n.d.). Lastly, given the economic benefits obtained from improved health, confidence, and greater social participation, the principle of social equity and inclusion will likely be realized (Lewis et al., 2021; Moody et al., n. d.).

It is worth noting here the benefits of realizing mental health for the Ati and other indigenous groups (Ninomiya et al., 2022). This should likewise be included and discussed here as valuable incentives if policymakers and local agencies initiate a collaborative and community based Ati mental health program. The benefits of change or improving health delivery generate and enforce positive realities when the Ati community is given a responsive mental health program. On the other hand, recognizing that there are inextricable links between mental health and public health, human rights, and socioeconomic development, investing in mental health would likely mean investing in strategies that ensure access to effective, quality, affordable mental health care for all; that tackle stigma, discrimination, and abuse; and that address underlying social and economic realities that shape people's mental health.

Three specific barriers have been identified by CMHAP 2013–2030 that are equally important to be addressed in the Ati community: lack of mental health services, lack of literacy, and stigma (Grant et al., 2021; Ninomiya et al., 2022; Pullen et al., 2022; Jatrana and Crampton,

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2021). Lack of mental health services has been observed to affect the community's behavior, leading them to deny the need and suppress any unhealthy circumstances in life. Health services may not necessarily be formal clinics, but simple guidance and a satellite health office that is partly manned by trained Ati would mean a lot (Lee et al., 2021; Jaramillo et al., 2021). The presence of a reliable person to care for one's health could awaken a sense of confidence to improve one's condition among the people.



Any form of engagement with the land, such as tending a bush garden, has a protective factor against anxiety and stress. (Sansait, 2009).

On the other hand, barriers could also be in the form of a lack of literacy programs, which could simply be provided by the presence of a learned community member or leader to explain using practical teaching media to suppress misconceptions about their illnesses in their own language and terminologies (Waddell et al., 2021). While folk beliefs may be sought in the absence of facilities and clear understanding, they could still be integrated or enhanced by an informed understanding of mental illnesses. Lastly, stigma could be perpetuated due to a lack of facilities and educational input that would remind people that there is an explanation and a cure for mental illness (Grant et al., 2021; Pullen et al., 2022). To remedy this, local health workers have to combat misinformation that further blames the victim as lazy, crazy, or cursed.

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To the Ati people and to the local government, which might be wary about the costs of mental health intervention, the CMHAP 2013–2030 emphasized that there is a core set of cost-effective interventions for priority mental health needs that are feasible, affordable, and appropriate. These could then be the basis for optimism that, by improving people's mental health, educational outcomes and community participation will likely be enhanced, leading to increased income productivity and social benefits for all (Lewis et al., 2021; Willen, 2022; Ang, 2021). In individual cases, mental health services should lead to empowerment and self-autonomy. However, in some situations, local authorities may legally supersede the preferences of individuals, which can lead to their being detained against their will. This forced treatment may lead to a fear of coercion, which can discourage people from seeking help. Safeguards should be provided so that these people in need may not lose "their rights to informed consent, confidentiality, privacy, and communication with family members."

Furthermore, in practice, these proposed formal Ati community mental health services must address not only the clinical but also the social service needs. Thus, care services must be reflected in non-health settings, including schools, prisons, and women's shelters, to ensure inclusion and fulfill basic needs, including social housing, legal, vocational, educational, employment, and social benefits (Moody et al., n.d.; Mejia-Lancheros et al., 2021; Phipps et al., 2021). This then calls for a whole-of-government approach where policies, services, and programs are expected to complement each other to address the various needs of each sector of the community (Medvedyuk, Govender, and Raphael, 2021).

6.1. Core principles of the Ati mental health plan

The first step in constructing a local health plan is to specify a common and workable vision, goals, and principles. In this regard, this has been well articulated in the CMHAP 2013–2030 document. In Figure 3 below, the vision (A) clearly recognizes important concepts in the program, like that it should be "culturally appropriate," "community-based," and "free from stigma, discrimination, or abuse." Thus, the call for indisputable and urgent action is echoed by the statement that countries, "no matter their resource constraints, can do something substantial to support change towards better mental health." Subsequently, this vision informs the goals (B), the guiding principles (C), and the definition of mental health (D).

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The themes in the expressed goals are all well elaborated in the previous section, especially the promotion of holistic well-being. This latter notion nonetheless would mean that health or mental health concerns should include not only their personal goals but likewise their cultural and material goals such as language, local beliefs, and enjoyment of land (Moschion & van Ours, 2021; Waddell et al., 2021; Flynn, 2021; Phipps et al., 2021). Through multi-sectoral and community-based engagements and with the support of national and local legislation and funding, the goals will likely be attuned to the Ati cultural context. The goal thus envisions a preventive approach by looking not only at the immediate factors but also at the structural and system-level determinants of health (Medvedyuk, Govender, and Raphael, 2021).

In respect to the expressed guiding principles (universal health coverage, human rights, empowerment of lived experience, life-course approach, evidence-based practice, and multi-sectoral action) identified and argued here, the case of Ati and the literature raised in the previous sections are reiterated here (Phipps et al., 2021; Reed, 2022). First, while the Ati unquestionably needs these provisions, the community must be continuously educated as to the coverage, responsibility, and accountability of each agency in delivering these services (Liu et al., 2022). Nonetheless, they might not be able to enjoy these immediately given the limited funding availability, yet transparent and sincere communication could be observed to build and sustain trust in the reliability of the services (Jacobs and Quinn, 2022). Thus, it is the responsibility of the assigned agency to make each program understandable in their own language and cognitive imagination and to keep track of the feedback to incorporate health education into health service delivery (Waddell et al., 2021; Patterson et al., 2022; Grant et al., 2021; Liu et al., 2022; Medvedyuk, Govender, and Raphael, 2021).

Second, human rights might be a contentious issue, but as regards the indigenous peoples, their rights to ancestral domain and self-determination are inviolable (Medvedyuk, Govender, and Raphael, 2021). Specifically, the doctrine is clear that "everyone has a right to dignified, humane, responsive, acceptable, and decent care that respects their human rights" (CRPD, 2008; CMHAP 2013–2030, 4.2). It is therefore up to the state’s conscience to become partners in identity and dignity building with the Ati people to overcome the colonial and post-colonial legacies of deprivation, dislocation, and cultural trauma (Alhassan et al., 2021; Galway, Esquega, and Jones-Casey, 2022; Fong et al., 2021; Fennig & Denov, 2022).

As a basic human right, mental health has intrinsic and instrumental value. This means that as mental health has protective and relevant values in the achievement of human goals, it must

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be ensured that policies incorporate health promotion in community development projects. In the case of the Ati, this could be translated by involving each sector to genuinely participate in the whole process of project development, implementation, and assessment (Patterson et al., 2022; Medvedyuk, Govender, and Raphael, 2021). Furthermore, this right basically means their right to be protected from threats to their health, that quality care be available and accessible, and that each should positively experience being included in their community affairs (Mwangi, 2022; Mullany et al., 2022; Reed, 2022; Jaramillo et al., 2021).

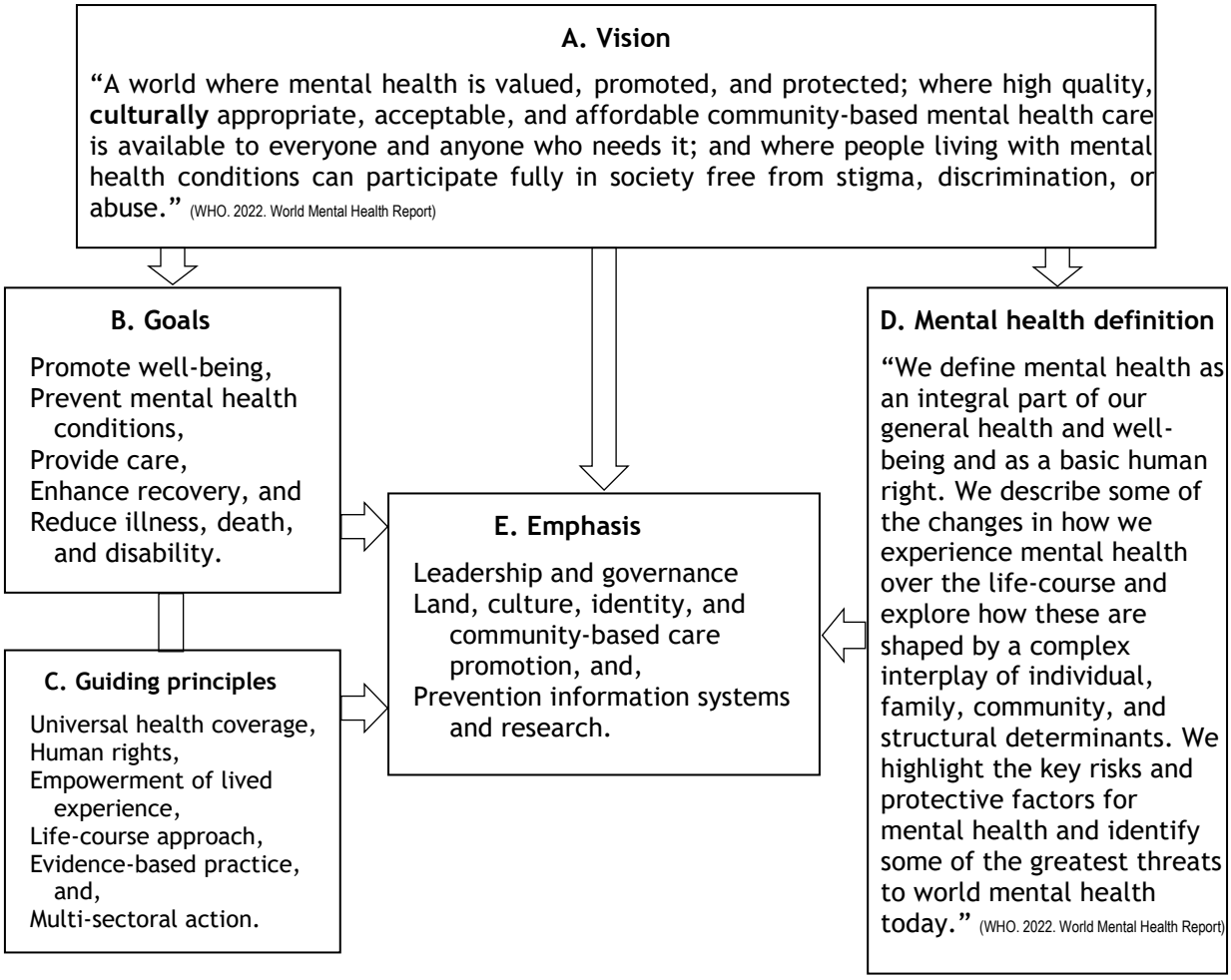


Figure 3. Recommended Core Principles of Ati Mental Health Plan

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This intrinsic and instrumental value could be evaluated by determining the extent to which the intervention or policy could be beneficial to an individual's capacity to cope with daily life pressures as well as to their capacity to contribute positively and freely in their society (Demissie et al., 2021). In the Ati context, specific attention has to be given to their financial needs as well as their vulnerability to discrimination and stigma (Grant et al., 2021; Pullen et al., 2022; Abdulhamed et al., 2022). In this condition, educational training and livelihood projects may be initiated sensitive to their cultural needs while enhancing their community status and identity (Fong et al., 2021; Duignan, Moffat, and Martin-Hill, 2022; Duignan, Moffat, and Martin-Hill, 2022; Jaramillo et al., 2021).



Almost every afternoon, this open field in front of their village becomes a lively place for children, where their shouts, jokes, and runs echo everywhere. With dogs, chickens, ducks, and other farm animals around, this idyllic place offers them a temporary respite from the stigma of the outside world. With inclusive policies, these children are likely to have the opportunity to live in a world where their difference is appreciated and celebrated. (Sansait, 2009).

Third, in the Ati community, empowerment of lived experience would basically mean the incorporation of the elderly, women, and children in the whole process of health delivery (Patterson et al., 2022; Phipps et al., 2021). This is necessary since not only do they belong to vulnerable sectors, but they also have a unique awareness and interest that could attune health programs based on their priorities and needs (Chan and Hazan, 2022; Galway, Esquega, and

Jones-Casey, 2022). Fourth, similarly, a life-course approach is relevant for any intervention because it always has to foresee the interconnections and evolving aspects and patterns of mental development (Thom and Grimes, 2022; Galway, Esquega, and Jones-Casey, 2022; Moschion & van Ours, 2021). In the view that mental stress and wellness are fluid realities within their group and across the bigger social spheres, and as these episodes of health and illness may come and go as one grows up, any diagnosis and health access must reflect a non-static view of their biological and cultural life (Jacobs and Quinn, 2022; Moody et al., n.d.; Moschion & van Ours, 2021; Jaramillo et al., 2021).

Fifth, the reliability and validity of approaches could never be ensured without evidence-based practice. This means that it is not only encouraged but likewise a necessary requirement that variables in any health program, from conception to evaluation, be clearly articulated as measurable (Jacobs and Quinn, 2022). While there might be peculiar concepts relative to the community only, these could still be represented by using the local terms and local ways of measuring them. Lastly, engagements have to be multi-sectoral given that current knowledge sees mental health as affecting different statuses and positions in the community (Moschion & van Ours, 2021; Pullen et al., 2022). While this could be subsumed under a community-based label, multi-sectoral is more specific, and that will oblige concerned agencies to locate and enable their critical and unique participation (Lewis et al., 2021).

Overall, the stated vision, goals, guidance principles, and definitions of the mental health plan are all forged to succeed by observing the given program emphasis (E), which includes the critical role of leadership and governance, the indispensable commitment to land, culture, identity, and community-based care promotion, and the sustained complementary tasks of prevention information systems and research (Pullen et al., 2022; Ang, 2021; Mullany et al., 2022). The primacy of leadership and governance is emphasized since nothing can happen without the commitment and example of those in authority. Leaders must continuously be made aware of the integral need to safeguard the health of the citizens since healthy citizens not only prevent bleeding of the medical budget but also definitely and positively contribute to their economy (Mwangi, 2022; Reed, 2022). Given that leaders hold elective positions, they are thus accountable to their countrymen by prioritizing or reallocating resources more on health, food, and education (their fundamental rights) than on feeding bureaucracy or being exorbitant on defense spending (Aghedu et al., 2022; Liu et al., 2022; Grant et al., 2021; Elgar et al., 2021; Weaver et al., 2022).

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For the Ati, "Tanan nga balay natukod dire pinaagi sa pagbinuligay namun, wara ti mabahul o magamay kay ang importante, ang pahinirupay kang tanan nga ga-istar dire." (Every house is built with everyone's cooperative generosity, and whether it is big or small, what is important is the kindness and affection of those who live in it.) (Sansait, 2009).

Second, community-based care promotion could not happen without including the questions of land, identity, and culture. For indigenous peoples, community health programs will always be well attended as they are premised on the promotion of their identity and culture based on land. Not only are they interested in this topic, but the enjoyment of these rights has a protective factor besides simply being a rightful act over their experience of colonization, deprivation, and displacement (Galway, Esquega, and Jones-Casey, 2022; Fennig & Denov, 2022; Alhassan et al., 2021). Lastly, at the community level, advocacy and local social movements cannot be initiated without information promotion and meaningful research (Ray, Wylie, and Corrado, 2022; Patterson et al., 2022). Thus, besides informing them about basic health protocols and habits, the knowledge that they co-produce will eventually empower them to see health as a community journey towards justice, harmony, respect, and security in their community (Medvedyuk, Govender, and Raphael, 2021; Waddell et al., 2021).

To make mental health feasible in the Ati community, robust information is necessary to guide policies, funding allocation, and medical responses necessary in their cultural setting.

Thus, evidence-based policies and services cannot happen without factual knowledge based on research that is relevant, reliable, accessible, and innovative (Patterson et al., 2022; Aghedu et al., 2022; Jaramillo et al., 2021). Areas of great importance identified in the CMHAP 2013–2030 are "the determinants of mental health in the Ati community; the prevalence of certain types of conditions; the feasibility and affordability of interventions; and the effectiveness and appropriateness of different interventions in different contexts."

6.2. Characteristics of community mental health centers

Figure 4 shows that the proposed preventive mechanism for the Ati community has five main components. The list of variables or factors to be considered as part of the recommendation for policy change and intervention is incomplete and demands continuous updating. The ideas included in the diagram will be discussed further below.

The central part, which is labeled the Prevention Mechanism Plot (C), lists the probable actions that are worth realizing for the Ati people. This component, however, will not be sustained without the continuous involvement of advocacy groups and social movements (D) and committed support for their welfare based on land, identity, and culture (E). Further, to realize these, supports from the individual-community (A) and from the legal-political spheres (B) are to be fostered as well. It should be noted that all these categories are not discrete and non-overlapping, for in the actual setting, these are fluid realities, and so it begs that this mechanism be seen as a dynamic guide in setting up priorities, analysis, and intervention for the Ati's wellbeing (Wiles et al., 2021; Pullen et al., 2022).

At the community level, policies must be adopted that are in line with the national agenda and appropriate for the local setting (Wiles et al., 2021; Bussalleu et al., 2021; Medvedyuk, Govender, and Raphael, 2021). Second, the identified trained cultural caregivers must be explicitly supported to sustain their health efforts meaningfully (Mullany et al., 2022; Lee et al., 2021; Jaramillo et al., 2021). Third, educational programs can enhance prevention and rehabilitation, especially if they are participated in by different sectors of the community (Grant et al., 2021; Liu et al., 2022). Fourth, the opportunity for learning and reinforcing identity and connections through the internet is emphasized as part of the health support structure (Lee et al., 2021). Lastly, in the Ati community, recognizing traditional roles can greatly assist in health

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recovery or illness prevention (Wiles et al., 2021; Lawrence et al., 2021; Demissie et al., 2021). Meanwhile, sufficient safeguards must be in place since, although traditional healing can be highly supportive and meaningful to people, it can also involve abusive practices (Elton, 2021; Mwangi, 2022; Hamersma & Ye, 2021).



Elders hope that simple rituals like this *panagda* will be successfully passed on to future generations, as each reenactment reaffirms their identity and reconnects with their ancestors, both of which are key components in maintaining the harmony and well-being of the community. (Sansait, 2009).

In the legal-political support (B) domain, besides ensuring expanded legislation that recognizes indigenous people's identity, needs, and potential to participate in health care programs, funding nonetheless becomes a concrete manifestation of commitment (Mullany et al., 2022; O'Connell et al., 2022; Gorsky and Manton, 2022). Thus, to realize a robust and workable plan, strong political will and commitment are essential to overcome the barriers. These commitments sought are based on their expressed public support, on policies and programs sponsored and created, and on the provision of funds allocated to carry out the project (Elton, 2021; O'Connell et al., 2022). Secondly, efforts at this level must centralize the historical claim for ancestral domain and self-determination to compensate for the demand for justice and human rights as indigenous peoples (Flynn, 2021; Reed, 2022).

Second, legal and political support must likewise be found in community-based organizational engagements so that sustainable efforts can be operationalized. Fourth, necessary training and orientation should be provided to health workers at the managerial level so that they can implement, monitor, and guide culturally prescribed health and wellbeing preferences for the community (Lee et al., 2021; Wiles et al., 2021; Haynes et al., 2021; Jaramillo et al., 2021). Lastly, health workers and elders themselves, being crucial as agents and authorities in health instructions and delivery, must be given attention as well, not only for their own personal and social needs but also for their ability to function effectively (Moody et al., n.d.; Moschion & van Ours, 2021).



This hut built to introduce literacy to children could play a role in enhancing success in education and assimilation. Meanwhile, the space also played as a community center where they could regularly and formally talk over the issues affecting them. With sufficient support and funding, culturally sensitive policies and mechanisms that enhance the Ati people's identity, security, and culture will likely produce positive outcomes in the future. (Sansait, 2009).

Going back to the elements of the prevention mechanism, as indigenous peoples, their cultural spaces, and activities crucial to their traditional living are to be recognized and thus should be integrated in the program (Wiles et al., 2021; Mwangi, 2022). These could be in the form of identifying, establishing, and funding meeting areas, learning hubs, gardens, forest lands, or ritual grounds where their community or cultural activities could be carried out meaningfully (Ang, 2021; Hamersma & Ye, 2021; O'Connell et al., 2022). Second, occasions

and circumstances that would lead them to distress have to be identified and removed or resolved so that they can increase their confidence and efficacy in the face of anxiety and illness (Jatrana and Crampton, 2021; Weaver et al., 2022).

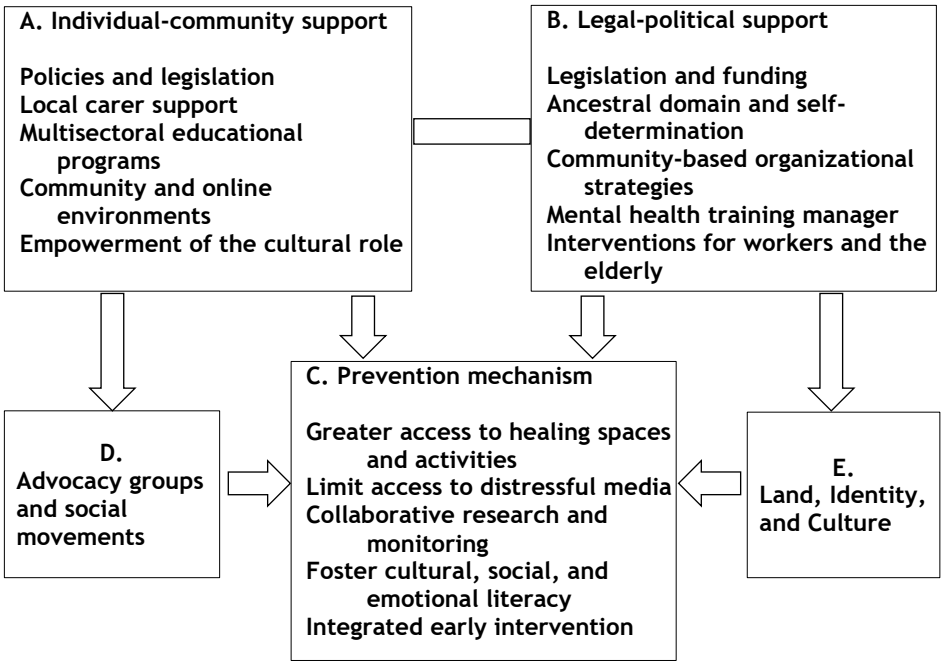


Figure 4. The Mental Health Preventive Mechanism of the Ati People Community

Third, research and monitoring processes should be taken as regular activities in all phases of Ati health interventions so that the community would increase awareness and appreciation not only of the continuity but also of the relevance and strength of their participation in the healing process or in illness prevention programs (Ninomiya et al., 2022; Patterson et al., 2022; Lewis et al., 2021; Mwangi, 2022). Fourth, through research and regular engagements, cultural, social, and emotional literacy can be fostered so that their cultural identity and attachments will become positive elements in their lives (Fong et al., 2021; Willen, 2022). Lastly, a holistic intervention requires that it be introduced as early as possible in their life stages to offset the cumulative effect of stress, anxiety, and other forms of mental illness in their community (Moschion & van Ours, 2021; Weaver et al., 2022; Elton, 2021; Chan and Hazan, 2022).

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As regards addressing the mental health promotion, protection, care, and recovery needs of the indigenous peoples, or Ati, it could not happen without a holistic approach for greater equality of opportunity (with respect to education, income, and social inclusion) as well as broad access to basic services in their lives (water, food, and transportation) (Alhassan et al., 2021; Mullany et al., 2022; Grant et al., 2021; Aghedu et al., 2022; Rosinger et al., 2021; Duignan, Moffat, and Martin-Hill, 2022; Elgar et al., 2021; Weaver et al., 2022) . This means that mental health extends beyond psychological well-being itself—from social equity and inclusion to economic growth and prosperity (Elton, 2021; Moschion & van Ours, 2021). To achieve this, political will, and funding, as stated above, are necessary, which might entail "reallocating limited resources, developing new policies, building new skills, establishing new partnerships, and engaging new stakeholders."

Funding research and services for mental health may not necessarily happen without some advocacy activity to raise public awareness and exert pressure on policymakers (Milligan et al. 2022). Nonetheless, once leaders are informed about the benefits of having mentally fit citizens, commitments can be achieved through reallocation of resources (Pullen et al., 2022; Aghedu et al., 2022). In budget deliberations, "feasibility, affordability, cost-effectiveness, human rights, and equity" are to be considered along the priority areas at various national and local levels to come up with "responsive and resilient health systems" (CMHAP 2013–2030).

On the policy level, four items could readily be incorporated into the Ati mental health plan based on the CMHAP 2013–2030 document: funding, medicine availability, workforce sufficiency, and use of the internet. Thus, research must continually specify and monitor the actual yearly allocated budget for health, specifically for Ati wellbeing, so that better resource spending and allocation can be proposed. Second, actual medicine and health service availability and affordability must be recorded in connection with prevalent mental health needs so that accountability and responses can be improved (Mwangi, 2022; Galway, Esquega, and Jones-Casey, 2022; Wiles et al., 2021; Moschion & van Ours, 2021). Thirdly, it is also noted that while mental health workers are limited in number and training, those who are in this sector are usually underpaid or unrecognized. Specifically, for the Ati people, a number of them could be sufficiently trained and given appropriate remuneration in this regard (Lee et al., 2021). Lastly, since digital literacy and internet access are now recognized as tools for disseminating information on time, these should likewise be included in intervention programs (Demissie et al., 2021; O'Connell et al., 2022; Jaramillo et al., 2021). In effect, being connected through the

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internet, the Ati people will likely have additional learning resources to increase awareness and confidence towards body and cultural healing in this digital age (Pullen et al., 2022; Aghedu et al., 2022; Mwangi, 2022).



In this land that seems barren, an Ati elder would have this to say: "Ang mga lupa pareho lang ra tanan sanda para kanamon. Wara ti bakante, kay tanan buta ri-a kang amon mga inagihan kang panumduman halin kauna pa, kag jan man ginahalinan kang amon nga mayad nga panglawason kag palangabuhian. Basta tugrui lang kami." (For us, all lands are equal. There is no such thing as empty land. It is always filled with our experiences and memories, and it is from that space that we derive our well-being and livelihood. Just give us one.) (Sansait, 2009).

Other than providing remedies, mental health care must likewise enable individuals to boost their competencies in self-care, which involves encouraging people to positively engage with or connect to their communities and nature (Elton, 2021; Mullany et al., 2022; Milligan et al. 2022; Mwangi, 2022; Patterson et al., 2022; Wiles et al., 2021). This lifestyle is seen as mutually beneficial in the community and therefore can positively reinforce their sense of confidence and capacity to face mental health issues (Burns et al., 2022; Moschion & van Ours, 2021). Policies, therefore, must likewise support this activity by making spaces available for interaction and personal growth (Wiles et al., 2021; McGuire, Morris, and Pollard, 2022; Milligan et al. 2022; Aghedu et al., 2022).

In the process of generating research data for monitoring Ati health status and needs, certain provisions from CMHAP 2013–2030 are highly significant. These include epidemiological data as well as mortality records caused by the type of illness prevalent in the

community. To have a concrete view of the economic and productivity costs or losses due to illness, tangible and intangible factors related to cultural, social, and relational expenditures that are undermining health may be identified (Milligan et al. 2022; Hamersma & Ye, 2021; Moody et al., n.d.; Jatrana and Crampton, 2021). This may include emotional and psychological pain as well as the efforts of unpaid caregivers who spend time and energy caring for others (Mullany et al., 2022). These could be addressed if gaps in information, governance, resources, and services are identified, acknowledged, and remedied (Elton, 2021; Aghedu et al., 2022). Furthermore, this local research and monitoring that prioritizes "comprehensive, independent, and comparable data" could greatly help in bridging the knowledge gap required for the country or region to design a more viable intervention program (Milligan et al. 2022; Waddell et al., 2021). Further, research must be able to transcend a basic approach or engagement into an applied one so that inadequacies in policies, plans, and laws will be sufficiently addressed in an iterative fashion (Pullen et al., 2022; Milligan et al. 2022; Waddell et al., 2021).



From the top of Guimaras Island, the view of Iloilo City reveals what the province will probably be like in the future. With committed leadership and local participation, any timely and relevant policy for Ati will surely enhance its success and ensure its survival. (Sansait, 2009).

Meanwhile, preventive mechanisms, given that they need concrete and sustained support in the face of global and internal socio-political strains, need empowering actions through advocacy campaigns and social movements (D). The support and motivation to enable the Ati

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community to translate their aspirations into a respectful voice will certainly increase their sense of determination and confidence as a people about their culture (Pullen et al., 2022; Galway, Esquega, and Jones-Casey, 2022). Through social movements, they will be able to realize the universality of their need to cooperate and mutually support other indigenous groups facing the same experiences of marginalization, dispossession, and poverty (Daz et al., 2022; Aghedu et al., 2022; Hamersma & Ye, 2021). Equally, as indigenous peoples sharing the same effects of colonization and decolonization with the rest, their needs are embedded in their movements and programs along their sacred link to land, identity, and culture (Fong et al., 2021; Galway, Esquega, and Jones-Casey, 2022; Alhassan et al., 2021). While legally they might be disadvantaged in land claims, by their sustained advocacy to realize their ancestral domain and self-determination, not only will they grow in political and moral strength, but they may also awaken the conscience of their leaders and their neighbors to the shared humanity of everyone in this world (Fong et al., 2021; Reed, 2022; Medvedyuk, Govender, and Raphael, 2021; Elton, 2021; Ninomiya et al., 2022; Gorsky and Manton, 2022).

Effective and meaningful delivery of services may include the use of teams that can function with flexibility in a local setting (Ang, 2021; Waddell et al., 2021). Necessarily, it must be represented not only by different sectors but also by trained psychiatrists, nurses, social workers, and other care professionals (Lee et al., 2021; Mullany et al., 2022; Alhassan et al., 2021). Given sufficient training, they will likely become flexible and mobile counterparts to fill the gap in the absence of medical professionals, and as their interventions involve health education and promotion, their role will likely prevent many community members from hospitalization (McGuire, Morris, and Pollard, 2022; Patterson et al., 2022; Grant et al., 2021; Palimaru et al., 2022). Also, community mental health teams are likewise mobile, which would enable them to deliver different services to different sectors' needs in their area. In effect, this would generally reduce the financial burden on the user and so encourage people to engage in ongoing care. Lastly, having community mental health teams can substantially reduce the number of people needing hospital care, and putting resources into this level is often cost-effective and helps hospitals avoid being overwhelmed (Alhassan et al., 2021; Pullen et al., 2022; Aghedu et al., 2022; Mullany et al., 2022).

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6.3. The structural challenges and advocacy possibilities

Besides being an individual experience, mental health is determined or structured by wider factors, such as socio-cultural and geopolitical influences, besides the availability or access to basic commodities such as water and food, services in the form of education and legal protection, and resources such as land and cultural integrity (Gorsky and Manton, 2022; Medvedyuk, Govender, and Raphael, 2021; Grant et al., 2021; Mullany et al., 2022; Rosinger et al., 2021; Duignan, Moffat, and Martin-Hill, 2022; Elgar et al., 2021; Weaver et al., 2022). These looming structures, too, must be identified and corrected. In this view, the Ati health programs must therefore include a recognition of their being a disadvantaged group defined by a lack of land security, being in a constricted and marginal space, and living a vicious life of poverty, unemployment, and lacking access to clean water and a nutritious diet (Wiles et al., 2021; Moody et al., n.d.; Daz et al., 2022; Rosinger et al., 2021; Duignan, Moffat, and Martin-Hill, 2022). Since these ongoing social and historical burdens are lived through their experiences of exploitation, social exclusion, stigma, and discrimination, in times of global crisis, they could become highly vulnerable not only to the disease but likewise to policies that are blind to their cultural needs (Elton, 2021; Grant et al., 2021; Galway, Esquega, and Jones-Casey, 2022; Pullen et al., 2022; Phipps et al., 2021). In their current condition, as their mobility is constricted due to a lack of secure space to continue their traditional lifestyle, it is most likely that economic breakdown will lead to social network disruption, which will further increase anxiety, vulnerability to mental and physical illnesses, and economic inequality (Galway, Esquega, and Jones-Casey, 2022; Moschion & van Ours, 2021; Ang, 2021; Demissie et al., 2021; Moody et al., n.d.; Weaver et al., 2022; Gorsky and Manton, 2022).

Favorable structural components in mental health programs are crucial because they could redefine norms and values as well as defend and support indigenous communities by upholding their rights and ensuring their "equal access to infrastructure, services, and opportunities." These possible promising policies, when taken together, will greatly enhance security for the Ati's mental health needs by addressing their financial insecurity, poverty, and income inequality along with their access to the labor market, education, safe and secure housing, and protection against discrimination (Grant et al., 2021; Abdulhamed et al., 2022; Phipps et al., 2021; Jacobs and Quinn, 2022; Daz et al., 2022; Mejia-Lancheros et al., 2021; Liu et al., 2022). Simultaneously, parallel social and structural ills have to be addressed as well, like their continued experience of abuse, exploitation, stigma, and landlessness (Pullen et al., 2022;

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Mwangi, 2022; Galway, Esquega, and Jones-Casey, 2022; Medvedyuk, Govender, and Raphael, 2021).

On the other hand, advocacy groups have a special place in overcoming community stigma through the three CMHAP 2013–2030 recommended strategies: education, contact, and protest. Through education, which includes literacy campaigns, public awareness campaigns, and a wide range of training and learning activities, myths and misconceptions could be addressed (Jatrana and Crampton, 2021; Elton, 2021; Lee et al., 2021). In the current digital age, factual knowledge about the Ati and other indigenous people's unique and integral lives in society and the world could be provided (Mwangi, 2022; Waddell et al., 2021). Meanwhile, contact strategies may include their actual or simulated presence or attendance (visibility) in various facets of society, in the academy, in various fora and conferences, as well as in many socio-civic activities (Ray, Wylie, and Corrado, 2022; Lee et al., 2021). This mode could not only enhance or invite further awareness but likewise improve confidence and esteem in the spirit of acceptance and appreciation. Lastly, protest and advocacy campaigns are self-empowering activities since they are formal ways in which these people may bring about their grievances (McGuire, Morris, and Pollard, 2022; Waddell et al., 2021).

These acts like public demonstrations, letter writing, petitions, product boycotts, and other advocacy campaigns might be contentious engagements, but nonetheless, they are within their inherent rights if they feel the need to redress any injustice done to them (Reed, 2022; Flynn, 2021). Indirectly, any form of social engagement, especially those that directly affect their identity and wellbeing, becomes an opportunity to enhance their community spirit and self-respect (Fong et al., 2021; Wiles et al., 2021; Jacobs and Quinn, 2022; Fennig & Denov, 2022). Any community-empowering activities thus must be tolerated, if not encouraged, since the experience of stigma and discrimination are not simple issues that could be removed in their lifetime (McGuire, Morris, and Pollard, 2022; Pullen et al., 2022; Nightingale and Richmond, 2021; Grant et al., 2021). They must be able to engage in sustainable political and social visibility guided by the principles of human rights and social justice to ensure their autonomy and progress for generations to come (Mullany et al., 2022; Flynn, 2021). In this regard, community self-help or advocacy groups must be encouraged away from the paternalistic control of neo-colonial or neo-feudal authorities in order for them to realize for themselves their strengths and other needs for which they alone have the experience and could improve

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(Alhassan et al., 2021; Milligan et al. 2022; Ward et al., 2021; Flynn, 2021; Ninomiya et al., 2022).

Advocacy should likewise be embedded in multi-sectoral venues or collaborative projects so that there is intelligent and appropriate information sharing, joint planning, strategic design and support, and appropriate health delivery (Reed, 2022; Ninomiya et al., 2022; Phipps et al., 2021; Aghedu et al., 2022; Ang, 2021; Hamersma & Ye, 2021). Thus, timely advocacy enlightened by reason and evidence and participated in by multi-sectoral members of the groups can greatly re-arrange and expand political commitment and leadership, leading to barrier reduction and greater enjoyment of accessible and humane mental health care (Jatrana and Crampton, 2021; Medvedyuk, Govender, and Raphael, 2021; Gorsky and Manton, 2022; Moschion & van Ours, 2021; McGuire, Morris, and Pollard, 2022; Kingsley et al., 2021; Palimaru et al., 2022; Jaramillo et al., 2021). The best resource in advocacy generation are stakeholders and those with lived experience, for they have the primary knowledge and clear interest in the success of their aspired and co-produced culturally meaningful health care delivery system (Reed, 2022; Ninomiya et al., 2022; Jatrana and Crampton, 2021; Burns et al., 2022; Waddell et al., 2021).



This memorable photo of several young people before the author left them reveals their inner strength and confidence, which are the basis of their community's hope. Despite the lack of education and competitive skills, their resilience will allow them to continue living and enjoying their culture and identity, along with the government's promised assistance. (Sansait, 2009).

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7. SUMMARY AND CONCLUSION

Sa kahangawa kag sa kabug-aton sang amon nadangatan,
sa luha na lang namon ini ginpautwas tanan.

As for the worries and burdens brought upon us by fate,
we release them all through our tears. – Tay Floro

This monograph was conceived to provide ethnographic and literary support in the task of articulating a mental health plan for one of the indigenous peoples in the Philippines, the Ati People. While the clarity of the demand was outlined in the World Health Organization's Comprehensive Mental Health Action Plan 2013–2030, the urgency is based on the actual needs of these people living in marginal states of the country. Furthermore, this task could inform efforts to realize the local constitutional mandate to protect and safeguard indigenous health and cultural and material conditions in parallel to fulfilling the United Nations' document on indigenous rights. Interestingly, however, while the country has a solid mental health law, the contextual and rightful strategy and plan appropriate for indigenous peoples are lacking.

The first part of section 3 chronicled the evolving earnestness and fascination of humanity with treating mental illness, from ancient rituals to the present medical infrastructure. In between these are the Greek adherence to a balanced basic life and the practice of the arts, the use of emetics or laxatives during the Middle Ages, and the establishment of asylums and hospitals starting in Baghdad and later in Europe. Later in Europe, the separation of mentally ill people from common criminals became a breakthrough in treatment along with a modification in lifestyle. But the most promising was the discovery of chlorpromazine, which revolutionized psychopharmacology and the medical treatment approach.

The second part related how the United Nations and the World Health Organization, through their documents, took serious steps to demand accountability from various states in addressing mental health issues. This section moves the focus and urgency to address mental health problems from individual communities and states to a greater united act informed by updated knowledge. At first, the approach was selected based on the emerging medical knowledge of the brain and behavior, but soon it encompassed the social conditions that predispose to the occurrence of mental illness. Then, to recognize and address an individual's right to health, the United Nations and other governing bodies associated with it, like the World Health Organization, and further, the World Bank, including the International Labor

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Organization, among others, openly and consistently advocated for the acceptance and realization of a universal mental health policy across the globe.

The next topic argued about the fundamental concepts found in subsequent United Nations' documents that provide crucial recognition of the rights of the indigenous peoples for their survival as distinct peoples. This idea is articulated in the Declaration on the Rights of Indigenous Peoples, which recognizes the rights of indigenous peoples to self-determination (articles 3 and 4), their collective right to own and control their lands and resources (articles 25–27), their right to free, prior, and informed consent in relation to legislation, measures, and projects that may have an impact on their rights (articles 10, 11, 19, 28, 29, and 32), and their right to participate in decision-making processes (articles 5, 18, and 27).

However, pertaining to the construction of mental health as a global concern, the first initiatives in contemporary history that call for its concrete and comprehensive approach or resolution happened in 2011. With the increasing incidence of mental, neurological, and substance abuse (MNS)-related illnesses side by side with relatively few studies about them, a consortium of researchers, advocates, and clinicians endeavored to come up with a grand agenda to address this gap and likewise to call for urgent action and budgeting. This initiative, entitled "Grand Challenges in Global Mental Health," "has identified priorities for research in the next 10 years that will make an impact on the lives of people living with MNS disorders."

As one of its positive developments, by 2015, The State of the World's Indigenous Peoples: Indigenous Peoples' Access to Health Services, Volume 2 by the UN's Department of Economic and Social Affairs (DESA) had come out of press. This document starts with a lucid reminder of the United Nations' great milestone with its Declaration on the Rights of Indigenous Peoples (UNDRIP) in September 2007 that, after more than 20 years of debate, has been signed by most states. The lesson is made clear that wherever there is failure to recognize their ownership of their lands and resources, their vulnerability to displacement, poverty, discrimination, and marginalization is aggravated. Thus, the most important thing is for researchers to characterize the indigenous people's mental conditions in their own circumstances and point of view, circumscribed by their vulnerability to "poverty, violence, disability, and inequality."

The section 4 earlier described the existential conditions of the Ati People and those of other indigenous groups who shared the same fate circumscribed by the laws, values, and expectations of their dominant Filipino neighbors. In this context, its first part narrated the Ati

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People's short prehistory, geographic location, cultural practices, land question, and selected notes about their mental wellbeing experiences. It was observed that as a people living in four dispersed communities in Guimaras, Island, Philippines, although they tend to keep their identity separate from the lowlanders, their locations, limited land area, poverty, and other social variables do not guarantee them a secure and meaningful future. Their numerous incapacities from lack of employment and income opportunities, along with the general lack of recognition of their rights and culture from the dominant society, revealed so much of their state of well-being that negatively affected their esteem and decision-making abilities.

Since the paper was aimed at generating a mental health plan fit for indigenous peoples in the country, especially the Ati community, two parallel histories of cultural transformation were likewise briefly reported, like that of the Batak of Palawan and the Agta of Casiguran, Philippines. These subsequent ethnographies reinforced the common imagery and voices about a common thread of a state of social-political-medical neglect along with vulnerability to illnesses and diseases. Given the consequential shared experiences of anxiety and stress affecting all former hunter-gatherer groups, it was deemed that policies should not be too particularistic to the point of being indifferent across space and time. Furthermore, the narratives advanced the idea that the urgency of a mental health program is not to be circumscribed by a narrow paradigm of mental threat since the same scenario is likewise encoded in the lives of other indigenous groups at different locations. Lastly, a brief note of Cultural Survival's appeal was included to acknowledge that this paper shares advocacy with other concerned groups for the rights, welfare, and mental health needs of indigenous peoples wherever they are.

In response to the above observations, section 5 was formulated to demonstrate the general understanding, view, and approaches reached by ethnographers, anthropologists, and other social scientists in addressing the mental health of indigenous peoples. By enumerating and analyzing each variable or factor affecting mental health, policymakers will have the opportunity to realize that indigenous peoples' relation to land is inextricable and has been fraught with trauma since colonial times. Twelve subtopics were composed to disclose the interconnections of history with the on-going experiences of displacement, dispossession, stigma, discrimination, and neglect as a living nexus between land and the mental health of indigenous peoples. Rather than simply mention the key concepts in passing, each theme or

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topic was given a comprehensive analysis so that important contextual lessons could be emphasized that were significant to the fates of indigenous peoples.

The section also emphasized that while the United Nations, through the World Health Organization, was calling attention and concrete action to global mental health needs, anthropologists who are exposed to varied communities and experiences, primarily in remote locations far from direct attention from the government, have always been attentive to this phenomenon as well. Long before any medical mapping of mental illness, anthropologists were already interpreting world processes through the concepts of world systems and their economic and psychosocial effects, as well as in the production of meaning. In other words, from the anthropological discipline, research revealed how mental health is produced and sustained by the manner in which communities are linked to global economic and political systems, as well as how these people interpret or adapt to these structures and constraints.

Section 6, forming the last central part of this manuscript, presented four main themes. The first reiterated the core health measures that policymakers and concerned agencies should be aware of and adopt and implement. In line with these, the benefits as a form of incentive and analogous justifications when Ati people's health needs are met Equally recognized were barriers to implementing health plans, which were derived from the experiences of other communities, to point out that despite the difficulties, solutions are widely available. The second theme identified and related the significance of the probable core principles of the Ati mental health plan. The third formulated the main characteristics of the Ati community mental health centers as a flexible, multi-sectoral, and culturally sensitive space and mechanisms where health is holistically linked to other competing issues and capacities in the community. For the last theme, two important notes were briefly examined: the geopolitical drivers and the role of advocacy movements in a community that seeks a comprehensive framework for health.

Given that the Ati's status as indigenous peoples makes them fit to belong to the priority groups that oblige states to comply with this plan, strategic actions were identified and supplied with necessary inputs reflective of the local needs. These are to provide treatment in primary care; make psychotropic medicines available; provide care in the community; educate the public; involve communities, families, and consumers; establish national policies, programs, and legislation; develop human resources; link with other sectors; monitor community mental health; and support more research.

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It saw that when concrete actions are realized, several benefits will be availed of, including reduction in suffering and improvement in mental health and well-being, realization of equity of access to all having mental illnesses, promotion of human rights, quality care leading to reduction of stigma and discrimination, empowerment leading to social and economic improvement, and realization of greater social participation and inclusion. Thus, the core principles of the proposed plan would have the following elements: leadership and governance; land, culture, identity, and community-based care promotion; and prevention information systems and research.



To end the day, it is of value that anyone with a spare amount provide one or two bottles of local rhum to neighbors and friends where an animated spirit is maintained that would keep away whatever doubts they have about the future. Indirectly, this regular habit reinforces their identity and esteem, yet it may lead to alcoholism. (Sansait, 2009).

To realize these principles, policies at the community level must include mechanisms to reinforce their culture, identity, healing practices, and opportunities for learning. At the legal-political domain, besides centralizing their claim for ancestral domain and self-determination to compensate for the demand for justice and human rights as indigenous peoples, sufficient funding must be available to make concrete the commitment necessary to overcome barriers. Also, to be included in healing is the support for community-based, multi-sectoral participation, along with the identification of spaces where supportive healing experiences could be realized.

Overall, this research reiterates that besides being an individual experience, mental health is determined or structured by wider factors such as socio-cultural and geopolitical influences,

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besides the availability or access to basic commodities such as water and food, services in the form of education and legal protection, and resources such as land and cultural integrity. In their current condition, as their mobility is constricted due to a lack of secure space to continue their traditional lifestyle, it is most likely that economic breakdown will lead to social network disruption, which will further increase anxiety, vulnerability to mental and physical illnesses, and economic inequality. Equally, these could not be sustained without positive support for local initiatives and advocacies in the form of education, contact, and protest. These could not only enhance awareness but likewise improve confidence and esteem in the spirit of acceptance and appreciation. Also, it should be understood that protest and advocacy campaigns are self-empowering activities since they are formal ways in which these people may bring about their grievances. In this regard, community self-help or advocacy groups must be encouraged away from the paternalistic control and dominance of neo-colonial or neo-feudal structures so that they themselves will achieve and celebrate their own well-deserved inherent rights and dignified lives today and in the generations to come.

As I end this book, I will always recall the last moment I glanced back at the determined, compassionate, and gleaming faces of your community, for whom I wish things would have been more dignified if their inherent rights as indigenous peoples had been recognized and protected early on. But history and fate may not be on your side, making your name a badge of alienation, dispossession, discrimination, and marginalization. Yet reflecting on your centuries of successful silent toil expended in an apprehensive adaptive lifestyle along with a dominant society that barely appreciates your existence, I still hold optimism, given appropriate recognition of your inherent rights and capacities rooted in your land, culture, and identity.

I know I may be unable to greet Tay Floro back upon my return, for he moved out early from this life, but here let me just inscribe his last words to me: "Mabalik ka gid ha." (Be sure to come back to us here.) Yes, Tay Floro, I will be back, but without any treasure to bestow, except that I am making sure that through this book, your people's dignified courage, industriousness, civility, creativity, humility, kindness, generosity, and tenacity will live on.



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Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge, and traditional cultural expressions, as well as the manifestations of their sciences, technologies, and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions.

(Article 31. UNDRIP, 2007)



Cover page. 2022. UN World mental health report.

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This paper describes how the once nomadic Ati people, located in the islands of Panay and Guimaras, Philippines, courageously live through poverty, illiteracy, prejudice, displacement, state neglect, and mental health problems. It is desired that this initiative could provide government agencies and other concerned groups with a concrete venue to work with for the overall wellbeing of this and other marginalized indigenous peoples in the region. By echoing the fundamental worldview and cultural identity of this group, their other needs could be holistically addressed as well.