



RESEARCH PAPER

OPEN ACCESS

Health management, life course experiences and social support among older adults with diabetes and hypertension in community settings

Genelyn S. Viadnes*

Jose Rizal Memorial State University, Dapitan City, Zamboanga del Norte, Philippines

Key words: Older adults, Diabetes, Hypertension, Health management, Social support, Life course perspective

Received: April 01, 2026 **Accepted:** April 14, 2026 **Published:** April 20, 2026

DOI: <https://dx.doi.org/10.12692/ijb/28.4.164-180>

ABSTRACT

The increasing prevalence of diabetes and hypertension among older adults presents significant challenges in community and resource-limited settings. This paper aimed to examine the relationships among life course experiences, health management practices, and social support in shaping the well-being of older adults in Dapitan City, Philippines. A mixed-methods cross-sectional design was employed, integrating quantitative survey data with qualitative data from focus group discussions and key informant interviews. Results indicated that the majority of participants demonstrated moderate to high levels of health management and social support. Life course experiences showed significant associations with coping mechanisms, health condition, socio-cultural engagement, and health management practices. Moderate relationships were observed with nutritional patterns and self-perception, while weaker associations were found in sleep and cognition. Despite these findings, several barriers to effective disease management were identified, including limited access to maintenance medications, insufficient healthcare services in geographically isolated areas, and financial constraints affecting treatment adherence. Qualitative findings further highlighted the importance of family support, cultural beliefs, and faith-related practices in influencing health behaviors and coping strategies. In conclusion, health management among older adults with diabetes and hypertension is shaped by interconnected clinical, social, and experiential factors. Strengthening primary healthcare services, improving access to essential medicines, and supporting family and community-based interventions are essential to enhance health outcomes in similar settings.

*Corresponding author: Genelyn S. Viadnes ✉ genelynvriadnes@jrmsu.edu.ph

INTRODUCTION

Population aging is accelerating globally, accompanied by a parallel rise in non-communicable diseases (NCDs), particularly diabetes mellitus and hypertension, which disproportionately affect older adults and contribute to functional decline, multimorbidity, and increased healthcare utilization (World Health Organization, 2022; United Nations Department of Economic and Social Affairs, 2023). In low- and middle-income countries (LMICs), these burdens are amplified by health system constraints, inequitable access to services, and socioeconomic vulnerabilities, necessitating integrated and context-responsive approaches to chronic disease management (World Health Organization, 2023; Dayrit *et al.*, 2018). Within the Philippine context, community-based elderly populations face compounded challenges related to access, affordability, and continuity of care, particularly in geographically dispersed settings.

The life course perspective offers a rigorous theoretical lens for examining how cumulative exposures, social determinants, and early-life conditions shape health trajectories across aging (Elder and Shanahan, 2006; Ben-Shlomo *et al.*, 2016). Contemporary evidence underscores that health behaviors, coping strategies, and disease outcomes in later life are products of dynamic interactions between biological, psychosocial, and structural factors across time (Halfon *et al.*, 2018). This perspective is especially salient in understanding chronic disease self-management among older adults, where resilience, health literacy, and adaptive capacities are embedded within prior life experiences and sociocultural contexts.

From a clinical and pharmaceutical standpoint, optimal management of diabetes and hypertension requires sustained adherence to pharmacotherapy, lifestyle modification, and continuous engagement with primary healthcare systems. However, persistent gaps in pharmacological management including limited access to essential medicines, fragmented drug supply chains, suboptimal medication

adherence, and risks associated with polypharmacy remain critical barriers in community-based elderly care (World Health Organization, 2021; International Diabetes Federation, 2023; Sinnott *et al.*, 2021).

Strengthening the role of primary healthcare providers and pharmacists is therefore essential to ensure rational drug use, medication safety, and continuity of care, particularly among vulnerable aging populations.

Beyond biomedical management, social determinants such as family support, community engagement, and culturally embedded health beliefs play a pivotal role in shaping health behaviors and outcomes. Empirical studies indicate that social support networks enhance treatment adherence, psychological well-being, and functional independence among older adults (Holt-Lunstad, 2021; Valtorta *et al.*, 2012). In the Philippine sociocultural milieu, intergenerational co-residence, collectivist values, and faith-based practices significantly influence coping mechanisms, care-seeking behaviors, and health decision-making processes (Alampay, 2024). These contextual factors necessitate culturally responsive and community-integrated interventions.

Despite growing global evidence, there remains a paucity of localized, mixed-methods research that simultaneously examines life course experiences, pharmacological management, and social support systems within community-based elderly populations in the Philippines.

Addressing this gap is critical for informing policies and interventions that are both evidence-based and contextually grounded. In Dapitan City, where disparities in healthcare access and service delivery persist, a comprehensive understanding of these intersecting determinants is essential for improving chronic disease outcomes among older adults.

Guided by an Integrated Life Course Community Health Framework, this study posits that life course experiences influence health outcomes both directly

and indirectly through health management practices (including pharmacological adherence) and social support systems, within the context of structural and cultural determinants. This study contributes a novel integrated life course community health perspective by examining how past experiences, social support systems, and current health management practices interact to shape the health outcomes of older adults with chronic conditions in a community setting. Accordingly, this study aims to assess the interrelationships among life course experiences, health management behaviors, and social support systems among older adults with diabetes and hypertension, and to generate evidence for the development of holistic, culturally responsive, and community-driven interventions aligned with Sustainable Development Goals (SDGs) 3, 10, and 11 emphasizing healthy aging and the management of non-communicable diseases among vulnerable populations.

MATERIALS AND METHODS

This study employed a cross-sectional, community-based survey design utilizing a mixed-methods approach. This design facilitated the collection of both quantitative data through structured questionnaires and qualitative data through focus groups and interviews. The cross-sectional approach provided a snapshot assessment of health conditions and related factors among older adults at a single point in time, offering insights into immediate needs and trends relevant to diabetes and hypertension management.

Research locale

The target population consisted of older adults aged 60 years and older residing in the barangays of Dapitan City, particularly members of the Diabetic and Hypertensive Club. This demographic was chosen due to its higher prevalence of chronic conditions such as diabetes and hypertension. Their lived experiences provided valuable insights into community-based management strategies. Inclusion criteria were: age 60 or above, registered members of the club, and residency within the barangay.

Exclusion criteria included individuals unable to provide informed consent or severely cognitively impaired to participate effectively.

Research sample and sampling technique

The study employed a purposive sampling technique, selecting older adults diagnosed with diabetes and hypertension who were actively residing in selected barangays of Dapitan City.

Participants were chosen based on inclusion criteria such as age (60 years and above), confirmed diagnosis of hypertension and/or diabetes, and willingness to participate in both survey and interview components.

The required sample size was calculated using power analysis techniques, ensuring an adequate power of 80% or higher to detect statistically significant associations and outcomes, depending on the expected prevalence of conditions.

Research instruments

This study utilized a structured questionnaire and semi-structured guides for focus group discussions (FGDs) and key informant interviews (KIIs).

Structured questionnaire

The questionnaire, titled "*Community-Based Assessment of Senior Citizens with Diabetes and Hypertension in Dapitan City: Exploring Life Course, Health Management, and Social Support*," was divided into several sections covering demographic information, life course experiences, health conditions, health management practices, nutrition and elimination patterns, physical activity, sleep and cognition, self-perception and relationships, coping and values, participation in socio-cultural programs, and general feedback. Participants indicated their level of agreement on a 4-point Likert scale (1 = Strongly Disagree to 4 = Strongly Agree).

The questionnaire was designed to comprehensively explore and quantify various aspects related to health,

social support, and community program participation among older adults with chronic conditions. Before full deployment, the instrument was pilot-tested with a small subgroup of similar demographics, resulting in a Cronbach's Alpha of 0.73, indicating acceptable internal consistency. Feedback from experts helped refine the questions to improve clarity and cultural relevance.

Focus group discussion guide

The focus group discussion (FGD) guide contained open-ended questions aimed at eliciting detailed narratives about participants' lived experiences, management strategies, social support, cultural influences, and perceptions of community programs. Discussions were conducted using a semi-structured approach, facilitating open dialogue among 6-10 participants. Prompts were used to ensure coverage of key themes while allowing flexibility for emergent topics.

Key informant interview protocol

The interview protocol targeted healthcare providers, barangay health workers, community leaders, and program facilitators involved with the elderly population. It comprised semi-structured questions exploring community health challenges, existing support systems, barriers to healthcare access, and program effectiveness.

Validation and reliability

The questionnaire underwent pilot testing with a small group of senior citizens with similar profiles to the main participants. The pilot aimed to identify ambiguities and improve question clarity. The reliability of the survey instrument was assessed using Cronbach's alpha, yielding a coefficient of $\alpha = 0.73$, indicating good internal consistency. Content validity was established through expert review by professionals in community health nursing and gerontology. The semi-structured guides for FGDs and KIIs were also reviewed for clarity and appropriateness, ensuring they effectively facilitated open, rich discussions while capturing relevant themes.

Data gathering procedure

Data were collected through a structured, multi-phase process integrating quantitative and qualitative approaches. For the quantitative component, a structured questionnaire based on Gordon's Functional Health Patterns was developed, covering domains such as health management, nutrition, physical activity, sleep quality, cognitive perception, and social roles.

The instrument included both closed-ended items for quantitative analysis and selected open-ended questions for additional insights. Questionnaires were administered through face-to-face interviews to ensure clarity, enhance participant understanding, and improve response rates. Prior to data collection, informed consent was obtained from all participants, with assurances of voluntary participation and confidentiality. For the qualitative component, focus group discussions were conducted with groups of six to ten participants to explore their life experiences, coping strategies, social support systems, cultural influences, and perceptions of community programs, guided by a semi-structured discussion framework. In addition, key informant interviews were carried out with healthcare providers, community leaders, and facilitators to examine community health challenges, available support systems, barriers to healthcare access, and program effectiveness. This integrated data collection process generated comprehensive evidence to inform the analysis of health management and social support among older adults with diabetes and hypertension.

Data analysis

A structured questionnaire was developed and administered to senior citizens diagnosed with diabetes and/or hypertension. The instrument was designed with a Likert-type scale comprising six subscales: Health Management Practices, Activity and Physical Functioning, Sleep and Cognition, Self-Perception and Relationships, Coping and Values, and Socio-Cultural Programs. Each item was rated on a 4-point scale: 1= Strongly Disagree, 2= Disagree, 3= Agree, 4 = Strongly Agree.

To ensure the reliability of the instrument, internal consistency was assessed using Cronbach's Alpha for each subscale. Data were encoded and analyzed using IBM SPSS Statistics, with descriptive statistics and reliability tests performed. Subscale scores were calculated as the mean of their respective items. A Cronbach's Alpha of 0.70 or higher was considered acceptable, indicating good internal consistency. The integration of quantitative and qualitative findings was performed through triangulation to enhance the validity and depth of interpretation.

Quantitative analysis

Descriptive statistics, including frequencies and percentages, were used to summarize the participants' demographic profile and responses across various dimensions such as health status, health management, coping strategies, and participation in socio-cultural programs. To examine the relationships between life course experiences and other health-related aspects, Spearman rank-order correlation was employed. All statistical tests were conducted at a 0.05 level of significance. The strength of correlation coefficients was interpreted using standard guidelines: values of 0.00–0.29 were considered weak, 0.30–0.49 moderate, 0.50–0.69 strong, and 0.70 and above very strong. Statistical significance was set at $p < 0.05$. This non-parametric test measured the strength and direction of association between life course experiences and variables such as health condition, self-management, nutritional practices, physical activity, sleep quality, self-perception, coping, and socio-cultural involvement.

The total population consisted of 50 registered members of the club. Based on power analysis to achieve an 80% statistical power at a 95% confidence level and assuming a medium effect size, the expected sample size was approximately 44 to 45 participants. Survey questionnaires were distributed to all members to ensure maximum reach.

However, only 20 members responded, resulting in a response rate of 44%. This lower-than-expected

response affected the statistical power of the quantitative analysis. As a result, the findings were analyzed primarily through descriptive statistics, and any inferred relationships were interpreted with caution, acknowledging the limited generalizability of the results.

Despite the limited sample size, the integration of qualitative data through focus group discussions (FGDs) and key informant interviews (KIIs) enabled methodological triangulation, thereby enhancing the depth, contextual richness, and credibility of the study findings. As an exploratory, community-based investigation, the study prioritizes contextual understanding over statistical generalizability, providing meaningful insights into the lived experiences and health management practices of older adults.

Qualitative analysis

Data from FGDs and interviews were analyzed through thematic analysis. This involved coding the transcripts to identify recurring themes and patterns related to participants' experiences, management challenges, social support systems, cultural influences, and perceptions of community programs. NVivo or similar qualitative analysis software was used to organize the data and facilitate systematic theme extraction, thereby enhancing the rigor and trustworthiness of the analysis.

To address the limitations posed by the low response rate, the study included a focus group discussion (FGD) using a prepared interview guide. The FGD allowed for the exploration of deeper insights into participants' beliefs, experiences, and challenges in managing their health conditions. Topics covered included daily routines, medication adherence, dietary practices, and barriers to accessing health services.

Qualitative data were subjected to thematic analysis, and emerging themes were used to complement and enrich the quantitative findings. This triangulation of data ensured a more robust and holistic interpretation of the study's outcomes.

Ethical considerations

This study adhered to strict ethical guidelines to protect the rights and well-being of the participants. Informed consent was obtained from all participants prior to their involvement, ensuring they were fully aware of the purpose, procedures, potential risks, and benefits of participation. Participants were assured of their right to withdraw from the study at any time without penalty. Anonymity and confidentiality were maintained throughout the research process by using coded identifiers and securely storing data.

RESULTS AND DISCUSSION

Profile of respondents

Table 1 shows that the majority of respondents were aged 60–69 years (70%), followed by those aged 70–79 years (25%), with only 5% aged 80–89. This indicates that the early elderly group constitutes the largest portion of the study population.

This pattern reflects national trends, where younger senior citizens are more likely to engage in community-based health programs due to better mobility and health-seeking behavior (Philippine Statistics Authority [PSA], 2021; World Health Organization [WHO], 2020). The predominance of this age group suggests greater participation in preventive and maintenance interventions for chronic conditions such as diabetes and hypertension.

These findings highlight the need to tailor community-based healthcare services toward younger older adults, who may benefit more from lifestyle modification, medication adherence, and social support interventions. At the same time, strategies should also anticipate the evolving physiological and psychosocial needs of older age groups as they progress through later stages of aging (Ona *et al.*, 2021).

Table 1. Profile of the respondents in age

Age	Frequency	Percentage
60-69 Years old	14	70%
70-79 Years old	5	25%
80-89 Years old	1	5%
	N=20	100%

Table 2 shows that the majority of respondents were female (70%), while males comprised 30% of the sample. This pattern reflects broader demographic trends in which women have longer life expectancy than men (Philippine Statistics Authority [PSA], 2021; World Health Organization [WHO], 2021).

In terms of chronic disease, women are more likely to live longer with conditions such as hypertension and diabetes, whereas men tend to experience higher premature mortality (Alharbi *et al.*, 2020; WHO, 2021). Women also demonstrate greater participation in community health programs and healthcare utilization, which may explain their higher representation in this study (Haldane *et al.*, 2019).

These findings highlight the need for gender-sensitive community-based interventions. Given the dual role of older women as both care recipients and caregivers, their health outcomes have broader implications for family well-being and intergenerational support systems (UN Women, 2021).

Table 2. Profile of the respondents in gender

Gender	Frequency	Percentage
Male	6	30
Female	14	70
	N=20	100%

Table 3 shows that half of the respondents attained tertiary education (50%), followed by those with secondary education (35%) and primary education (15%), with none reporting no formal education. This indicates a relatively educated group of older adults.

Higher educational attainment is associated with better health behaviors, improved treatment adherence, and increased utilization of healthcare services (Cutler and Lleras-Muney, 2010; World Health Organization [WHO], 2021). It also contributes to higher health literacy, which is essential in managing chronic conditions such as hypertension and diabetes (Nutbeam, 2008).

In the context of community-based care, these findings suggest that many older adults have the capacity to

engage effectively in health programs and decision-making. However, the presence of individuals with lower educational attainment highlights the need for inclusive and simplified health communication strategies (Paasche-Orlow and Wolf, 2007).

Overall, the results underscore the importance of tailoring interventions to varying educational levels to enhance participation, understanding, and health outcomes.

Table 3. Profile of the respondents in educational attainment

Educational attainment	Frequency	Percentage
No formal education	0	0
Primary	3	15
Secondary	7	35
Tertiary	10	50
	N=20	100%

Table 4 shows that half of the respondents were married (50%), followed by widowed (35%) and single individuals (15%). This distribution reflects varying levels of social support among older adults.

Marriage is associated with increased emotional and practical support, which can enhance medication adherence and healthcare access among individuals with chronic conditions (Robles *et al.*, 2014; Umberson and Montez, 2010). In contrast, widowed and single older adults may face challenges such as loneliness, reduced support, and lower quality of life (Valtorta *et al.*, 2018).

These findings highlight the importance of considering marital status in designing community-based health interventions. Tailored support mechanisms are needed, particularly for those with limited immediate support systems, to improve health management and overall well-being.

Table 4. Profile of the respondents in marital status

Marital status	Frequency	Percentage
Single	3	15
Married	10	50
Widowed	7	35
	N=20	100%

Table 5 shows that the majority of respondents live with their families (90%), while a small proportion live alone (10%). This reflects the Filipino cultural norm of intergenerational cohabitation. Living with family provides essential support for chronic disease management, including assistance with medication, emotional well-being, and access to healthcare (Wang *et al.*, 2018; Choi *et al.*, 2015). In contrast, older adults living alone may face increased risks of social isolation, poor self-care, and limited access to services (Courtin and Knapp, 2017).

These findings highlight the importance of incorporating living arrangements into community-based health strategies. While family support remains a key strength, targeted interventions are needed to support older adults who live alone and may be more vulnerable.

Table 5. Profile of the respondents in living arrangement

Living arrangement	Frequency	Percentage
Alone	2	10
With family	18	90
	N=20	100%

Table 6 shows that most respondents (90%) reported no additional co-morbidities, while only 10% had other chronic conditions. This is notable, as multi-morbidity generally increases with age (Marengoni *et al.*, 2011).

This finding may reflect effective health management or possible underdiagnosis due to limited access to comprehensive medical assessments in community settings. Even with low prevalence, co-morbidities remain clinically significant, as managing multiple conditions requires coordinated care and increases the risk of treatment complications (Tinetti *et al.*, 2012).

These results highlight the need for regular health screening and early detection programs in community settings. Strengthening preventive services and health education can support timely identification and holistic management of co-morbidities among older adults.

Table 6. Profile of the respondents in co-morbidities

Co-morbidities	Frequency	Percentage
Yes	2	10
No	18	90
	N=20	100%

Table 7 shows that most respondents reported high life course experiences (85%), while 15% had moderate levels, with none in the low category. This suggests that older adults generally perceive their accumulated life experiences positively.

Life course theory emphasizes that past experiences shape coping, resilience, and health behaviors in later life (Elder, 1998; Settersten, 2003). High scores may reflect strong adaptive capacity, sustained community engagement, and cultural values that support aging, particularly within the Filipino context (Badana, 2018).

However, those with moderate life course experiences may have encountered greater life stressors, which can influence health outcomes. These findings highlight the importance of integrating life experiences into community-based interventions to promote resilience and support holistic well-being among older adults.

Table 7. Life course experience

Range	Frequency	Percentage	Description
5 to 10	0	0%	Low
11 to 15	6	15%	Moderate
16 to 20	14	85%	High
	N=20	100%	

Table 8 shows that most respondents rated their health condition and daily functioning as high (85%), while 15% reported moderate levels, with none in the low category. This indicates a generally positive perception of well-being and functional independence despite chronic conditions.

These findings suggest that older adults maintain autonomy and resilience in managing daily activities, which is a key indicator of healthy aging (World Health Organization [WHO], 2015). Contributing factors may include strong family support and cultural values that promote intergenerational care in the Filipino context (Cruz, 2016).

The results are consistent with the concept of successful aging, where individuals sustain physical, cognitive, and social functioning despite chronic illness (Rowe and Kahn, 1997). This underscores the importance of community-based programs that support active engagement and self-management among older adults.

Table 8. Health condition and daily functioning

Range	Frequency	Percentage	Description
5 to 10	0	0%	Low
11 to 15	6	15%	Moderate
16 to 20	14	85%	High
	N=20	100%	

Table 9 shows that most respondents demonstrated high engagement in health management practices (85%), while 15% reported moderate levels, with none in the low category. This indicates active self-management among older adults with chronic conditions.

Effective management of diabetes and hypertension requires medication adherence, lifestyle modification, and regular monitoring (ElSayed *et al.*, 2023). The high level of engagement suggests that respondents are proactive and likely supported by family, health literacy, and accessible community health services (Dayrit *et al.*, 2018).

These findings align with self-care principles in chronic disease management, emphasizing patient empowerment and sustained behavioral change (Lorig and Holman, 2003). Overall, strong health management practices contribute to improved quality of life and reduced healthcare burden.

Table 9. Health management practices

Range	Frequency	Percentage	Description
5 to 10	0	0%	Low
11 to 15	6	15%	Moderate
16 to 20	14	85%	High
	N=20	100%	

Table 10 shows that most respondents demonstrated moderate levels of nutritional and elimination practices (90%), while only 10% achieved high levels,

with none in the low category. This indicates general awareness but suboptimal adherence.

Proper nutrition and elimination are essential in managing diabetes and hypertension, requiring dietary control, adequate fluid intake, and regular routines (ElSayed *et al.*, 2023; National Institute on Aging, 2022). The predominance of moderate scores may reflect both individual effort and external constraints such as limited resources, reduced mobility, and dietary limitations (Dayrit *et al.*, 2018).

These findings highlight the need for targeted interventions that promote improved dietary practices and elimination health. Culturally appropriate nutrition education and strengthened community support services may help older adults achieve optimal self-care (World Health Organization [WHO], 2015).

Table 10. Nutritional and elimination patterns

Range	Frequency	Percentage	Description
5 to 10	0	0%	Low
11 to 15	18	90%	Moderate
16 to 20	2	10%	High
N=20		100%	

Table 11 shows that most respondents had moderate levels of physical activity and functional independence (60%), while 40% demonstrated high levels, with none in the low category. This indicates a baseline level of physical engagement among older adults.

Physical activity is essential in managing diabetes and hypertension, as it helps regulate blood glucose, maintain weight, and reduce cardiovascular risk (World Health Organization [WHO], 2020). Functional independence also contributes to quality of life and reduces the risk of frailty (Caspersen *et al.*, 1985; Giena *et al.*, 2018).

The predominance of moderate activity suggests that while respondents remain active, there is room to enhance engagement. Targeted community-based interventions, such as age-appropriate exercise programs and health worker support, may help improve

physical functioning and mobility (Philippine Statistics Authority [PSA], 2020; WHO, 2015).

Table 11. Physical activity and function

Range	Frequency	Percentage	Description
5 to 10	0	0%	Low
11 to 15	12	60%	Moderate
16 to 20	8	40%	High
N=20		100%	

Table 12 shows that most respondents had moderate sleep and cognitive functioning (45%), while 40% were in the low category and only 15% in the high category. This indicates a concerning level of sleep disturbance and potential cognitive decline among older adults.

Poor sleep is common among individuals with chronic conditions and is associated with impaired cognition and reduced daily functioning (Cricco *et al.*, 2001; Grandner, 2017; Li *et al.*, 2019). Contributing factors may include limited cognitive stimulation, poor sleep hygiene, and condition-related issues such as pain, medication effects, and nocturia (Ohayon, 1997).

These findings highlight the need for targeted interventions addressing both sleep and cognitive health. Strategies such as promoting regular routines, physical activity, and cognitive stimulation, along with early screening, are essential to improve overall well-being (Mander *et al.*, 2017; Philippine Council for Health Research and Development [PCHRD], 2020).

Table 12. Sleep and cognition

Range	Frequency	Percentage	Description
5 to 10	8	40%	Low
11 to 15	9	45%	Moderate
16 to 20	3	15%	High
N=20		100%	

Table 13 shows that 55% of respondents reported high self-perception and positive relationships, while 45% were in the moderate range, with none in the low category. This indicates generally strong psychosocial well-being among older adults.

Positive self-perception and social relationships are associated with better coping, emotional well-being, and

treatment adherence (Pinquart and Sørensen, 2001; Antonucci *et al.*, 2014). Social support also helps buffer stress and manage chronic conditions such as diabetes and hypertension (White *et al.*, 1992).

These findings may reflect strong family and community ties in the Filipino context, which promote emotional support and connectedness (Alampay, 2014). They highlight the importance of integrating psychosocial and relational support into community-based health programs.

Table 13. Self-perception and relationships

Range	Frequency	Percentage	Description
5 to 10	0	0%	Low
11 to 15	9	45%	Moderate
16 to 20	11	55%	High
N=20		100%	

Table 14 shows that most respondents demonstrated high coping ability and value alignment (70%), while 30% were in the moderate range, with none in the low category. This indicates strong resilience among older adults with chronic conditions.

Coping mechanisms and value systems are important psychosocial resources that support adaptation to illness and life transitions (Folkman and Moskowitz, 2004). In the Filipino context, cultural and spiritual values further reinforce resilience and a sense of meaning (Alampay, 2014; Esteban, 2015).

These findings highlight the role of psychosocial strengths in promoting well-being and support the development of culturally sensitive, strengths-based community interventions for older adults (Pinquart and Sørensen, 2000).

Table 14. Coping and values

Range	Frequency	Percentage	Description
5 to 10	0	0%	Low
11 to 15	6	30%	Moderate
16 to 20	14	70%	High
N=20		100%	

Table 15 shows that most respondents rated their engagement in socio-cultural programs as moderate (85%), while 15% reported high

engagement, with none in the low category. This suggests that programs are generally accessible but may not fully meet the needs of older adults.

Socio-cultural participation is linked to improved well-being, social connectedness, and life satisfaction among older adults (Pinquart and Sørensen, 2001). In the Filipino context, shared cultural experiences also support identity and meaning in later life (Esteban, 2015).

These findings indicate the need to enhance the relevance, frequency, and diversity of socio-cultural programs to better support holistic care and social engagement among seniors with chronic conditions.

Table 15. Socio-cultural programs

Range	Frequency	Percentage	Description
5 to 10	0	0%	Low
11 to 15	17	85%	Moderate
16 to 20	3	15%	High
N=20		100%	

Table 16 shows that most respondents had a moderate overall status (60%), while 40% were in the high category, with none in the low range. This indicates generally stable but variable levels of health, social support, and well-being.

The predominance of moderate scores suggests that while older adults are managing their conditions and maintaining social connections, gaps remain in achieving optimal outcomes.

Table 16. Summary table of the overall status

Range	Frequency	Percentage	Description
45 to 99	0	0%	Low
100 to 139	12	60%	Moderate
140 to 180	8	40%	High
N=20		100%	

Aging with chronic illness requires a multidimensional approach that integrates physical, social, and psychological support (Esteban, 2015; Pinquart and Sørensen, 2001).

These findings highlight the need to strengthen community-based programs that promote

comprehensive care, including disease management, social participation, and mental well-being, to improve the overall quality of life among older adults.

Table 17 shows that life course experiences were positively associated with multiple health domains. A very strong correlation was observed with coping ($r = 0.8611$), indicating that richer life experiences are linked to better adaptive behaviors (Esteban, 2015).

Strong correlations were also found with health condition ($r = 0.6771$), health management ($r = 0.5645$), physical activity ($r = 0.5534$), socio-cultural involvement ($r = 0.6299$), and moderate associations

with nutrition ($r = 0.4515$) and self-perception ($r = 0.4818$). These findings suggest that meaningful life experiences support improved self-care, functional ability, and social engagement (Pinquart and Sørensen, 2001).

In contrast, sleep and cognition showed a weaker association ($r = 0.2509$), indicating that these domains may be more influenced by current health and environmental factors (Alampay, 2014).

Overall, the results highlight the importance of a life course perspective in elderly care, emphasizing the role of past experiences in shaping resilience, health behaviors, and overall well-being.

Table 17. Correlation between life course experience and various health aspects

Health Aspects	Spearman rank correlation	Interpretation
Life course exp. and health condition	0.6771	Strong relationship
Life course exp. and health management	0.5645	Strong relationship
Life course exp. and nutritional	0.4515	Strong relationship
Life course exp. and physical	0.5534	Strong relationship
Life course exp. and sleep	0.2509	Moderate relationship
Life course exp. and self-perception	0.4818	Strong relationship
Life course exp. and coping	0.8611	Very strong relationship
Life Course Exp. and Socio-cultural	0.6299	Strong relationship

Emergent themes and interpretation

Theme 1: Navigating chronic illness through limited resources

Senior citizens with diabetes and hypertension in Dapitan City face persistent *financial constraints* in managing their health. From affording maintenance medications to lacking personal medical equipment (e.g., glucometers, BP apparatus), the economic burden of chronic disease management is a recurring concern. While some local government units provide medications through programs like the Hypertensive and Diabetic Club, availability is inconsistent and often limited.

“More funds allocated to senior citizens to buy medicines for their maintenance,” one participant emphasized, while a key informant noted, “Medical supplies sometimes are not available.”

This reflects the findings of Yadav *et al.* (2020), who highlighted that financial hardship significantly influences treatment adherence among elderly

patients with chronic illnesses in low-resource settings.

The burden of disease is compounded by socioeconomic status, suggesting the need for stronger policy integration of Universal Health Care at the LGU level to ensure consistent access to medications and health commodities (Dayrit *et al.*, 2018).

Theme 2: Family as the frontline care network

Family support emerged as a *central pillar* of health management. Senior citizens described their children or immediate family as instrumental in daily routines, emotional encouragement, and decision-making.

“No, my children are there to help me,” said one elder when asked if they ever felt alone.

Another stated, “Family member is part and parcel in the success of patient’s treatment.”

The role of informal caregivers, especially family members, echoes existing research that underscores the importance of family-centered interventions for chronic disease management in aging populations (Alhabib *et al.*, 2022).

In the absence of institutionalized caregiving systems, families serve as primary health actors.

Capacity-building programs that include caregiver training would enhance this informal care model's effectiveness.

Theme 3: Health beliefs, culture, and alternative practices

Several participants noted the use of herbal remedies such as garlic and liniment oils, and even consultations with "quack doctors." Cultural beliefs, especially in coastal or remote barangays, still influence compliance and treatment-seeking behavior.

"Cultural beliefs sometimes affect their compliance," shared a healthcare worker, noting that some patients attribute their illnesses to spiritual causes.

Traditional health beliefs are deeply rooted in Filipino culture, particularly in rural areas where biomedical services are limited. As Real *et al.* (2023) argue, health programs must recognize and respectfully integrate local beliefs to improve engagement and outcomes.

Bridging biomedical care with culturally sensitive health education may address misconceptions and foster better health-seeking behaviors.

Theme 4: Gaps in community-based support and accessibility

Respondents indicated limited accessibility to healthcare services, particularly in geographically distant barangays. The absence of regular mobile consultations and limited health programs at the barangay level further marginalizes older adults.

"The nearest doctor is miles away," lamented one informant, while another suggested, "Mobile medical consultation would help."

These barriers align with studies on healthcare access among older populations in the Philippines, which highlight transport costs, facility distance, and the lack of elder-friendly services as major access issues (Badana and Andel, 2018).

Community outreach initiatives such as mobile clinics and barangay-based health days are critical in mitigating geographical and financial barriers to care.

Theme 5: Resilience through faith, optimism, and personal agency

Despite challenges, participants demonstrated strong resilience, often rooted in faith, acceptance, and lifestyle adaptation.

"Do not let your disease hinder you from doing what you love," said one participant. Another added, "Strong faith in the Lord is what strengthens me."

This spiritual and emotional resilience is a protective factor for many Filipino elders, providing psychological support in the absence of formal systems (Lima *et al.*, 2020).

Integrating psychosocial support and spiritual wellness into chronic disease programs may align with the lived experiences of the elderly and promote holistic health.

Integrated interpretation of quantitative and qualitative findings

This study examined the interplay between health management practices, social support systems, and life course experiences among older adults with diabetes and hypertension in Dapitan City using a mixed-methods approach. The integration of quantitative findings with qualitative narratives provides a more nuanced understanding of how structural, socio-cultural, and individual factors collectively shape health outcomes in later life.

Socioeconomic barriers and health management

Quantitative results indicated that the majority of respondents demonstrated moderate to high levels of overall health management, suggesting generally functional yet variably supported health practices. However, the predominance of moderate scores points to underlying constraints that may limit optimal disease management.

This is further elucidated by qualitative findings, which identified financial limitations as a persistent barrier to accessing medications and diagnostic services. Participants described inconsistent availability of resources despite existing local health programs. These findings align with evidence that economic constraints significantly influence treatment adherence and health outcomes among older adults in low-resource settings (Cutler and Lleras-Muney, 2010).

Taken together, the results suggest that while individual capacity for self-management exists, structural economic barriers constrain sustained health maintenance, underscoring the need for strengthened implementation of Universal Health Care policies and consistent provision of essential health commodities (Dayrit *et al.*, 2018).

Family as the core support system

The quantitative findings revealed high levels of coping and values among respondents, indicating strong psychosocial adaptation. This is corroborated by qualitative data highlighting the central role of family as the primary source of emotional, financial, and caregiving support.

Participants consistently identified family members as key contributors to their daily health routines and decision-making processes. This convergence reinforces the critical role of social relationships in influencing health outcomes (Umberson and Montez, 2010) and reflects the deeply embedded intergenerational support systems characteristic of the Filipino context.

These findings suggest that health interventions should extend beyond the individual to include family members, emphasizing the importance of family-centered care and community-based caregiver support programs.

Cultural beliefs and treatment compliance

Correlation analysis demonstrated significant relationships between life course experiences and both health management ($r= 0.5645$) and self-perception ($r= 0.4818$), indicating that accumulated experiences and internalized beliefs influence present health behaviors.

Qualitative findings further revealed the continued reliance on traditional practices, including herbal remedies and consultation with local healers. These insights highlight the enduring influence of cultural beliefs on treatment decisions.

Consistent with prior research, integrating cultural perspectives into healthcare delivery is essential for improving patient engagement and adherence (Alampay, 2024). The findings emphasize the need for culturally responsive health education strategies that bridge traditional practices with evidence-based care.

Accessibility and community-based health services

While quantitative data indicated moderate engagement in socio-cultural and community health programs, qualitative findings exposed significant barriers related to accessibility, particularly among residents in remote barangays. Participants reported challenges such as transportation difficulties and irregular availability of healthcare services.

This apparent discrepancy suggests that reported program engagement does not necessarily equate to consistent access to care. These findings are consistent with studies indicating that geographic and mobility constraints significantly affect healthcare utilization among older adults in the Philippines (Badana and Andel, 2018).

The results underscore the need for expanded community outreach services, mobile health clinics, and decentralized care delivery systems to address geographic inequities.

Psychosocial resilience and spiritual coping

A very strong correlation between life course experiences and coping ($r = 0.8611$) highlights the central role of resilience in chronic disease management. Qualitative narratives further illustrate how participants draw on faith, acceptance, and positive outlooks to navigate their health conditions.

These findings align with literature emphasizing the role of spirituality and psychological resilience in promoting well-being among older adults (Rowe and Kahn, 2015). Spiritual beliefs function not only as coping mechanisms but also as sources of meaning and emotional stability.

This suggests that holistic care approaches incorporating psychosocial and spiritual dimensions may enhance treatment adherence and overall quality of life.

Proposed policies and programs

The findings highlight interconnected challenges among older adults with diabetes and hypertension, including limited access to medicines, strong reliance on family caregivers, cultural health beliefs, geographic barriers to healthcare, and spiritual coping mechanisms. In response, several community-based and evidence-informed programs are proposed.

The Barangay-Based Essential Health Access Program aims to improve availability of maintenance medicines and basic diagnostic tools through barangay health stations and local government support. The Family Caregiver Support and Skills Enhancement Program seeks to strengthen caregiving capacity through training, health literacy resources, and psychosocial support for caregivers. The Culturally Sensitive Health Promotion Campaign will integrate local beliefs and practices with evidence-based health education using context-appropriate

materials and community health champions. The Mobile Geriatric Wellness Caravan is designed to deliver regular medical services, diagnostics, and medicines to geographically isolated areas. Lastly, the Faith-Based Resilience and Mental Wellness Support Program promotes psychosocial and spiritual well-being through partnerships with religious organizations and community support groups.

These initiatives collectively address the multidimensional needs of older adults by improving access to care, strengthening family and community support systems, and integrating cultural and spiritual dimensions into health promotion. Implementation requires collaboration among local government units, healthcare providers, families, and community stakeholders to enhance health outcomes and promote dignity and well-being among older adults with chronic illnesses.

CONCLUSION

This study provides a comprehensive understanding of the health management, social support, and life course experiences of older adults with diabetes and hypertension in Dapitan City through a mixed-methods approach. The findings demonstrate that while many older adults exhibit moderate to high levels of self-management and resilience, these capacities are shaped and, at times, constrained by broader socio-economic, cultural, and structural factors.

The integration of quantitative and qualitative results highlights that effective chronic disease management extends beyond individual behaviors. Financial limitations, inconsistent access to medications and healthcare services, and geographic barriers continue to hinder optimal care. At the same time, strong family support systems, cultural beliefs, and spiritual coping mechanisms play a crucial role in sustaining health and well-being among the elderly.

These findings underscore that aging with chronic illness is a multidimensional process requiring coordinated and context-sensitive interventions.

Health outcomes are not solely determined by clinical care but are deeply influenced by social relationships, cultural context, and access to essential resources.

Therefore, there is a need to strengthen community-based and integrated health systems that address both medical and social determinants of health. Policies and programs should prioritize equitable access to healthcare services, enhance family-centered care approaches, and incorporate culturally responsive and holistic strategies in managing chronic conditions.

Ultimately, promoting healthy aging in Dapitan City requires a shift toward inclusive, accessible, and person-centered care systems ensuring that older adults are supported not only to live longer, but to live meaningful, dignified, and empowered lives.

ACKNOWLEDGMENTS

The author sincerely acknowledges the support of the local government of Dapitan City and participating barangays for their cooperation. Gratitude is extended to the older adult participants for their valuable time and insights. Appreciation is also given to the healthcare workers and community partners who assisted in data collection, as well as to Jose Rizal Memorial State University for its institutional support. The author further thanks colleagues, mentors, and family for their encouragement throughout this work.

REFERENCES

- Alampay LP.** 2024. Cultural values, parenting and child adjustment in the Philippines. *International Journal of Psychology* **59**(4), 568–577. <https://doi.org/10.1002/ijop.13117>
- Alharbi BA, Masud N, Alajlan FA, Alkhanein NI, Alzahrani FT, Almajed ZM, Alessa RKM, Al-Farhan AI.** 2020. Association of elderly age and chronic illnesses: role of gender as a risk factor. *Journal of Family Medicine and Primary Care* **9**(3), 1684–1690. https://doi.org/10.4103/jfmpc.jfmpc_1060_19
- American Heart Association.** 2023. Healthy eating for older adults.
- Badana ANS, Anandel R.** 2018. Aging in the Philippines. *The Gerontologist* **58**(2), 212–218. <https://doi.org/10.1093/geront/gnx203>
- Bengtson VL, Settersten RA Jr.** 2016. *Handbook of theories of aging* (3rd ed.). Springer.
- Ben-Shlomo Y, Cooper R, Kuh D.** 2016. The last two decades of life course epidemiology and its relevance for research on ageing. *International Journal of Epidemiology* **45**(4), 973–988. <https://doi.org/10.1093/ije/dywo96>
- Centre for Reviews and Dissemination.** 2013. GPs' perspectives on the management of patients with multimorbidity: systematic review and synthesis of qualitative research. *Database of Abstracts of Reviews of Effects (DARE)*.
- Choi NG, Marti CN, Bruce ML, Hegel MT, Wilson NL, Kunik ME.** 2014. Six-month postintervention depression and disability outcomes of in-home telehealth problem-solving therapy for depressed, low-income homebound older adults. *Depression and Anxiety* **31**(8), 653–661. <https://doi.org/10.1002/da.22242>
- Courtin E, Knapp M.** 2017. Social isolation, loneliness and health in old age: a scoping review. *Health and Social Care in the Community* **25**(3), 799–812. <https://doi.org/10.1111/hsc.12311>
- Cruz G, Natividad J, Gonzales M, Saito Y.** 2016. *Aging in the Philippines: findings from the 2007 Philippine Study on Aging*. University of the Philippines Population Institute.
- Cutler DM, Lleras-Muney A.** 2010. Understanding differences in health behaviors by education. *Journal of Health Economics* **29**(1), 1–28. <https://doi.org/10.1016/j.jhealeco.2009.10.003>

- Dayrit MM, Lagrada LP, Picazo OF, Pons MC, Villaverde MC.** 2018. The Philippines health system review. World Health Organization.
- Elder GH Jr, Shanahan MJ.** 2006. The life course and human development. In: Handbook of child psychology (6th ed.). Wiley.
- Elder GH.** 1998. The life course as developmental theory. *Child Development* **69**(1), 1–12.
<https://doi.org/10.2307/1132065>
- ElSayed NA, Aleppo G, Aroda VR, Bannuru RR, Brown FM, Bruemmer D, Gabbay RA.** 2023. Classification and diagnosis of diabetes: standards of care in diabetes—2023. *Diabetes Care* **46**(Suppl. 1), S19–S40. <https://doi.org/10.2337/dc23-S002>
- Haldane V, Chuah FLH, Srivastava A, Singh SR, Koh GCH, Seng CK, Legido-Quigley H.** 2019. Community participation in health services development, implementation, and evaluation: A systematic review. *PLOS ONE* **14**(5), e0216112.
- Halfon N, Forrest CB, Lerner RM, Faustman EM.** 2018. Handbook of life course health development. Springer.
<https://doi.org/10.1007/978-3-319-47143-3>
- Holt-Lunstad J.** 2021. A pandemic of social isolation? *World Psychiatry* **20**(1), 55–56.
<https://doi.org/10.1002/wps.20839>
- International Diabetes Federation.** 2023. IDF diabetes atlas (10th ed.).
- Lorig KR, Holman H.** 2003. Self-management education: history, definition, outcomes, and mechanisms. *Annals of Behavioral Medicine* **26**(1), 1–7.
- Marengoni A, Angleman S, Melis R, Mangialasche F, Karp A, Garmen A, Meinow B, Fratiglioni L.** 2011. Aging with multimorbidity: A systematic review. *Ageing Research Reviews* **10**(4), 430–439.
- Nutbeam D.** 2008. The evolving concept of health literacy. *Social Science and Medicine* **67**(12), 2072–2078.
- Ona DID, Jimeno CA, Jasul GV Jr, Bunyi MLE, Oliva R, Gonzalez-Santos LE, Villanueva NJ.** 2021. Clinical practice guidelines for hypertension in the Philippines. *Journal of Clinical Hypertension* **23**(9), 1637–1650.
- Paasche-Orlow MK, Wolf MS.** 2007. Health literacy and health outcomes. *American Journal of Health Behavior* **31**(Suppl. 1), S19–S26.
- Philippine Statistics Authority.** 2021. Philippine population data sheet.
- Robles TF, Slatcher RB, Trombello JM, McGinn MM.** 2014. Marital quality and health. *Psychological Bulletin* **140**(1), 140–187.
- Rowe JW, Kahn RL.** 1997. Successful aging. *The Gerontologist* **37**(4), 433–440.
- Rowe JW, Kahn RL.** 2015. Successful aging 2.0. *The Journals of Gerontology: Series B* **70**(4), 593–596.
- Settersten RA Jr.** 2006. Aging and the life course. In: Handbook of aging and the social sciences (6th ed.). Elsevier.
- Tinetti ME, Fried TR, Boyd CM.** 2012. Multimorbidity. *JAMA* **307**(23), 2493–2494.
- Umberson D, Montez JK.** 2010. Social relationships and health. *Journal of Health and Social Behavior* **51**(Suppl.), S54–S66.
- UN Women.** 2021. The impact of gender on older persons' lives.
- United Nations Department of Economic and Social Affairs.** 2023. World social report 2023.
- United Nations.** 2023. World social report 2023.

Valtorta N, Hanratty B. 2012. Loneliness and health. *Journal of the Royal Society of Medicine* **105**(12), 518–522.

Valtorta NK, Moore DC, Barron L, Stow D, Hanratty B. 2018. Social relationships and health care utilization. *American Journal of Public Health* **108**(4), e1–e10.

Wang J, Mann F, Lloyd-Evans B, Ma R, Johnson S. 2018. Loneliness and mental health. *BMC Psychiatry* **18**(1), 156.

World Health Organization. 2015. World report on ageing and health.

World Health Organization. 2020. Healthy ageing and functional ability.

World Health Organization. 2021. Guideline for the pharmacological treatment of hypertension in adults.

World Health Organization. 2021. Health literacy development for noncommunicable diseases.

World Health Organization. 2022. World health statistics 2022.

World Health Organization. 2023. Noncommunicable diseases progress monitor 2023.