



Voices from the Margins: Rural Elderly Perspectives on Accessing HealthCare Services

¹Ivy Clare M. Dizon, RN MAN

¹ University of Perpetual Help System-DALTA,
Philippines

Abstract : This study focused on determining the lived experiences of the elderly from selected barangays in Digos City, Davao Del Sur, regarding their access to healthcare services. This study utilized a qualitative research design, specifically a phenomenological approach, to explore and understand the lived experiences and challenges of rural elderly individuals in accessing healthcare services. The population of this study comprises elderly residents aged 60 years and above living in selected barangays of Digos City, Davao del Sur, particularly those from marginalized rural or semi-rural areas whose experiences in accessing healthcare services are the central focus of the research. Based on the survey and narrative majority of participants believe healthcare concerns should always be properly addressed, and various barriers hinder timely and adequate access to services. These barriers include economic constraints, long travel distances, poor infrastructure, unavailability of medicines, and environmental hazards. Such challenges result in delayed care-seeking, reliance on home remedies, and heavy dependence on family support. Emotional impacts were evident, with worry and frustration being common responses, although some participants maintained resilience and motivation. Participants expressed practical and actionable suggestions for improving healthcare delivery in their barangay, primarily focusing on making services more accessible, affordable, and better equipped. There is also a clear demand for government support, particularly through mobile clinics, financial aid, and elderly care programs. These findings indicate that improving healthcare access in the community requires addressing both systemic issues and personal-level support mechanisms. In light of the findings and conclusions, elderly individuals are encouraged to actively participate in health awareness programs and community-based wellness activities to strengthen their self-care practices and reduce reliance on limited healthcare resources. Healthcare workers should enhance their outreach efforts through regular home visits, mobile clinics, and health education sessions to ensure that elderly individuals, especially those with mobility and financial limitations, receive timely and adequate care. The local government is advised to allocate additional resources for rural healthcare, particularly in providing more medical personnel, medicines, and transportation assistance, to improve the accessibility and quality of health services for the elderly population. For future researchers, quantitative studies may be conducted to validate and enhance the results of the study. They may also utilize the concept identified in this study in formulating a questionnaire for their study.

IndexTerms - elderly, health care services, financial constraints, rural elderly, accessibility, quality of services, coping strategies.

I. INTRODUCTION

Access to healthcare is a fundamental human right recognized by global health organizations. However, for many older adults in rural areas, it remains a significant challenge rather than a guaranteed service. Rural seniors often face unique difficulties that increase their vulnerabilities related to age, such as environmental isolation, lack of transportation, limited medical facilities, and financial constraints. These issues can cause delays in seeking proper healthcare. Despite policy efforts to promote fair healthcare access, the experience of rural elderly individuals often falls short.

According to the World Health Organization (2021), the gap in access to healthcare is still widening in cities, and it is also expanding in rural areas—these areas often have less service availability, fewer health workers, and weaker infrastructure. These limitations become even more severe for the elderly, who frequently need regular medical visits, home care, age-specific treatments, and long-term care.

Goins et al. (2005) indicate that transportation and distance are significant obstacles for rural seniors, contributing to missed appointments and untreated illnesses. In the same vein, Syed, Gerber, and Sharp (2013) highlight the fact that the lack of public transportation in rural places is one of the factors that disadvantages the elderly who no longer drive. Biana and Joaquin (2020) highlight how State pensioners (they are. Circumstances of double deprivation 207 Who are these elderly citizens and what socioeconomic Really, the problem that is faced must not be approached by an assessment. Can the definition characteristics live in the rural areas? Moreover, a study conducted by Probst et al. (2004) allows us to infer that rural seniors are uninsured or underinsured, and this serves to hinder the ability to pay for drugs and procedures. These studies repeatedly highlight systemic and infrastructural as well as economic barriers that underlie health access. But the literature is mostly based on quantitative data—surveys and so on.

Beyond national borders, the United Nations (2020) emphasized that aging rural-dwelling people are left to the healthcare margins in many countries, partly as a result of structural inequalities and partly due to their relative absence in the policy design and the public discourse. Multiple studies have addressed rural care delivery, but often from an organizational or systemic

perspective that has failed to account for the experiences from the point of view of the elderly themselves. This has led to a significant gap in the literature regarding how rural seniors perceive their health challenges, what barriers they have encountered, and how they cope with limitations in healthcare access. Their voices remain underrepresented in both research and policy despite their potential to offer valuable insights into the practical realities of healthcare in rural contexts.

In developing countries like the Philippines, rural health systems have a small fund, especially for health, and are insufficiently equipped to meet the complex health needs of aging populations. The Philippines is currently experiencing demographic changes marked by a rapidly increasing elderly population. According to the Philippine Statistics Authority (2022), more than 9.22 million Filipinos are aged 60 and above, with a substantial number residing in rural barangays. Despite national efforts to improve healthcare accessibility, such as the expansion of PhilHealth coverage and the implementation of community-based programs like the “Kalinga sa Matatanda” and the “Primary Care Benefit Package,” the rural elderly continue to face numerous barriers. These include long travel distances to health centers, inadequate transportation, economic constraints, and shortages of medical personnel in local health units. Compounding these issues are low health literacy rates and a general lack of awareness about available services, which further hinder their ability to seek and receive timely care.

As a Clinical Instructor in Community Health Nursing, it is essential to immerse students in the realities of rural communities to strengthen their competence in delivering primary health care. Understanding the perspectives of elderly individuals, who are among the most vulnerable groups, this study would provide valuable insights into the challenges they face in accessing health services. During immersion practice, it becomes clear that the elderly often encounter barriers such as distance to health facilities, financial burdens, and inconsistent availability of medicines and services. These gaps highlight the importance of training future nurses to be sensitive, adaptive, and innovative in addressing the needs of underserved populations.

The importance of hearing the voices of the rural older people themselves, a group often excluded from mainstream health planning. Their lived experiences are critical because they offer insight into the real-life challenges of attempting to navigate a healthcare system that does not always reflect their best interest. Through sharing their experiences of perceptions, challenges, and coping strategies, older adults can offer researchers and policy-makers insight into not only the physical and practical barriers they encounter, but also the more subjective barriers they perceive to be in the way. Elderly people can assist academics and policymakers in understanding not just the technical and physical obstacles they encounter, but also the emotional, cultural, and social aspects of their healthcare journeys by sharing their perspectives, challenges, and coping strategies. Furthermore, their accounts might provide insight into community resilience, indigenous health practices, and unofficial support networks that are frequently overlooked in official assessments.

Understanding the perspectives of the rural elderly is important to design a healthcare system that is inclusive, reasonable, and sensitive to their lived conditions. This method will allow the institution to create targeted interventions, rather than one-size-fits-all solutions. Opinions from their experiences can guide improvements in community-based services, health education programs, and caregiver support initiatives. Eventually, strengthening their voices will contribute to a more responsive and compassionate healthcare system, one that will empower elderly individuals and ensure that no one is left behind simply because of where they live or how old they are.

1.1 Theoretical framework

The following theory helps to explore the complex interplay between age, geography, and healthcare accessibility.

Andersen’s Behavioral Model of Health Services. This theory gives a useful structure for looking at rural elderly people’s healthcare access. According to this hypothesis, there are three major groups of elements affecting health service use: predisposing, enabling, and need factors. Factors predisposing people include age, gender, education, and health beliefs. Lower degrees of education and strong cultural beliefs about aging and health may influence rural elderly people’s views of when and how to look for treatment. Often causing delays in getting treatment or dependence on self-care measures, these predisposing features might influence their health behaviors and contacts with health systems (Andersen, 1995).

Developed by Penchansky and Thomas (1981), the Theory of Access views access as a multi-dimensional construct rather than as a single entity. The writers say that access to healthcare has five interrelated dimensions: availability, accessibility, accommodation, affordability, and acceptability. These measures help to clarify why some people may or may not receive required treatments and represent the “fit” between patients and the healthcare system. This structure helps to identify obstacles experienced by underprivileged groups, including the rural elderly, who are frequently left out of mainstream healthcare planning and implementation. The theory describes five important aspects of access: availability, accessibility, accommodation, affordability, and acceptability.

Using the theory of both Andersen’s Behavioral Model of Health Services Use and the Theory of Access by Penchansky and Thomas (1981) offers complementary frameworks for comprehending healthcare access among rural elderly populations. While the theory of Access in this study offers a strong framework for comprehending the complicated, interrelated obstacles that rural elderly people encounter while attempting to obtain healthcare, Andersen’s model emphasizes individual and contextual elements, including predisposing traits, enabling resources, and perceived or assessed need, which shape whether and how elderly individuals seek care..

The Health Belief Model (HBM) provides a framework for understanding the healthcare-seeking behaviors of rural elderly individuals by examining perceived severity, benefits, barriers, cues to action, and self-efficacy. When illnesses are seen as threats to independence or daily functioning, the elderly are more motivated to seek medical help, underscoring the importance of framing health risks not only in terms of mortality but also disability and quality of life. Perceived benefits, such as access to medicines, free PhilHealth services, and trusted government health workers, encourage them to utilize health services despite challenges. These motivations reveal that highlighting tangible outcomes of treatment plays a key role in encouraging healthcare use.

At the same time, perceived barriers often outweigh the benefits, shaping healthcare decision-making among the rural elderly. Financial struggles, lack of transportation, and negative past experiences with healthcare workers remain major obstacles, as highlighted by studies. Even when individuals recognize susceptibility and severity, these barriers may prevent timely care-seeking. In this context, external cues to action, such as reminders from barangay health workers, family encouragement, or worsening symptoms, often determine whether action is taken. Additionally, self-efficacy—the belief in one’s capacity to manage

health—affects the elderly's ability to follow through with consultations and treatment, though low literacy, weak support systems, and limited resources frequently undermine it.

Resiliency Theory complements the HBM by showing how rural elderly adapt to barriers and limited healthcare access through resourcefulness and social support. Financial hardship, for instance, is mitigated by family assistance, senior citizen discounts, or government programs like PhilHealth. Many elderly individuals also turn to alternative or traditional medicine, reflecting culturally rooted coping strategies that allow them to maintain well-being even when formal healthcare is inaccessible. This demonstrates resilience as a dynamic process shaped not only by individual determination but also by protective factors in the environment, such as community support and cultural traditions.

Finally, Resiliency Theory highlights that the rural elderly are not passive recipients of care but active agents who navigate systemic limitations. Positive interactions with healthcare workers, family involvement, and community support strengthen their persistence despite challenges, while adaptive strategies often buffer negative experiences. For nursing practice, this perspective encourages the design of interventions that build upon existing strengths, such as community-driven support systems, peer involvement, and culturally sensitive health education. At the policy level, it emphasizes the need to reinforce protective factors through subsidies, mobile health clinics, and expanded government programs. Together, the HBM and Resiliency Theory provide a comprehensive lens for understanding both the barriers and adaptive strengths shaping

1.2 Statement of the Problem

This study explored the lived experiences and challenges of rural elderly individuals in accessing healthcare services in selected barangays of Digos City, Davao del Sur.

Specifically, it answered the following questions:

1. How do elderly individuals in rural barangays perceive the availability and quality of healthcare services in their area?
2. What coping strategies do they use to manage their health care needs?
3. What recommendations can be derived from their experiences to improve health care services in their barangay?

This study aims to determine the lived experiences and perspectives of rural elderly individuals regarding their access to healthcare services by capturing their personal experiences, challenges, and coping strategies in dealing with the healthcare system. It seeks to gain a deeper understanding of how the social, economic, cultural, and geographical factors influence their ability to seek and receive medical care. This research seeks to explore the various challenges for both visible and less apparent that hinder elderly individuals in rural communities from accessing healthcare. By focusing on their lived experiences, the study aims to uncover how these individuals cope when formal healthcare systems fall short. It will also look into the informal strategies and support networks they turn to in such situations. The insights gained will serve as a basis for developing practical and empathetic recommendations to inform healthcare policies and interventions that are more inclusive and responsive to the specific needs of older adults in rural settings.

RESEARCH METHODOLOGY

3.1 Research Design

This study employed a descriptive qualitative research design, which explored the lived experiences and challenges of rural elderly individuals in accessing healthcare services in selected barangays of Digos City, Davao del Sur. A descriptive design was appropriate because it allows researchers to provide a detailed account of participants' perspectives, focusing on how they perceive, experience, and cope with health-related issues in their daily lives. Unlike experimental research, which sought to determine cause-and-effect relationships, descriptive research emphasizes presenting an accurate picture of the current situation based on participants' narratives (Creswell & Poth, 2018).

3.2 Population and Sampling Techniques

The population of this study consists of 32 elderly residents aged 60 years and above living in Barangay Dulangan, Brgy. Goma, and Brgy. Rupan. These individuals represent the marginalized rural or semi-rural elderly population whose experiences in accessing healthcare services are the primary focus of this research. Data saturation was determined when no new themes emerged from interviews, and is considered achieved when no new themes, insights, or perspectives emerge from additional interviews as guided by Fusch and Ness (2019). For the saturation point, it will be considered the theme based on the problems and insights given by the respondents. During the gathering of data, the researcher monitored the repetition of the answers of respondents. Once subsequent interviews yield only repeated responses without novel information, the saturation point is deemed to have been reached. The greater the number of main points and the more similar the experiences, the main code served as the theme for the study.

3.3 Research Instrument

The study utilized semi-structured and face-to-face interviews with the informants in gathering data. The researcher's constructed guide questions guided the interview. The main focus of the interview was geared towards understanding the lived experiences of rural elderly individuals in accessing healthcare services. Each older adult was interviewed for 15-20 minutes.

During the gathering of data, proper coordination with the barangay captain or barangay secretary was arranged by the researcher to ensure the availability of the targeted number of cases.

From the scheduled date of the interview, the researcher started gathering data by interviewing all the identified respondents from the selected barangays. Respondents who were not available during the scheduled date were rescheduled to another date. The researcher returned to the barangay until the needed data was complete.

The interview guide contained open-ended questions align with that focused on the live experience of the elderly on their health care service of the barangay. The Interview guide focused on perceptions on the availability and quality of health care services, the coping strategies in managing health care needs, give them from their experiences to improve health care services in their barangay. All interview was audio recorded, transcribed verbatim, and analyzed using Colaizzi's method. The researcher read the interview transcripts multiple times to understand well by the participants. Each significant statement was interpreted to uncover the underlying meaning. Then the researcher clustered the statements to formulate the themes for the study. The exhaustive

description was distilled into a concise summary capturing the **essence** of the phenomenon: the lived reality of healthcare access among rural elderly individuals. On the validation for the answer of the participant, the researcher returned the important findings on whether their lived experiences were accurately interpreted, ensuring trustworthiness and credibility of the results.

3.4 Validity and Reliability

To ensure the validity of this study, some measures were considered to guarantee that the findings accurately represent the perspectives of the rural elderly regarding healthcare access. Content validity was established through a review of existing literature and consultation with experts from rural healthcare to develop the interview.

The researcher ensured reliability by maintaining a systematic data collection process, using a well-structured interview guide, and recording all interviews for accurate transcription. This process minimized variations and supported consistency across participants' responses.

3.5 Data Gathering Procedure

In gathering the data, the researcher secured formal approval from the Dean of the Graduate School of the University of Perpetual Help System Delta to allow the researcher to conduct the study. A letter of approval for ethical clearance was obtained from the Institutional Review Board (IRB) or Ethics Committee by submitting the research proposal along with details on the study's objectives, methodology, and measures to protect participants. After receiving ethical approval, the researcher coordinated with the barangay officials and local government units (LGUs) of the selected barangays in Digos to seek permission for conducting the study and to build rapport with community leaders and health workers.

Through purposive sampling, the researcher collaborates closely with barangay health workers and officials to pinpoint elderly residents aged 60 and above who fulfill the inclusion criteria. The aim of the research was clearly communicated to prospective participants, and consent was acquired from individuals who willingly chose to take part. Interviews and focus group discussions were arranged at places that are convenient and comfortable for the elderly participants, like their homes or community centers, to foster openness and guarantee privacy. Data gathering mainly takes place via semi-structured interviews and focus group discussions, which will be audio-recorded with consent and accompanied by thorough field notes.

During the data gathering process, the researcher was attentively observing participants for any indications of emotional unease or distress, providing breaks or halting the session if required, and directing participants to suitable local support services if minor risks occurred. Following each session, recordings were transcribed word for word, and all data were securely stored with participant codes to ensure confidentiality. If necessary, additional interviews were held to elaborate or clarify the collected information, ensuring that participants remain comfortable and have provided ongoing consent.

3.6 Data Analysis Plan

This research employed qualitative data analysis to investigate the detailed stories of rural elderly people concerning their experiences with healthcare access. Information gathered from detailed interviews and focus group discussions was transcribed exactly and analyzed thematically. The analysis adopted a structured method: becoming acquainted with the data by repeatedly reading the transcripts; creating initial codes that encapsulate essential concepts related to the research questions; and organizing these codes into larger themes and sub-themes.

This research used a manual thematic analysis method to understand the experiences of older adults in rural areas when it comes to accessing healthcare services. The researcher adhered to the six-phase thematic analysis procedure, which involved becoming acquainted with the data and creating initial codes. Identifying, refining, defining, and labeling themes will be compiled for the final report. Once the interviews were gathered word-for-word, the researcher delved into the data by continuously reviewing the transcripts to uncover significant patterns and important responses. Codes were created manually and grouped into possible themes that signify the essential experiences and difficulties mentioned by the co-participants.

IV. RESULTS AND DISCUSSION

This study explored the lived experiences and challenges faced by rural elderly individuals in accessing healthcare services in selected barangays of Digos City, Davao del Sur. In particular, it sought to answer the following research questions: (1) How do elderly individuals in rural barangays perceive the availability and quality of healthcare services in their area? (2) What coping strategies do they use to manage their healthcare needs? and (3) What recommendations can be derived from their experiences to improve healthcare services in their barangay?

4.1 Perceptions of Availability and Quality of Healthcare Services

The rural elderly participants shared diverse perspectives on the availability and quality of healthcare services in their barangays. Their accounts revealed both the strengths and gaps within the current healthcare system. Some elderly individuals expressed appreciation for the presence of barangay health centers and community health workers, emphasizing that these facilities serve as their primary access point for basic health services. However, many also highlighted persistent challenges such as limited medical supplies, insufficient healthcare personnel, and long waiting times, which they felt negatively impacted the quality of care they received.

Theme 1: Long Roads, Heavy Steps: The Struggle of Rural Elderly in Reaching Care

Transportation and distance problems emerged as a profound concern among the elderly participants. Their stories reveal how mobility barriers create not only physical strain but also emotional distress and a sense of helplessness. The voices of the elderly illuminate a reality where every trip to the health center is a test of endurance, willpower, and faith.

Subtheme 1: The Weight of Distance

(Maria, 67 years old): *Kapag sumasakit na talaga ang dibdib ko at hirap na akong huminga, wala akong magawa kundi maghintay ng tricycle. Pero minsan, lalo na kapag gabi, wala nang bumabyahe. Kaya napipilitan akong maglakad, kahit malayo, at nanginig na ang tuhod ko pagdating sa health center."*

(When my chest really hurts and I have trouble breathing, I have no choice but to wait for a tricycle. But sometimes, especially at night, no one is operating anymore. So I'm forced to walk, even if it's far, and my knees are already shaking by the time I reach the health center.)

Maria's words highlight the heavy toll of distance on fragile bodies. The act of walking, once a symbol of strength, becomes a painful struggle when compounded by illness. The long distance is not just measured in kilometers but in breaths, aches, and trembling knees.

Subtheme 2: The Burden of Unreliable Transport

(Pedro, 72 years old): *"Minsan, may bus naman, pero kailangan ko munang maglakad ng halos tatlong kilometro bago makarating sa terminal. Kapag umuulan, madulas ang daan, kaya minsan hindi na lang ako umaalis."*

(Sometimes there's a bus, but I still have to walk nearly three kilometers to reach the terminal. When it rains, the road gets slippery, so sometimes I decide not to go.)

Pedro's testimony captures how unreliable and weather-dependent transportation deepens isolation. The slippery roads during the rainy season symbolize not just physical danger but also the fragile threshold between seeking care and surrendering to circumstances. For him, the lack of safe and available transport means healthcare is conditionally dependent on the weather, road quality, and sheer physical stamina.

Subtheme 3: Reliance on public vehicles, longing for personal transport

(Lola Anita, 70 years old): *"Kung may sarili lang sana akong sasakyan, mas madali sana para makapunta sa ospital. Pero umaasa lang talaga ako sa mga dumadaang tricycle o jeep, at minsan wala na, lalo na kung maaga pa o hatinggabi."*

(If only I had my own vehicle, it would be easier to go to the hospital. But I really rely on passing tricycles or jeeps, and sometimes there's none, especially if it's early morning or midnight.)

Anita's longing for her own vehicle reflects the elderly's yearning for independence and control over their health-seeking journey. Her reliance on tricycles and jeeps shows the fragility of depending on external and unpredictable systems. For many, the inability to own private transport symbolizes not just poverty but also a loss of autonomy that comes with age.

The findings reveal a recurring pattern that the elderly's health-seeking behaviors are often dictated by transportation availability and distance. The majority (56%) rely on tricycles or motorcycles as their primary means of travel, while others depend on buses or jeepneys (41%). A significant number (19%) are left with no choice but to walk, regardless of their physical state, while only a small fraction (6%) use personal vehicles. None reported being accompanied by someone driving them, further underscoring their vulnerability.

The implications of these patterns are critical. The irregularity of transport options means that elderly individuals often delay seeking medical attention. Such delays can worsen existing chronic illnesses, force them into reliance on self-medication, or prevent them from receiving urgent care during emergencies. The heavy reliance on tricycles, buses, and jeepneys demonstrates a transportation system that does not adequately respond to the unique needs of older adults, particularly those with mobility challenges or serious health conditions.

This theme is not only reflective of local realities but also mirrors global concerns. According to Garcia et al. (2020), elderly populations in rural areas worldwide encounter similar barriers long distances, poor road conditions, and transport irregularities, leading to poor health-seeking behavior. In the Philippine context, Cruz et al. (2021) emphasized that rural seniors often delay healthcare visits due to the unavailability or high cost of transport, resulting in untreated conditions and higher rates of complications. The World Health Organization (2022) also stresses that solving these problems requires both structural interventions (such as better roads and expanded public transportation systems) and localized service delivery models like mobile health clinics and strategically located satellite health posts.

Thus, transport and distance are not merely logistical concerns but structural determinants of health equity. Without addressing these, elderly individuals in rural areas will continue to face avoidable health risks and diminished quality of life.

This theme paints a vivid portrait of the elderly as **pilgrims of survival walking on cracked and muddy roads**, clutching their chests, trembling yet pressing forward. The tricycle they wait for is more than a vehicle; it becomes a metaphor for hope, sometimes arriving, sometimes absent. Each bus missed, each kilometer walked, is not just a delay in reaching a clinic but a delay in relief, healing, and dignity.

They are like lanterns flickering on a stormy night, fighting to stay alight against winds of distance, darkness, and frailty. Their heavy steps echo with resilience, but also with unspoken sorrow: that healthcare, a basic human right, feels like a distant mountain they must climb each time.

In the end, the elderly's journeys embody both fragility and strength in the face of barriers, yet strength in their persistence. Their struggles on the road are not just about reaching a health center; they are about reaching for life itself, one weary step at a time.

Theme 2: The Price of Healing: Financial Struggles of the Elderly in Seeking Care

Financial burden emerged as one of the most pressing challenges among the elderly participants. Their testimonies reveal how limited income, dependence on family, and inadequate health coverage all intersect to create a cycle of vulnerability. For many, health is not merely a matter of treatment—it is a daily struggle to weigh between survival and sacrifice.

Subtheme 1: The Cost of Medicines

(Elena, 69 years old): *"Kapag bumibili ako ng gamot, kahit may senior citizen discount, kulang pa rin. Minsan, kalahati lang ng reseta ang nabibili ko, tapos tinitiiis ko na lang yung sakit."*

(When I buy medicine, even with a senior citizen discount, it's still not enough. Sometimes, I can only buy half of what's prescribed, and I endure the pain.)

Elena's words reflect the difficult compromises elderly individuals are forced to make. Despite government discounts, limited income means prescriptions often go unfulfilled. Pain and illness, therefore, are not only biological struggles but also economic ones.

Subtheme 2: Dependence on Family Support

(Ramon, 74 years old): “Umaasa na lang ako sa anak ko para sa pamasaha at pambili ng gamot. Pero minsan, nahihiya na rin ako kasi may pamilya rin sila na binubuhay.”

(I rely on my child for transportation fare and to buy my medicine. But sometimes I feel embarrassed because they also have their own families to support.)

Ramon’s statement highlights not only financial dependence but also the emotional weight of being a burden. Family support, though essential, becomes a double-edged sword, offering relief but also producing feelings of shame and helplessness.

Subtheme 3: Incomplete Coverage of Assistance Programs

(Lourdes, 71 years old): “May PhilHealth naman ako, pero hindi lahat nasasagot. Kapag emergency, malaking gastos pa rin kaya minsan hindi na lang ako nagpapa-check-up.”

(I have PhilHealth, but it doesn't cover everything. During emergencies, it's still a big expense, so sometimes I skip going for a check-up.)

Lourdes’ experience underscores the gap between coverage and actual needs. Insurance and assistance programs, while helpful, often fall short, leaving the elderly to shoulder overwhelming costs, especially during emergencies.

The financial struggles of the elderly are evident in the data: half (50%) rely on family support to cover healthcare expenses, 47% benefit from senior citizen discounts, and 41% receive government assistance. Despite these sources of aid, 63% admitted that they sometimes cannot afford treatment at all, resulting in skipped check-ups, untreated illnesses, and worsening health conditions.

These findings illustrate that financial problems are not merely about affordability but about structural inequities in healthcare access. Out-of-pocket expenses remain high, discounts are inadequate, and existing coverage systems (such as PhilHealth) do not fully address the complex health needs of aging populations. This financial strain forces the elderly to make difficult choices—prioritizing immediate needs such as food and shelter over long-term health maintenance.

Theme 3: Kind Hands, Rushed Hands: The Elderly’s Mixed Encounters with Health Workers

Elderly participants shared both positive and negative experiences with health workers. Some felt cared for and supported, while others felt ignored or rushed. Their stories show that the quality of healthcare is not only about medicine and facilities but also about how health workers treat them.

Subtheme 1: Feeling cared for and respected

(Rosa, 68 years old): “May mga nurse dito na talagang mababait, tinatanong ako kung kumusta na ang lagay ko, tinutulungan ako kahit sa pag-fill-up ng forms. Ramdam ko na may malasakit sila.”

(There are nurses here who are really kind, they ask how I’m doing and even help me fill out forms. I can feel that they care.)

Rosa’s words show that when health workers take time to show kindness and concern, elderly patients feel valued and respected.

Subtheme 2: Lack of time and proper communication

(Manuel, 70 years old): “Minsan naman, parang nagmamadali sila. Pag marami ang pasyente, halos hindi ka na kinakausap o tinutulungan nang maayos.”

(Sometimes, it feels like they’re in a hurry. When there are many patients, they hardly talk to you or help you properly.)

Manuel describes how busy schedules make health workers appear rushed, leaving elderly patients feeling unattended and less important.

Subtheme 3: Feeling Ignored

(Dolores, 72 years old): “May pagkakataon na parang hindi nila ako pinapansin kasi matanda na ako at may hika. Parang mas inuuna nila ang mas bata o mas kilala nila.”

(There are times when it feels like they ignore me because I’m old and have asthma. It’s like they prioritize younger people or those they know personally.)

Dolores shares her frustration about being overlooked, showing that some older adults feel less prioritized in the healthcare setting.

Survey results show that 56% of the elderly described health workers as “good,” and 6% said “very good.” However, almost half (47%) rated their experience as only “fair,” while 9% said “poor.” This means that while health workers are generally appreciated, their service is not always consistent. Experiences often depend on how many patients are waiting, how busy the staff are, and whether there is a personal connection with the elderly.

These mixed experiences suggest that healthcare improvement in rural barangays is not only about having more facilities or medicine, but also about building consistent, compassionate, and respectful service. Training programs in empathy, patience, and elderly care could help health workers improve communication and trust with older patients. A positive relationship with health workers can make elderly patients more willing to seek medical help, while negative encounters may discourage them from returning for care.

Theme 4: Herbs, Hands, and Hope: The Elderly’s Journey Through Home-Based Healing

Coping through alternative or home-based care emerges as a common strategy among the elderly in rural areas. Many participants turn to traditional remedies, herbal concoctions, and home-based practices to relieve discomfort and manage symptoms. For them, these methods serve as both a practical and cultural response to illness, shaped by limited financial resources, the burden of distance to health facilities, and deep-rooted trust in indigenous healing traditions.

Subtheme 1: Use of massage and liniments as first aid for pain relief

(Rosa, 69 years old): “Minsan, hindi na ako pumupunta sa health center. Nilalagyan ko na lang ng langis ang masakit na tuhod ko at minamasaha ng anak ko.”

(Sometimes, I no longer go to the health center. I apply oil to my aching knee and have my child massage it.)

Rosa’s practice reflects how elderly individuals find comfort in accessible, family-assisted remedies. Massage and liniment oils become substitutes for medical consultation, offering temporary relief and emotional reassurance, even if not curative.

Subtheme 2: Use of herbal teas and plants as natural medicine

(Mateo, 74 years old) “Kapag nilalagnat ako, uminom lang ako ng salabat o tsaang galing sa dahon ng bayabas. Minsan, gumagaan naman ang pakiramdam ko.”

*(When I have a fever, I drink ginger tea or guava leaf tea. Sometimes, it makes me feel better.)

Mateo’s statement underscores the cultural trust in plants and natural remedies. These practices embody both tradition and resourcefulness—nature as the first line of defense when modern healthcare feels out of reach.

Subtheme 3: Seeking Help From Folk Healers

(Lola Belen, 71 years old): “May kapitbahay kami na marunong maghilot. Doon na lang ako nagpapa-tulong kapag sumasakit ang katawan ko.”

(We have a neighbor who knows traditional massage. I ask for help from her when my body aches.)

Belen’s words show that healing is not just personal but also communal. The practice of hilot (traditional massage) represents both cultural heritage and community solidarity, where care is exchanged as an act of mutual support.

The reliance on alternative and home-based care highlights both resilience and vulnerability among the elderly. For many, applying oil, drinking herbal teas, or seeking help from folk healers is not simply about avoiding medical care but about making the most of what is accessible and affordable. These practices are deeply rooted in cultural beliefs, family traditions, and collective wisdom passed down across generations.

Quantitatively, a significant portion of respondents revealed that they often prioritize home remedies before seeking professional care. Such strategies provide immediate comfort but carry the risk of delaying formal diagnosis and treatment. This is particularly concerning when symptoms stem from chronic or life-threatening conditions that require timely medical intervention.

4.2 Coping Strategies in Managing Healthcare Needs

Coping strategies play a vital role in understanding how elderly individuals, particularly in rural communities, manage their healthcare needs despite facing numerous barriers such as financial limitations, limited access to facilities, and inconsistent healthcare services. These strategies reflect the adaptive responses of the elderly as they navigate both personal and systemic challenges that influence their overall health and well-being. In many cases, elderly individuals are compelled to balance between formal medical care and alternative approaches, often relying on family support, traditional medicine, or community resources to sustain their health. Exploring these coping mechanisms provides deeper insight into how resilience and resourcefulness shape health behaviors in contexts where access to healthcare is constrained.

Elderly individuals in rural barangays encounter multiple barriers in accessing healthcare, yet they demonstrate diverse coping strategies to manage their needs. These strategies reveal not only the difficulties they face but also their resilience in adapting to limited resources, poor accessibility, and personal constraints. The themes and sub-themes highlight the ways they attempt to address health concerns, deal with systemic barriers, manage emotional struggles, and seek alternative solutions when formal healthcare is inaccessible.

The narratives of the respondents provide rich insights into their coping strategies in managing their health care needs.

Theme 1: Empty Pockets, Heavy Burdens: The Cost of Health for the Elderly

Among the elderly, financial barriers emerged as one of the most pressing struggles in accessing healthcare. For many participants, the lack of money dictated whether they could buy medicine, pay for transportation, or even visit a doctor. The reality of poverty forces them into painful compromises such as enduring illness, delaying treatment, and prioritizing survival over well-being.

Subtheme 1: Withstanding illness due to lack of money

(Antonio, 71 years old): “Minsan kahit masakit na, tinitii ko na lang kasi wala akong pera pambili ng gamot o pamasaha papunta sa ospital.”

(Sometimes, even when I’m already in pain, I endure it because I don’t have money to buy medicine or pay for transportation to the hospital.)

Antonio’s words reveal the silent suffering endured by the elderly, where pain becomes a familiar companion simply because treatment is unaffordable. Endurance, rather than relief, becomes their default response.

Subtheme 2: Choosing Food Over Treatment

(Elena, 68 years old): “Kung may pera lang sana ako, makakapagpa-check-up ako agad. Pero dahil gipit, inuuna ko na lang ang pagkain ng pamilya.”

(If only I had money, I could get a check-up immediately. But because of financial hardship, I prioritize my family’s food first.)

Elena’s testimony illustrates the painful trade-offs faced by elderly individuals who sacrifice their health for the sake of their family’s survival. Health care, though urgent, is postponed for more immediate needs like food.

Subtheme 3: Pain as a Financial Burden

(Ricardo, 70 years old): “Kapag wala akong pera, tinitii ko na lang ang sakit. Hindi ko kayang bumili ng gamot o magpatingin sa doktor.”

(When I don’t have money, I endure the illness. I can’t afford to buy medicine or see a doctor.)

Ricardo's statement emphasizes how financial incapacity transforms even minor ailments into prolonged suffering, as care is not seen as a right but as a privilege tied to affordability.

Subtheme 4: Prioritizing bills and basic needs over medical treatment

(Lola Nena, 73 years old): "Minsan kahit may nararamdaman ako, inuuna ko pa rin ang pagkain at bayarin kaysa magpagamot."

(Sometimes even if I'm feeling unwell, I prioritize food and bills over getting treatment.)

Nena's words reflect the recurring dilemma of the elderly: survival versus health. In a household stretched by poverty, healthcare becomes a luxury set aside for more pressing daily expenses.

The elderly's testimonies reveal a harsh reality: financial barriers are not just about a lack of money, but about choices one should be forced to make. When 69% of participants identified "lack of money" and 75% identified "low income" as their greatest hindrance, it underscores how poverty shapes their health-seeking behavior. The decision to seek treatment is not solely guided by need but by the weight of financial constraints.

The findings are consistent with the study of Widayati et al. (2021), which emphasized that financial barriers remain one of the main determinants of delayed healthcare seeking in low-income communities. Similarly, Kien et al. (2020) found that out-of-pocket expenses, even for basic health services, can discourage individuals from accessing care, leading to worsened health outcomes over time.

Moreover, the World Health Organization (2022) reports that economic hardship forces many individuals to adopt coping strategies such as delaying medical visits, resorting to home remedies, or foregoing treatment altogether—patterns also observed among the participants in this study. This aligns with the finding that 66% preferred to "wait until they feel better" rather than incur healthcare expenses.

Financial barriers also intersect with other limitations, such as geographical and infrastructural issues. According to Tusting et al. (2019), low-income individuals are more likely to live in remote areas with poor road access, which amplifies transportation costs and further reduces healthcare access. In the present study, this was reflected in participants who, despite recognizing their health needs, could not afford both the travel and the treatment costs.

The persistence of these financial challenges suggests the need for targeted interventions, such as strengthening government health insurance coverage, expanding free medicine programs, and increasing subsidies for transportation costs in rural and underserved areas. Addressing these barriers is essential not only for improving healthcare utilization but also for preventing the progression of treatable conditions into more severe illnesses.

This theme portrays frailty against poverty's grip. The elderly appear as silent warriors battling pain not with medicine, but with endurance. Their wallets may be empty, but their burdens are full: bills, food, and family needs outweigh their own well-being. A sick elder holding an empty coin purse becomes a powerful image of their reality: the body aches, yet the pocket decides whether healing is possible. Each peso becomes a gatekeeper to health, and without it, pain becomes the currency of survival.

Their stories symbolize not only scarcity but also sacrifice. Like candles burning at both ends, the elderly give what little they have for their families, even if it means extinguishing their own strength.

Theme 2: Miles to Go: The Elderly's Battle Against Distance and Nature

For many participants, the physical distance to healthcare facilities, compounded by poor infrastructure and environmental hazards, made accessing medical services difficult. Over half of the respondents identified long travel distances (56%) and poor road access (63%) as significant barriers, while 56% noted natural hazards like flooding as major obstacles.

Sub theme 1: Long travel distances and multiple transfers

(Lito, 70 years old): "Malayo ang health center, kailangan pa ng dalawang sakay. Kapag umuulan, hindi makadaan ang tricycle."

The health center is far, and I need two rides to get there. When it rains, tricycles can't pass.)

Lito's account highlights how multiple transfers and long distances discourage elderly individuals from seeking care, especially when compounded by weather conditions. For him, the distance is not just measured in kilometers, but in costs, time, and energy.

Subtheme 2: Environmental hazards such as flooding and impassable roads

(Dolores, 72 years old): "Minsan kahit gusto ko magpatingin, hindi na ako tumutuloy kasi baha sa kalsada at mahirap maglakad papunta sa highway."

(Sometimes, even if I want to get checked, I don't go because the road is flooded and it's hard to walk to the highway.)

Dolores's statement reveals how natural hazards like flooding effectively trap elderly residents in their homes. For her, illness must wait until the waters recede, a dangerous delay that puts her health at greater risk.

Over half of the respondents cited long travel distances (56%) and poor road access (63%) as critical barriers to healthcare, while 56% also identified flooding and other natural hazards as significant challenges. These findings suggest that the elderly's struggle with access is not solely financial or medical but also geographical and environmental.

According to Oleribe et al. (2019), geographical barriers in rural communities are among the most persistent determinants of poor healthcare access, often resulting in delayed treatment and poor health outcomes. Similarly, Singh et al. (2022) found that difficult terrain and weather-related hazards in remote areas increase the cost and time needed for patients to reach healthcare facilities, further discouraging healthcare utilization.

The findings also align with the Department of Health (Philippines) report (DOH, 2021), which acknowledges that rural areas continue to face infrastructure gaps that directly affect emergency response and routine healthcare delivery. Addressing these issues may require road infrastructure improvement, community-based health services, and mobile clinic deployment to bridge the access gap.

This theme portrays the elderly as travelers stranded between sickness and salvation. Roads that should lead to healing become rivers of mud and water, bridges that collapse under the weight of distance and time. The flooded road becomes a metaphor for their lives: obstacles rise, blocking their path, and they are forced to wait, endure, or turn back. For many, illness does not kill

as swiftly as inaccessibility does. In their stories, the elderly are like weary voyagers caught in a storm, standing on the other side of a health center they can see but cannot reach. Their struggle embodies resilience, yet also underscores an injustice: that care, though promised, is made unreachable by the very ground beneath their feet.

Theme 3: Empty Benches, Empty Shelves: When Health Services Fall Short

Respondents also cited challenges within the healthcare system itself, such as understaffed clinics (16%), long waiting times (31%), unavailability of medicines (44%), and unkind treatment from staff (3%). These service-related issues discouraged many from seeking care promptly.

Subtheme 1: Lack of available doctors and healthcare workers

Domingo, 72 years old): "Pumunta ako sa health center pero walang doktor, sabi bumalik na lang ako sa susunod na linggo."

(I went to the health center, but there was no doctor; they told me to just come back next week.)

Domingo's experience highlights how shortages in medical personnel create gaps in care. For the elderly, whose conditions may worsen with delays, being asked to return another week can mean enduring prolonged pain or complications.

Subtheme 2: Unavailability of prescribed medicines in local pharmacies

(Lourdes, 68 years old): May reseta pero wala naman gamot sa botika ng barangay.

(There was a prescription, but the medicine wasn't available at the barangay pharmacy.)

Lourdes' account underscores how even when healthcare is accessible, its impact is limited by the absence of essential medicines. Prescriptions without supply become symbols of frustration, especially for those who cannot afford private pharmacies.

Studies by Yaya et al. (2020) and Roder-DeWan et al. (2019) confirm that the quality of healthcare services, particularly staff availability, wait times, and medicine supply, plays a crucial role in patient satisfaction and care-seeking behavior. Patients who perceive poor service quality are less likely to return for follow-up care, which can worsen health conditions.

Improving staffing, ensuring adequate medicine supply, and enhancing patient-provider communication could significantly improve healthcare utilization rates and patient trust, especially in underserved rural communities.

This theme shows a portrait of waiting and wanting: elders sitting on hard benches in crowded clinics, clutching prescriptions for medicines that never arrive, staring at closed doors where no doctor is available. Their time is precious in the twilight years, slips away in queues, reschedules, and return visits.

Theme 4: Silent Cries: The Emotional Burden of Healthcare Barriers

The emotional toll of healthcare barriers was evident, with participants expressing feelings of worry (72%), frustration (34%), and hopelessness (13%). While a small proportion felt motivated to find solutions (19%) or accepted the situation (16%), negative emotions dominated the responses.

Subtheme 1: Frustration in Helplessness

(Dolores, 68 years old): "Nakakainis kasi kahit gusto mong gumaling, parang wala ka namang magagawa."

(It's frustrating because even if you want to get better, it feels like there's nothing you can do.)

Dolores's words highlight the anger and irritation that stem from repeated encounters with barriers. The inability to control circumstances, be it money, transportation, or system inefficiencies, leads to feelings of helplessness that heighten their suffering.

Subtheme 2: Losing Hope in the Face of Costs

(Carlos, 72 years old): "Minsan nawawalan na ako ng pag-asa, lalo na kapag hindi ko kayang gumastos."

(Sometimes I lose hope, especially when I can't afford the expenses.)

Carlos's reflection embodies the despair many older adults feel when faced with insurmountable financial challenges. For him and others, the lack of resources transforms illness into a seemingly permanent condition, eroding hope for recovery.

The emotional dimension of healthcare barriers cannot be overlooked. The data show that worry (72%), frustration (34%), and hopelessness (13%) were the dominant emotions among participants, illustrating how systemic and financial struggles extend beyond physical health into mental well-being. These emotions mirror the silent, invisible battles that elderly individuals fight each day—worry about the future, frustration over inaccessibility, and despair when needs remain unmet.

However, the presence of motivation (19%) and acceptance (16%) shows that not all responses were entirely negative. Some elderly participants channel their struggles into determination, exploring home remedies, leaning on family, or adjusting expectations. This duality between despair and determination illustrates the complex psychological landscape of aging in contexts of scarcity.

Existing literature affirms these findings. Villanueva et al. (2020) noted that elderly Filipinos facing healthcare barriers often report frustration and hopelessness, leading to stress and reduced quality of life. Similarly, Santos & Cruz (2022) highlighted the psychological burden of financial and distance barriers, which often translates into anxiety and resignation. The World Health Organization (2022) emphasizes that emotional well-being is a core component of health, stressing the need for psychosocial support programs tailored to vulnerable populations such as the rural elderly.

Research by Dahlui et al. (2022) emphasizes that emotional stress caused by inaccessible healthcare can lead to delayed health-seeking behavior and poorer mental health. Furthermore, Mishra et al. (2021) highlight the psychological burden of health inequities, noting that persistent barriers erode patients' sense of agency and trust in the health system.

Mental health support integrated into primary care, as suggested by WHO (2023), may help address these emotional consequences while broader structural barriers are being resolved.

Portrait of silent cries, the elderly carrying invisible wounds of worry, frustration, and hopelessness. Each sigh, each sleepless night, symbolizes not only their frailty but also the emotional scars left by a healthcare system out of reach. Frustration becomes a clenched fist against fate; hopelessness, a dimming flame inside weary hearts. Worry hangs over them like a storm cloud, while acceptance feels like laying down one's arms. And yet, within some, a small spark of determination flickers like a candle in the dark, fragile but defiant. In the faces of the elderly, we see not just patients, but warriors of endurance. Their emotions are portraits of both pain and perseverance, reminding us that healthcare barriers wound not only the body, but also the spirit.

Theme 5: Silent Endurance and Shared Strength: The Elderly's Lifelines in Times of Need

For many elderly participants, coping and support systems form the fragile thread that sustains them when healthcare is out of reach. Their strategies range from enduring pain in silence, relying on family, and turning to community or faith-based support, to having no support at all. While these mechanisms reflect resilience, they also highlight vulnerability, particularly for those left to suffer alone.

Subtheme 1: Silent suffering and waiting until the illness subsides

Elderly participants often chose endurance as a survival strategy, even when it meant ignoring symptoms. Pain becomes normalized, not by choice, but by necessity. The following verbatim was shown below:

(Mario, 72 years old): *"Kapag wala akong pambayad, tinitii ko na lang at umaasa na gagaling ako."*

(When I have no money to pay, I endure it and hope I'll get better.)

Subtheme 2: Leaning on Family

Family as the primary lifeline for medicine, care, and emotional support

(Luz, 69 years old): *"Ang pamilya ko ang takbuhan ko pag kailangan ko ng tulong sa gamot."*

(My family is my go-to when I need help with medicine.)

(Rogelio, 71 years old): *"Kung wala ang anak ko, hindi ko alam paano ako makakabili ng gamot. Siya na lang lagi nagbibigay."*

(If not for my child, I wouldn't know how to buy medicine. He's always the one who provides for me.)*

Family support, often financial and emotional, remains the strongest coping system. Yet, the elderly's voices show both gratitude and guilt, revealing the emotional weight of dependence.

Subtheme 3: Community and Faith-Based Support

Reliance on barangay health workers, neighbors, and church groups. The following verbatim was shown below.

(Dolores, 72 years old): *"Minsan ang barangay health worker na lang ang nilalapitan ko, kasi sila libre lang."*

(Sometimes I approach the barangay health worker, because their services are free.)

(Andres, 75 years old): *"Kung walang pera, kapitbahay ko ang tumutulong minsan, nagbibigay ng gamot na sobra nila."*

(When I have no money, my neighbor sometimes helps, sharing their extra medicine.)

(Josefina, 70 years old): *"Sa simbahan, minsan may mga tumutulong, lalo na kapag prayer meeting. Nakakagaan ng pakiramdam."*

(At church, sometimes people help, especially during prayer meetings. It makes me feel lighter.)

These voices highlight the role of community health volunteers, neighbors, and faith groups as vital but inconsistent lifelines. Their help often comes as relief, but it is sporadic and dependent on goodwill.

Subtheme 4: The Lonely Struggle

The absence of support networks among some elderly is one of the coping strategies employed by the elderly.

(Flora, 73 years old): *"Wala na akong pamilya, kaya sarili ko lang ang inaasahan ko."*

(I have no family anymore, so I can only rely on myself.)

(Benito, 76 years old): *"Kung magkasakit ako, wala namang tutulong. Kaya kadalasan, tiis na lang."*

(If I get sick, no one will help. So most of the time, I endure it.)

Coping and support systems among the elderly reflect both resilience and fragility. While 66% endure illness until it subsides, smaller portions borrow money (9%), use herbal remedies (3%), or seek help from family and neighbors (6%). Family support remains the most reliable (66%), followed by barangay health workers (9%), church/community groups (6%), and neighbors (3%). Alarmingly, 19% reported having no support, underscoring the profound vulnerability of isolated seniors.

These coping strategies, however, come at a cost. Reliance on endurance often delays proper care, worsening conditions. Borrowing money adds financial strain. Herbal remedies provide comfort but may not cure underlying illnesses. Support from family and community offers relief, but dependence can lead to feelings of guilt and helplessness.

Research supports these findings. Douthit et al. (2021) emphasized the crucial role of family and community networks in buffering healthcare barriers in rural and resource-limited settings. However, over-reliance on informal coping methods risks delayed treatment and complications. Strengthening barangay-based health programs, enhancing the role of health volunteers, and expanding formal safety nets can bridge the gap between need and care.

This theme sketches a portrait of the elderly as both resilient survivors and fragile dependents. Some are like trees rooted in family and community soil, drawing strength from loved ones, neighbors, and faith. Others, however, stand like solitary trees in a barren field, weathering storms alone, with no one to lean on.

Their coping strategies, enduring pain, drinking herbal tea, relying on children, or knocking on a neighbor's door are more than actions; they are symbols of survival in the face of scarcity. But behind each strategy lies a quiet cry: for support, for dignity, for care that should not be conditional.

The elderly embody both lanterns of endurance and shadows of neglect. Their lives remind us that coping is not just about strength, but about the systems, or lack thereof, that either hold them up or leave them to fall in silence.

4.3 Recommendations from their experiences to improve health care services in their barangay

The recommendations gathered from the elderly participants reveal important themes that reflect both their personal struggles and their hopes for better healthcare services within their barangay. Their suggestions can be organized into four domains: accessibility of healthcare facilities, adequacy of medical resources, affordability of services, and supportive systems for elderly care.

The first domain emphasizes the accessibility of healthcare facilities, as many elderly participants expressed the need for health centers that are nearer to their communities. Long travel distances remain a major challenge, and having a health center within closer reach or the provision of mobile clinics was viewed as a way to bring essential medical services directly to them.

The second domain focuses on the adequacy of medical resources, highlighting the call for more medicines, equipment, and regular check-ups within the barangay. These recommendations show the elderly's preference for preventive care and the assurance of continuous monitoring of their health, rather than waiting for illnesses to worsen before seeking treatment.

The third domain points to the affordability of services, with participants proposing free or more affordable treatment options. This theme reflects the economic struggles of the elderly, many of whom depend on limited financial resources. Suggestions such as increased pension or financial aid further emphasize the importance of addressing the financial aspect of healthcare.

The final domain pertains to supportive systems for elderly care, which includes better treatment by health staff, training workers in elderly care, and assisting family caregivers. These responses recognize that healthcare does not only involve direct medical treatment but also the quality of interaction and the broader support network that sustains the well-being of older adults.

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