

Health-Promoting Behaviors and Quality of Life of Filipino Older Persons

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Abstract - *The aim of this study was to examine the relationship between health-promoting behaviors and quality of life (QoL) of older persons in Iloilo City. Conducted from January to February 2014, this research utilized 223 randomly-selected older persons as participants who were classified according to age, sex, civil status, educational attainment, work status, monthly family income, type of family structure, and health status. The data were obtained using two published and validated instruments: the Health-Promoting Lifestyle Profile Instrument II (1995) and the World Health Organization Quality of Life Instrument (2004). Reliability testing was done among 20 randomly-selected older persons. The descriptive statistics employed were the frequency count, rank, percentage, mean, and standard deviation; while the inferential statistics utilized were the t-test, one-way analysis of variance (ANOVA), and Pearson product-moment correlation coefficient (r), all set at .05 alpha level of significance. The overall health-promoting behaviors was low and the quality of life was neither poor nor good. Significant differences were noted in the older persons' health-promoting behaviors when classified according to age, monthly family income and health status. On the other hand, significant differences were noted in QoL when the older persons were grouped according to age and monthly family income. There was a significant relationship between the six sub-scales of health-promoting behaviors and the four domains of the QoL. The results showed that health-promoting behaviors are positively associated with better quality of life scores in the older persons living in Iloilo City.*

Keywords: *health-promoting behaviors, quality of life, older persons*

I. INTRODUCTION

Ageing is currently the most important demographic trend worldwide. Further ageing of societies in developed countries is now accompanied by

unprecedentedly rapid ageing of populations in developing countries. By 2050, two billion people—or nearly one out of every four people—will be older than 60 years (World Health Organization, 2013).

Population ageing is a phenomenon indicated by a steady increase in the number and proportion of the elderly and a corresponding decline in the proportion of younger age groups. This is due to an increase in life expectancy, mortality reduction, and fertility reduction that are brought about by advances in medical technology and medical care as well as the improved socio-economic conditions (Philippine Department of Social Welfare & Development & the Department of Health, 2007).

According to the National Statistical Coordination Board of the Philippines, Filipino senior citizens account for 6.9 percent of the population and this will increase to approximately 7.8 percent by the end of the Aquino administration. By 2040, it is projected that out of 141.7 million Filipinos, approximately 19.6 million will be “young ones.” Indeed, the share of seniors to total population has been steadily increasing over time, and the average age of the *Filipino* has also been increasing (Virola, 2011).

The 2010 Census of Population and Housing recorded that the total population in Iloilo City is 424,619 and based on the 2012 Socioeconomic Profile of the Iloilo City Government, the total population of senior citizen is 31,612. This is approximately 7.4 % of the total population.

According to Lis, Reichert, Cosack, Billings and Brown (2008), the arguments why health promotion is of great importance are manifold and refer to the individual as well as the societal level. First, health is a basic right of (older) people; second, health is one of the most important predictors of life satisfaction in old age; third, health is a prerequisite for an independent life in old age; fourth, health is vital in maintaining an acceptable quality of life in older individuals and ensuring the continued contributions of older persons to society; fifth, health is a determinant of economic

growth and competitiveness (e.g., decreasing early retirement of older workers); and lastly, a healthy population reduces health-care spending and lowers the burden on the health-care system.

Inventor, Henricks, Rodman, Imel, Holemon, and Hernandez (2005) emphasized that providing health-related education and training is an important focus of care throughout the hospital stay and in preparation for discharge of the elderly patient. Since many physically ill and demented patients are unable to retain and apply needed information, family members and other caregivers are regularly involved in education. Health teaching is individualized, but may include topics such as effective use of medications for management of pain and agitation, dietary restrictions for certain medications, diabetic regimen, safe ambulation, transfers, and use of assistive devices to assure that effective interventions are continued after discharge.

According to Abaquin (1999), quality of life is a multifaceted construct that encompasses the individual's capacity and abilities with an aim of enriching life when it can no longer be prolonged. This includes proper care of the body, mind, and spirit to maintain integrity of the whole person despite limitations brought by the present situation. This can be seen with the following dimensions of man—physical, psychological, social, religious, level of independence, environment, and spiritual.

Quality of life, as the outcome of this study, is inextricably linked to health-promoting behaviors. Further, the analysis of the gathered data would show if there is a significant relationship between health-promoting behaviors and quality of life of older persons.

II. OBJECTIVES OF THE STUDY

This study aimed to find out the level of health-promoting behaviors and quality of life of older persons in Iloilo City. Specifically, it determined the level of health-promoting behaviors of older persons taken as an entire group and classified according to their profile in terms of age, sex, civil status, highest educational attainment, employment status, monthly family income, type of family structure, and health status; to identify the quality of life of older persons taken as an entire group and classified according to profile; to test the significant differences in the level of health-promoting behaviors of older persons classified according to profile; to test the differences in the quality of life of older persons classified according to profile; and to test

the relationship between the level of health-promoting behaviors and quality of life of older persons.

III. METHODS

This study aimed to describe the level of health-promoting behaviors and quality of life of older persons in Iloilo City. Furthermore, it aimed to ascertain the relationship between the aforementioned variables. This descriptive-correlational study; conducted from January to February 2014; employed a one-shot survey design. According to Polit and Beck (2010), a correlation is an interrelationship or association among variables, that is, a tendency for variation in one variable to be related to variation in another. The purpose of correlational research, like experimental research, is to understand relationships among variables, but without manipulation of independent variables.

This survey allowed the researcher to collect information about the older persons' profile, health-promoting behaviors and quality of life from a sample that has been drawn from a determined population. The target participants of this study were the 223 randomly-chosen older persons aged 60 years old and above, living in Iloilo City. The participants were selected based on the eligibility criteria set by the researcher in accordance with the National Ethical Guidelines for Health Research 2011 of the Philippine Health Research Ethics Board. Further, the inclusion and exclusion criteria placed parameters on the selection of the research sample (King & Hinds, 2012).

To qualify as participant of the study, one must be 60 years old or older; oriented; coherent; able to read/write, and willing to sign the informed consent and; a bonafide resident of Iloilo City for at least two weeks. On the other hand, those who have impaired cognitive and mental functioning; are institutionalized and hospitalized were excluded from the study. Out of the 223 randomly-selected participants, four (three refused to participate, one had severe dementia) were excluded and substituted.

Since the population of older persons in Iloilo City is big, random sampling was employed. According to the 2012 Socio-economic Profile of Iloilo City Government, the city is composed of six districts; namely, (1) Molo District, (2) La Paz/Lapuz District, (3) Mandurriao District, (4) Jaro District, (5) Arevalo District, and (6) the City Proper District.

To ensure every older person in Iloilo City have an equal, independent chance of being selected as a participant of the study, the researcher used the stratified random sampling technique.

One barangay per district was included in the study. The barangays were chosen at random using the fishbowl technique. All names of the barangays were written on slips of paper. One barangay was drawn per district. The six randomly-selected barangays served as the venue of the study, which were the following: Barangay Calumpang (Molo District), Barangay Progreso (Lapuz & La Paz District), Barangay Guzman-Jesena, (Mandurriao District), Barangay Sta. Cruz (Arevalo District), Barangay Balabago (Jaro District), and Barangay Rizal Pala-pala II (City Proper District). Next, a sampling frame was established per district.

The sample size (n) was determined using Slovin's formula. The number of samples was determined for each district. Using the table of random numbers, samples were picked from each district until the sample size (n) was reached.

The research participants were classified according to age, sex, civil status, educational attainment, employment status, monthly family income, type of family structure, and health status.

This study utilized two published, translated, and validated data-gathering instruments that were used to gather data.

The Health-Promoting Lifestyle Profile II (HPLP II) is a 52-item, four-point, Likert styled instrument consists of the following six subscales: spiritual growth, interpersonal relations, nutrition, physical activity, health responsibility, and stress management. The HPLP measured the health-promoting lifestyle of the participants. The researcher was granted permission to use the instrument by Dr. Susan Noble Walker, University of Nebraska Medical Center College of Nursing, United States of America.

The World Health Organization Quality of Life-BREF (WHOQOL-BREF) project was initiated in 1991. The aim was to develop an international cross-culturally comparable quality of life assessment instrument. It assesses the individual's perceptions in the context of his/her culture and value systems, and his/her personal goals, standards and concerns. The WHOQOL-BREF (French for "brief") instrument was developed collaboratively in a number of centres worldwide, and has been widely field-tested. Because the WHOQOL-BREF focused upon respondents' "perceived" quality of life, it is not expected to provide a means of measuring in any detailed fashion symptoms, diseases or conditions, nor disability as objectively judged, but rather the perceived effects of disease and health interventions on the individual's quality of life. The WHOQOL-BREF is, therefore, an assessment of a

multi-dimensional concept incorporating the individual's perception of health status, psycho-social status and other aspects of life.

Permission to use the WHOQOL-BREF instrument for a period of one year was granted to the researcher by Ms. Sibel Volkan and Dr. Somnath Chatterji through email correspondence and submission of User Agreement for WHOQOL-BREF.

Individual items were rated on a 5-point Likert scale where 1 indicates low, negative perceptions and 5 indicates high, positive perceptions.

The WHOQOL-BREF instrument comprised 26 items and denoted an individual's perception of quality of life in four domains. The WHOQOL-BREF was interpreted using the following scale: Very Poor QOL: 1.00-1.50; Poor QOL: 1.51-2.50; Average QOL: 2.51-3.50; Good QOL: 3.51-4.50; and Very Good QOL: 4.51-5.00 and 1.00-1.50 -- *Very Low*; 1.51-2.50 -- *Low*; 2.51-3.50 -- *High*; 3.51-4.00 -- *Very High*

Both instruments, the Health-Promoting Lifestyle Profile II and WHOQOL-BREF were originally written in the English language were translated to Hiligaynon dialect by five native Ilonggo speakers. The initial translation was done by the researcher and was presented to a community health nurse investigator, a nursing instructor in Gerontology, a professional translator for Mother Tongue-Based Multilingual Education under the K-to-12 curriculum program and an Ilongga officer of the Office for Senior Citizens' Affairs (OSCA) for validation. Revisions were made based on the experts' comments and suggestions.

To ensure that the translation was appropriate to the methodology without introducing bias into the process, a back-translation of the Hiligaynon version to the English language was done by a registered nurse who is a native speaker of the dialect.

After the translation, the HPLP II and WHOQOL-BREF (Hiligaynon Version) were pilot-tested among 20 randomly selected senior citizens living in Barangay South Baluarte, Molo, Iloilo City who had fairly similar characteristics with other older persons but were not part of the study population area. Questions which were not clear and not readily answered during the reliability testing were revised.

To analyze the data, frequency count, percentage, rank, mean, and standard deviation were used as descriptive statistics, while the t -test, one-way analysis of variance (ANOVA) and Pearson's product-moment correlation coefficient (r) were employed as inferential statistical tools. All statistical computations were processed via the Statistical Package for the Social

Sciences (SPSS) software, version 17.0. Significance level for all inferential statistics was set at .05alpha.

IV. RESULT AND DISCUSSION

In general, the participants were mostly females (75.78%), widowed (47.53%), had at least graduated from high school (76.24%), unemployed (92.83%), and lived with their extended families (87.00%). Majority of them had low monthly family income (82.96%). More than three-fourths (76.68%) self-reported to have no diagnosed medical condition. One in ten senior citizens reached at most elementary (10.77%) and 31.39% at most high school. More than 14% of them had post-secondary education and about 23.77% were college undergraduates while only 19.73% were able to finish a college degree. It was noted that more than half (51.57%) of the participants belonged to the low-income families. This has an implication to the availability of financial resources, which the elderly can utilize for

their health promotion and maintenance and illness prevention.

As to family structure, about four out of five older persons were living with their extended family. This reflects the Filipino culture, wherein the older members of the family are taken care of by their relatives and younger family members.

As to health status, the data implied that less than a quarter of the elderly reported to have medical diagnoses. It seems that only a minority of them had sought medical consultation or had been assessed by a healthcare provider. Considering that as one's age increases, the risk for developing illnesses also increases. Probably, the older persons' medical illnesses remained undiagnosed. Among those who reported that they have diagnosed medical conditions claimed to have visual problems, hypertension, diabetes, hernia, rheumatoid arthritis, and increased cholesterol levels.

Table 1. *Distribution of Participants; Level of Health-promoting Behaviors of Older Persons and Degree of Quality of Life of Older Persons in Iloilo City*

Category	Profile		Health Promoting Behavior			Degree of Quality of Life of Older Persons in Iloilo City		
	F	%	M	Description	SD	M	Description	SD
A. Entire group	223	100.00	2.48	Low	0.59	2.62	Average	0.69
B. Age	101	45.29	2.39	Low	0.53	2.51	Average	0.67
60–69 years (young-old)								
70–79 years (middle-old)	85	38.12	2.64	High	0.59	2.86	Average	0.62
≥80 years (oldest old)	37	16.59	2.33	Low	0.69	2.39	Poor	0.74
C. Sex: Male	54	24.22	2.58	High	0.54	2.68	Average	0.66
Female	169	75.78	2.45	Low	0.61	2.61	Average	0.70
D. Civil status								
Married & common-law relationship	93	41.71	2.49	Low	0.56	2.59	Average	0.67
Single	18	8.07	2.25	Low	0.45	2.41	Poor	0.73
Widowed	106	47.53	2.50	Low	0.64	2.68	Average	0.69
Separated	6	2.69	2.41	Low	0.56	2.70	Average	0.72
E. Educational attainment								
Elementary undergraduate	9	4.04	2.37	Low	0.38	2.87	Average	0.68
Elementary graduate	15	6.73	2.46	Low	0.58	2.57	Average	0.75
High school undergraduate	29	13.00	2.53	High	0.49	2.58	Average	0.67
High school graduate	41	18.39	2.39	Low	0.60	2.64	Average	0.70
Post-secondary (voc'l)	32	14.35	2.45	Low	0.58	2.51	Average	0.66
College undergraduate	53	23.77	2.46	Low	0.65	2.65	Average	0.69
College graduate	31	13.90	2.56	High	0.62	2.50	Poor	0.73
Post-graduate	13	5.83	2.66	High	0.72	2.98	Average	0.57
F. Work status								
Employed	16	7.17	2.23	Low	0.46	2.64	Average	0.72
Unemployed	207	92.83	2.50	Low	0.60	2.62	Average	0.69
G. Monthly family income								
Low (less than Php 15,000.00)	115	51.57	2.10	Low	0.44	2.06	Poor	0.56
High (Php 15,000.00 and above)	108	48.43	2.88	High	0.46	3.11	Average	0.43

Table 1 (cont). *Distribution of Participants; Level of Health-promoting Behaviors of Older Persons and Degree of Quality of Life of Older Persons in Iloilo City*

Category	Profile		Health Promoting Behavior			Degree of Quality of Life of Older Persons in Iloilo City		
	F	%	M	Description	SD	M	Description	SD
H. Type of family structure								
Nuclear	12	5.38	2.48	Low	0.66	2.48	Poor	0.87
Extended	194	87.00	2.48	Low	0.60	2.63	Average	0.67
Dyad	5	2.24	2.72	High	0.66	3.02	Average	0.78
Single person family	12	5.38	2.38	Low	0.46	2.45	Poor	0.69
I. Health status								
With diagnosed medical condition	52	23.32	2.66	High	0.58	2.76	Average	0.70
Without diagnosed medical condition	171	76.68	2.42	Low	0.59	2.58	Average	0.68

The older persons in the study had low level of health-promoting behaviors when taken as an entire group as indicated by the mean score of 2.48. The results imply that the older persons' frequency of engagement in health-promoting lifestyles is inadequate to promote health. Their health-compromising lifestyles can place them at risk for developing chronic illness and poor health.

When classified according to sex, male older persons had *high* health-promoting behaviors, while their female counterparts had low health-promoting behaviors. In terms of civil status and work status, all groups had *low* health-promoting behaviors as reflected by means ranging from 2.23 -2.50.

According to educational attainment, those who are high school under- graduates, college graduates, and post-graduates had *high* health-promoting behaviors. This means that their lifestyle is adequate to promote health and wellness. All the other groups of older persons had *low* health-promoting behaviors as indicated by mean scores ranging from 2.37-2.46.

Older persons with high monthly family income had *high* health-promoting behaviors, while those with low monthly family income had behaviors that were inadequate to promote health and wellness. As to the type of family structure, only those living in a dyad had *high* health-promoting behaviors. Those who had nuclear, extended, and single person family structures had *low* health-promoting behaviors. Older persons who self-reported to have diagnosed medical condition had *high* health-promoting behaviors. Those who have no diagnosed medical condition had behaviors that were inadequate to promote health and wellness.

The overall mean score obtained by the older persons in the HPLP II was 2.58, indicating that the participants did not consistently incorporate health-promoting behaviors into their lifestyles. The subscale with the highest mean score was nutrition. This seems

to show that, older persons in this study adequately engage in various types of health-promoting behaviors related to healthy eating habits. However, they had low health-promoting behaviors in the other five subscales. The least frequently reported subscale of health promoting behaviors was physical activity. This indicates that the older persons seldom engage in regular physical exercise program and leisure time physical activities. They also got low health-promoting behaviors score in spiritual growth, health responsibility, stress management, and interpersonal relationship.

Table 2. Health-Promoting Behaviors of Older Persons on Six Subscales of Health-promoting Lifestyle Profile

Subscale	M	Description	SD	Rank
Nutrition	2.52	High	0.62	1
Interpersonal relationship	2.50	Low	0.67	2
Health responsibility	2.49	Low	0.65	3.5
Stress management	2.49	Low	0.65	3.5
Spiritual growth	2.46	Low	0.62	5
Physical activity	2.41	Low	0.56	6

The data in Table 2 showed that the older persons in the study, as an entire group, perceived an *average* quality of life. When classified as to the age, the oldest old perceived a *poor* quality of life, while the young-old and the middle-old had an *average* global life quality.

When grouped according to sex, both male and female older persons had an *average* quality of life. As to civil status, only the singles perceived a *poor* quality of life. All the other sub-categories of civil status perceived an *average* quality of life. When taken as to educational attainment, only those who are college graduates perceived a *poor* quality of life. All the other sub-groups perceived an *average* quality of life.

In terms of work status, both gainfully working and unemployed participants perceived an *average* quality of life. Moreover, the older persons with monthly family income of less than Php 15,000.00 perceived a *poor* quality of life while those with monthly family income of Php 15,000.00 and above perceived an *average* quality of life.

In terms of the type of family structure, those who came from nuclear and single person families had *poor* quality of life, while those who lived with their extended and dyad families had an *average* quality of life.

Finally, when classified according to health status, the participants with and without medical condition perceived an *average* quality of life.

The older persons had an *average* perception of their QOL on the four domains as indicated by the mean scores ranging from 2.58-2.67. This implies that they have neither poor nor good perception of QOL in terms of the physical, psychological, social, and environmental domains. Psychological health had the highest mean score while physical health had the lowest mean score.

Table 3. *Quality of Life of Older Persons on Four Domains of WHOQOL-Bref*

Domain	M	Description	SD	Rank
Psychological Health	2.67	Average	0.66	1
Social Relationships	2.60	Average	0.74	2.5
Environment	2.60	Average	0.81	2.5
Physical Health	2.58	Average	0.66	4

Table 4 reveals the differences in the health-promoting behaviors among older persons grouped.

Table 4. Differences in the Health-Promoting Behaviors Among Older Persons Grouped According to Sex, Work Status, Monthly Family Income, and Health Status

Category	M	SD	df	t-value	Sig.
Sex: Male	2.58	0.54	221	1.46	.147
Female	2.45	0.61			
Work status					
Employed	2.23	0.46	221	1.74	.083
Unemployed	2.50	0.60			
Monthly family income					
Low	2.10	0.44	221	12.88*	.000
High	2.88	0.46			
Health status					
With diagnosed medical condition	2.66	0.58	220	2.53*	.012
Without diagnosed medical condition	2.42	0.59			

* $p < .05$

Data in Table 4 revealed that there were significant differences in the level of health-promoting behaviors of older persons when classified according to monthly family income and health status, thus, the null hypothesis, that there are no significant differences in the level of health-promoting behaviors of older persons grouped according to monthly family income and health status was rejected.

It appears that the older persons' health-promoting behavior is significantly influenced by their family income and health status. Those with higher family income have significantly better health-promoting practices than those who came from low-income families. Those who self-reported to have diagnosed medical condition have significantly engaged in a healthier lifestyle than those without a medical condition. On the other hand, no significant differences were noted in the level of health-promoting behaviors of senior citizens when they were classified according to sex and work status.

Table 5. Differences in the Health-promoting Behaviors Among Older Persons Grouped According to Age, Civil Status, Educational Attainment and Type of Family Structure

Category	Sum of Squares	df	Mean Square	F	Sig.
Age					.003
Between groups	3.94	2	1.97	5.81*	
Within groups	74.65	220	0.34		
Total	78.59	222			
Civil status					.404
Between groups	1.04	3	0.35	0.98	
Within groups	77.55	219	0.35		
Total	78.59	222			
Educational attainment					.881
Between groups	1.09	7	0.16	0.43	
Within groups	77.50	215	0.36		
Total	78.59	222			
Family structure					.779
Between groups	.39	3	0.13	0.36	
Within groups	78.20	219	0.35		
Total	78.59	222			

* $p < .05$

The one-way analysis of variance (ANOVA) computations revealed a significant difference in the level of health-promoting behaviors of older persons when grouped according to age. The Scheffe post hoc test results further revealed that the middle-old has significantly better health-promoting behaviors than the young-old and the oldest-old.

On the other hand, no significant differences existed in the level of health-promoting behaviors of senior

citizens classified according to civil status, educational attainment and type of family structure.

Data in Table 6 revealed a significant difference in the degree of quality of life of older persons grouped according to monthly family income.

Table 6. Differences in the Quality of Life Among Older Persons Grouped According to Sex, Work Status, Monthly Family Income, and Health Status

Category	M	SD	df	t-value	Sig.
Sex					
Male	2.68	0.66	221	0.630	.529
Female	2.61	0.70			
Work status					
Employed	2.64	0.71	221	0.104	.917
	2.62	0.68			
Unemployed					
Monthly family income					
Low	2.16	0.56	212	14.21*	.000
High	3.11	0.43			
Health status					
With diagnosed medical condition	2.76	0.70	220	1.66	.098
Without diagnosed medical condition	2.58	0.68			

* $p < .05$

It appears that the older persons' degree of quality of life is significantly influenced by their family income. Those with higher family income have significantly better quality of life than those living with low-income families.

On the other hand, no significant differences existed in the degree of quality of life of older persons classified according to sex, work status, and health status.

The one-way analysis of variance (ANOVA) computations revealed that a significant difference existed in the degree of quality of life of older persons classified according to age. The Scheffe post hoc test results further revealed that the middle-old has significantly better quality of life than the young-old.

On the other hand, no significant differences existed in the degree of quality of life of older persons classified according to civil status, educational attainment and type of family structure.

Table 7. Results for the Differences in the Quality of Life Among Older Persons Grouped According to Age, Civil Status, Highest Educational Attainment, and Type of Family Structure

Category	Sum of Squares	df	Mean Square	F	Sig.
Age					
Between groups	8.00	2	4.00		
Within groups	96.93	220	0.44	9.09*	.000
Total	104.93	222			
Civil status					
Between groups	1.22	3	0.41	0.87	.460
Within groups	103.70	219	0.47		
Total	104.93	222			
Educational attainment					
Between groups	3.43	7	0.49	1.04	.407
Within groups	101.51	215	0.47		
Total	104.93	222			
Family structure					
Between groups	1.40	3	0.47		
Within groups	103.53	219	0.47	0.99	.399
Total	104.93	222			

* $p < .05$

Data in Table 8 showed that there was a positive substantial correlation and a highly significant relationship between health-promoting behaviors and quality of life.

Table 8. Correlation Matrix Showing the Relationship Between Health-promoting Behaviors and Quality of Life of Older Persons in Iloilo City(N=223)

	HPLPAVE	Remarks
QOLAVE	0.662*	Highly Significant
Sig.(2-tailed)	0.000	

* $p < .05$

This implies that the older persons' health-promoting behaviors significantly influenced their quality of life. The higher the health-promoting behavior, the better is the quality of life. Likewise, improvement in the degree quality of life of older persons is directly proportional to the frequency of their health-promoting lifestyles.

Data in Table 9 revealed that there was a positive substantial correlation and significant relationship among the six subscales of health-promoting behaviors and the four domains of quality of life.

First, health responsibility had a positive substantial and significant correlation with the four domains of QOL: physical health, psychological, social and environment. Second, physical activity also correlated positively with the four domains of QOL: physical health, psychological, social, and environment.

Table 9. Pearson Correlation Among the Six Subscales of Health-promoting Lifestyle Profile II and Four Domains of World Health Organization Quality of Life-BREF

		Physical Health	Psychological	Social	Environmental
Health responsibility	Pearson <i>r</i>	.632*	.511*	.577*	.627*
	<i>Sig.</i>	.000	.000	.000	.000
	<i>N</i>	223	223	223	223
Physical activity	Pearson <i>r</i>	.510*	.471*	.496*	.568*
	<i>Sig.</i>	.000	.000	.000	.000
	<i>N</i>	223	223	223	223
Nutrition	Pearson <i>r</i>	.513*	.439*	.443*	.562*
	<i>Sig.</i>	.000	.000	.000	.000
	<i>N</i>	223	223	223	223
Spiritual growth	Pearson <i>r</i>	.587*	.527*	.541*	.632*
	<i>Sig.</i>	.000	.000	.000	.000
	<i>N</i>	223	223	223	223
Interpersonal relations	Pearson <i>r</i>	.568*	.472*	.526*	.589*
	<i>Sig.</i>	.000	.000	.000	.000
	<i>N</i>	223	223	223	223
Stress management	Pearson <i>r</i>	.619*	.554*	.555*	.644*
	<i>Sig.</i>	.000	.000	.000	.000
	<i>N</i>	223	223	223	223

* $p < .05$

Third, there was a statistically significant relationship between nutrition and the four domains of QOL: physical health, psychological, social and environment.

Fourth, spiritual growth had a significant relationship with the four domains of QOL: physical health, psychological, social and environment.

Fifth, there was a positive correlation between the interpersonal relations and the four domains of QOL: physical health, psychological, social and environment.

Finally, a statistically significant relationship existed between the stress management and the four domains of QOL: physical health, psychological, social and environment.

V. CONCLUSIONS AND RECOMMENDATIONS

The over-all health promoting behavior of older persons in Iloilo City was low. It appears that the frequency that they engage in health promoting lifestyles was inadequate to promote health. This may be due to the interplay of factors that may have affected the older persons' knowledge about a healthy lifestyle and the consequences of unhealthy practices, and access and utilization of health services. The mean scores on the HPLP II subscales seem to imply that the older persons had healthy eating habits and good nutrition practices. However, there is a need to modify their lifestyles to improve self-awareness and spiritual growth, identify stressors and manage them appropriately, assume own health responsibilities, and

communicate and have better interpersonal relationships with their families and friends. Moreover, they need to engage in regular physical exercise. It is concluded that there is a dire need to improve the older persons' health promoting behaviors. Due to an increase in longevity, health promotion behaviors become more important in the maintenance of function, independence, and quality of life of older persons. The overall quality of life of older persons in the study was average. This implies that it is neither poor nor good. It appears that the older persons are neither satisfied nor dissatisfied with their psychological health, social relationships, and environment and they are least satisfied with their physical health. During the ageing process, an individual encounters psychological, social, environmental and physical changes that may affect his/her quality of life. Pathologic changes, coupled with progressive age-related changes, may lead to a decrease in function that can influence one's comfort, independence, freedom from pain, and cognitive and physical function. Further, the older persons' low promoting behaviors have placed them at risk for developing chronic illnesses and associated disabilities. Age, monthly family income, and health status significantly influenced the health-promoting behaviors of older persons. The 70 to 79 years old have significantly better health-promoting behaviors compared to those who are in their 60s. It can be inferred that as one gets older, the health promoting behavior increases. As one ages, he/she gains more life

experiences and becomes more health conscious in the process. When grouped according to monthly family income, those with higher family income had significantly better health promotion practices. The availability of finances can influence an individual's awareness, access, and utilization of health services as well as exposure to mass media, better education, and other opportunities to learn more about healthy lifestyle practices. When classified as to health status, participants with self-reported diagnosed medical condition have significantly better health-promoting behaviors. Knowledge of one's health condition can influence taking action to maintain health and prevent diseases. The experience of knowing that one is sick has likely increased the older person's health consciousness to maintain a better health condition. It was noted, however, that less than one out of four older persons in the study reported to have a diagnosed condition. It can be inferred that majority of them may be suffering from acute or chronic illness, but because they have not sought medical consultation, they remain to be undiagnosed. However, without regard to sex, civil status, educational attainment, family structure, and work status, the older persons in this study have comparable health-promoting behaviors. Only age and family income have significantly influenced the quality of life of the older persons. The middle-old have significantly better quality of life than the young-old. It appears that 70 to 79 year-old persons are more satisfied with their quality of life than those who are in their 60s. This may be due to the fact that the middle-old also have significantly better health promoting practices than the young-old. This might have influenced the middle-olds' satisfaction with their lives thus resulting to a more positive quality of life. In spite of their life experiences, they have seen the importance of maintaining a healthy life and a higher quality of life. Further, those with higher family income have significantly better quality of life. It can be noted that the participants belonging to this income class also have significantly better health promoting behaviors. Available resources may have influenced the observance of a healthier lifestyle, thus leading to a more positive outlook and better satisfaction with life. However, irrespective of sex, civil status, educational attainment, family structure, work status, and health status, the older persons tend to have comparable quality of life. The positive moderate correlations and highly significant relationships between health promoting behaviors and quality of life imply that health promoting, behaviors are important predictors for

the quality of life of of older persons in Iloilo City. It can be inferred that a healthy lifestyle can significantly influence the maintenance of function and independence, and at the same time, satisfaction with life among the older persons. Health-promoting behaviors play a key role in the quality of life. Improvement in health-promoting behaviors can result to better satisfaction and a more positive outlook in terms of the physical, social, psychological, and environmental domains of the quality of life. Therefore, programs and interventions geared towards the improvement of the older persons' control of their behavior to promote health and prevent diseases, can have a positive impact on their quality of life. The promotion of a healthier lifestyle should be considered as a major strategy in the improvement of the quality of life of older persons. It is recommended that the Office for Senior Citizens' Affairs- Iloilo City Chapter, Department of Health Region VI, the PHILHEALTH, DSWD, and other government and non-government organizations committed to promote health and improve the quality of life of older persons. The needs of the senior citizens must be addressed by these programs. Older persons who are living in poverty, are chronically-ill, and with disability must be given priority. Policymakers should consider direct family support and uphold the value of family solidarity in order to maintain healthy behaviors and a high quality of life among vulnerable older persons who are living in extreme poverty. It is strongly recommended that age-appropriate, low-cost and practical community health programs may be provided for older persons. Focus may be placed on promotion of physical activity, spiritual growth, nutrition, health responsibility, interpersonal relationship, and stress management; hence enabling them to improve their health-promotion practices. Nurses and allied professionals should consider the importance of life-long learning among older persons. Community health workers may perform age-appropriate screening tests such as routine blood pressure check-up and physical assessment. Those with signs and symptoms should be referred to the barangay health center to be examined by a medical doctor. Nurses can take part in strengthening the support systems of families with an older person by being a part of it, or by identifying available community resources that are socially and financially feasible. In this light, support groups for families of the older persons can be organized. The nurses act as facilitators of these support groups. Nurses and allied health professionals must promote holistic care of older persons in the delivery of

primary, secondary, and tertiary prevention. The older person and family members or significant others must be involved in the nursing process, A Day Care Program for older persons, aside from the existing Asilo de Molo, Home for the Older Persons in Iloilo City may be initiated. This can be spearheaded by the OSCA and DSWD. Day care facilities may cater to abandoned, abused, neglected, and needy senior citizens, The Care of the Chronically-Ill and the Older Person, Elective II in the 4th Year, 2nd semester as embodied in the CHED Memorandum 14 series of 2009, should be strengthened, enhanced, and refined. Community-based related learning experiences should be encouraged with emphasis on the current trends and issues and evidence-based interventions in the care of the older persons. Curriculum development for this elective is deemed to be relevant, Filipino nurses and medical researchers should further study the health-promoting behaviors and quality of life of Filipino older persons. These populations reflect the socioeconomic diversity within the community and diversity in geographic locations. Comparative studies of Filipino elderlies can also be studied with regard to their living arrangement, A study on the attitudes towards ageing and toward older persons among healthcare professionals, including students taking up nursing, medicine and allied health sciences, is also recommended. The research paradigms may include qualitative and quantitative methodology and may be longitudinal in design. Finally, the use of diet, exercise, activity, rest and relaxation, and social support as research variables of interest in self-care and health promotion of older persons would seem efficacious and may be researched quantitatively and qualitatively.

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