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# Older Adults' Perceptions of Alternative Arthritis Management

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**Abstract.** This qualitative phenomenological study explored the perceptions and lived experiences of older adult women in Barangay Looc, Mandaue City, concerning alternative management strategies for osteoarthritis. Addressing a gap in the literature on culturally rooted non-pharmacological practices, the study aimed to understand how older women managed joint pain without or instead of Western medicine. Using purposive and snowball sampling, six female participants aged 60 and above were selected and interviewed using a semi-structured guide. Data were analyzed through thematic analysis. Results revealed five core insights: (1) the widespread use of culturally embedded self-management practices such as hilot, tuba-tuba, and gabon; (2) significant fear and mistrust of pharmaceutical treatments due to personal or familial trauma; (3) the persistence of complex physical symptoms such as pain, stiffness, and fatigue; (4) the pursuit of partial relief as a sufficient outcome to maintain functionality; and (5) the restoration of agency through functional independence. Although traditional remedies often provided only temporary relief, they were viewed as effective in enabling daily activities and preserving autonomy. These findings emphasize the importance of culturally sensitive, trauma-informed geriatric care and the integration of traditional practices into nursing strategies. The study concludes that recognizing culturally grounded practices supports patient-centered care, improves adherence, and enhances quality of life for older adults with osteoarthritis.

**Keywords:** Alternative management; Arthritis; Joint pain; Non-pharmacological remedies; Older adults.

## 1.0 Introduction

Osteoarthritis, a leading cause of chronic pain and disability among older adults, significantly impairs mobility and quality of life worldwide. The degenerative nature of this joint disease imposes a heavy burden on physical functioning, particularly in aging populations. In the Philippines, where older adults often face economic challenges and limited access to health services, alternative or non-pharmacological treatments remain a common choice for managing osteoarthritis symptoms (Sullivan et al., 2019; Petersen et al., 2023). Globally, there is growing interest in the use of complementary and alternative medicine (CAM) to manage chronic illnesses. Sullivan et al. (2019) found that older individuals often prefer CAM due to its perceived safety and compatibility with holistic health beliefs. Similarly, Petersen et al. (2023) and Wang et al. (2022) reported that older adults are drawn to culturally familiar, self-directed remedies that support autonomy. Rondilla et al. (2021) emphasized that Filipino elders rely heavily on indigenous healing practices, including herbal treatments and hilot (traditional massage), due to their affordability and cultural significance. Meanwhile, Ferreira et al. (2023) highlighted the persistent

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functional limitations caused by osteoarthritis despite continued use of conventional treatments, suggesting that alternative approaches play a vital role in everyday symptom management.

The continued use of traditional remedies such as haplas, tuba-tuba leaves, gabon compresses, and hilot reflects a deep connection between health and culture. However, scholarly understanding of how older adults perceive these practices remains limited, particularly in low-resource communities. There is a need to explore the cultural, emotional, and practical motivations behind treatment preferences and behaviors among the elderly. Despite the increasing acceptance of CAM, limited studies have investigated the subjective meanings older adults attach to their treatment choices, especially in localized, culturally distinct areas like Barangay Looc, Mandaue City. This gap is important to address, as it influences how nurses, public health educators, and policy-makers engage with older populations. Without understanding patients' cultural frameworks, health interventions risk being misaligned with the values and expectations of the communities they serve (Papadopoulos, 2021).

This study addressed this gap by exploring the lived experiences and treatment perceptions of older adult women with osteoarthritis in Barangay Looc. Drawing upon the Gate Control Theory of Pain (Melzack & Wall, 2020) and empowerment-based care frameworks (Wang et al., 2022), the research examined how beliefs and backgrounds influenced the adoption of non-pharmacological strategies. The findings of this study contribute to culturally competent geriatric nursing, health policy, and education by offering insights into age- and culture-specific pain management preferences. The results have implications for community-based nursing practice, particularly in underserved areas where alternative remedies are integrated into everyday life. Thus, this research aimed to deepen understanding of the functional, cultural, and emotional dimensions of arthritis management among older adults, while promoting inclusive, patient-centered care aligned with Sustainable Development Goal 3.

## 2.0 Methodology

### 2.1 Research Design

This study utilized a qualitative phenomenological design to explore the lived experiences and treatment perceptions of older adults in Barangay Looc, Mandaue City, regarding their use of alternative management strategies for osteoarthritis. The phenomenological approach, grounded in Patton (1990), was selected for its ability to capture the richness of participants' subjective experiences. This design was appropriate in addressing the research questions as it facilitated an in-depth understanding of cultural and emotional contexts that influenced pain management decisions.

### 2.2 Research Informants

Participants were selected through purposive and snowball sampling. The inclusion criteria were: female, aged 60 and above, clinically diagnosed with osteoarthritis, and residents of Barangay Looc. Exclusion criteria included cognitive impairment or inability to provide informed consent. Participants were classified into WHO-designated age subgroups: young-old (60–74), middle-old (75–84), and old-old (85+). A total of six participants were selected, sufficient to achieve data saturation in phenomenological research.

### 2.3 Research Instrument

This study employed a researcher-made semi-structured interview guide as the primary data collection tool. The questions were developed based on a review of relevant literature on alternative and culturally rooted approaches to osteoarthritis management (Nguyen et al., 2011; Papadopoulos, 2021) and were aligned with the study's objectives. The guide featured open-ended questions designed to elicit participants' perceptions, experiences, and practices related to non-pharmacological pain management.

To ensure content validity, the interview guide was reviewed and approved by a content expert in qualitative and geriatric nursing. It was also graded and endorsed by two Master of Arts in Nursing (MAN), Registered Nurses (RN) as part of the university's research evaluation process. Although pilot testing was not conducted, trustworthiness was maintained through consistent delivery of interview questions and peer validation. While statistical reliability is not typically applied in qualitative research, dependability was supported through reflexive practices and adherence to the study protocol.

### 2.4 Data Gathering Procedure

This section presents the process of data collection employed in the study. To understand the effectiveness and

acceptability of non-pharmacological approaches among older adults with osteoarthritis in Barangay Looc, Mandaue City, the researchers used a qualitative approach incorporating semi-structured interviews. Prior to data collection, permission was obtained through formal letters sent to key authorities, including the Dean of the University of Cebu College of Nursing, the Barangay Captain of Barangay Looc, and the local health center. These letters detailed the study's purpose, ethical safeguards, and the researchers' intent to collaborate with the local community.

With approval granted, the data collection took place over seven days. Researchers visited various areas within the barangay and conducted on-the-spot, in-depth interviews with older adult women who met the inclusion criteria. Initial participants were identified through barangay referrals and expanded through snowball sampling. Interviews were conducted in participants' homes or other comfortable locations, using Cebuano as the medium. Each session lasted 30 to 60 minutes. No fixed schedule was used to ensure participant comfort and voluntary participation. All interviews were recorded using mobile devices and supplemented by handwritten field notes.

### 2.5 Data Analysis Procedure

This study involved the collection and analysis of qualitative data. Verbatim transcripts from the semi-structured interviews were analyzed using thematic analysis based on the process described by Morse et al. (2002). Researchers read each transcript multiple times to gain a comprehensive understanding of participants' lived experiences. Coding was conducted inductively, with emerging concepts grouped into categories and synthesized into overarching themes.

To ensure validity and trustworthiness, several techniques were applied. Member checking was used by presenting preliminary findings to selected participants for feedback and confirmation. Peer debriefing was conducted by consulting with experienced qualitative researchers to validate the interpretation of themes. An audit trail was maintained to document all coding decisions and analysis steps, enhancing the transparency and dependability of the results. Data triangulation was also achieved by integrating field notes with transcribed narratives.

Although statistical reliability is not applicable in phenomenological studies, consistency in analysis was ensured by following a structured coding process. A reflexive approach and adherence to qualitative research standards supported the integrity of the findings.

### 2.6 Ethical Considerations

This study received ethical clearance from the University's Research Ethics Committee. Prior to data collection, participants were provided with a detailed information sheet outlining the study's objectives, procedures, potential risks and benefits, and their rights as voluntary participants. Written informed consent was obtained before any interviews were conducted. To safeguard participant privacy, all identifying information was removed from transcripts and field notes, and data were coded to ensure anonymity. All research data were securely stored and accessible only to the research team, with audio recordings deleted after transcription and verification. Participants were reminded of their right to withdraw at any point without penalty, and interviews were conducted in private and respectful settings. The researchers followed the ethical principles outlined by McNeilly et al. (2020), ensuring participant protection, confidentiality, transparency, and the overall moral integrity of the study.

## 3.0 Results and Discussion

### 3.1 Culturally Embedded Self-Management Practices

The first and most dominant theme that emerged from the participants' narratives was the profound reliance on culturally embedded self-management practices for managing osteoarthritis. This reliance extended far beyond mere preference—it was tied to their identity, values, and sense of continuity with ancestral knowledge. All six participants articulated a belief that their methods of healing and pain relief—such as the use of herbal poultices, hilot (traditional massage), tuba-tuba (Jatropha leaves), gabon, atis leaves, and various kinds of haplas (topical oils)—were not just alternatives to biomedical interventions but were the primary and often only acceptable means of managing their chronic joint pain.

Older adults in Barangay Looc learned these practices from their elders and community members, and they passed them down to younger generations. This transmission of knowledge reinforced a collective sense of trust in these methods. In many ways, these remedies served as both physical and psychological tools—restoring not only temporary comfort but also personal autonomy and social belonging. One participant noted:

*"Mag haplas, mag hilot… mao na gyud ni sukad pa sa among ginikanan"*
(I apply oils, get massages… we have done this since our ancestors).

This revealed how their treatment behaviors were deeply woven into the community's cultural fabric.

The accessibility of these remedies also played a central role in their use. Most participants indicated that purchasing pharmaceutical drugs was financially burdensome. In contrast, herbal remedies could be grown at home or sourced locally. The preparation of these treatments, whether by steeping, pounding, or boiling plants, was often performed with confidence and pride, showcasing a kind of experiential health literacy that is frequently overlooked in clinical settings. Their perceived safety, minimal side effects, and cultural relevance made these treatments the default option for managing pain, particularly among middle-aged and older participants.

Notably, variations emerged across age categories. The young-old participants (ages 60–74) were more open to hybrid practices, occasionally combining traditional methods with pharmaceuticals, especially during pain flare-ups. They expressed a balanced perspective, believing that while Western medicine might offer fast relief, traditional approaches ensured long-term well-being. In contrast, middle-aged participants (75–84) demonstrated staunch adherence to traditional practices, often rooted in mistrust of medical institutions. For them, traditional healing represented both resistance to external influence and affirmation of cultural heritage. The lone old-old participant (85+) embodied pragmatic flexibility. Having lived through different eras of healthcare access, she chose treatments based on availability and perceived effectiveness rather than loyalty to a particular system.

These findings echo those of Rondilla et al. (2021), who emphasized the persistence of Filipino traditional healing practices in the face of globalization and modernization. Similarly, Sullivan et al. (2019) and Petersen et al. (2023) observed that older populations globally are increasingly inclined to integrate cultural knowledge with personal health management, particularly when conventional healthcare systems are perceived as inaccessible or impersonal. In this context, culturally embedded self-management strategies are not only valid forms of care but essential to the physical, emotional, and cultural resilience of aging populations.

Thus, geriatric nurses and healthcare practitioners must take into account these cultural preferences when designing and implementing pain management plans. Rather than dismissing such practices as unscientific or outdated, professionals should seek to validate and integrate them where possible. By fostering a respectful and inclusive dialogue, healthcare providers can bridge the gap between traditional wisdom and modern medical knowledge, ultimately enhancing patient trust and adherence.

**3.2 Fear, Trauma, and Mistrust of Pharmaceuticals**
A powerful and recurring theme across participant narratives was the presence of fear, trauma, and mistrust toward pharmaceutical medications. For many of the older adult women interviewed, their aversion to Western medicine was deeply emotional, influenced by past experiences that had left lasting psychological imprints. Their narratives revealed that decisions around pain management were not made purely based on rational evaluation of effectiveness or cost, but instead were entangled with personal and familial histories of perceived medical harm.

Several participants recounted instances where medications, especially those for pain, were believed to have caused severe side effects or even death. One particularly emotional account came from Participant A, who stated:

*"Mahadlok ko muinom og tambal… namatay akong bana tungod sa tambal"*
(I am afraid to take medicine… my husband died from medicine).

This statement was echoed in different ways by others, with concerns centering particularly around kidney failure and internal damage. Pharmaceutical medications, mainly when prescribed for long-term use, were perceived not only as ineffective but also as potentially fatal.

This pervasive fear was especially dominant among the middle-aged participants (75–84). For them, Western medicine symbolized a dangerous external force, disconnected from their lived realities and bodily knowledge. This group was also the least likely to have had consistent access to quality healthcare during earlier decades, which may have contributed to a compounded mistrust over time. Scientific data did not typically inform their understanding of medication risks, but by lived observation: witnessing others who became worse or died shortly after starting medication.

Young-old participants (60–74), though still wary, exhibited a more ambivalent stance. They were more likely to use medication when pain became unbearable or when healthcare providers whom they trusted recommended it. However, even they expressed a need for reassurance and were more inclined to stop medication once symptoms subsided. This "conditional acceptance" highlights an important space for health intervention: the trust between nurse and patient. With appropriate dialogue and support, some patients may be open to carefully monitored pharmaceutical use as an adjunct to their traditional methods.

The old-old participant in the study presented a notably practical attitude. She acknowledged fears but prioritized what was effective and available. She had witnessed both good and bad outcomes from medication and no longer viewed it as wholly negative or positive. Instead, she described selecting treatment based on what helped her continue her routine with minimal interruption. This realism, built on decades of navigating healthcare on her terms, suggested that for some older adults, decisions are made on a case-by-case basis rather than from fixed beliefs.

Research supports these qualitative observations. McNeilly et al. (2020) argue that mistrust of healthcare systems among older adults is often grounded in real experiences of exclusion, miscommunication, or harm. Alzubaidi et al. (2020) found that older patients' concerns about side effects were among the most significant barriers to medication adherence, particularly in communities with strong cultural traditions. These concerns are not necessarily irrational—they reflect the historical failure of healthcare systems to address patients' emotional and cultural realities.

Importantly, participants also distinguished between types of medication. Oral drugs, especially those for daily maintenance, were seen as more dangerous than topical or "external" applications. This distinction reveals an embodied understanding of medicine: what is ingested is seen as invasive, while what is applied externally is more controllable and thus less threatening. Oils, rubs, and liniments were widely accepted—even when purchased from pharmacies—because they were perceived as gentle and non-disruptive to internal systems.

These insights hold crucial implications for geriatric care. Healthcare providers must develop trauma-informed strategies when introducing pharmaceutical options to older adults who have experienced or witnessed adverse outcomes. These strategies should include not only education about medication safety but also time for listening, building rapport, and negotiating treatment plans. It is also essential to acknowledge patients' fears as legitimate, rather than dismissing them as ignorance or noncompliance.

Effective communication in this context must be culturally tailored. For example, it may involve explaining medication regimens using local analogies or community role models who have successfully used both traditional and Western treatments. Nurses may need to engage with family members who hold influential opinions about care. Furthermore, healthcare facilities should consider integrating traditional healers or cultural mediators who can bridge the trust gap and facilitate shared understanding.

Ultimately, this theme emphasizes that mistrust is not an obstacle to be "fixed" but a reality to be respected and carefully navigated. When healthcare providers approach patient resistance with humility and cultural sensitivity, they open the door to more meaningful and sustainable healthcare relationships.

**3.3 Persistence of Physical Symptoms**

Another central theme in the study was the persistence and complexity of physical symptoms associated with osteoarthritis. All participants, regardless of age, described a continuous struggle with pain, stiffness, swelling, numbness, weakness, and fatigue. These symptoms affected multiple areas of the body but were most commonly

reported in the knees, hips, and lower back—areas crucial for mobility and performing daily tasks. The chronic nature of these symptoms shaped how participants viewed their condition and informed the strategies they used to manage it.

Unlike acute illnesses, osteoarthritis presented for these women as a constant, fluctuating presence in their lives. The symptoms did not appear as isolated episodes but as a continuum that varied in intensity from day to day. Some days were better, others worse—but the pain never truly disappeared. This ever-present discomfort was deeply personal and, as described by one participant:

*"Sakit sa tuhod, hawak, likod… panluya, banhod, kakapoy"*
(Pain in knee, hip, back… stiffness, numbness, fatigue).

Her words illustrated how this condition manifested not only as physical suffering but also as a draining, exhausting experience that permeated every aspect of life.

Participants also described how environmental and dietary triggers influenced symptom severity. Cold weather, for example, was frequently cited as a factor that intensified joint pain and stiffness. Similarly, the consumption of certain foods, such as those perceived as "malamig" (cold), was believed to exacerbate discomfort. These observations reflected an understanding of illness that integrated both physical and environmental elements, consistent with indigenous Filipino health beliefs (Rondilla et al., 2021). Such beliefs did not contradict biomedical explanations but coexisted with them, offering patients a richer, more nuanced framework for interpreting their experiences.

The response to these persistent symptoms was not passivity, but adaptation. Participants described having developed personal regimens over time—daily rituals involving hilot, warm compresses, herbal drinks, and periods of rest—to cope with pain and maintain function. When symptoms were mild, a simple massage or application of oil would suffice. When symptoms flared, some turned to over-the-counter medications, though often with hesitation or after exhausting traditional methods. These individual strategies, honed through experience, exemplify what Nguyen et al. (2011) call "lay expertise"—the ability of patients to manage chronic illness through trial-and-error and accumulated knowledge.

This process of adaptation was not without limitations. The older participants, especially the middle-old and old-old, admitted that specific movements or tasks had become impossible due to persistent symptoms. One participant remarked that while she could still clean and cook, she could no longer bend down to sweep under the furniture or carry heavy containers of water. However, rather than expressing despair, she focused on what she could still do, not what she had lost. This attitude highlighted a critical shift in how older adults framed their health: less in terms of complete recovery and more in terms of maintaining a functional baseline.

The literature supports the idea that older adults prioritize function over symptom elimination. Abdulla et al. (2019) and Ferreira et al. (2023) both argue that chronic pain in older populations should be managed with an emphasis on quality of life rather than complete eradication of pain, which is often unrealistic. These researchers advocate for a goal-oriented approach in which symptom control is calibrated around functional targets—such as walking unassisted, climbing stairs, or sleeping through the night.

In line with these principles, participants in this study expressed that pain relief, while desirable, was not their ultimate goal. Their primary concern was how their symptoms affected their ability to perform tasks essential for daily living. As one participant put it:

*"As long as I can still cook for my grandchildren, I can bear the pain."*

This powerful statement demonstrates that these women measured the success of their arthritis management not in medical terms, but in human terms—whether or not they could still fulfill their roles as caregivers, homemakers, and community members.

The fluctuating nature of symptoms also contributed to emotional and psychological strain. Participants

expressed frustration, sadness, and occasional hopelessness, especially when they experienced flare-ups that forced them to rest or seek help. However, these moments of vulnerability were often countered by a strong sense of resilience. Many found strength in their routines, in their faith, or in the knowledge that others shared their symptoms in the community. This communal aspect of suffering, while not reducing the pain itself, helped normalize the experience and reduce feelings of isolation.

These findings suggest that healthcare professionals must take a comprehensive view of chronic pain management—one that encompasses physical, emotional, and cultural dimensions. Standard clinical assessments may not capture the full impact of persistent symptoms on older adults' lives. Nurses should be trained to conduct narrative-based assessments, allowing patients to share how their symptoms affect daily routines and sense of self. Such approaches not only provide more accurate information but also affirm the patient's expertise in managing their condition.

Additionally, clinicians should recognize that persistent symptoms often lead to treatment fatigue. Patients may become disillusioned with interventions that promise relief but fail to deliver sustained benefits. In this context, setting realistic expectations, celebrating minor improvements, and validating the patient's efforts become essential parts of care. Encouraging small daily wins—like being able to walk to the kitchen unaided or sleep through the night—can boost morale and reinforce adherence to management plans.

Overall, the persistence of physical symptoms in osteoarthritis demands more than medical treatment. It requires a holistic understanding of how older adults live with and respond to pain. The experiences of the participants in this study reveal a rich tapestry of strategies, beliefs, and emotional resilience, shaped by years of navigating their illness. Recognizing and supporting this complex reality should be a cornerstone of geriatric nursing care.

**3.4 Temporary Relief, Functional Sufficiency**

A salient insight that emerged from the participants' responses was a redefinition of what constituted "successful" pain management. Rather than seeking permanent or complete relief from osteoarthritis symptoms, the older adult women in this study expressed satisfaction with temporary or partial relief—so long as it enabled them to accomplish their daily tasks. This concept, referred to here as "functional sufficiency," reflects a pragmatic approach to chronic pain management, rooted in lived realities rather than idealized biomedical outcomes.

Participants often began their accounts of pain management by describing the types of relief they obtained through herbal compresses, topical ointments, or hilot. These traditional methods were described as *"temporary," "bitaw gamay lang muhunong"* (just enough to stop [the pain] a little), or *"makalihok na ko"* (I can move again). Although none of these remedies eliminated the symptoms, their ability to restore short-term functionality—such as walking without limping, bending over, or sweeping the floor—was highly valued. As one participant phrased it, *"Basta makatindog ko, maayo na"* (As long as I can stand up, that is already good).

This functional lens was consistent across age groups, though the specific tasks associated with functionality varied. The young-old participants (60–74), who were often still engaged in economically productive activities such as selling goods or fetching water, prioritized pain relief that allowed them to remain mobile and active outside the home. For them, being able to walk to the market or tend to a small garden represented more than utility—it was also a matter of pride and continued contribution to household income.

Middle-aged participants (75–84) had largely transitioned into more domestic roles and emphasized their ability to perform housework, cook meals, and provide care to grandchildren. They reported that even modest relief was enough to let them complete these tasks, which they viewed as essential to their identity and familial values. One participant expressed:

*"Makalaba ko, makasilhig gihapon, mao nay importante"*
(I can still do laundry and sweep—that is what matters).

The lone old-old participant (85+) focused on the simplest yet most critical form of functionality: mobility. She reported that when her knees hurt less, she could walk to the bathroom without help. This, she said, gave her a sense of "freedom" and helped her avoid burdening her family. For her, the goal of pain management was not

productivity or caregiving but maintaining dignity and self-sufficiency in her most basic needs.

This emphasis on functionality over cure resonates with the concept of "meaningful relief" described by Benson et al. (2020), which asserts that older adults often assess treatments based on their ability to help restore participation in daily life rather than on complete symptom elimination. Similarly, Tao et al. (2023) argue that older patients interpret therapeutic success through the lens of their roles, routines, and personal goals, rather than biomedical indicators. This contextual definition of success calls into question the effectiveness of standard clinical pain assessments, which may overlook the subjective and culturally constructed dimensions of pain experience.

Participants' emphasis on temporary relief as "good enough" also underscores a deep acceptance of the chronic nature of their condition. They did not harbor expectations of full recovery or long-term remission; instead, they sought ways to "live with" their arthritis in a manner that preserved autonomy. In this light, temporary relief strategies such as herbal balms and hilot were not inferior to pharmaceuticals—they were seen as more aligned with the body's natural rhythm and more compatible with their daily lives.

Interestingly, even when pharmaceutical drugs provided longer-lasting relief, participants often preferred traditional remedies because they did not interfere with their routines. Oral painkillers were viewed as potent but potentially disruptive due to side effects such as dizziness, drowsiness, or gastrointestinal upset. One participant mentioned:

*"Di ko ganahan og tambal nga makatulog ko permi. Gusto ko lihok gihapon ko"*
(I do not like medicine that makes me sleepy. I want to keep moving.

This statement illustrates how the perception of a treatment's value is intricately tied to its effect on functional independence.

The value placed on movement—on being able to act, help, or get around—was further reinforced by the emotional satisfaction participants derived from their roles. For example, the act of cooking for a grandchild or cleaning a shared living space was not only a physical accomplishment but also a reaffirmation of their identity as caregivers. When traditional remedies enabled such acts, even temporarily, they were embraced as successful treatments.

This finding challenges healthcare providers to reconsider how treatment outcomes are measured. In settings like Barangay Looc, success cannot be determined solely by reductions in pain scores or improvements in joint flexibility as recorded in clinical settings. Instead, it must be informed by the patient's metrics: Can they walk to the store? Cook dinner? Sleep through the night? These questions reflect what matters to older adults managing chronic conditions.

Healthcare professionals should thus adopt a goal-oriented, person-centered approach to pain management. Rather than focusing solely on pharmacological interventions with the intent to eliminate symptoms, providers must work collaboratively with older adults to define functional targets. These targets will vary depending on age, role, and personal values, but should always reflect the individual's lived experience.

Moreover, recognizing the legitimacy of partial relief can foster better communication between patients and providers. When healthcare workers understand that "enough to move" is often the benchmark for success, they can better align treatment recommendations with patient expectations. This also opens the door to integrating traditional remedies within formal care plans, particularly when they demonstrate effectiveness in supporting functional goals.

In conclusion, the emphasis on temporary relief and functional sufficiency reflects an efficient and culturally informed approach to osteoarthritis management. Older adults in this study redefined success not by the absence of pain but by their ability to live well despite it. Their perspectives compel us to expand our definitions of care, making room for flexibility, cultural understanding, and a sincere appreciation of what it means to remain functional in old age.

**3.5 Agency through Functional Independence**

The final core theme that emerged from the narratives of participants was the restoration and preservation of personal agency through functional independence. This theme reflected a profound link between the ability to manage arthritis symptoms—even minimally—and the maintenance of dignity, identity, and self-determination in later life. Participants articulated that their ultimate goal was not simply to reduce pain or follow a prescribed treatment but to remain in control of their daily lives. In doing so, they framed arthritis not solely as a medical condition but as a challenge to their autonomy—a challenge they actively resisted through self-care and determination.

For the women in this study, being able to perform everyday tasks was not merely about convenience; it was deeply connected to their sense of worth and purpose. These tasks included cooking, cleaning, caring for grandchildren, and attending church or community gatherings. Performing them independently meant that they were still contributing members of the household and community, despite advancing age and illness. One participant shared:

*"Makahimo pa ko og buluhaton, makaluto, makalimpyo"*
(I can still do chores, cook, clean).

Her tone was not one of resignation but of pride—independence was not only functional, but symbolic of her ongoing relevance.

Age-specific variations were again evident. Young-old participants emphasized mobility and engagement in external activities. They described doing errands, joining church groups, and even participating in small-scale trading or market selling. These activities gave them a sense of productivity and social belonging. When arthritis symptoms restricted these actions, participants expressed frustration, not just because of the pain, but because of the perceived loss of contribution to society.

Middle-aged participants emphasized domestic productivity. For them, wellness was defined by their ability to maintain the home environment—cooking meals, washing clothes, and taking care of grandchildren. These roles were often seen as extensions of their identity as mothers and matriarchs. Inability to perform these roles was interpreted as a loss of status and personal agency. One middle-old participant explained:

*"Kung di ko makabuhat sa balay, mura kog way pulos"*
(If I can't do housework, I feel useless).

Her statement highlights the emotional toll of functional decline, beyond physical limitations.

The old-old participant offered perhaps the most distilled perspective: the core of her independence was the ability to manage personal hygiene and mobility without assistance. She described small victories, such as standing up from bed unassisted or walking to the bathroom alone, as triumphs. These moments, though physically minor, held tremendous symbolic weight. For her, needing help was equated with burdening her children, an outcome she wished to avoid at all costs. This reflects a well-documented cultural value in Filipino households where older adults strive to remain helpful and not "be a burden" (Iskak & Pa-alisbo, 2019).

The centrality of agency in the experience of chronic illness has been emphasized in the literature. McAuley et al. (2020) demonstrated that perceived autonomy is one of the strongest predictors of life satisfaction in older adults. Similarly, Papadopoulos (2021) advocated for a person-centered approach in geriatric nursing, one that recognizes how deeply autonomy is woven into cultural, emotional, and psychological well-being. The findings of this study affirm that for older women with osteoarthritis, agency is not a luxury—it is a fundamental need.

Moreover, participants in this study made active decisions about how to manage their illness, even when those decisions contradicted biomedical advice. Their choices—to prioritize hilot over tablets, to keep moving despite pain, or to hide symptoms to avoid being pitied—were informed by personal philosophies of resilience and dignity. These decisions were not made lightly; they were strategic, based on long-standing experience and contextual understanding of their bodies. One participant remarked:

*"Basta makalihok ko, di ko magreklamo"*
(As long as I can move, I won't complain).

This attitude reflected both strength and stoicism, but also the normalization of discomfort as a trade-off for autonomy.

Participants also described how functional independence influenced their emotional state. Being able to contribute to household routines or participate in communal prayer gave them a sense of normalcy, which in turn reinforced psychological well-being. Conversely, periods of functional decline—when pain was too severe or when help was needed for basic activities—were associated with feelings of frustration, guilt, and even shame. These emotional states were not necessarily rooted in physical suffering, but in the perceived erosion of personal and social identity.

This dynamic further underlines the importance of culturally competent and emotionally sensitive nursing care. Health professionals must understand that for many older adults, especially women in tight-knit communities, independence is not simply about safety or convenience—it is about dignity. Recommendations that limit movement or suggest long-term dependency, even if medically sound, may be perceived as dehumanizing if not framed appropriately.

Nursing interventions that support functional independence may include teaching energy-conservation techniques, facilitating access to mobility aids, offering culturally familiar exercises, or even involving family caregivers in ways that preserve, rather than replace, the older adult's role. For example, rather than taking over household tasks entirely, caregivers can offer assistance that empowers the patient to perform tasks at a modified pace. Healthcare practitioners should also validate and celebrate small milestones in independence, using language that reinforces competence and self-worth.

Importantly, this theme also has implications for public health messaging. Community-based programs should move beyond generic advice about "healthy aging" to recognize and promote the specific roles that older adults play within households. Messages that reinforce their value as caregivers, advisors, and cultural stewards can strengthen motivation to remain independent and adhere to self-care practices.

In summary, the narratives of these older women reveal that managing arthritis was not merely about controlling pain, but about maintaining agency through the preservation of functional independence. Whether walking unaided, cooking for a grandchild, or choosing a preferred treatment, each act of autonomy served as a reaffirmation of identity and personal worth. Geriatric care must therefore go beyond clinical outcomes and seek to honor the person behind the patient—supporting not just the aging body, but the enduring self within.

## 4.0 Conclusion

This study offers a deeper look into how older adult women in Barangay Looc, Mandaue City, manage osteoarthritis using culturally rooted, non-pharmacological practices. Through a phenomenological approach, it shows that treatment decisions—across the young-old, middle-old, and old-old groups—are shaped not only by physical needs but also by cultural beliefs, personal goals, and life experiences. Traditional remedies such as haplas, herbal compresses, and hilot were chosen not just for being accessible and affordable, but because they held personal and cultural meaning, helping participants maintain their independence and carry out daily routines.

A key contribution of this study lies in its nuanced understanding of how age-related differences influence self-care decisions in osteoarthritis management. By highlighting the functional goals prioritized by each age group—ranging from productivity to routine maintenance to basic mobility—the study challenges conventional approaches to chronic pain care, which often emphasize symptom eradication over functional adaptation. The findings underscore the importance of tailoring care plans to the personal and age-specific realities of older adults, rather than applying uniform treatment models.

From a nursing practice perspective, the study provides critical evidence supporting the integration of culturally familiar and patient-defined remedies into care strategies. This approach not only aligns with the principles of

person-centered care but also enhances patient trust, adherence, and overall well-being. For health policy, the research calls attention to the need for inclusive frameworks that recognize traditional healing systems as legitimate components of community health infrastructure, particularly in underserved areas where biomedical services may be limited or distrusted.

In terms of nursing education, the study highlights the importance of incorporating cultural competence and trauma-informed care into gerontological nursing curricula. Nursing students and professionals must be trained to navigate the emotional and cultural dimensions of care, especially when engaging with older adults who have longstanding relationships with alternative practices. Educational programs should also encourage reflective practice and community engagement, allowing future nurses to build trust and rapport with patients who operate within distinct cultural paradigms.

The implications for future research are equally significant. Further studies are needed to explore the clinical efficacy and safety of widely used traditional remedies, including potential interactions with pharmacological treatments. Longitudinal studies could examine how older adults adapt their pain management strategies over time and how cultural practices evolve across generations. Comparative studies across different regions or ethnic groups may also provide valuable insights into the diversity of osteoarthritis experiences and management.

In conclusion, this study advances the discourse on culturally responsive, function-focused geriatric care. By recognizing traditional practices as integral to older adults' health strategies, it paves the way for more inclusive, respectful, and sustainable models of osteoarthritis management. The findings reaffirm the importance of honoring cultural context in health care delivery and call for collaborative, interdisciplinary efforts to bridge traditional and biomedical knowledge systems in the service of aging populations.

## 5.0 Contributions of Authors

The authors indicate equal contribution to all sections and have reviewed and approved the final version.

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## 7.0 Conflict of Interests

The authors declare no conflict of interest regarding the publication of this paper.

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