HeLP (Healthy Lifestyle Practices): Basis for Health Promotion, Community Wellness Program, and Extension Service Development in a Rural Barangay of a Lake Town Municipality

Prof. Sheela Mae N. Bagacina, MAN
Camarines Sur Polytechnic Colleges

HOW TO CITE:
Sheela Mae N. Bagacina, (2026). HeLP (Healthy Lifestyle Practices): Basis for Health Promotion, Community Wellness Program, and Extension Service Development in a Rural Barangay of a Lake Town Municipality International Journal of Special Education, 41(13s), 1003-1014

ABSTRACT:

Rural and geographically isolated communities in the Philippines face increasing risks from lifestyle-related noncommunicable diseases, yet evidence-based data to guide community-level interventions remain limited. This study assessed the healthy lifestyle practices of residents in Barangay San Ramon, Buhi, Camarines Sur, a Geographically Isolated and Disadvantaged Area (GIDA), to inform the development of a targeted community wellness program and extension service. A descriptive survey and total enumeration method were used to collect data from 328 households, including 13 newly relocated families, using a validated researcher-made questionnaire. Most respondents were female (69.5%), aged 42 and above (47.9%), married (54.3%), Roman Catholic (79.9%), elementary graduates (37.8%), laborers (32.0%), and low-income earners (₱5,000 and below) at 75.3%. Moreover, 42.4% were classified as non-NHTS, indicating varying levels of socioeconomic vulnerability. A family history of hypertension was reported by 49.7%, and 36.3% had current cases. Healthy lifestyle behaviors such as proper diet (M=2.65), physical activity (M=2.53), and stress management (M=2.51) were "often" practiced. Sleep hygiene (M=2.4) was "sometimes" observed, and vices (M=1.47) were rarely engaged in. Physical (M = 2.55) and social/environmental (M = 2.42) factors had a moderate influence on lifestyle practices. Chi-square analysis revealed significant relationships between demographic variables and health behaviors. These findings underscore the urgent need for a culturally responsive Community Wellness Program and Extension Service to improve and sustain health outcomes in this rural GIDA community.

Keywords: Healthy Lifestyle; Practices; Promotion; Wellness; Extension

Introduction

In recent decades, a seismic epidemiological shift has upended global and Philippine public health, from battling communicable scourges like tuberculosis and malaria to confronting a relentless surge in non-communicable diseases (NCDs) such as cardiovascular disease, type 2 diabetes, obesity, and hypertension. Fueled by cultural shifts, sedentary lifestyles, processed diets, tobacco use,

alcohol excess, and chronic stress, this NCD epidemic now reaches even rural barangays in lake town municipalities, where geographic isolation, fragile health infrastructure, low literacy, and socioeconomic barriers amplify vulnerability and limit healthy practices. Thus, NCDs are no longer merely biomedical concerns but deeply embedded social and community challenges. The HeLP (Healthy Lifestyle Practices) study ignites an essential response by offering an evidence-based framework for innovative health promotion, community wellness initiatives, and extension services to address modifiable risk factors. It fosters sustainable behavior change and drives these underserved communities towards resilience, aligning with Sustainable Development Goal 3, which focuses on universal health coverage.

This local reality mirrors a broader global trend. According to the World Health Organization (2025), non-communicable diseases, including cardiovascular diseases, type 2 diabetes, obesity, hypertension, and cancers, now account for 74% of all deaths worldwide, with low- and middle-income countries bearing 80% of the premature mortality burden. This shift is closely linked to rapid urbanization, the globalization of processed food systems, declining physical activity, and increased tobacco and alcohol consumption, which have gradually displaced communicable diseases as the dominant public health threat. In the Western Pacific Region, which includes the Philippines, this burden is even more pronounced, with NCDs responsible for 80% of all deaths, diabetes affecting 10.4% of adults, and hypertension impacting 26% of the population. Collectively, these patterns underscore that four modifiable risk factors, poor diet, physical inactivity, tobacco use, and harmful alcohol consumption, account for nearly 80% of premature NCD deaths, reinforcing the urgency of prevention-oriented, lifestyle-focused interventions.

While these statistics illustrate the scale of the problem, they also reveal a critical point of intervention. As noted by Saleem (2023), although genetic predisposition and environmental exposures influence health outcomes, lifestyle behaviors such as diet, physical activity, sleep quality, stress regulation, and avoidance of harmful substances play a decisive role in either protecting health or accelerating disease. Similarly, Etherton and Petersen (2021) define a healthy lifestyle as the consistent practice of balanced nutrition, regular physical exercise, adequate sleep, stress management, and complete avoidance of tobacco exposure. However, they caution that awareness alone does not guarantee behavior change, particularly in settings shaped by poverty, limited access, and social constraints. Therefore, integrating lifestyle promotion into healthcare and community systems is essential not merely to educate individuals, but to create supportive environments for sustained healthy behavior.

This emphasis on structural and community support aligns closely with global development priorities. According to UNICEF (2024), Sustainable Development Goal 3 focuses on ensuring healthy lives and promoting well-being for all at all ages, addressing key issues such as non-communicable diseases, universal health coverage, access to essential medicines and vaccines, and health equity for underserved populations. The goal prioritizes regions with high morbidity and vulnerable populations and calls for strengthened research, health financing, risk reduction, and health system governance. Thus, community-level research and interventions like HeLP directly contribute to achieving SDG 3 targets.

Further reinforcing this need, Garg (2025) highlights that lifestyle-related diseases, including heart disease, diabetes, obesity, and mental health disorders, are major global threats driven by poor diet, inactivity, substance use, and chronic stress. In rural and low-resource settings, these risks are intensified by limited healthcare access and low health literacy. Importantly, evidence from global interventions shows that community-led, culturally adapted, and low-cost programs are effective in promoting healthy behaviors. This suggests that localized, community-based wellness initiatives are both practical and impactful in reducing disease risk.

At the national level, similar priorities are emphasized. The Department of Health–Central Luzon (2023) underscores that healthy lifestyle adoption is crucial in preventing chronic diseases such as diabetes, hypertension, heart disease, stroke, and cancer. Risk factors include unhealthy diets, physical inactivity, excess body weight, and sedentary work patterns. The DOH recommends regular physical activity, balanced nutrition, and positive psychosocial well-being to reduce lifestyle-related risks and improve overall health. These recommendations further support the rationale for community-based lifestyle interventions. It is based on these arguments that prompted the faculty researchers to conduct a study assessing the healthy lifestyle practices of residents in Barangay San Ramon, Buhi, Camarines Sur, as a basis for health promotion, community wellness program development, and extension service initiatives. This focus was guided by the growing burden of lifestyle-related non-communicable diseases in rural and geographically isolated communities, where limited access to health services, low health literacy, and socioeconomic constraints continue to hinder the adoption of healthy behaviors. On this basis, the study aimed to: (1) determine the demographic of the respondents; (2) evaluate the healthy lifestyle practices; (3) identify the factors affecting these practices; (4) examine the significant relationship between the respondent's profile and the healthy lifestyle practices; and (5) formulate a culturally appropriate and community-responsive plan for health promotion, wellness program, and extension service development. Through this approach, the study aimed to develop evidence-based and context-sensitive interventions that enhance community capacity, promote sustainable behavior change, and contribute to improved health and well-being in rural barangays.

Demographic and socioeconomic factors further shape individuals' capacity to engage in healthy behaviors. Furst and Jay (2019) found that men reported higher physical activity levels and greater confidence in sustaining exercise than women, suggesting that gender differences influence health behavior engagement. Raghupathi and Raghupathi (2020) demonstrated that higher educational attainment is strongly associated with improved health outcomes, while Pratap et al. (2021) emphasized that unemployment and underemployment increase vulnerability to poor health through financial strain and limited access to care. Similarly, Finkelstein et al. (2022) and Payo and Cisneros (2024) found that poverty restricts access to nutritious food, healthcare, and stress-reducing resources, thereby heightening chronic disease risk. Life transitions and social conditions also influence lifestyle patterns. Werneck and Winpenny et al. (2020) reported that entry into marriage is associated with increases in body mass index, identifying early marriage as a potential intervention point for weight management. The World Health Organization (WHO, 2022) further emphasized that Indigenous populations experience disproportionate health risks and limited access to services, highlighting the need for culturally grounded, participatory approaches in health promotion. At the population level, noncommunicable diseases remain a growing global burden. Kario et al. (2024) reported that over one billion individuals worldwide have hypertension, yet diagnosis, treatment, and control rates remain critically low. Cerf (2021) emphasized that healthy eating and regular exercise are cost-effective strategies for reducing the burden of NCDs, while Faseru et al. (2022) demonstrated that adherence to healthy lifestyle behaviors significantly lowers mortality risk even among former smokers. Lifestyle behaviors also affect sleep, stress, and mental health. Dzierzewski et al. (2021) and Feingold and Smiley (2022) linked poor sleep to unhealthy eating, sedentary behavior, obesity, depression, and diabetes. Ramar et al. (2021) identified sleep as an often-neglected yet essential component of health promotion. Sharma and Vipin (2020) further showed that work-related stress is influenced by demographic factors such as age, gender, income, and marital status, which may undermine healthy routines.

Protective factors such as physical activity and social connectedness are also well-documented. Saqib and Dai et al. (2020) found

that moderate physical activity improves health outcomes and reduces disease risk, while the Centers for Disease Control and Prevention (CDC, 2024) emphasized that strong social relationships promote emotional resilience and healthier behaviors. However, Proctor et al. (2023) warned that declining social connections due to increasing digital engagement may weaken these protective effects, particularly among younger populations. Philippine-based studies provide contextual evidence on lifestyle behaviors and health risks. Soberano et al. (2024) found significant differences in lifestyle behaviors and health perceptions between younger and older adults in rural Philippine communities, emphasizing the need for age-specific and culturally sensitive interventions. Agdeppa et al. (2020) reported poor overall diet quality among Filipino adults, with dietary patterns high in meat, sweetened beverages, and refined carbohydrates associated with increased risks of obesity, diabetes, hypertension, and dyslipidemia. These findings underscore the urgent need for targeted nutrition education and interventions. Emerging evidence also shows rising engagement in risky behaviors among Filipino youth. Baron (2025) reported increasing trends in smoking, vaping, and alcohol use among young Filipinos, highlighting the influence of age, social norms, and policy environments on unhealthy behavior formation. These trends reinforce the importance of early preventive interventions within schools and communities. The American Heart Association (2020) and Kang et al. (2020) further emphasized that vulnerability is shaped by intersecting demographic factors such as gender, income, education, and geographic location, which affect access to health resources and the ability to sustain healthy behaviors. These findings are particularly relevant in rural and low-income Philippine settings, where structural barriers remain pronounced.

Methodology

This study used the descriptive survey method of research since its purpose was to assess the healthy lifestyle practices as a basis for health promotion, community wellness program, and extension service development in a rural barangay of a lake town municipality. The descriptive research method aimed to describe a population, situation, or phenomenon (McCombes, 2019) accurately and systematically. It involved the description, recording, analysis, and interpretation of the present condition. The respondents of this study were selected based on the Barangay Household Profile as of 2023. The barangay had a total population of 1,888, with 315 households and 390 families. There were 993 males and 895 females, and 133 of them were senior citizens. Only the head of the family served as the respondent for each household residing in Barangay San Ramon. If the head of the family was not available or present during the survey, the spouse or any adult family member participated instead. A descriptive survey method and total enumeration were employed to collect data from a total of 328 households using a validated researcher-made questionnaire. While the initial target was 315 households, an additional 13 newly transferred-in households were identified and tracked during the actual survey.

Results and Discussions

1. Profile of the Respondents

Table 1. Profile of the Respondents

Profile	Frequency	Percentage (%)	Rank
a.1. AGE			
18-23 years old	15	4.6	**5**
24-29 years old	52	15.9	**3**

30-35 years old	57	17.4	**2**
36-41 years old	47	14.3	**4**
42 and above	157	47.9	**1**
Total	**328**	**100.0**	
a.2. SEX AT BIRTH			
Male	100	30.5	**2**
Female	228	69.5	**1**
Total	**328**	**100.0**	
a.3. CIVIL STATUS			
Single	25	7.6	**3**
Married	178	54.3	**1**
Live-in	93	28.4	**2**
Separated	7	2.1	**4**
Widowed	25	7.6	**3**
Total	**328**	**100.0**	
a.4. HIGHEST EDUCATIONAL ATTAINMENT			
Elementary Graduate	124	37.8	**1**
Elementary Undergraduate	84	25.6	**2**
High School Graduate	65	19.8	**3**
High School Undergraduate	33	10.1	**4**
College Graduate	18	5.5	**5**
College Undergraduate	4	1.2	**6**
Total	**328**	**100.0**	
a.5. RELIGION			
Roman Catholic	262	79.9	**1**
Iglesia ni Cristo	2	0.6	**3**
Mormons	2	0.6	**3**
Born Again	62	18.9	**2**
Total	**328**	**100.0**	
a.6. OCCUPATION			
Student	6	1.8	**7**
Fisherman	28	8.5	**4**

Farmer	52	15.9	**3**
Construction Worker	11	3.4	**5**
Laborer	105	32.0	**2**
Office worker	7	2.1	**6**
Others (Housewife)	119	36.3	**1**
Total	**328**	**100.0**	
a.7. FAMILY MONTHLY INCOME			
5,000 Below	247	75.3	**1**
5,001 to 10,000	77	23.5	**2**
10,001 to 15,000	2	0.6	**3**
15,001 to 20,000	1	0.3	**4**
20,001 and above	1	0.3	**4**
Total	**328**	**100.0**	
a.8. HOUSEHOLD CLASSIFICATION			
4Ps	121	36.9	**2**
IPs	68	20.7	**3**
Non-NHTS	139	42.4	**1**
Total	**328**	**100.0**	
b. HISTORY OF PRESENT ILLNESS			
Hypertension/High blood pressure	119	36.3	**2**
Stroke/Cerebrovascular Disease	6	1.8	**7**
Diabetes	12	3.7	**5**
Obesity and Overweight	17	5.2	**4**
Osteoarthritis	7	2.1	**6**
Osteoporosis	1	0.3	**8**
Lung Disease	21	6.4	**3**
Substance Abuse: Alcohol	1	0.3	**8**
None	144	43.9	**1**
Total	**328**	**100.0**	
c. GENETIC PREDISPOSITION			

Hypertension/High blood pressure	163	49.7	**1**
Stroke/Cerebrovascular Disease	17	5.2	**5**
Diabetes	21	6.4	**3**
Obesity and Overweight	20	6.1	**4**
Cancer	14	4.3	**7**
Alzheimer's Disease	1	0.3	**10**
Epilepsy	2	0.6	**9**
Osteoarthritis	15	4.6	**6**
Lung Disease	25	7.6	**2**
Depressive Disorders	1	0.3	**10**
Substance Abuse: Alcohol	6	1.8	**8**
Substance Abuse: Illegal Drugs	1	0.3	**10**
Total	**328**	**100.0**	

Test of Significant Relationship Between the Respondent's Profile and the Healthy Lifestyle Practices

Relationship Between the Demographic Profile and the Healthy Lifestyle Practices of the Respondents in terms of Diet / Eating Habits

Relationship Between the Demographic Profile and the Healthy Lifestyle Practices of the

TABLE 2. DIET/EATING HABITS

Indicators	Computed X^2 Value	Computed p-value (0.05)	Decision	Interpretation
Age	29.070[a]	0.004	Rejected	Significant
Sex at Birth	11.945[a]	0.008	Rejected	Significant
Civil Status	30.714[a]	0.002	Rejected	Significant
Educational Attainment	17.226[a]	0.306	Accepted	Not Significant
Religion	10.708[a]	0.296	Accepted	Not Significant
Occupation	25.942[a]	0.209	Accepted	Not Significant
Family Monthly Income	2.368[a]	0.984	Accepted	Not Significant
Family Orientation	8.732[a]	0.189	Accepted	Not Significant
Current Health Status or History of Present Illness	16.579[a]	0.866	Accepted	Not Significant
Genetic Predisposition or Family History	26.065[a]	0.889	Accepted	Not Significant

Respondents in terms of Physical Activities

Table 3. PHYSICAL ACTIVITIES				
Indicators	**Computed X^2 Value**	**Computed p-value (0.05)**	**Decision**	**Interpretation**
Age	32.952[a]	<0.001	Rejected	Significant
Sex at Birth	10.201[a]	0.017	Rejected	Significant
Civil Status	46.604[a]	<0.001	Rejected	Significant
Educational Attainment	13.280[a]	0.581	Accepted	Not Significant
Religion	4.057[a]	0.908	Accepted	Not Significant
Occupation	77.005[a]	<0.001	Rejected	Significant
Family Monthly Income	24.940[a]	0.003	Rejected	Significant
Family Orientation	8.732[a]	0.189	Accepted	Not Significant
Current Health Status or History of Present Illness	24.539[a]	0.431	Accepted	Not Significant
Genetic Predisposition or Family History	32.608[a]	0.631	Accepted	Not Significant

Relationship Between the Demographic Profile and the Healthy Lifestyle Practices of the Respondents in terms of Stress Tolerance

TABLE 4. STRESS TOLERANCE				
Indicators	**Computed X^2 Value**	**Computed p-value (0.05)**	**Decision**	**Interpretation**
Age	40.325[a]	<0.001	Rejected	Significant
Sex at Birth	7.800[a]	0.05	Rejected	Significant
Civil Status	46.951[a]	<0.001	Rejected	Significant
Educational Attainment	10.503[a]	0.787	Accepted	Not Significant
Religion	5.392[a]	0.799	Accepted	Not Significant
Occupation	79.118[a]	<0.001	Rejected	Significant
Family Monthly Income	6.757[a]	0.662	Accepted	Not Significant
Family Orientation	8.423[a]	0.209	Accepted	Not Significant
Current Health Status or History of Present Illness	17.539[a]	0.825	Accepted	Not Significant
Genetic Predisposition or Family History	21.950[a]	0.968	Accepted	Not Significant

Relationship Between the Household Demographic Profile and the Healthy Lifestyle Practices of the Respondents in terms of Vices

TABLE 5. VICES

Indicators	Computed X^2 Value	Computed p-value (0.05)	Decision	Interpretation
Age	19.111[a]	<0.001	Rejected	Significant
Sex at Birth	8.909[a]	0.003	Rejected	Significant
Civil Status	18.789[a]	<0.001	Rejected	Significant
Educational Attainment	13.167[a]	0.022	Rejected	Significant
Religion	22.150[a]	<0.001	Rejected	Significant
Occupation	16.348[a]	0.022	Rejected	Significant
Family Monthly Income	5.438[a]	0.142	Accepted	Not Significant
Family Orientation	13.205[a]	0.001	Rejected	Significant
Current Health Status or History of Present Illness	22.390[a]	0.004	Rejected	Significant
Genetic Predisposition or Family History	25.415[a]	0.013	Rejected	Significant

Relationship Between the Household Demographic Profile and the Healthy Lifestyle Practices of the Respondents in terms of Sleep Pattern

TABLE 6. SLEEP PATTERN

Indicators	Computed X^2 Value	Computed p-value (0.05)	Decision	Interpretation
Age	16.897[a]	0.031	Rejected	Significant
Sex at Birth	1.853[a]	0.396	Accepted	Not Significant
Civil Status	11.587[a]	0.171	Accepted	Not Significant
Educational Attainment	13.313[a]	0.207	Accepted	Not Significant
Religion	5.411[a]	0.492	Accepted	Not Significant
Occupation	26.616[a]	0.022	Rejected	Significant
Family Monthly Income	9.437[a]	0.15	Accepted	Not Significant
Family Orientation	7.280[a]	0.122	Accepted	Not Significant
Current Health Status or History of Present Illness	15.413[a]	0.495	Accepted	Not Significant
Genetic Predisposition or Family History	31.819[a]	0.132	Accepted	Not Significant

Conclusion

1. Lifestyle practices in this rural community are heavily influenced by age, sex, marital status, occupation, and socioeconomic conditions, reflecting the interplay between demographic characteristics and environmental constraints.
2. Diet, physical activity, and stress-coping behaviors are inconsistent, with moderate

adherence to healthy practices and selective engagement in preventive care.

3. Engagement in vices is low, suggesting cultural and social norms favor avoidance of harmful behaviors.
4. Sleep patterns remain suboptimal, with regular naps compensating for insufficient nightly sleep, indicating a need for targeted sleep hygiene interventions.
5. Family health history and genetic predisposition contribute selectively to lifestyle choices, particularly physical activity, vices, and sleep behaviors.
6. Social and digital environments increasingly shape health behaviors, while financial constraints exert only a minor influence.
7. Overall, lifestyle practices are more strongly shaped by life-stage, occupational demands, health status, and familial risk than by education, religion, or income, highlighting the need for integrated, context-sensitive interventions.

Recommendations

1. Nutrition and Diet: Implement culturally appropriate community nutrition education targeting age, sex, and marital status differences, emphasizing balanced diets and reduction of high-fat, sugary, and salty foods.
2. Physical Activity: Develop age- and gender-inclusive exercise programs that accommodate occupational schedules and promote sustained moderate-to-vigorous activity.
3. Stress Management: Strengthen social support networks and provide community-based stress-coping workshops, focusing on proactive emotional regulation and engagement in recreational activities.
4. Vices Prevention: Promote family- and religion-based health literacy programs to reduce risk behaviors, incorporating peer influence management and targeted counseling for high-risk groups.
5. Sleep Hygiene: Conduct educational campaigns on regular sleep schedules and adequate nightly rest, complemented by workplace and community strategies to reduce fatigue and promote restorative sleep.
6. Health Screening and Preventive Care: Encourage regular check-ups and adherence to prescribed medications, with special focus on individuals with chronic conditions or familial risk factors.
7. Community-Based Interventions: Utilize digital platforms and seminars to disseminate health messages, while maintaining face-to-face support to strengthen traditional social networks.
8. Policy and Program Development: Establish an integrated, evidence-based wellness program that considers demographic, health, and familial factors, ensuring equitable access to preventive and health-promoting resources.

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