

Beliefs And Perceptions Of Hypertensive Patients Regarding Socio-cultural factors On Blood Pressure Control In Two Rural Communities Of Ekiti State: An Exploratory Qualitative Study

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ABSTRACT

Introduction: Achieving optimal blood pressure control remains a challenge, especially in rural setting and could be due to sociocultural factors influencing patient's beliefs and biomedical understanding of blood pressure control. Hence, this study explored hypertensive patient's beliefs and perceptions regarding blood pressure control in two rural communities of Ekiti State, Southwest Nigeria.

Materials and Methods: This cross-sectional qualitative study explored four focus group discussions with open ended questions on 16 hypertensive patients who were purposively recruited. All the conversations were audio-recorded, transcribed verbatim and thematically analyzed.

Results: The only theme was participants' perceptions of sociocultural factors influencing their blood pressure and five sub-themes including access to healthcare services, health literacy, dietary and lifestyle behaviors, medication adherence, family and social support. Majority of participants claimed they have unlimited access to healthcare facility, could read the information on hypertension, and were aware of dietary food for optimal blood pressure but cost, long waiting time, unavailability of drugs at healthcare facility, lack of information and certain cultural practices and traditional food during social events were barriers to achieving optimal blood pressure.

Conclusion: Misconceptions of certain sociocultural factors were influencing management of hypertension in rural communities of Ekiti State. Therefore, it is important to institute measures to overcome these misconceptions and barriers and facilitate consistent adherence to biomedical treatment to improve blood pressure control.

Key words: Qualitative research, Perceptions, Focus Groups, High Blood Pressure, Rural Nigeria

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INTRODUCTION

Hypertension or high blood (BP) pressure is the most prevalent and modifiable risk factors for cardiovascular diseases such as strokes and heart attacks.^{1,2} It accounts for a global population of one billion and predicted to rise to 1.56 billion by 2025.^{1,3} Previous reports suggest that over the past decade, the prevalence of hypertension has increased globally with higher burden recorded in low- and middle income countries.^{2,4} In Nigeria, a recent study estimated the crude prevalence of hypertension to be between 2.1 to 47.2% depending on the BP cut-off point, setting, sex and ethnic group being assessed.⁵ However, despite the increased advancement in hypertension diagnosis and availability of antihypertensive medications, achieving optimal BP remains a challenge, especially in rural setting.

A possible reason for this could be difference between patient's beliefs and biomedical understanding of sociocultural factors contributing to BP control.⁶ Kleinman in his lay explanatory model proposes that people's understanding of their illness often differs from biomedical understanding of diseases and these differences could influence treatment outcomes.⁷ Patients' perceptions of blood pressure control have been different due to differences in sociocultural factors such access to healthcare, low health literacy,⁸ unhealthy dietary and lifestyle behaviors,⁴ poor medication adherence,⁹ and low availability of social support.¹⁰

Health literacy helps patient to obtain the necessary information about high BP, and empowering them to make a better decision on best way to manage their BP.^{11, 12} Improving health literacy is one of the most cost- effective interventions to reduce the incidence of non-communicable diseases.¹³

Previous studies on perceptions of hypertensive patients towards healthy dietary consumptions to improve BP control have recently been documented.^{4, 14} A recent study targeting dietary changes for BP control has focused on providing advice on diet that is usually not affordable or not acceptable by the rural dwellers.¹⁵

Medication adherence is another important component of BP control.¹⁶ However, perception of side effects of medications often lead to poor adherence resulting in poor BP control.⁶

In addition to perceptions of medication usage for BP control, family and social support has also been identified as an important sociocultural factor in BP management.^{9, 10} Strong family and social networks and support systems can encourage medication adherence, promote healthy lifestyle behaviors, and provide emotional and practical assistance to individuals with hypertension.^{9,10,17}

Previous studies on sociocultural factors influencing BP control in sub-Saharan Africa (SSA) are either quantitative approach or conducted in urban settings. To the best of our knowledge, this is the first qualitative study on hypertensive patients' beliefs and perceptions regarding sociocultural factors on BP control in rural communities of Ekiti State. Given the high burden of hypertension, low rate of BP control in SSA, this study is crucial to provide targeted interventions that could influence individuals' actions towards their BP control.

MATERIALS AND METHODS

Study area: The study areas were Ilogbo and Igbole rural communities which are located in Ido-Osi local government area of the Northern Senatorial district of Ekiti State, Nigeria.¹⁸ Igbole and Ilogbo rural communities were purposively selected because of their rich cultural and socio-

economic characteristics.

Study population: This was the population of individuals diagnosed with hypertension who were permanent resident of Ilogbo and Igbole rural communities.

Study design: The study involved a qualitative approach using an explanatory model design. The explanatory model was Kleinman's Explanatory Model.¹¹

Selection criteria: Participants for this study were recruited from November 2024 to February 2025. Inclusion criteria were patients diagnosed with hypertension, aged 18 years and above, who were permanent resident of the communities, and being on antihypertensive medication for at least six months. Exclusion criteria were patients with secondary hypertension, with other co-morbidities, pregnant and lactating women and those with known glaucoma on treatment.

Instrument and procedure for qualitative data collection

A semi structured interview and Focus Group Discussion (FGDs) were the research instrument while the principal investigator served as the interviewer and coordinator of the discussion. A trained research assistant served as recorder using a tape recorder, note pads, and a camera.¹⁹

Ethical Consideration:

Ethical approval was obtained from the Institution Review Board of Federal Teaching Hospital Ido-Ekiti with approval number (ERC/2024/10/30/1207A) before the study was conducted.

Permissions for the study was obtained from the traditional leaders of the autonomous communities.

Operational definition

Focus group discussions (FGDs): This is a valuable tool used to generate insights into people's experiences, attitudes, perceptions, values, and opinions about a defined area of interest.

Selection of participants, validation and reliability of Research Instrument and procedure for data collection:

Prior to the study, the records of hypertensive patients attending the comprehensive health center (CHC) in the two rural communities were assessed and 18 participants identified with uncontrolled blood pressure were selected using a purposive sampling technique and were invited to participate in the survey after their consent has been taken.¹⁵ In order to achieve the objectives of FGD, the content of semi-structured interview was developed based on the English literatures which have highlighted the global hypertension management.^{9, 21, 22} The questionnaires were developed in English and translated into Yoruba and later backward translation to English language by a competent translator to ensure quality control. The questions were prepared in an opened ended format and were pre-tested for content validity, face validity, and clarity by two cardiologists and one community health physician with vast experience in hypertension management research and were further adjusted after pilot study with six hypertensive patients in another rural community who were not part of the study target population. Initially, 18 participants were invited to participate in the FGD, but two participants did not attend due to their time constraint. Eventually a total of 16 participants attended which were divided into four groups (with two groups each from Ilogbo and Igbole communities respectively) which followed the standard guideline.²³ A FGD of 4-8 people are usually recommended as group more than eight participants are difficult to control.^{6, 9, 22}

FGDs were grouped by sex because previous research suggests that due to the socio-cultural context, women may not actively participate in discussions in the presence of men.^{6,9,24}

Prior to the FGD, participants were told to be seated for at least five minutes before their BP were being measured. A BP monitoring apparatus (Brand: Omron® with model HEM-7080) was used to monitor participants' BP level. The participants were enjoyed to interact freely with each other, exchange ideas based on their experiences, and consider no individual contribution as right or wrong.⁶ Information sheet was explained and informed written, thumb-printed and verbal consent was obtained from each participant. The researcher assumed the role of moderator and was assisted by local community extension officer. Prior to the FGD, moderator introduced himself, his background and qualification. He then briefed the participants about the general objectives of the study. He encouraged them to freely participate in the discussion by giving several probes and the discussion was conducted in their local language. The conversations and discussions were audio-recorded and field notes were utilized when necessary during FGD. Four FGDs were conducted until saturation of the content which ranged from one hour to one hour and 30 minutes. When there were no new theme identified, a conclusion was made at this saturation point. The study was in accordance with strengthening the COnsolidated criteria for REporting Qualitative research (COREQ).²⁵

Data Analysis:

After the FGDs, all the conversations and interviews were transcribed verbatim from Local Language directly to English language by two appointed translators from the local communities while listening to the audio recording played by the research assistant in the

presence of the researcher who also counterchecked the data for quality. Because some of the participants could not read, write, or speak English, transcripts were not returned to the participants for cross-checking. Using thematic approach to data analysis, textual data were explored and read several times by the researcher to identify themes and sub-themes (categories). The coding framework generated by the researcher involved initial pre-identified codes derived from previous studies on hypertension in Ghana.^{6, 9} Open ended inductive codes were generated based on socio-cultural context of the study areas.^{6,9} Codes were reviewed and active data coding of transcripts begins. Checking was done by the researcher where the transcription was compared to ensure correctness and the text data were coded thematically and analyzed deductively and inductively using Nvivo* version 12 pro which is a qualitative software for data storage, coding, and theme development. The researcher analysed all transcripts in constant comparison in QRS NVivo 12 pro.

RESULTS

In this study, 16 hypertensive patients were recruited. The age of participants ranged from 21-72 years, and most of the participants were traders (31.7%) and 6.3% had no formal education and majority of the participants were Christians (75.0%). In terms of their blood pressure, only one-quarter (25.0%) of the participants had their BP control. The demographics and clinical findings of the participants are shown in Table 1.

Table 1: The demographics and clinical findings of the participants

Variables	Frequency	Percentage
Age in years		
21-39	3	18.8
40-59	8	50.0
60 & above	5	31.2
Gender		
Male	8	50.0
Female	8	50.0
Occupation		
Farmer	4	25.0
Trader	5	31.3
Artisan	3	18.7
Civil Servant	2	12.5
Housewife/unemployed	2	12.5
Education		
None	1	6.3
Primary	5	31.2
Secondary	9	56.2
Tertiary	1	6.3
Religion		
Christianity	10	62.5
Islam	4	25.0
Traditional	2	12.5
Blood Pressure Level		
Controlled BP	6	37.5%
Uncontrolled BP	10	62.5%

One theme was developed via the thematic content analysis namely, sociocultural factors influencing BP control and five subthemes as shown in Table 2.

Theme and sub-themes of sociocultural factors influencing BP control

Theme: Sociocultural beliefs and practices influencing BP control.

Five subthemes were identified which were; (1) accessibility, affordability, and availability of hypertension care services, (2) Health literacy, (3) diets and lifestyle behaviors, (4) medication adherence and (5) family support.

Table 2: Sociocultural factors influencing blood pressure control

Theme:	Sub-themes:	Categories/quotes:
Sociocultural factors influencing blood pressure control	2.1: Accessibility and affordability of healthcare services	2.1: “My house is not too far from government facility, so, I visit government facility anytime I want” (n=14) “My house is very far from government facilities but I have a motorcycle that I used to ride whenever I want to go and treat myself” (n=3) “My problem is not about going to government facilities but the cost of drugs is too expensive for me” (n=17) “At times, I will get to government facility and the nurse will tell me that the type of drugs that is good for my BP has finished” (n=5) “The last time I went to the government facility, the y told me that doctor was not around” (n=4) “I prefer going to Pharmacy shop close to my house because pharmacists are drug expert” (n=11)
	2.2: Participants’ health literacy	2.2: “Emm... For me, I have read the flyer pasted on the clinic wall before, but I couldn’t understand the content written there” (n=10) “Am a pastor, I can read, write, and speak English very well”(n=18) “Emm... We are Ekitis, the Fountain of knowledge” (with chorus “yesoooo” and “claps” from majority of participants).n=6)
	2.3: Diets and Lifestyle behaviors/practices	2.3: “I have since stopped adding salt to m y food for over a year now because doctor told me that it is risk for my life” (n=4) “Emm... for me I still use salt but very small” (n=2) “Why would I not add salt to my food? food without salt is tasteless” (n=2) “I have taken alcohol before but since doct or told me that my BP was high, have been running away from alcohol” (n=5) “Emm... for me, I take alcohol but not much to intoxicate me” (n=1). One man nodded his head in agreement. “I was told in the clinic that I should take bitter kola instead of cigarette smoking” (n=1) “Hmm...doctor (referring to the moderator) you live in city. Car takes you to all places” (n=1) Another participant chipped in” from air conditional car to air conditional office and air conditional room” there was laughter. “Going up and do wn in the house, trekking to farm, church and market in this town is even more than any exercise” (n=2). “Yeah, I do not need any other exercise” (n=12)

Theme:	Sub-themes:	Categories/quotes:
	2.4: Medication adherence	"I go with my drugs anywhere I travel to" (n=5) "I take my drugs everyday" (n=12) "Em.. as for me, I didn't like taking the drug every day. So, at times, i missed them for 2-3 days" (n=4) "I stopped taken the drug when my BP is normal" (n=3) "I skipped taking the drug when I have no money to buy them" (n=2) "Am bored of taking too much medications every day" (n=3) "I stopped taken the drugs because it affects my sexual performance" laughter (n=1) "I only take the drug when I felt uncomfortable with serious headache or poor sleep" (n=1)
	2.5: Family and Social Support	"I didn't enjoy the support of my family in the management of my high" (n=6) "Anytime I asked my brother to send me money for my BP, he would say that I should stop thinking too much (laughter)" (n=2) "My husband is really supporting me. He provides the money and would not allow me to sleep at night until I take my dr ugs" (n=2) "I don't know what our government is doing for us? Please doctor, help us tell our governor to subsidize the cost of these drugs for us" (n=6)

DISCUSSION

This qualitative study provides in-depth insights on participants' perceptions regarding BP and it explores the sociocultural beliefs and practices influencing BP control in two rural communities of Ekiti State, Nigeria, a relative grey area of research. This study is the first of its kind in Ekiti State, Southwest Nigeria, highlighting the sociocultural factors influencing BP control. In this study, despite participants' recognition of easy access to health care facility, barriers such as cost, unavailable of medications and long waiting time due to inadequate physicians were the contributing socio-economic factors to achieving better BP control. This findings was

consistent with previous study where financial constraint is the major reason for not adherence to antihypertensive medications.²⁶

The health literacy of majority of hypertensive patients in this study is inadequate, making opinions on the information regarding high BP to be low. This is consistent with recent research in Indonesia which reported that health literacy is not limited to measuring patient skill in reading health-related words or numbers, but instead focuses more on how written materials can changes patients' beliefs and actions, and how patients understand medical instruction.⁸ Inadequate health literacy which was explored in

this study can cause patients to be misinformed and to have difficulty following medical instructions, and is associated with BP control. However, despite the inadequate health literacy explored in this study, eagerness for controlling BP was portrayed through the concerns raised by hypertensive patients as they perceived high BP as a dangerous and fast killer. This finding is consistent with the study by Mgbahurike *et al*,²⁷ where participants in agreed that hypertension is a serious health concern.²⁷ Tailored intervention strategies to improve understanding of health information relating to BP control is advocated in rural setting to improving their health literacy.

Furthermore, with regards to lifestyle practices of the participants, proven biomedical risk factors such as smoking, alcohol consumption, and inadequate exercise were believed by the participants as contributing to uncontrolled BP. This is comparable with several other studies in Nigeria.^{4, 5, 28} Also, other studies in SSA were in agreement with finding in this study.^{4, 6, 9} The idea that -household and workplace chores are equally regarded as adequate exercise has not been reported in other studies and may give false impression to the patients that they are compliance with recommended activities leading to poor BP control. Dietary approaches to stop hypertension (DASH) is a globally recommended strategy for patients with high BP which has been implemented for over three decades.²⁸ The DASH approach emphasized varieties of fruits and vegetables, however, the daily diet consumed by the participants in this study indicates lack of different types of food in their local market. This barrier of availability of variety of fruits and vegetables highlights the significant of considering the local market context when designing culturally acceptable dietary interventions for the control of high BP in rural areas. Charlton and colleagues in their

study posited that sometimes the DASH diet is not feasible and sustainable to people living in rural settings due to high poverty rate and poor knowledge of complications of uncontrolled BP.²⁹ They recommend that in order to control BP in the rural area, people may not need to change what they eat, but instead be making small adjustments to current daily salt intake.²⁹ This recommendation is important to adopt as it has proven to be effective in other similar settings.⁴

With regards to medication adherence, a significant numbers of participants were not adherence to their medications and this is not unique to this study. Non adherence to antihypertensive medications has been the most important contribution to poor BP control particularly in rural setting and has been reported by several studies.^{4, 6} While several reasons may contribute to poor adherence to antihypertensive medications, the reasons explore in this study include high cost of drugs and taken too many drugs on daily basis, which are similar to findings of other studies on hypertension and other chronic diseases.^{6, 9} Another barrier to medication adherence and subsequently poor BP control was the fear of sexual dysfunction as experienced by few participants in this study. This finding is in line with previous studies by Tan *et al*,⁹ and Kretchy *et al*,³⁰ which have reported side effects of antihypertensive medications as contributing to poor BP control.^{9, 30} Health interventions therefore need to take these perceptions into consideration in designing appropriate and culturally sustained methods of addressing these challenges.

Furthermore, it appears that while many participants in this study recognized the role of family and social support to improving their compliance to medication adherence and subsequently BP control, there are sociocultural and economic barriers that impede family and

other social support groups' inability to adequately support people with high BP. Barriers explored in this study include failure of participants to disclose their diagnosis to their relations, perceptions of family members on the etiology of hypertension, poverty within family members and lack of support from government. Studies have shown that social support contributes significantly to improving health outcomes.^{6, 10} Therefore, targeted interventions involving stakeholders from communities and government circles are needed to promote family and social support for patients with high BP.

CONCLUSIONS

It is evident that hypertensive patients experienced several sociocultural factors and barriers that influence their management of BP in the study areas. These socio-cultural barriers often delayed or discouraged the use of biomedical treatments which are essential in ensuring adequate control of BP. It is important to institute measures to overcome these barriers and facilitate consistent adherence to biomedical treatment and lifestyle behaviors especially in rural areas to improve rate of BP control.

Limitations:

The dominant voice from the vocal participants would override other voices in the method of FGDs.³⁰ Also, limiting the FGD size to four participants at a time would reduce the diverge range of information compared to when there is increased numbers of participants in the FGDs.

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