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Illness Perception of Women Living with Hypertensive Condition: A Qualitative Study

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ABSTRACT

Background: Many facets of a patient's life are affected by hypertension. Also, attitudes, values, and experiences, as well as patients' social and cultural circumstances, all play an essential role in the treatment of hypertension. The study's primary objective was to explore hypertensive women's perceptions of their illnesses.

Methods: The study was conducted using a qualitative phenomenological research approach from March 2021 to August 2021. A total of twelve hypertensive women were purposefully selected from the medical OPD of Gandaki Medical College Teaching Hospital and Research Centre (GMCTHRC). The necessary data were gathered using a semi-structured interview guide. In addition, the thematic analysis method was used to analyze the transcribed material. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used when drafting this paper.

Results: Four major themes were generated; i) Perceptions towards hypertension, ii) Diagnosis, treatment, and management of hypertension, iii) Adherence to medications, and iv) Experiences with health care and recommendations. The majority of hypertensive women considered hypertension to be a treatable non-communicable illness. Family members greatly aided drug adherence. There were, however, certain financial hurdles to medication compliance. For half of the patients, the healthcare systems were unsatisfactory.

Conclusions: The findings suggest that hypertensive women's non-adherence to medication is a common occurrence that reflects a conscious decision based on her knowledge and views of the medical illness and its treatment. The way women think about hypertension needs to alter. There were knowledge gaps discovered, emphasizing the need for more patient education.

Keywords: Experiences; hypertension; perceptions; women.

INTRODUCTION

Hypertension is a significant public health problem affecting an estimated 1.13 billion people worldwide and two-thirds living in low- and middle-income countries.[1] Hypertension poses a significant risk factor for cardiovascular disease (CVD).[2] However, despite evidence indicating that females are more at risk of dying from hypertension-related CVD than males, females do not consider hypertension as a severe health issue.[3]

Females from middle- and low-income nations have a higher prevalence of hypertension than from high-income nations.[4] A systematic review and meta-analysis of 23 studies from Nepal estimated that females were more likely to suffer negative repercussions related to hypertension compared to males.[5] Patients' illness perceptions, along with their social and cultural conditions, all play a role in hypertension treatment.[6-8] Illness perception is a critical factor in determining if they seek medical help, and their perceptions can be modified through appropriate information.[9,10] Therefore, this study aimed to explore hypertensive women's perceptions of their illness.

METHODS

The consolidated criteria for reporting qualitative research (COREQ) checklist was followed throughout this study (Appendix 1).

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A qualitative descriptive phenomenological research design was used to explore hypertensive women's perceptions of their illnesses.

The study lasted six months, from March 2021 to August 2021, and was conducted at Gandaki Medical College Teaching Hospital and Research Centre (GMCTHRC), a 750-bedded teaching hospital in Pokhara.

Hypertensive women attending the medical OPD of GMCTHRC comprised the study population. The participants were selected by a non-probability purposive sampling technique. Data saturation was considered to determine the sample size. Women diagnosed as hypertensive by various health institutions or consulting physicians were included in the study. The following were the eligibility requirements: i) Women who have had essential hypertension for at least a year and ii) Women aged 20 years and above.

Data were collected from June 2021 to July 2021. Semi-structured face-to-face interviews were conducted using an interview guide. Past literature on the topic was reviewed to create a rough interview guide in English and then translated into the Nepali language. Before the data collection, a pilot interview was done among two hypertensive women from the same setting, but no changes were made to the interview guide.

A Participant Information Sheet (PIS) was created and provided to the participants meeting the inclusion criteria, and then were interviewed by the first (DKC) and the fourth (SH) author. After acquiring the informed written consent, each interview started with a general question, "What is your perception of hypertension?". The fourth author further directed the interview by asking probing questions. A digital voice recorder was used to record the interviews after obtaining permission from the participants. The reflective notes were taken following the interviews.

The duration of the interview sessions varied depending on the participants' tolerance. However, on average, the interviews lasted between 25 and 40 minutes. Sampling and data collection proceeded until no new information was obtained. Data saturation was achieved after interviewing 12 participants.

Ethical approval for this study was taken from the institutional review committee of GMCTHRC before the initiation of the study. Written consent was also obtained from the research participants.

Audio recordings were transcribed verbatim within 24 hr post-interview by the two assigned translators who translated the transcriptions into English, and back translation was done to ensure linguistic accuracy and reliability. The first and fourth authors used Braun and Clarke's six phases of thematic analysis[11] to evaluate all transcripts thematically. However, to get a sense of the whole, all the authors reviewed the interviews multiple times. The same authors then extracted units of analysis where the texts were broken down into simplified sense units, abstracted and coded. The "open coding" method was followed, and codes were then compared and sorted into categories based on their variations and similarities. Finally, all of the researchers discussed and updated the proposed categories. After an agreement from all the authors, the underlying senses of the categories were articulated as themes. When no new themes were identified, a conclusion was made at this saturation point.

Several strategies were employed to determine the trustworthiness of the study. The member check approach was used along with group meetings of the study team to ensure data dependability. Data conformability was achieved by systematically collecting data and keeping the records properly. Written reflective notes and precise documentation of all code decisions were used to maintain transparency.

RESULTS

Table 1. Socio-demographic characteristics of the participants.

Socio-demographic characteristics	Age	Marital Status	Education	Occupation
Participant 1 (P1)	35	Unmarried	Bachelor	Business
Participant 2(P2)	32	Unmarried	Masters	Engineer
Participant 3 (P3)	42	Married	Bachelor	Teacher
Participant 4(P4)	55	Married	Primary	Housewife
Participant 5 (P5)	39	Married	Bachelor	Teacher
Participant 6 (P6)	40	Married	Masters	Banker
Participant 7 (P7)	49	Married	Secondary	Housewife
Participant 8 (P8)	60	Married	Primary	Housewife
Participant 9 (P9)	62	Married	Primary	Housewife
Participant 10(P10)	50	Married	Primary	Housewife
Participant 11(P11)	38	Married	Bachelor	Business
Participant 12 (P12)	58	Married	Primary	Housewife

Twelve hypertensive women were recruited for the study. They were aged 32 to 62 years (Mean age: 46.67). Out

of them, six were employed and six were housewives. Table 1 summarizes the participants' demographic and work characteristics.

Four themes emerged from the data analysis, with ten subthemes under the four themes. (Table 2)

Table 2. Key themes and sub-themes.

Key Themes	Sub-Themes
1. Perceptions towards hypertension	a) Awareness of hypertension and its causes b) Symptoms and complications c) Preventive measures on hypertension d) Religious beliefs towards hypertension
2. Diagnosis and management of hypertension	a) Diagnosis of hypertension b) Management of hypertension
3. Adherence to medication	a) Barriers: side effects of drugs, financial issues, negligence b) Facilitators: family members, trust on medications
4. Experiences with health care and recommendations	a) Health care experiences b) Health care suggestions to hypertensive patients

Hypertension was mentioned as a health issue by several patients. However, while patients had a general idea of their illness, the depth and sophistication of this understanding differed significantly. Most participants were unaware of women's acceptable blood pressure levels. In addition, many participants expressed their lack of knowledge regarding the disease. However, the participants believed obesity, poor diet, genetics, and age to be the potential cause of hypertension.

"I believe that obesity is the most common cause of hypertension. There are a number of chubby people diagnosed with HTN in the community where I live." (P5)

"I think hypertension is inherited genetically. My both parents had hypertension, and so do I. So, I think genetics is the leading cause." (P1)

The participants expressed dizziness and headache as predominant hypertensive symptoms in addition to trouble communicating, edema, and double or blurry vision.

"My eyesight becomes blurry when my blood pressure rises. I also experience double vision... these are some concerning signs that I'm about to become ill."(P8)

The participants were aware of severe hypertension consequences, citing kidney failure, paralysis, and heart attack as examples.

"I believe that paralysis is the most common HTN consequence. HTN has an effect on the kidneys as well." (P3)

When questioned about hypertension prevention strategies, participants indicated that avoiding red meat, oil, and salt in their diet, and decreasing stress can prevent hypertension.

"A proper diet should be followed to avoid hypertension. When I consume anything and see that it raises my blood pressure, I typically avoid eating it again." (P7)

Television, radio, and social media sites such as Facebook and YouTube in addition to hospital doctors, health care workers, and hypertensive colleagues were the major sources of information on hypertension for the participants

"I had some rudimentary knowledge about HTN prior to my diagnosis, such as the idea that it is a treatable condition and that proper medical therapy may control high blood pressure. This sort of information was obtained through television and You tube." (P12)

The participants believed that religion or culture has nothing to do with the disease. One of the participants, on the other hand, correlated her disease to her religious values.

"A lot of people my age believe that diseases are caused by our prior misdeeds. Everything I'm going through right now, whether it's an illness or a happy event, I feel is linked to my previous actions." (P4)

Many participants stated that they were unaware of the symptoms that they were experiencing. They went to the hospital after being persuaded by the ideas of the people around them. As a result, the hospital physicians and others at the adjacent drugstore diagnosed this illness.

All of the participants had no idea about illness

screening and were unaware that hypertension might be asymptomatic.

"I was fully asymptomatic when I was first told I had been diagnosed with hypertension, so I didn't believe it…I tried to control my blood pressure via food and exercise rather than seeking medical help…my husband took me to a doctor." (P6)

The most effective perceived self-management methods for hypertension were a healthy diet, exercise, and weight loss. On the other hand, working women and older adult hypertensive women were hesitant to exercise regularly. In addition to allopathic treatment, one participant perceived herbal or ayurvedic medicine (e.g., garlic, Karela juice) as effective management of hypertension. The following comments demonstrate this.

"I'm of such an age where I cannot workout. Because of my knee pain, I can't even walk correctly. As a result, I attempt to stick to a low-salt diet. But there's nothing else I can do to keep my blood pressure in check." (P9)

"I make an effort to eat a low-salt diet. I am a full-time employee…I feel more exhausted and won't be able to go for a morning stroll. The most of the time, I walk to work…I suppose that makes up for my early walk." (P6)

Family members remained the most critical determinants for adequate medication adherence, according to the participants. In addition, several participants said that hypertensive friends and relatives helped them stick to their drug regimen.

"I do take my medications on schedule. Many of my friends have had hypertension for a long time. They frequently emphasize the necessity of adequate drug adherence…I have relatives who work in the hospitals… all of these have contributed to my ability to take my medications on time." (P3)

Trust in the abilities of medicines to treat illness also emerged as a facilitator of medication adherence.

"I have no apprehensions about taking medications. Medicines are created with the goal of curing an illness. So, why should we be afraid of such drugs? I have good adherence to meds since I don't have any fear." (P5)

The barriers to poor drug adherence differed across the participants where some participants perceived the side effects of medication as reasons for low drug adherence.

"I become nauseous whenever I take anti-HTN medications. My gastritis is becoming worse…nausea-like sensation is the one that scares me the most and affect my drug compliance." (P4)

High medication costs were also a perceived barrier to medication adherence among the participants. The following quote supports this statement:

"My financial situation is not good. I do have a number of co-existing disorders, such as anxiety and asthma… antihypertensive medications are not covered by my national insurance… because of the cost, I frequently forego it." (P1)

Some participants also stated that as they have become older, they either forget to take their medications or purposefully miss them.

"*As far as I'm aware, anti-HTN medications must be used for the rest of one's life. I have to bring my medication with me whenever I travel…when I'm at a party or traveling, I purposefully skip my pills.*" (P7)

The health-care systems were unsatisfactory to half of the participants where participants expressed long wait times, costly OPD tickets, and unpleasant health personnel behavior as difficulties encountered while visiting hospitals.

"I have to get a new OPD ticket every time I go to the hospital for my follow-up… My medical costs are rising as a result of many blood tests and diagnostic tests performed on each follow-up…I am frequently advised to perform certain tests without being told why… health-care system in my country are causing further challenges in the life of a sick person." (P10)

The participants recommended appropriate medication adherence, proper nutrition, and financial stability as measures that can improve hypertension patients' quality of life. The aged hypertensive woman, on the contrary, expressed that having access to health services within walking distance could improve one's quality of life.

"To improve the life of a hypertensive patient, you must strike a balance between your professional and personal lives. You should eat well and stay away from stressors as much as possible." (P6)

"The availability of health services and medicines within a short distance could aid older folks like me who can't go a large distance to buy medication or seek

medical treatment." (P9)

DISCUSSION

This study focused on hypertensive women's perceptions of their condition. The current study found that most participants were ignorant of the average blood pressure level. In addition, dizziness and headache were the most common hypertensive symptoms for most patients. These findings are in line with another study conducted in Bangladesh, where most participants had no idea about the normal blood pressure range, and the predominant hypertension symptoms were dizziness and neck discomfort.[12]

Obesity was found to be a significant perceived risk factor for hypertension, and religious beliefs are unrelated to hypertension management in the current study. Research from Penang, on the other hand, found that the majority of respondents were unfamiliar with obesity as a risk factor for hypertension.[13] Furthermore, a study conducted in Thailand concluded that patients' traditional beliefs and assumptions sometimes prevent them from accepting or stopping medical treatment.[14] However, the study setting may have contributed to the difference in religious beliefs about hypertension between the two studies.

Regarding the use of complementary and alternative therapy to control hypertension, only one patient embraced the use of such therapy to control hypertension in the current study. However, these results contrast with a study done in Malaysia, which found that despite being prescribed medicine by a general practitioner, a significant percentage of participants used herbal and traditional treatments for chronic illness.[15]

The current study identified financial issues and negligence as significant barriers to medication adherence. This finding is supported by a study conducted in India which revealed out-of-pocket payments and forgetfulness as significant barriers to medication adherence.[16] Similarly, this study's findings are consistent with a study from Nepal that highlighted forgetfulness and lack of time as obstacles to medication adherence.[17] The health-care systems were unsatisfactory to only half of the patients in this study. Similarly, a study in Ethiopia revealed that participants could not receive adequate information, counseling, or education on self-management practices from their health care providers.[18]

This study thoroughly reflected the misconceptions about hypertension among hypertensive women; however, it has some limitations. First, this study used purposive sampling to choose hypertensive women from only one hospital. As a result, the study's findings may not accurately reflect the experiences of all hypertensive women in the area. Second, as the study included participants from an urban setting, the findings may differ from those of women from rural settings.

CONCLUSIONS

The perspectives of hypertensive women toward their illness were highlighted in this qualitative study. Most women believed that hypertension could be fatal if not managed appropriately. Obesity was perceived as a possible cause, with headache and dizziness being the most reported symptoms. Radio, television, and social media (Facebook) were the primary sources of medical information, with almost everyone believing that religion and culture had no bearing on disease causation. However, as the hypertensive women were ignorant that hypertension might be asymptomatic, they were unaware of the significance of illness screening. The numerous impediments that hinder women from seeking and getting therapy at health care facilities, such as the long waiting hours and costly OPD tickets, are reported in this study.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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