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2. The LJN has the tripartite mission of:
 - (a) Promoting a culture of excellence in Nursing Research.
 - (b) Encouraging the exchange of profound and innovative ideas capable of generating creative practice in nursing research practise.
 - (c) Disseminating information on nursing related development that are not usually easily available to academics and practitioners.
3. The Journal will accordingly encourage the publication of the following categories of papers.
 - (a) Research papers that move away from orthodoxy and which really break new grounds in terms of methodology and findings.
 - (b) Essays and issues papers that contribute to reorienting received ideas, values and practices.
 - (c) Documents emanating from national and international conferences, as well as from largescale research work that emerging trends and thinking in nursing related development.
4. LJN is published biannually in any area of nursing interest or relevant to needs of academics and practitioners.

In this edition, nineteen (19) manuscripts scale through the eye of the needle of the Editor-in Chief. The title of the papers in this edition are: Assessment of client satisfaction with contraceptive services in public health care facilities in Zamfara State, Nigeria; Sociocultural and economic determinants of open defecation practices in Kano State, Nigeria; effect of simulation based training on midwives' skills in managing retained placenta with umbilical vein oxytocin injection in health facilities, Osun State, Nigeria; Nurses Level Of Preparedness In Management Of Patient With Viral Hemorrhagic Fever In Emergency Ward In University Of Ilorin Teaching Hospital, **Nigeria**; Nursing Education: A Sine Qua Non For Addressing The Healthcare Demands Of The 21st Century; Influence Of Nursing Training On Their Competency In Selecting Wound Dressing Materials At A Secondary Health Facility In Ilorin, Kwara State, Nigeria; Prevalence And Outcome Of Malaria Infection Among Children Below 11 Years In A Tertiary Healthcare Facility In Benin City From 2018-2020; Factors Influencing Prevalence Of Gender Based Violence Among Men And Women In Bagudo LGA Kebbi State, Nigeria; Knowledge Of Health Implications Of Rape And Associated Factors Among Male Undergraduates In Ahmadu Bello University Zaria, Nigeria; Quackery In Nursing, The Causes, Effects And Control Measures: The Nigeria Experience; Knowledge, attitude and practice of injection safety among nurses in Nigeria: a case study of University of Ilorin Teaching Hospital Ilorin, Kwara State, Nigeria; Awareness Of Computer Vision Syndrome Among Staff Of Information Communication And Technology Unit Of University Of Benin Teaching Hospital, Benin City, Edo State, Nigeria; Utilization Of Personal Protective Equipment Against Organic Dusts Among Poultry Farmers In Ona-Ara Local Government Area, Ibadan, Nigeria; Predictors Of Surgical Site Infection Amongst Post Operative Patients In Federal Medical Centre Lokoja, Nigeria; Evaluation Of The Involvement Of Nurses In Policies And Policy Formulation In Nigeria; Determinants of Stress and Coping Mechanisms among Nurses in Aminu Kano Teaching Hospital, Kano State, Nigeria; Influence Of Nursing Training On Their Competency In Selecting Wound Dressing Materials At A Secondary Health Facility In Ilorin, Kwara State, Nigeria; Adaptation To Stress And Academic Performance Of Students In Nursing Institutions In Oyo State, Nigeria; Medication Adherence And Quality Of Life Of Hypertensive Patients Attending Selected Hospitals In Port Harcourt, Rivers State, Nigeria; Perspectives Of Youth On The Legalization Of Abortion In North Central Nigeria.

EDITORIAL DESK

Welcome to LAUTECH Journal of Nursing!

LAUTECH Journal of Nursing focus on but not limited to research findings in the different areas of Nursing: Nursing Care, Nursing Education, Medical Surgical Nursing, Maternal and Child Health Nursing, Community Public Health Nursing, and Psychiatric/Mental Nursing. This journal is published to promote quality scholarly writing and hence instigating and generating vibrant discourse in the different areas of nursing. Apart from providing an outlet for publications of research findings, it offers opportunities for professionals and students to disseminate their views or position on topical issues and emerging theories within the scope of the journal. The Journal is peer reviewed by seasoned scholar. Eighty authors have contributed in one way or the other to the thirteenth edition of the journal.

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MEDICATION ADHERENCE AND QUALITY OF LIFE OF HYPERTENSIVE PATIENTS ATTENDING SELECTED HOSPITALS IN PORT HARCOURT, RIVERS STATE, NIGERIA

ALIGWO CLOTHILDA CHINWE; NWOZICHI CHINOMSO; & OKAFOR NGOZI

ABSTRACT

Hypertension is a prevalent global condition and a leading cause of cardiovascular including cerebrovascular morbidity and mortality. Medication adherence plays a crucial role in the quality of life of hypertensive patients, but poor adherence remains a significant clinical challenge. This study aimed to assess medication adherence and quality of life among hypertensive patients attending selected hospitals in Port Harcourt, Rivers State. A quantitative, cross-sectional descriptive research design was used, with a sample size of 148 hypertensive patients from NHIS clinics. Data was collected using a modified WHO (2019) STEPS Instrument and analysed using descriptive statistics, linear regression with a significance level set at 0.05. The demographic characteristics indicate that the majority of respondents are within the age group of 46 to 60 years (48.2%), males (64%), married (58.3%) and the level of education is secondary school (43.9%). Further findings reveal that the majority of respondents are Civil servants and Artisans/farming (20.9%) with monthly income of 51,000 100,000 (45.3%). The result indicated that the level of medication adherence by hypertensive patients is low ($\bar{x}=2.36$) and the respondents are experiencing moderate quality of life ($\bar{x}=2.58$). Hypothesis testing revealed that there is a relationship between the medication adherence and quality of life of the respondents ($P=0.000$). The study concluded that while most patients exhibited low adherence and moderate quality of life, improving treatment adherence through interventions that address psychological factors and promote understanding of medical prescriptions could enhance the quality of life in hypertensive patients

Keywords: Demographic Data; Hypertensive Patients; Medication Adherence; Quality of Life

INTRODUCTION

Hypertension is a prevalent global condition and the primary contributor to cardiovascular and cerebrovascular morbidity and death. Medication adherence significantly influences the quality of life in hypertension patients, making it a crucial aspect of their management. Inadequate compliance with antihypertensive therapy continues to be a global therapeutic problem. Despite being a preventable condition, the prevalence of hypertension has been steadily growing. Hypertension affects almost one in four persons worldwide and causes over ten million deaths each year. According to the GBD research of 2016, hypertension resulted in 1.63 million fatalities in India in that same year. GBD statistics indicated that more than half of the fatalities resulting from ischaemic heart disease (54.2%), stroke (56.2%), and chronic kidney disease (54.5%) were linked to elevated systolic blood pressure. Hypertension is becoming a significant health issue (Abdulkadir, Awosan, Oche, & Sabir, 2020). Factors that elevate the risk of hypertension include advanced age, genetic predisposition, overweight or obesity, physical inactivity, a high-sodium diet, and excessive alcohol use.

Modifications in lifestyle, such as adopting a better diet, ceasing tobacco use, and increasing physical activity, can contribute to the reduction of blood pressure. Certain individuals may still require medication. Hypertension is diagnosed when systolic blood pressure measurements are ≥ 140 mmHg and/or diastolic blood pressure readings are ≥ 90 mmHg on two separate occasions. Hypertension is connected with many

risk factors, including Alterable risk factors encompassing poor dietary habits (excessive sodium intake, high consumption of saturated and trans fats, and insufficient fruit and vegetable intake), sedentary lifestyle, tobacco and alcohol use, and overweight or obesity. Non-modifiable risk factors encompass a familial history of hypertension, age above 65 years, and concomitant conditions such as diabetes or renal illness. Certain symptoms manifest due to hypertension; nevertheless, the majority of individuals with hypertension remain asymptomatic. Only significantly elevated blood pressures can induce headaches, impaired vision, chest discomfort, and further symptoms. As per the World Health Organisation (Adeloye, Aderemi, Basquill, Obi, & Thompson, 2015). The prevalence of hypertension is disproportionately significant, with an estimated 1.28 billion persons aged 30 to 79 globally affected, the majority (two-thirds) residing in low- and middle-income nations. Approximately 46% of persons with hypertension are oblivious to their illness. Fewer than half of people (42%) with hypertension receive a diagnosis and treatment. Approximately 21% of persons with hypertension have their condition under control. Hypertension is a significant contributor to early mortality globally. A global objective for non-communicable illnesses is to decrease the prevalence of hypertension by 33% from 2010 to 2030 (Agarwal, & Oparil, 2021).

Medication adherence refers to the degree to which a patient's medication consumption aligns with the prescribed health recommendations. Medication adherence is a critical determinant of therapy outcomes in individuals with chronic illnesses. Regardless of a drug's potency, it cannot exert its effects unless the patient administers it. Compliance with therapy is the crucial connection between intervention and result. Patients who adhered to their whole hypertension treatment regimen were considerably less likely to exhibit increased blood pressure.

Adherence to drugs is correlated with enhanced health benefits and patient outcomes. Non-adherence constitutes the primary impediment

to hypertension control and a substantial barrier to successful management of the condition. A multitude of global research on non-adherence have yielded diverse outcomes. The non-adherence rate in a global research was 45%, with a substantial proportion of hypertension patients with comorbidities failing to comply with medication. Inadequate adherence to therapy is a primary factor contributing to the poor response to blood pressure (BP) reduction therapies in patients diagnosed with 'resistant hypertension,' affecting up to 10% to 20% of individuals with elevated BP. Complications of hypertension, such as renal problems, mostly arise from non-adherence to antihypertensive medicines and the prolonged use of a single class of antihypertensive pharmaceuticals without dosage adjustments (Aladeneyi, Adeneyi, Owolabi, Fawole, Adeolu, Goon, & Ajayi, (2017). Insufficient compliance with antihypertensive therapy is a global issue.

The present global health and economic condition is exacerbating the issues at hand. Hypertension is a prevalent global condition and the primary contributor to cardiovascular and cerebrovascular morbidity and death (American Heart Association. 2016). Hypertension is a chronic medical disorder characterised by abnormally elevated arterial blood pressure. Hypertension is characterised by a systolic pressure over 130 mmHg and a diastolic pressure beyond 80 mmHg (Anchala et al. 2014). The morbidity and death rates associated with hypertension (HTN) are significant, presenting a substantial public health challenge globally. Hypertension is sometimes termed a silent killer due to its asymptomatic characteristics, complicating detection in several individuals (Anchala et al. 2014). Global population-based observational research provided a comprehensive overview of the worldwide burden of hypertension, the primary avoidable cause of mortality. The authors calculated that in 2015, the global prevalence of hypertension was 1.39 billion cases, constituting 31% of the adult population. This indicated a 5.2% rise in worldwide prevalence from 2010 to 2015 (Angaw, Dadi, & Alene, 2015). Prevalence of

hypertension among federal ministry civil servants in Addis Ababa, Ethiopia: A call for a workplace-screening program. *BMC Cardiovascular Disorders*, 15(1), 76-81.

Hypertension is projected to affect approximately 1 billion individuals worldwide and remains the primary risk factor for various cardiovascular diseases. By 2025, this number is expected to rise to 1.56 billion. Currently, about 26% of the global population suffers from hypertension, with projections indicating an increase to 29% by 2025, largely due to rising prevalence in economically developing countries. By 2025, hypertension is anticipated to account for approximately 54% of strokes, 47% of ischemic heart disease cases, and 13.5% of disability-adjusted life years (DALYs). Additionally, it is a significant risk factor for renal and ocular complications. In Nigeria, the prevalence of hypertension and other non-communicable diseases is increasing, contributing to a higher incidence of cardiovascular diseases and their associated effects. Among hypertensive patients, adherence to treatment is a well-documented factor influencing effective blood pressure management. Patients with comorbidities and those on multiple medications face an increased risk of non-adherence.

Anti-hypertensive drugs effectively control blood pressure, prevent target organ damage, avoid cardiovascular disease, and reduce mortality. Although anti-hypertensive medicines are effective, non-adherence to these treatments restricts good clinical results. Comprehending adherence and formulating strategies to enhance adherence levels is challenging due to the multitude of factors influencing these levels. The World Health Organization suggested classifying these elements into five primary categories: socio-economic factors, therapeutic factors, health-care system considerations, condition factors, and patient-related factors. Stress has been shown to negatively impact adherence to anti-hypertensive medication and result in inadequate blood pressure management. Conversely, patients cognisant of the detrimental effects of stress exhibit superior commitment to therapy. Additional patient-related variables, including tobacco consumption and elevated body mass index (BMI), may adversely influence adherence

to antihypertensive therapy. Low social support may be a prevalent risk factor for non-adherence in older patients, considering socio-economic considerations (Fenerty, et al. 2012).

High blood pressure (HBP) is a chronic illness that can lead to severe consequences, hence affecting patients' quality of life. Numerous research studies have demonstrated the adherence rate among hypertension individuals. The disease's impact on quality of life can lead to emotional consequences, prompting individuals to abandon their medication. Socio-demographic factors influencing medication adherence include age, gender, co-morbidities, patient knowledge about the disease, and the quantity of medications (Fenerty, et al. 2012). Many clients perceive no justification for drug use, remain unaware of advancements in therapy, focus excessively on limits, or fail to recognise improvements in their conduct.

The quality of life serves as a significant outcome metric in healthcare, and comprehending the impact of medication adherence on quality of life is crucial for hypertensive patients. The examination of quality of life in hypertension patients has become a crucial aspect of professional procedures. Most research on the quality of life of hypertensive patients has been undertaken in industrialized nations with varying socio-cultural contexts, which may affect both the perception of quality of life and the experience of hypertension symptoms. Limited information is available about the quality of life of hypertensive patients in poor nations (Fenerty, et al. 2012; Angaw, et al. 2015).

Objectives of the study

The specific objectives of the study are:

- 1) To determine the level of medication adherence among hypertensive patients attending the selected hospitals.
- 2) To evaluate the quality of life of these hypertensive patients.
- 3) To examine if medication adherence significantly predicts the quality of life of hypertensive patients in these hospitals.

H₀₁: Medication adherence will not significantly predict quality of life of hypertensive patients attending selected hospitals in Port Harcourt Rivers State.

RESEARCH METHODS

Design: The study adopted a quantitative, cross-sectional, descriptive research design.

Setting: The focus on hypertensive patients attending two hospitals in Port Harcourt, Rivers State, allowed for accurate and comprehensive data collection. Specifically, the University of Port Harcourt Teaching Hospital (UPTH) and Rivers State University Teaching Hospital (RSUTH) were selected for the study.

Target Population: The population consisted of male and female hypertensive patients attending NHIS clinics in the two selected hospitals with a combined total population of 202 hypertensive patients.

The inclusion criteria for participation were patients aged 18-70 years who voluntarily agreed to participate in the study.

Exclusion criteria included patients with severe complications such as stroke or kidney failure, those too weak to participate, and those unwilling to partake in the research.

Sample Size Determination: The sample size was determined using the Taro Yamane formula, resulting in an initial sample size of 133. To account for non-response, an adjustment of 10% was applied, resulting in a final sample size of 148 respondents.

Sampling Technique: Simple random sampling technique was employed to select the participants from the NHIS clinics in both hospitals. This non-probability sampling method allowed for the selection of patients who were available and willing to participate at the time of data collection.

Instrument: An adapted questionnaire, modified by the researcher, was used to gather data. The questionnaire comprised three sections:

Section A collected socio-demographic information;

Section B assessed medication adherence using a Likert scale; and

Section C measured quality of life, also using a Likert scale. Validity and reliability of the instrument were ensured through expert review and a pilot test.

The instrument underwent face and content validation by experts in nursing science, who verified that the questionnaire appropriately measured the intended constructs. Reliability was assessed by administering the questionnaire to 30 hypertensive patients, with results yielding Cronbach's alpha values of 0.798 for the overall instrument, indicating strong internal consistency.

Sections B and C also showed acceptable reliability, with values of 0.702 and 0.754, respectively, demonstrating the questionnaire's effectiveness in measuring medication adherence and quality of life.

Data collection: Data collection was conducted over six weeks, with questionnaires distributed at both hospitals' NHIS clinics. Data were collected on Mondays, Wednesdays, and Fridays to accommodate the hospitals' clinic schedules. A total of 148 questionnaires were distributed, all of which were completed and returned, ensuring a 100% response rate.

Data analysis: Data analysis was performed using SPSS version 20.0. Descriptive statistics, such as tables, were used to analyze socio-demographic characteristics. Multiple regression and chi-square tests were employed to test the study hypotheses, with significance levels set at $p < 0.05$.

Ethical Consideration: The researcher obtained verbal consent from each participant and ensured the anonymity and confidentiality of responses. Participants were informed of their right to withdraw from the study at any time without consequence. Ethical approval for the study was obtained from the Babcock University Health Research Ethics Committee, and the study adhered to ethical principles such as anonymity, confidentiality, informed consent, voluntary participation, and fairness in treatment.

RESULTS

It should be noted that one hundred and thirty-nine (139) respondents were estimated and participated in this study. All questionnaires were distributed and adequately filled and used in the analysis. Thus 93.9% questionnaire retrieval success was recorded.

Table 1 indicated that respondents within the age of 18-30 years were 8(5.8%), those within 31-45 years were 21(15.1%), 46-60 years were 67(48.2%), above 60 years were 43(30.9%). Males were 89(64%), females were 50(36%). 21(15.1%) were single, 81(58.3%) were married, 23(16.5%), 14(10.1%) were widowed. 12(8.6%) had no formal education,

23(16.5%) were primary school certificate holders, 61(43.9%) were secondary school certificate holders, while 43(30.9%) had tertiary education. On monthly income in Naira, 7(5%) had less than 10,000, 28(20.1%) had between 10,000 -50,000, 63(45.3%) earned 101,000 and above. The demographic characteristics indicate that majority of respondents are within the age group of 46 to 60years (48.2%), males (64%), married (58.3%) and the level of education is secondary school (43.9%). Further findings reveal that majority of respondents are Civil servants and Artisans/farming (20.9%) with monthly income of 51,000 100,000 (45.3%)

Table 1: Distribution of respondents by socio-demographic characteristics

Socio-Demographic Characteristics	Frequency	Percentage
Age		
18 30 years	8	5.8
31 45 years	21	15.1
46 60 years	67	48.2
Above 60 years	43	30.9
Total	139	100.0
Gender		
Male	89	64.0
Female	50	36.0
Total	139	100
Marital status		
Single	21	15.1
Married	81	58.3
Divorced	23	16.5
Widowed	14	10.1
Total	139	100.0
Highest level of education		
No formal education	12	8.6
Primary	23	16.5
Secondary	61	43.9
Tertiary	43	30.9
Total	139	100.0
Employment status		
Unemployed	18	12.9
Civil servants	29	20.9
Trading	25	18.0
Artisans/farming	29	20.9
Retiree	27	19.4
Others	11	7.9
Total	139	100.0
Monthly Income in Naira		
<10,000	7	5.0
10,000 50,000	28	20.1
51,000 100,000	63	45.3
101,000 and above	41	29.5
Total	139	100.0

Table 2 summarizes the level of medication adherence by hypertensive patients. From the table, the mean score of I know what each of my medication is for is ($\bar{x}$ =2.25), I have trouble remembering when to take my medications ($\bar{x}$ =2.32), I always think that some of my medications are not helping me ($\bar{x}$ =2.51), I avoid taking some of my medications because of side effects ($\bar{x}$ =2.47), I take my medicines daily ($\bar{x}$ =2.32), When my blood pressure is under control, I sometimes

stop taking my medicine ($\bar{x}$ =2.50), When I travel, I sometimes forget to take along my medications ($\bar{x}$ =2.30), Whenever I feel worse when taking medication, I stop taking the medicine. ($\bar{x}$ =2.31), Too much of medication make me uncomfortable ($\bar{x}$ =2.11) and lastly, I take my medication only when I am sick ($\bar{x}$ =2.51). It could be concluded in this study that the level of medication adherence by hypertensive patients is low. ($\bar{x}$ =2.36).

Table 2: Medication adherence by hypertensive patients

S/N	Items	Always (%)	Occasionally (%)	Never (%)	Mean	SD
1.	I know what each of my medications is for.	47(33.8%)	80(57.6)	12(8.6)	2.25	0.60
2.	I have trouble remembering when to take my medications.	53(38.1%)	77(55.4)	9(6.5)	2.32	0.59
3.	I always think that some of my medications are not helping me	74(53.2)	62(44.6)	3(2.2)	2.51	0.54
4.	I avoid taking some of my medications because of side effects.	72(51.8)	61(43.9)	6(4.3)	2.47	0.58
5.	I take my medicines daily	53(38.2)	77(55.4)	9(6.5)	2.32	0.59
6.	When my blood pressure is under control, I sometimes stop taking my medicine.	74(53.2)	60(43.2)	5(3.6)	2.50	0.57
	When I travel, I sometimes forget to take along my medications	52(37.4)	77(55.4)	10(7.2)	2.30	0.60
8.	Whenever I feel worse when taking medication, I stop taking the medicine.	67(48.2)	48(34.5)	24(17.3)	2.31	0.75
9.	Too much medication make me uncomfortable.	56(40.3)	42(30.2)	41(29.5)	2.11	0.83
10	I take my medication only when I am sick	73(52.5)	64(46.0)	2(1.4)	2.51	0.53
					2.36	

Table 3 summarizes the quality of life of hypertensive patients. From the table, the respondents mean score of Night sweats is ($\bar{x}$ =2.27), Dissatisfaction with my personal life is ($\bar{x}$ =2.30), Feel anxious and nervous ($\bar{x}$ =2.29), Poor memory ($\bar{x}$ =2.27), Accomplishing less than I used to ($\bar{x}$ =2.30), Feeling of wanting to be alone ($\bar{x}$ =2.27), aching in muscles and joints ($\bar{x}$ =2.29), Feeling tired or worn out ($\bar{x}$ =2.38), Difficulty sleeping ($\bar{x}$ =2.09), Aches in back of neck or

head ($\bar{x}$ =2.46), Decrease in physical strength ($\bar{x}$ =2.47), Decrease in stamina ($\bar{x}$ =2.13), Lack of energy ($\bar{x}$ =2.47), Dry skin ($\bar{x}$ =2.24), Changes in appearance, texture or tone of my skin ($\bar{x}$ =2.26), Low backache ($\bar{x}$ =2.47), Frequently urination ($\bar{x}$ =2.28), Involuntary urination when laughing or coughing ($\bar{x}$ =2.47), Decrease in my sexual desire ($\bar{x}$ =2.51). This study shows that the respondents are experiencing moderate quality of life ($\bar{x}$ =2.58).

Table 3: Quality of Life of Hypertensive Patients

S/N	ITEMS	Always (%)	Occasionally (%)	Never (%)	Mean	SD
	Night sweats	50(36.0)	77(55.4)	12(8.6)	2.27	0.61
1.	Dissatisfaction with my personal life.	50(36.0)	80(57.6)	9(6.5)	2.30	0.58
2.	Feel anxious and nervous	51(36.7)	77(55.4)	11(7.9)	2.29	0.60
3.	Poor memory	51(36.0)	77(55.4)	12(8.6)	2.27	0.61
4.	Accomplishing less than I used to	50(36.0)	80(57.6)	9(6.5%)	2.30	0.58
5.	Feeling of wanting to be alone	50(36.0)	77(55.4)	12(8.6)	2.27	0.61
6.	Aching in muscles and joints	50(36.0)	79(56.8)	10(7.2)	2.29	0.59
7.	Feeling tired or worn out?	96(69.1)	0(0.0)	43(30.9)	2.38	0.93
8.	Difficulty sleeping?	66(47.5)	20(14.4)	53(38.1)	2.09	0.92
9.	Aches in back of neck or head	72(53.2)	59(42.4)	8(5.8)	2.46	0.61
10.	Decrease in physical strength?	74(53.2)	57(41.0)	8(5.8)	2.47	0.61
11.	Decrease in stamina	69(49.6)	19(13.7)	51(36.7)	2.13	0.92
12.	Lack of energy	74(53.2)	57(41.0)	8(5.8)	2.47	0.61
13.	Dry skin?	81(58.3)	10(7.2)	48(34.5)	2.24	0.94
14.	Changes in appearance, texture or tone of my skin	84(60.4)	7(5.0)	48(34.5)	2.26	0.94
15.	Low backache?	74(53.2)	57(41.0)	8(5.8)	2.47	0.61
16.	Frequent urination	54(38.8)	70(50.4)	15(10.8)	2.28	0.65
17.	Involuntary urination when laughing or coughing	74(53.2)	57(41.0)	8(5.8)	2.47	0.61
17.	Heart discomfort (unusual awareness of heartbeat, heart skipping, heart racing, tightness)	77(55.4)	19(13.7)	43(30.9)	2.24	0.90
18.	Decrease in my sexual desire	105 (75.5)	0(0.0)	34(24.5)	2.51	0.86
19.					2.58	

Test of Hypothesis

H₀₁: Medication adherence will not significantly predict quality of life of hypertensive patients attending selected hospitals in Port Harcourt Rivers State.

Table 4 shows that the independent variable (medication adherence) accounts for 45.6% of the variance on quality of life of hypertensive patients (R^2 adjusted= 0.456). The analysis of

variance of the linear regression data yielded an F-ratio value which was found to be significant at 0.05 alpha level ($F(1,137)=9.588$; $P<0.05$). This implies that the null hypothesis was rejected. Medication adherence significantly contributed to quality of life as ($B = 0.678$; $t=5.872$; $p <0.05$). Hence, there is a relationship between the medication adherence and quality of life of the respondents.

Table 4: Linear regression analysis showing the medication adherence and quality of life.

R=0.678, $R^2=0.460$, Adjusted $R^2=0.456$, Standard error of estimate = 4.149						
Variables	Un-standardised Coefficients		Standardized Coefficients	T	Sig.	Remark
	B	Std.Error	Beta			
(constant)	39.841	3.164		12.590	.000	
Medication Adherence	.781	.133	.678	5.872	.000	Sig

($F_{(1,137)} = 9.588$; $p<0.05$).

DISCUSSION OF FINDINGS

The aim of this study was to assess the relationship between medication adherence and quality of life among hypertensive patients attending two selected hospitals in Port Harcourt, Rivers State. The demographic analysis indicates that the majority of respondents are male, aged 46 to 60 years, married, and have attained a secondary school level of education. Further findings reveal that most respondents are civil servants or artisans/farmers, with a monthly income ranging from ₦51,000 to ₦100,000. Ogedegbe et al. (2012) examined the demographic factors influencing medication adherence among hypertensive patients, particularly African Americans, and found that a significant portion exhibited low adherence levels. The study identified age and education as notable factors, concluding that older age, lower education levels, and higher negative affect were associated with poorer medication adherence. Additionally, the presence of comorbidities, such as diabetes, and the use of multiple medications further negatively impacted adherence. Similarly, Dhingra et al. (2021) and Brown et al. (2020) found that demographic characteristics, including education, age, and income levels, play crucial roles in influencing adherence to hypertension treatment. Notably, individuals with higher education and better socioeconomic status tend to adhere more closely to prescribed treatments, leading to an overall improvement in their quality of life.

The results indicated that medication adherence among hypertensive patients is low. However, this finding contrasts with Trevisol, Moreira, Kerkhoff, Fuchs, and Fuchs (2011), who found that most hypertensive patients demonstrated average adherence to medication. Agarwal and Oparil (2021) conducted a large cohort study using electronic monitoring and patient surveys to assess medication adherence in hypertensive patients. Their findings revealed that while initial adherence was high, long-term adherence significantly declined over time, with nearly 40% of patients becoming non-adherent after

the first year. Key barriers to adherence included medication side effects and complex dosing regimens. Similarly, Jankowska-Polanska, Dudek, and Uchmanowicz (2020) conducted a cross-sectional study evaluating medication adherence in elderly hypertensive patients. They found that less than half of the participants adhered to their prescribed regimens, with poor adherence linked to low health literacy and polypharmacy (the use of multiple medications). The researchers concluded that targeted interventions focusing on patient education and support are necessary to improve adherence. Mills et al. (2016) conducted a systematic review and meta-analysis examining the prevalence and determinants of medication adherence among hypertensive patients across various regions. Their findings indicated significant regional disparities in adherence rates, with lower adherence observed in low- and middle-income countries. Socioeconomic factors, limited healthcare access, and low patient awareness were identified as major contributors to poor adherence.

The study further indicate that the respondents are experiencing moderate quality of life. In line with this study, Chin & Lee (2014) concluded that the quality of life of hypertensive patients is at moderate level. They further stated that the quality of life of people with hypertension is affected by several factors, among them are linked to the very existence of infirmity and its chronic degenerative character, to the discovery of the disease, to the negative effects on physical, emotional and social aspects, as well as those related to medication therapy. Similarly, Ayele et al. (2020) found that the quality of life of hypertensive patients is influenced by the duration of the disease, adherence to treatment, and the level of social support. They emphasized that long-term hypertension management and patient education significantly affect the overall well-being of patients. Esmaeili et al. (2019) further supported this by explaining that hypertension impacts patients' physical, emotional, and

social lives, leading to feelings of isolation and decreased life satisfaction. They found that many patients struggle with managing the daily implications of the disease. Ghimire et al. (2021) examined the quality of life among hypertensive patients in Nepal and found that the disease notably impacts the physical and mental dimensions of health, emphasizing how social and cultural factors also play a role. Li et al. (2020) added that medication adherence and emotional well-being are key factors in determining the quality of life for patients with hypertension, as poor adherence often leads to worse physical outcomes, thereby negatively affecting mental health.

Hypothesis tested reveals that there is a significant relationship between the medication adherence and quality of life of the respondents. This finding is in line with the study of Wu, Lennie, Chung, Frazier, Dekker, Biddle & Moser (2012) who explored studies conducted in Spain, USA and Pakistan. Similarly, Ayele et al. (2020) found that adherence to antihypertensive medications was a crucial determinant of quality of life among Ethiopian patients, noting that better adherence was associated with improved physical and emotional health. Kumari et al. (2021) also demonstrated a strong link between medication adherence and quality of life in hypertensive patients in India, emphasizing that poor adherence led to worsening symptoms, further deteriorating the patient's quality of life. Abdulkadir et al. (2020) conducted a study in Nigeria and found that non-adherence to antihypertensive medication significantly reduced patients' physical and mental well-being, further supporting the relationship between adherence and quality of life. AlHewiti (2019) examined medication adherence among hypertensive patients in Saudi Arabia and concluded that patients with higher adherence levels reported better quality of life outcomes, particularly in their ability to manage the disease without frequent complications.

CONCLUSION

Sequel to the findings of this study, it is concluded that most of the hypertensive patients had moderate medication adherence and quality of life respectively. It is also concluded that medication adherence predicted quality of life of hypertensive patients.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made:

1. It is important to explore psychological precursors of treatment adherence behaviour in hypertensive patients.
2. There is a need for increased knowledge on hypertension and its complications among hypertensive patients attending hypertensive clinics in Nigeria.
3. Government should provide funding for the production of information education materials increase general knowledge about hypertension among hypertensive patients
4. Government needs to provide health insurance coverage for the improvement of quality of life among hypertensive patients.
5. Family members and social support networks should be strengthened to improve the quality of life for hypertensive patients.
6. To carry out interventions that change negative attitudes toward treatment adherence and promote medical prescription knowledge, which may help to improve the quality of life of hypertensive patients?

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