HEALTH RISK MANAGEMENT PRACTICES AMONG PEOPLE WITH HYPERTENSION ATTENDING THE ASHONGMAN COMMUNITY HOSPITAL, ACCRA

BY

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MARCH, 2019
DECLARATION

I Peter Fataw, declare that this Dissertation is my original work, except for duly referenced ones and that no form of this has been presented elsewhere for another research

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DEDICATION

This work is dedicated to my ever loving and supportive mother Fuseina Dokurugu.
ACKNOWLEDGMENT

I thank the almighty God for his guidance, grace and mercies throughout this exercise.

I am very grateful to my supervisor Dr. Emmanuel Asampong under whose supervision this work has been a success.

This work would not have been successful without the support and encouragement of the Head of the Department of Social and Behavioral Sciences, Dr. Phylis Dako-Gyeke, Professor Philip Adongo (immediate past Head of Department) and all faculty members.

To friends, Rita, Ibrahim, Toufic and my family, God bless you for the tremendous support. Not forgetting my lovely wife Anne, whose beaming smiles has lit my way through out this work.

To my course mates, journey was made easy because your support, God bless you all.
ABSTRACT

**Background:** Hypertension is a global pandemic and one of the leading causes of preventable premature deaths worldwide and associated with debilitating complications such as strokes, heart failure and blindness. Health risk management practice is indicated for all patients with hypertension regardless of drug therapy because it may reduce or even abolish the need for antihypertensive medications. This study therefore explored the health risk management practices among patients with hypertension attending the Ashongman community hospital.

**Methods:** This qualitative study was conducted using purposive sampling technique. Five (5) Focus group discussions with an average of nine (9) participants per group participated in the study. There were two (2) women groups, two (2) men groups and one (1) mixed (men and women) group. Data was analysed based on themes.

**Results:** The results indicated that generally there was a good understanding about hypertension, although most participants did not view hypertension as a separate medical condition and undermined its seriousness as a single disease. The common health risk management practices were reduction in Stress, reduction in salt intake, consumption of less fatty foods, reduction of alcohol consumption and well as engaging in exercise, however many participants did not adequately practice this health risk management practices due to poor understanding. The use of herbal preparation as substitutes or compliments for medication was a common practice among participants. Poverty, Cost of health care, and co morbidities, were some barriers to positive health risk management practice, however participants who had supportive family and neighbours were able to significantly overcome these barriers. Meanwhile participants who had poor support could not overcome these barriers.
The study highlighted on the need for hospitals to incorporate health risk management practices in the out-patient education forums.
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LIST OF ABBREVIATIONS

CVD   CARDIOVASCULAR DISEASES
DALY  DISABILITY- ADJUSTED LIFE-YEARS
FGD   FOCUS GROUP DISCUSSION
HBM   HEALTH BELIEVE MODEL
NHIS  NATIONAL HEALTH INSURANCE SCHEME
WHO   WORLD HEALTH ORGANIZATION
UNICEF UNITED NATIONS INTERNATIONAL CHILDREN'S EMERGENCY FUND
CHAPTER ONE

INTRODUCTION

1.1 Background

Hypertension is a global pandemic and one of the most prevalent diseases worldwide and it is one of the main causes of preventable premature deaths worldwide (Mills et al., 2016), with associated debilitating complications such as strokes, heart failure, kidney failure, blindness (World Health Organization, 2013).

The rates of hypertension are higher in low and middle-income countries (31.5%) than in high-income countries (28.5%), with an estimate of 1.04 billion people now living with hypertension in low and middle income countries (Mills et al., 2016). Prevalence of hypertension among adults in Ghana is between 36% (Lamptey et al., 2017) and 48% (Health, 2015) with only 4% having controlled blood pressure (Lamptey et al., 2017).

Although about a one out of four of the adult population in low-income communities of Ghana have hypertension, the awareness levels, treatment and management is abysmally low (Awuah et al., 2014). Few participants in a study by Legido-Quigley et al. (2015) were aware of ways to prevent high blood pressure. Once diagnosed, most reported taking medication but had little information about their condition and also had a poor understanding of their treatment regime.

Health risk management practices are part and parcel of a person, a family or a community’s identity being the result of an evolving mix of personal, experiential and sociocultural factors. Significantly, individual’s behavioral pattern with regards to healthy lifestyle choices such as
dietary habits, physical activity, alcohol consumption, smoking, and stress management contributes to wellness and longevity (Iyalomhe & Iyalomhe, 2010).

1.2 Problem Statement

Hypertension affects about 1.13 billion people worldwide. As at the year 2015, the worldwide prevalence of hypertension in females and males aged over 18 years were around 20% and 24% respectively. Central and Eastern Europe collectively have the highest proportion of men with elevated blood pressure, that is nearly two in every five men, whereas sub-saharan africa has the highest proportion of women with hypertension, translating to nearly one in every three women (World Health Organization, 2016). The trend of hypertension rates is predicted to rise by 9% and 13% among men and women respectively by year 2025 (Twagirumukiza et al, 2011).

Major Complications of uncontrolled hypertension such as cardiovascular diseases (CVDs), are predicted to account for four times as many deaths as from communicable diseases by the year 2020 (Guwatudde et al., 2015).

In sub-Saharan Africa, the burden of Hypertension is rapidly becoming a major public health issue. For instance in Ghana, the burden of hypertension is on the increase as more Ghanaians are now living longer because of improving healthcare and also rapid urbanizations with accompanied negative lifestyle changes (Addo et al., 2012). Inadequate knowledge, awareness and beliefs about hypertension has led to management practices that are dangerous to the treatment and control of hypertension (Donkor et al., 2015). Segbefia et al.(2012), in a study revealed that participants understanding about hypertension was limited to their beliefs in witches and wizards. Participants resorted to complimentary treatment and not adherent to treatment with reasons of forgetfulness and outlook of their hypertensive status. Increasingly, Collaborative efforts are urgently needed to combat the emerging hypertension burden in low-
and middle-income countries (Mills et al., 2016). Dietary risk factors and physical inactivity together contribute for 10.0 % of global disability-adjusted life-years (DALY)s in 2010, with the most prominent dietary risks being diets low in fruits and those high in sodium (or salt) (Paolo et al., 2016)

Even though patients report of having regular attendance at the hypertensive clinic of the Ashongman community hospital, where routine education on hypertension management is done, the ashongman community hospital records in the year 2016 revealed that, an estimated 90% of the people with hypertension who attend the hypertensive clinic do not have a well-controlled blood pressure.

Treatment and control of hypertension is beyond just the intake of daily medications and thus needs multi-dimensional approach and conscious pragmatic behavioural patterns that promote blood pressure reduction. Hence, individuals with hypertension needs to adhere to some positive health management practices that are known to be helpful in the control of hypertension (World Health Organization, 2013) therefore, this study seeks to explore the health risk management practices amongst people with hypertension attending the Ashongman community hospital.

1.3 Justification

There is the need to incorporate healthy lifestyle management practices in the management of hypertension. Despite the high rates of hypertension in Ghana, only about 4% (Heart Foundation, 2016) to 8.9% (Guwatudde et al., 2015) of the people with hypertension have controlled blood pressure. There is very scanty data regarding health risk management practices among hypertensive people in Ghana and for that matter the new Ashongman estate and the surrounding communities.
Regular aerobic exercise, weight reduction, decreased dietary salt intake, smoke cessation, and moderation of alcohol consumption are some of the recommended health management behavioural interventions in the management and control of hypertension that reduces blood pressure (Lamptey et al., 2017). Inadequate understanding and practice of recommended health risk management practices in hypertension could greatly contribute to this poorly controlled blood pressure levels among this population. For instance in the Ashongman community hospital, almost 90% of the people with hypertension, have poorly controlled blood pressure (hypertensive clinic records, 2017). However, there is no known research conducted to explore the lifestyle management practices among the said population. Perhaps, this study will envision the health risk management practices among the hypertensive population (negative or positive) that affect the management and control of the hypertension. The aim of this research is to explore the health risk management practices among people with hypertension attending the Ashongman community hospital.

1.4 Research Questions

1. What is the general understanding about hypertension among people with hypertension attending the Ashongman community hospital?
2. What are the health risk management practices explore by people with hypertension attending the Ashongman community hospital.
3. What factors influence the health risk management practices of people with hypertension attending the Ashongman community hospital?
1.5 Research Objectives

1.5.1 General Objective

To explore the health risk management practices among patients with hypertension attending Ashongman Community Hospital.

1.5.2 Specific Objectives

1. To find out the level of understanding about hypertension amongst people with hypertension attending the Ashongman community hospital.

2. To explore the health risk management practices amongst hypertensive people attending the Ashongman community hospital.

3. To identify the factors that influence health risk management practices for people with hypertension attending the Ashongman community hospital.
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter reviews available studies regarding health risk management practices that help to optimise health and prolong life. The chapter pays particular attention to the health risk management practices that control hypertension and maintain normal blood pressure among people with hypertension.

2.2 Health Risk Management Practices Among People With Hypertension

Health risk management practices have direct links to incidence, prevalence and complication of diseases. Early recognition of the symptoms of diseases, early reporting to healthcare facilities, and adherence to effective treatment regimen can enormously decrease morbidity and mortality (Abidin at al, 2014, Strecher, 2015)

According to World Health Organization, 2013 behavioral risk factors, such as unhealthy diet, excessive consumption of alcohol, physical inactivity and tobacco use can promote the development of hypertension and vice versa. Behavioural risk factors can be influenced by work, income, living conditions which often are made worst by rapid urbanization.

Poverty however under minds efforts to the management of hypertension (Seedat, 2010). In a study conducted by Musoke et al, 2014, it was observed that Individuals may reduce hospital visits due cost of healthcare. Among barriers to health risk management practices, cost and perceived quality of healthcare service providers are the most significant factors in the health decision making process. Oli et al (2014) asserted that individuals in their study who had diabetes in addition to their hypertension were more likely to take health risk management practice
Individuals appear to be more enthusiastic about engaging in health risk management practice when they had other co-morbidities like diabetes which they often perceive as more deadly than hypertension (Anthony et al., 2012). Also, Lachat et al. (2013) reported similar findings in the study.

### 2.2.1 Physical Activity

The benefits of exercise are comparable to the effect of drugs on hypertension and hence rigorous exercise should be encouraged in the management of hypertension (Bjorntorp, 2014).

Regular aerobic exercise is essential for blood pressure reduction and also protects against the development of high blood pressure (Heart Foundation, 2016).

Recommended exercise for control of blood pressure includes accumulation of 150–300 minutes (2.5–5 hours) of moderate-intensity activity or 75–150 minutes (1.25–2.5 hours) of vigorous intensity activity, or an equivalent combination of both each week in combination with muscle strengthening activities on at least 2 days each week.

That is about least 30 minutes of moderate-intensity physical activity on most, preferably all, days (Aburto et al., 2013).

### 2.2.2 Dietary Habits

Determining the influence of various nutrients on blood pressure is a complex and evolving research area. While some relationships between food and cardiovascular health have not yet been clearly quantified. There is good evidence that a reduction in salt intake reduces blood pressure, a reduction in salt intake causes a dose-dependent reduction in BP in men and women of all ages and ethnic groups and in patients already on medication (Cappuccio & Capewell, 2015) and that black people are more sensitive than white people to the beneficial effect of reducing salt intake (Cappuccio & Capewell, 2015). Dietary risk factors such as low fruits intake
and high in sodium (or salt) are some of the prominent risk factors for hypertension and cardiovascular disease. (Stephen et al., 2012).

2.2.3 Alcohol Abuse

Harmful alcohol consumption is a significant predictor of for high blood pressure development.(Collart et al., 2015; Son, 2011). Alcohol appears to have modest but consistent and independent effect on blood pressure (Skliros et al., 2012).

2.2.4 Sleep Pattern

Sleep is an vital aspect of life however sleep pattern of below or above the median of 7 to less than 8 hours per night is associated with an increased prevalence of hypertension, particularly at the extreme of less than 6 hours per night.(Palagini et al., 2012)

Lack of sleep and hypertension are related and often coexist. Evidence suggest that the increasing prevalence of elevated blood pressure within the in the twenty first century could be related both to poor sleep behaviour influenced by modern lifestyle and this associations are stronger in women than in men.(Wang et al., 2015)

2.3 Theoretical Background

The theoretical base for this study is the health belief model. The Health Belief Model is one of the most widely accepted conceptual frame work of health behavior, focusing on behavioural change at the individual level. The model has been used with great success for almost half a century to promote greater condom use, seat belt use, medical compliance, and health screening use, to name a few behaviors.

Health Belief Model addresses a person’s perceptions of the threat of a health problem and the accompanying appraisal of a recommended behavior for preventing or managing the problem. The model asserts that for people to adopt recommended physical activity behaviors, their
perceived threat of disease (and its severity) benefits of action must outweigh their perceived barriers to action (Raingruber, 2013). The model suggests that decision-makers make a mental calculation about whether the benefits of a particular suggested behavior change outweigh its practical and psychological costs or barriers. Participants make internal assessment of the actual benefits behavior change, and make a decision whether or not to act. This model identifies four aspects of this assessment: perceived susceptibility to ill-health (risk perception), perceived severity of ill-health, perceived benefits of behavior change, and perceived barriers to taking action. The concept of self-efficacy, or the perceived ability to actually take a recommended action, was later recognized as an important component or factor (Strecher, 2015, Asampong et al., 2015).

2.3.1 Perceived Susceptibility

Perceived Susceptibility refers to subjective assessment of risk of developing a health problem. The Health Belief Model predicts that individuals who perceive that they are liable to a health problem will engage in behaviors to reduce their risk of developing the health problem while individuals with low perceived susceptibility may deny that they are at risk for contracting an illness. Individuals who believe they are at low risk of developing an illness are more likely to engage in unhealthy, or risky, behaviors and individuals who perceive a high risk that they will be personally affected by a health problem are more likely to engage in behaviors to decrease their risk of developing the condition (Raingruber, 2013).

2.3.2 Perceived Severity

Perceived Severity refers to subjective assessment of the severity of a health problem and its potential consequences. The Health Belief Model proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviors to prevent the health
problem from occurring (or reduce its severity). Perceived seriousness encompasses beliefs about the disease itself (e.g., whether it is life threatening or may cause disability or pain) as well as broader impacts of the disease on functioning in work and social roles. For instance, an individual may perceive that hypertension is not medically serious, but if he or she perceives that there would be serious financial consequences as a result of being absent from work for several days, then he or she may perceive hypertension to be a particularly serious condition (Legido-Quigley et al., 2015)

### 2.3.3 Perceived Benefit

Health-related behaviors are also influenced by the perceived benefits of acting. Perceived Benefits refer to an individual’s assessment of the value or efficacy of engaging in a health promoting behavior to decrease risk of disease. If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behavior regardless of objective facts regarding the effectiveness of the action. For example, individuals who believe that reducing salt intake help in managing and reduce risk hypertension are more likely to comply than individuals who believe that reducing salt intake will not reduce the risk of hypertension (Raingruber, 2013).

### 2.3.4 Perceived Barrier

Health-related behaviors are also a function of perceived barriers to acting. Perceived barriers refer to an individual’s assessment of the obstacles to behavior change. Even if an individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behavior. In other words, the perceived benefits must outweigh the perceived barriers for behavior change to occur. Perceived barriers to acting include the perceived inconvenience, expense, danger (e.g., side
effects of a medical procedure) and discomfort (e.g., pain, emotional upset) involved in engaging in the behavior. For instance, lack of access to affordable health care and the perception that a hypertensive medication will cause significant impotence may act as barriers to receiving the hypertensive medication (Boslaugh, 2014).

2.3.5 Cues To Action

The Health Belief Model posits that a cue, or trigger, is necessary for prompting engagement in health-promoting behaviors. Cues to Action can be internal or external. Physiological Cues (e.g., pain, symptoms) are an example of internal cues to action. External Cues include events or information from close others i.e. the media, or health care providers promoting engagement in health-related behaviors. Examples of cues to action include a reminder postcard from a hypertensive clinic, the illness of a friend or family member, and product health warning labels (Meinema et al., 2015). The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers. For example, individuals who believe they are at high risk of a serious illness and who have an established relationship with a primary care doctor may be easily persuaded to get screened for the illness after seeing a public service announcement, whereas individuals who believe they are at low risk of the same illness and also do not have reliable access to health care may require more intense external cues in order to get screened (Raingruber, 2013).

2.3.6 Self-Efficacy

Self-Efficacy refers to an individual’s perception of his or her competence to successfully perform a behavior. Self-efficacy was added to the health belief model to better explain individual differences in health behaviors. The model was originally developed in order to explain engagement in one-time health-related behaviors such as being screened for cancer or
receiving an immunization. Eventually, the health belief model was applied to more substantial, long-term behavior change such as diet modification, exercise, and smoking (Strecher, 2015). All things being equal, a person with a higher level of self-efficacy is more likely to attempt to perform a desired behavior, such as quitting smoking (Segbefia et al., 2012).

2.4 Health Belief Model and Health Risk Management Practices Amongst People With Hypertension

Health Belief Model is important guide for understanding health risk management practices. All the constructs are eminent factors for examining health risk management practices in hypertension.

In a study conducted by Hur (2012), the results of the study indicated that health belief and health risk management practices are significantly strongly correlated. The construct of the model can be used to examine and health risk management practices among people with hypertension and help hypertensive clinics as well as the Ghana health service to design hypertensive programs that will bring about positive health risk management practices.

The six constructs are examined below in context of health risk management practices:

Perceived Susceptibility is very important in order to ensure compliance, before an individual will accept a diagnosis of hypertension and follow a health risk management practices, that must understand that he/she can have the hypertension without symptoms. An individual who perceive hypertension as a separate medical condition with potential serious health complications is more likely to engage in positive health risk management practice with regards to hypertensive management (Abu et al., 2018).
Perceived Severity is the sense of seriousness of the disease, before an individual will adhere to positive health risk management practice, it is important to perceive that hypertension can lead to blindness, strokes, heart attack; it is dangerous to ignore high blood pressure, because this increases the chances of life-threatening complication (Legido-Quigley et al., 2015). Lee (2012) stated that when patients have more knowledge about hypertension, or higher perceived severity of hypertension, the attitude toward the treatment of hypertension will be more favorable significantly.

The construct of Perceived Benefit signifies the necessity of a hypertensive patient to perceive health risk management practice to be superior in benefit when compare with barrier to action, the belief that health risk management practice will manage their hypertensive states without negative side effect or excessive difficulty is necessary. Lee (2012) asserted that individuals who had experience of health risk management practice are more likely to adhere to such practices, compare to individuals without experience.

Another factor in promoting compliance to hypertension information is Perceive Barrier, the belief that benefit of complying with positive health risk management practices must outweigh challenges of complying with such practices., e.g. patient who belief that hypertension medication are too expensive (barrier) but realize that without taking the drugs he will fall ill and be unable to participate in economic activities might comply to hypertension information. An individual with co morbidities such severe arthritis, heart conditions might not see it worthwhile to go through pain and the inconvenience of exercise in that state (Owusu-Akyem et al., 2017, Adewale et al., 2013)
To promote and ensure consistent health risk management practices in people with hypertension, Cues to Action such as symptoms, print material, reminder letter, or pill calendar, text messages, television, radio, social media can be used to instigate adherence to health risk management practices. Chou (2010) noted that reading about illness information, knowing about services, and consulting with others about one’s illness triggers positive health risk practices.

The last and most critical construct that shapes compliance with health risk management practice in is Self efficacy, people are more likely to adopt a health behavior if they think they will be successful. Hypertensive clinic must break down skills to learn as well as hypertensive information in simple and manageable task to enable easy learning. In a study conducted by Lee et al (2010) Hypertension control self-efficacy emerged as the most significant contributing factor to hypertension self-care.

2.5 Conclusion of Literature Review

The literature review explored on the health risk management practice that help to optimise health and prolong life especially amongst people with hypertension. It extensively defines the motivating and demotivating factors that influences health risk management practices on a global scale. The review also outlined the Health Beliefs Model as an important guide for examining the health risk management practices among people with hypertension.

In Ghana, data on health risk management among people with hypertension is scanty. The literature review indicates a significant knowledge gap between people with hypertension and the standards necessary to obtain and maintain controlled blood pressure levels.

This study aimed to bridge this identifiable gap in knowledge by reporting the factors that influence health risk management practices among people with hypertension attending the Ashongman community hospital, Accra.
CHAPTER THREE

METHODOLOGY

3.1 Study Area

The study was conducted at New Ashongman, a community under the GA east municipality, Greater Accra region.

GA east municipality is located at the northern part of greater Accra region with a population of about 147,742 according to the year 2010 population and housing census. With the capital Abokobi, it shares boundaries to the west with GA west municipality, to the east with La Kwantanang municipality, Accra metropolitan assembly to the south and Akwapim south district to the north. The community falls within the savannah ecological zone with bi-modal rain pattern and temperature between 25.1°C to 28.8°C. New Ashongman is a diverse peri-urban settlement with high number of population migrants and literacy rates.

3.2 Study Site

The Ashongman community hospital is a 100-bed capacity hospital situated in New Ashongman near Kwabenya in the GA east municipality.

With an average annual OPD attendance of about 70,000, the community hospital (TCH) offers a wide range of health care services to the people of GA east municipality and beyond. It has an active hypertensive clinic that runs twice a week with an average attendance of about 100 patients per clinic day.

3.3 Study Design

A qualitative research approach was used in this study. Participants were selected using purposive sampling technique. Focus group discussion (FDG) was used to gather data from the
participants and the FGD continued until saturation was reached (Tobias et al., 2017). A translator was trained on the FGD guide to understand the meaning of each question before the interview. The questions were translated on the spot.

The focus group discussions (FGD) centered on health risk management practice among people with hypertension attending the hypertensive clinic at the Ashongman community hospital. A total of five FGDs (two women groups, two men groups, and a one mixed group of men and women) took part in the FGDs. The focus group discussion constituted an average of nine members per group with smallest group been the male group (27 participants) and the largest group been the mixed group (11 participants). The rest of the group had nine (9) participants each. Selection of participants were based on the hypertensive clinic days of the Ashongman community hospital, which is scheduled twice a week on every Tuesday and Thursday. Participants of the FGD came from both the catchment area and outside the catchment area. In order to encourage group discussions, all questions were open ended. Each clinic day has an average attendance of about a hundred hypertensive people.

### 3.4 Study Population

The study population was made of all people diagnosed with hypertension for more than one year and attend clinic at the Ashongman community hospital.

### 3.5 Data Collection Techniques And Tools

The Ashongman community hospital’s conference room was the center for the FGD because of its convenience. The data was collected by research assistants who were fluent speakers of Twi, Ga and also English were helped by an expert translator. All notes were taken and recording gathered by the research coordinator after every FGD.
Participants were selected using purposive sampling technique based on clinic days, that is, on every Tuesday and Thursday and the data collection continued at the hypertensive clinic days for the FGD until saturation is reached.

Data was collected using a focus group discussion (FGD) guide and constituted open-ended questions. The FGD guide was centred on health risk management practice among people with hypertension attending the Ashongman community hospital.

### 3.6 Data Management

The transcripts were read several times and cross-checked by other researchers on the research team. All discussions were done in the local language and translated into English language during the transcription process. However, local language terminologies were not translated into English to preserve their informative meanings. All FGDs were translated verbatim and transcribed into Microsoft Word by the research team. Additionally, they expanded the FGD notes taken during the discussion sessions. In a situation where there was disagreement between the two research assistants, they reviewed the transcripts and the original recordings until consensus was reached.

### 3.7 Data Analysis

Data was subjected to qualitative content analysis and analysed based on themes. The data was coded, and sub-themes developed for the data analysis.

### 3.8 Ethical Considerations

#### 3.8.1 Ethical Approval

Ethical approval was sought from the Ethical Review Committee of the Ghana Health Service and Permission also sought from management the Ashongman community hospital. Informed
consent was obtained from all participants and confidentiality assured before their engagement in the study.

3.8.2 Voluntary Participation and Informed Consent

Informed consent (written) of the participants was sought for after explaining the purpose of the study. Each participant was provided with the information sheet and informed consent to sign for voluntary participation in the study. Participants were further given the opportunity to ask questions or seek clarification after reading the information sheet. Also, they were made aware of the right to pull out from the study at any point without any consequences.

3.8.3 Potential Risks/ Benefits

There were no anticipated risks to the participants of this study. The content of the discussions and questionnaire were not particularly sensitive. Furthermore, the burden on participant time was small with discussions taking place in a location convenient to them. Benefits from the study were to explore the health risk management practices among people with hypertension and broadens participants knowledge about hypertension management.
3.8.4 Privacy And Confidentiality

The FGDs were conducted in convenient private place with the door closed. The discussion only took place in a location that both the participants and the interviewer were comfortable with regards to protection of privacy to permit freedom of speech as well as minimize risk of being overheard. Data was transferred to the principal investigator’s personal computer, which was then pass worded, to limit access of the data to a second party aside the research team.

3.9 Quality Control

All research assistants employed were trained on data collection before the commencement of the field work.

Supervision of the discussions was done strictly by the lead researcher to maintain data quality and was available for any needed clarifications on the research during filed work.

At the end of the day, research team conducted a review meeting to discuss issues raised during the day for a quick assessment of the completed tools. The lead researcher visited each research assistant to oversee data collection process and all notes and recordings that were taking by the research assistants during the discussion were compared and synchronised.

3.10 Pre-Testing Of Instruments

Pre–testing of study instruments was done at the Ghana atomic energy hospital which is located at Dome and directly opposite the Kwabenya police station.

Pre-testing the appropriateness of the instruments gave the researcher the opportunity to identify shortcomings of the questions and then corrected them. Inappropriate questions were either taken off or modified. The coding scheme and data entry process were also tested and inconsistencies discovered in the coding system rectified.
3.11 Limitation Of Study

This study was conducted in a peri-urban community with relatively high standards of living and literacy rates as compared to most parts of Ghana and hence might not be necessarily generalised for the rest of the population. There is the need for funding to enable a large scale research in all regions of Ghana and if possible on international level in order to make a more generalised conclusion.
CHAPTER FOUR

RESULTS

4.1 Participants’ Characteristics

All five focus group discussion groups were made up of people diagnosed with hypertension for at least one year and seeking health care at the Ashongman community hospital, Accra. The five groups made up of forty-five (45) participants of which twenty-four were women and twenty-one men, all participants were between the ages of thirty-five and seventy-six. Most of the participants resided in new Ashongman area and Dome but hailed from diverse areas of Ghana. Fifteen participants were pensioners and had attained educational level of college or above. Ten participants were in active service and had attained a college degree or above and twenty participants had received primary education or no education.

4.2 Participants Understanding Of Hypertension

Hypertension is generally referred to as high blood pressure. Participants had varied notions about hypertension and what they perceived to be the cause of hypertension. Most of the participants had some understanding about hypertension, although very few seem to understand that hypertension can be a silent disease condition. Participants often diverted to talk about other co morbidities like diabetes, heart problems, surgical conditions and skin infections rather than focusing on the hypertension. Some of the views of the participants are stated below

“Hypertension means my blood level goes high, mine goes high whenever I get feel sick especially when I get fever or when my blood sugar goes high” (A female participant from group one)
“This is how understand hypertension; when blood is not flowing well through the blood vessels maybe some obstruction. Normal blood pressure is 120/80 so when yours goes above that then its hypertension, I was told that I had hypertension when I went to do my hernia surgery, I think the hernia might have caused it, I don’t feel anything normally except increased heart beat and when that happens ,I know that I’m getting sick and maybe the sickness is causing my BP to go high” (A male participant in male group (two) 2 stated)

“Bp is Mogyà) bruso (literally excess blood) when you take the hypertension drugs it will come down, but it will never go away, and the drugs can even make you weak” (A male participant in same group said)

“Normal blood pressure is 120/80 so when is goes to about 150/90 then is not good. That is my understanding of hypertension” (female participants in female group 1)

Another participant in the same group added

“That’s it, she is very right that is what I was thinking too but also you can get hypertension when you get upset or worry too much”

Some participants thought hypertension was caused by thinking a lot and stress whilst other often related and understood hypertension to be heart attack or stroke.

“Hypertension is when you think a lot and eat bad food then it affects your heart and you can get a stroke and can die. I was diagnosed with hypertension after my husband died because I was thinking a lot about how to take care of the children but now my blood pressure is controlled because I do not think about unnecessary things again, I know God is in control” (A female participant in group two (2) stated)

“Hypertension is caused by thinking a lot” (A female participant in mixed group simply said)
As for hypertension, when you are stressed up or have a lot of problems that you are thinking about, then you can get hypertension. (A male participant in male group two)

I have had hypertension for about 20 years, I was told after my first born....... I think it was caused by the child birth (A female participant in female group 1)

Many participants reported that they were first told of their elevated blood pressure at community screening (including Churches and Mosques) and that they were referred to go to the clinics for management. Even though there was general belief among them that cure from all disease comes from God, there was a significant understanding among them that hypertension was a long term disease.

For instance, A female participant in female group 2 noted ‘the doctors from ....... Visited my church last 2 years and screened us for hypertension. My blood pressure was high, and they advised me to report to the clinic for further check-up.... Papa (referring Reverend Minister) encourage all of us who were referred to clinic to do our best and report to the clinic’.

A male participant in a male group 2 also stated ‘we do occasionally invite a health worker to educate us before Friday prayers, sometimes they talk about hypertension’.

4.3 Health Risk Management Practices Amongst Participants

Participants practiced varied health risk management activities believed to help to control their blood pressure. Most of the participants were engaged in some form of Activity(s) that they perceived were instrumental in controlling their blood pressure levels although they often digress to talk about management of co morbidities like diseases like Diabetes, arthritis, malaria and other sicknesses.

‘Doctors say that the medications will control the blood pressure, so I try to be taking them just as doctor said  even though I do forget sometimes, we do not only take medications from the
hospital but also prekese and sometimes aloe Vera which I planted in my house, and I believe it works so well for me. I sleep well, at least 7 hours a day and I think it helps my blood pressure levels...and my blood sugar” (A participant in male group one (1) stated)

A participant in mixed group who was incidentally present in the same group with his wife and neighbour noted

“We try good dieting as in eating less fat and exercising on regular basis, but our knees are now weak. I do exercise every morning and evening to help control my hypertension. We have also tried to reduce alcohol consumption and some of us have even stopped alcohol including smoking as per advice from the clinic ‘I take garlic capsule every day’”

“I realise each time I’m regular on clinic visit, my blood pressure is better controlled because I am always encouraged and advised to maintain good diet, exercise and take my medication. We do not always have normal blood pressure levels when we do come, but overall I think we have reduced hospital admissions’’ (A Female participant in group 5 also participant noted)

A female participant in the mixed group said

I always take my medications as the Doctor says but every time my blood pressure is high, I do not know what to do again. I try to exercise but my knees and waist hurt.

A male participant in male group 4) participant noted when asked about the health risk management practices they adhered to

“Eerhhh the food we eat, I think less sugar and exercise. I also ride bicycle from madina to okponglo every day.it helps me look fit, oh yes I do take moringa and sometimes Dandelion and honey mixed with ginger”
Generally, most of the participants were engaged in some form of activities they believed to be good health practice although their understanding of recommended lifestyle modification appeared inadequate.

For instances, some of the participants knew that adherence to medication regime together with recommended diet and exercise were health risk management practices to control blood pressure but they could not give a good explanation of what diet or exercise they should engage in, also their adherence to medication regimen were inconsistent.

“‘We have were told in the church to watch our diet, exercise and take our prescribed antihypertensives regularly.so because of that I currently try to eat less food and also sweep around the house myself..........I also take herbal medications one Abochie sells and sometimes I do prepare moringa myself and drink to help control blood pressure’” (A female participant stated)

“‘Too much intake of food is bad for hypertension and especially salt, so as for me, I do not add extra salt to my food even if I need to put some salt but just a little. I love kobi (locally salted fish) and I am currently doing my best to reduce the intake’” (A female participant from female group 2 said).


Factors influencing the health risk management practices varied among participants at the various group discussions. Generally, the determinants can be analysed with regards to perceived severity of hypertension, perceived threats of hypertension, perceives benefits of adherence, perceived barriers to adherence, cost of health care and family support.
4.4.1 Perceived Susceptibility

Some participants were of the notion that, there could be bad consequence on their general health if they did not adhere to lifestyle recommendation and control their blood pressure levels and hence had more tendency to stick to recommended dietary and exercise, medication regime and lifestyle recommendation.

“Hypertension can cause heart attack, blindness and even sudden death as you people have been telling us. I was told by doctors at Korle bu that I had an enlarged heart because my blood pressure levels were going too high. I see that if I do not sit up on exercise and control my Blood pressure, it will not end up well for me, as for my medication I have been very regular since I heard that news about my heart” (A male participant in the mixed group noted)

4.4.2 Perceived Severity

Participants who perceived their hypertensive state to be severe expressed more willingness to adhere to recommended regimen for hypertension control.

“Madam nurse, I am dying oo, I am dying. Each time I check my blood pressure, I’m always told that its very high, sometimes I feel so dizzy and my heart will be beating ‘periperi’ (referring to palpitation) and I must sit down and rest before I can do anything. As for me I am very ready to follow anything the doctor advise me to do, except that the exercises make me feel dizzy “says an elderly female participant in the mixed group “I already have heart issues and every now and then my feet get swollen and I can’t breathe well, the doctor told me it was my heart failing me and that my kidneys are not also working very well. I currently have no option than to adhere to the advice of the Doctors since that has kept me alive.so I take every appointment seriously with the Doctors, the dieticians and the Physiotherapist’ ” A male participant in male group one (1) said
4.4.3 Perceived Benefits

Generally, participants believed that health risk management practices with regards to recommended diet, exercise, medication and reduction in salt as well as alcohol consumption had a benefit in controlling their blood pressure levels and preventing complications arising from uncontrolled hypertension and improve their quality of life.

A group participant stated

“I believe if my blood pressure is well controlled, I would have no issues in going to work as I am the breadwinner of my family. Each time I get hospitalised there are financial crisis in the house “A female participant in female group one (1)

When asked about the benefits of health risk management practices in hypertension

A participant in male group one (1) noted

“As for me, I want to live long and enjoy the fruits of my labour, I am old, and my entire life has been serving my children, now that I can get anything I want, I wouldn’t want to miss that. I do my best to exercise regularly, I try to watch my diet very well eat less fat and salt and I do not miss my medications …..that has helped me to maintain a good pressure level.

“I think I feel better ever since I joined this clinic my understanding about hypertension has changed and I am now able to manage my health better, I feel much healthier than before and even my children are happy” (A female participant in the mixed group).

“I have been hypertensive for more than 20 years, I use to drink and smoke all the time and was always in and out of hospital admission. I am ok now because I look well after my life and have stopped drinking alcohol and smoking” (A male resident in male group 1).
4.4.4 Perceived Barriers

Despite knowing the benefits of good health risk management practices, many participants were unable to adhere to recommended practices because of various perceived barriers. Some prevalent reasons were poverty and cost of non NHIS insured medications and co-morbidities like arthritis, diabetes mellitus, heart conditions and physical disabilities including paralysis due to stroke.

Below were some expressions by participants in various groups.

“I am poor .... I had stroke and cannot use my left side well, I stick lotto to survive so I always think about how to live the day and especially whenever the pharmacy hand over a prescription for me to buy medications outside, I immediately feel sick, because I know I can’t afford “A male participant in mixed group

A female participant in female group 2 said

‘Sometimes my son buys the medications for me, it is not always though and occasionally I have to go without medications for days. in those days I would normally resort to garlic capsules and dandelion until I get a supply of medications’.”

As for me, no one helps me with anything, my children don’t have money to support me and my husband is always stressing me with unnecessary fighting, because of that sometimes I don’t even get lorry fair to come to hospital” A female participant in mixed group lamented

“When I start to exercise, I see that my blood pressure becomes controlled but it’s very difficult because of my joint pains and heart condition. A female participant in female group two

(2)

“It’s very hard to stick to medications every day, I just can’t do it even though I observe improve health each time I follow the medications. Another issue is that my husband likes to eat
fatty foods and like salt. I am the one who cooks for him and I am not able to have a separate diet because he finances everything “A female participant in female group one (1)

“I do security work and often do not sleep at night, I am sure it’s the reason why my blood pressure is always high but hmm what can I do “A male participant in male group One (1)

Few male participants perceived that the anti-hypertensive medications make him tired and loses libido

“As for me, each time I take the medication, my manhood becomes weak and my body also feel so weak, so I take it whenever I feel my blood pressure is rising but I do take garlic capsules and dandelion. “A male participant in male group two (2)

Another male participant in same group nodded in agreement and said “me too”

Many participants explained that the national health insurance has been beneficial in reducing the cost of health care, but they still must pay for other services whenever they come to hospital. Also, it cost more to have a recommended diet practice.

“These days, the insurance only pays for consultation and some few drugs, most of the medications have to be bought and if we have no money then we will normally miss medication until you get money to buy. Even the laboratory things are not fully covered by the Insurance, I hope the government will do something about it “A female participant in mixed group

Another participant said

“I wake up very early each time and I have to take two or three cars to get to clinic. Its very expensive and tiring, besides I still have to pay for some medication”

(A female participant in the mixed group)
The medication given to us at the NHIS side is very poor in quality, I see it doesn’t help control my blood pressure, so I always buy them all but that cost me a fortune. I spent all my monthly retirement allowance on medication”

A male participant in male group 2

4.4.5 Cues Of Action

Participants who had perceived symptoms related to hypertension such as headache, palpitations or dizziness also stated adhering to health risk management practices.

A female participant in the mixed group said ‘I started having headaches and occasionally feeling dizzy ........... so the doctor told me, that I had hypertension.......I knew something bad will happen to me, if I did not follow the doctor’s advice. She lamented, ‘hmmm last year my father diet of stroke’.

Participants with access to information and support from family and friends had better health risk management practices and especially spouse who were both hypertensive.

“In my neighbourhood we are about 10 people with hypertension, so we keep each other on tract by organising regular exercised and encouraging ourselves for regularly hospital visits. We have been able to help some amongst us to quite alcohol” A male participant in mixed group.

4.4.6 Self Efficacy

Participants knowledge and understanding of health risk management practice were significant factors in self-efficacy. Participants perception of competence to perform health risk management practice tend to boost their confidence and hence promote adherence to health risk management practices.
For instance, in male group 1 a participant noted ‘I still look young and healthy after more than 20 years of hypertension because I understood that, once I was diagnosed with hypertension, I needed to quit smoking, minimise alcohol intake and start regular exercise’.

“We know that we have hypertension, so my wife cooks food low in fat and salt, and we encouraged ourselves to take medications regularly. I have stopped taking alcohol thanks to my wife’s constant encouragement. We have also resolved to exercise (brisk walking) about 3 times a week. We are very happy in spited of constraints of hypertension and we leave a very normal life” A male participant in male group two (2)
CHAPTER FIVE

DISCUSSION

5.1 Understanding Of Hypertension Among Participants

The study revealed that, the general knowledge about hypertension among participants was good. Majority of many participants understood hypertension to be increase in blood pressure, although few participants interpreted hypertension to be excess blood or heart disease. These findings corroborated with findings of segbefia et al.(2012) but disagrees with that of the findings reported by Awuah et al. (2014).

Many participants poorly understood health risk management in hypertension and as such were engaged in several practices based on their knowledge which were not necessary a helpful practice in the management of hypertension. This findings agrees with that of Donkor et al. (2015), who reported that participants in their studies had Inadequate knowledge, low awareness and beliefs about hypertension that that led to management practices dangerous to the treatment and control of hypertension

The findings of this study showed that, the awareness of hypertension as a separate medical condition was low among participants and the level of knowledge about complications of hypertension associated with hypertension such as kidney disease and heart disease were low. This findings disagrees with the findings reported by Abu et al.(2018. But corroborates with that of the findings of segbefia et al.(2012).

Other medical and surgical conditions such as diabetes, Arthritis, malaria, skin diseases were taken more seriously than hypertension and participants on occasions had to be prompted that the
study was exclusively about hypertension. Similar findings have been reported by Legido-Quigley et al.(2015). Participants who had other co morbidities, for instance diabetes appeared to show more enthusiasm regarding the practice of a healthy lifestyle than those who had only hypertension. Similar findings have been reported in other qualitative studies conducted in low to middle income regions( Oli, et al.,2014;;Anthony et al.,2012; Lachat et al., 2013).

This study also revealed that, participants perceived hypertension was frequently precipitated by acute symptoms, related or unrelated to their hypertension. Participants had mixed beliefs on the causes of hypertension, similar finding s were noted by segbfia et al.(2012). However, very few participants associated their hypertensive state to Bad omen or witch craft, majority of the participants in this study associated their hypertensive state to lifestyle and family history. Many reported having immediate relatives like parents or close relatives with hypertension and believed that they might have inherited the hypertension from them. This findings are contrary to reports by of segbefia et al.(2012), who reported that participants blamed their hypertensive state on some witchery or bad omen.

There was a popular belief among participants that, hypertension is caused by mental stress, many participants recounted a family lose, a devastating experience in their life time or work-related stress as the cause of their hypertensive state. This finding was similar to reports in other qualitative studies by Segbefia et al.(2012). A study by Legido-Quigley et al.(2015),also indicated that mental stress or long term psychological trauma were some of the most attributed factors to the development of hypertension among participants.
5.2 Health Risk Management Practices Among Participants

Health risk management practices are indicated for all people with hypertension because it may reduce the need for medications with their associated side effects. Poor health management practices, such as unhealthy diet, excessive consumption of alcohol, physical inactivity and tobacco use can promote the development of hypertension and vice versa, WHO.(2013) and adherence to effective treatment regimen can enormously decrease morbidity and mortality (Abidin at al, 2014, Strecher, 2015).

The study suggested efforts were made by majority of people diagnosed with hypertension to aligned with some health risk management practices that they perceived to be beneficial in the control and maintenance of normal blood pressure levels, these finding corroborates with findings of Natali et al.(2014). However, few of the participants were aware of the recommended health practices to control blood pressure. Even though participants report taking medications, they had little information about their hypertensive states and resorted to diverse practices that they believed to be beneficial in their blood pressure control. Similar findings have been reported in a study by Legido-Quigley et al. We (2015)

Majority of the participants were on one or more unorthodox preparation like dandelion, Aloevera, garlic capsule among others in combination with their regular antihypertensives to help control their blood pressure levels. Some participants reported occasionally taking the herbal preparation especially when they fear side effects of the orthodox medications. Similar findings were reported by segbefia et al.(2012) who reported that majority of respondents in their study combine herbal treatment with medications to control their hypertension.

Exercise recommendations with regards to regular exercises and reduction of sedentary life were generally thought as a good health risk management practice by majority of the participants,
many participants reported engaging in various physical activities perceived to be beneficial in the management of their hypertensive state. Common practices among participants were walking, riding bicycle and doing household chores including weeding and sweeping around their homes. However adherence was low due to various reasons such as other co morbidities, work schedule and lack of motivation, this finding are concordat with report by (Owusu-akyem et al. (2017) and Adewale et al. (2013) who stated similar reasons for low rates of adherence exercise recommendations.

This study indicated that, participants viewed weight reduction and management as significant health risk management practices. Most participants perceived obesity and overweight as a health risk and linked to hypertension, heart diseases and diabetes. Participants who perceived themselves to be overweight expressed desire to reduce in weight. Similar findings have been reported in a study by Abu et al. (2018).

Healthy dietary intake as a health risk management practices was unanimously thought by participants in this study as a good health practices and bad dietary habits linked to hypertension, however there were mixed opinions regarding the understanding of good dietary practice. While majority of participants inadequately understood the dietary recommendations in hypertension, few could not adhere to such recommendations because of financial constraints and poor self-control. The findings of this study corroborates with reports of studies by Owusu-akyem et al., (2017) and Adewale et al. (2013).

Oli et al. (2014) also found out that the incidence of hypertension and pre-hypertension increases with the increase in the alcohol consumption and has direct relationship between the risk factors and hypertension. Generally, participants of this study perceived alcohol consumption and
smoking as an unhealthy practice linked to raised blood pressure and other health complications. The study revealed conscious efforts by participants engaging in alcohol consumption and smoking to either minimise or quit.

Sleep is an vital aspect of life however sleep pattern of below or above the median of 7 to less than 8 hours per night is associated with an increased prevalence of hypertension, particularly at the extreme of less than 6 hours per night (Palagini et al., 2012). Lack of sleep and hypertension are related and often coexist. This study found out that, majority of the participants perceived lack of sleep be a significant cause of poor blood pressure control. Some participants in the study feared that, their poor blood pressure control was related to related both to poor sleep behaviour influenced by work schedule with many women expressions more of such concerns. Similar findings have been reported by Wang et al. (2015).

5.3 Factors That Influences Health Risk Management Practices Among Participants

This study indicated that, perceived severity of hypertension, perceived threats/risk perception, perceived benefits of healthy practices, perceived barriers to health risk management practices were significant factors that influenced the health risk management practices among participants of the study. Cost of health care and family supports appeared to have very significant influence on health risk management practices among participants. These findings are consistent with similar studies by Boslaugh (2014) and Strecher (2015).

5.3.1 Perceived Susceptibility

Participants in this study who perceive, that they are at risk of hypertensive complications engaged in health risk management practices to reduce the risk of potential complications or severity and vice versa. For instance, participants who perceived that hypertension can cause
heart attack, blindness and even sudden death also reported adhering to health practices perceived as health risk management practice, such as regular exercise and dietary controls. This finding corroborates with that of the study by Raingruber, (2013) who reported similar findings.

### 5.3.2 Perceived Severity

Participants who perceived their hypertensive status to be severe were more eager to adhere to health risk management practices even though their understanding about health risk management practices were generally inadequate, these participants expressed how they were trying to exercise, quit alcohol consumption, reduce smoking and eat healthier food. They were more particular of symptoms they perceived to be signs of increased blood pressure and to seek help at the health facility more promptly. Similar findings have been reported in studies by Legido-Quigley et al.(2015).

### 5.3.3 Perceived Benefit

This study revealed that participants, who perceived health risk management practices as beneficial, also explore such health risk management practices perceived to be instrumental in controlling their blood pressure levels. Participants reported feeling better after reducing salt intake, reducing alcohol consumption, exercising, eating fewer fatty foods. Participants also reported improve quality of life as they can go to work with their blood pressure been controlled. Similar findings were reported in a study by Raingruber.(2013). Also, Lee (2012) reported that individuals in their study who had experience of health risk management practice are more likely to adhere to such practices, compare to individuals without experience, similar finding was reported in this study.
### 5.3.4 Perceived Barriers

The study revealed that cost was a major barrier to good health risk management practices as participants struggled to pay for transportation to the hospital, do co-payments for medications, and often must travel long distances to buy unavailable medications. These findings corroborates with similar qualitative studies (Legido-Quigley et al., 2015). Also, poverty was a significant barrier as some participants were unable to adhere to dietary recommendations because they were unable to provide themselves with the recommended diet due to poverty and hence ate any food to survive (Segbefia et al., 2012).

Health risk management practices with regards to adhering to exercise recommendation was a major problem for the elderly and those with co morbidities such as arthritis and heart diseases, many participants expressed enthusiasm to engage in exercise but were unable to do so because of age related mobility complications and other sickness, prominent among them was Arthritis and heart disease. Similar findings have been reported in studies by Owusu-Akyem et al. (2017) and Adewale et al. (2013).

Factors such as social network, family members and neighbours were instrumental in helping participants to overcome those barriers, however, participants who lacked such support, struggled to maintained good health risk Management practices. Although contrasting findings have been reported in a study by Meinema et al. (2015). Similar finding were reported in studies by Legido-Quigley et al. (2015).

Unanimously, participants perceived the national health insurance scheme as ineffective and administratively confusing and participants accessing the national health insurance system perceived that the treatment was inferior and medications substandard to that provided under
the private health insurances and ‘cash and carry’ systems (pay before treatment) this findings corroborated with studies by Awuah et al. (2014) and Legido-Quigley et al. (2015).

Decrease in libido or sexual function is a serious masculine problem and many men will rather stop taking anything that negatively affects their sexual function. The study revealed that fear of decrease libido and impotence was a significant reason for many male participants in the various discussions. Some participants occasionally missed medications intentionally because they feared that continues intake of the anti-hypertensives would weaken their libido. This finding corroborates with reports of previous qualitative studies in Ghana by Segbefia et al. (2012).

This study also revealed that religion had very little influence on health risk management practices among the participants in the various groups. Participants appeared to be influenced by their community, irrespective of their backgrounds. This finding disagrees with Segbfia et al. (2012) who site religion and superstitious beliefs in witchcraft or bad omen as a significant influence on understanding of hypertension and for that matter influence on hypertensive risk management practices among participants.

5.3.5 Cues To Action

This study revealed that participants who had symptoms perceived to be related to hypertension such as headache, palpitation or dizziness also reported adhering to a perceived health risk management practice. These participants reported adhering to doctors’ recommendations with regards to health risk management practices, also participants whose close relatives had suffered some form of disability or death related to hypertension reported committing to some health risk management practice. Similar reports were found in a study by Raingruber (2013).
The study also revealed that participants with access to information like media education or community sensitization were more ardent to health risk management practices as well as those with support from family or friends. Similar findings have been reported in studies by Meinema et al. (2015). Chou (2010) noted that reading about illness information, knowing about services, and consulting with others about one’s illness triggers positive health risk practices. This report corroborates with the findings of this study.

5.3.6 Self-Efficacy

This study revealed that participants perception of competence to perform health risk management practice tend to boost confidence and promote adherence to positive health risk management practice. Participants in the study who were successful in controlling their hypertensive levels due to adherence to health risk management practice also reported desire to continue such practices. The findings of this study corroborate with the findings of a study by Segbefia et al. (2012) However, this revealed that participants self efficacy is one of the interwoven factors involed in adherence to health risk management practices in hypertension. the study does not suggest self efficacy as the most significant construct contributing to adherence to health risk management practice in hypertension and therefore disagrees with the findings of lee et al. (2010).
CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.1 Conclusion

Generally, participants had fair understanding about hypertension and possible factors that may aggravate their hypertensive state. They however lacked understanding that hypertension is a separate medical condition and can be a silent condition. Participants, who demonstrated higher knowledge of hypertension, also reported engaging in healthier risk management practices. The study highlighted that regular hospital visits and availability of medications does do not necessary translate into full compliance of medications as some participants intentionally missed medications for fear of side effects. Majority of the participants resorted into herbal preparations to compliment and occasionally substitute their regular hospital medications. Even though majority of the participants expressed desire to adhere to health risk management practice for hypertension, lack of understanding, poverty, cost of healthcare and poor self-control were some major reasons that hindered their ability to practice such health risk management practices like healthy diet, exercise, weight reduction, medication adherence and stress reduction. Many Participants made reasoned decisions about health risk management practice to control their blood pressure, relying on their bodily experiences, notions and other medical information. This, however, may lead to practices that diverges from that which are recommended health risk management practices in the control and management of hypertension.

The study indicates the continued need to address patients’ perspectives and educate on regular bases the recommended health risk management practices aimed at controlling blood pressure levels. Identifying and adopting education strategies to improve knowledge of hypertension
among patients may enhance participants health risk management practices for optimal hypertensive control.

6.2 Recommendation

The following recommendations are being made to improve health risk management practices among people with hypertension.

6.2.1 Health Care Facility (Ashongman Community Hospital)

There should be a regular education at the hypertensive clinics on recommended health risk management practices that helps to control hypertension as well as the dangers of unlicensed medication or herbal substitutes or compliments. This education must be broken down into simple task and information to facilitate easy understanding and enable success as this boost individual confidence and promote adherence.

Patients should be encouraged to join/form keep fit groups to encourage exercise.

Hypertensive clinics should encourage patients to invite their significant family/friends for education as their understanding of health risk management practices will promote their support of care and management of hypertension.

Based on the findings of this study, there is the need for the hospital’s management to liaise with the national health insurance scheme to improve access to all relevant hypertensive medications in other to ease suffering of the poor hypertensive patients.
REFERENCES


Hypertensive clinic records (2017). The Ashongman community hospital, Accra


APPENDIX

Appendix 1: Consent Form

Informed Consent Form

University of Ghana

School of public health

Informed Consent for Participants

Please read this document carefully. Sign your name below only if you agree to participate and you fully understand your rights. Your signature is required for participation. You must be 18 years of age to give your consent to participate in research. If you desire a copy of this consent form, you may request one and we will provide it.

The policy of the school of public health is that all research participation in the Department is voluntary, and you have the right to withdraw at any time, without prejudice, should you object to the nature of the research. You are entitled to ask questions and to receive an explanation after your participation.

Description of the Study: This is a qualitative research study that seeks to explore the health risk management practices among people with hypertension attending the Ashongman community hospital, Accra-Ghana. To do this, we will ask you answer open ended questions in the focus group discussion.

Nature of Participation: You will be required engaged in a focus group discussion on health risk management practice in hypertension. All questions will be open ended questions.
Purpose of the Study: To explore the health risk management practice among people with hypertension. This means we want to find out the health risk management practices currently been used and the factors that influences those health risk management practices.

Possible Risks: There are no risks associated with engaging in an interview. There are no right or wrong answers to the questions and you are therefore not to worry about how you perform on answering questions.

Possible Benefits: When your participation is complete, you will be given an opportunity to learn about this research, which may be useful to you in your understanding of the myriad of factors that influence health risk management practices in hypertension. You also will have an opportunity to contribute to public health by participating in this research.

Confidentiality: Your name will not be mentioned. All data will be kept in secured files. All identifying information will be removed as soon as your participation is complete. No one will be able to known your identity.

Opportunities to Question: Any technical questions about this research may be directed to:
Principal Investigator: FATAW PETER Phone: 0209670837, Dr Emmanuel Asampong of school of public health, university of ghana on (024427853) and Hannah Frimpong of the Ghana Health Service Ethical Review Committee on (0507041225)

Opportunities to withdraw at will: If you decide now or at any point to withdraw this consent or stop participating, you are free to do so at no penalty to yourself. You are free to skip specific questions and continue participating at no penalty.
I have read the statements above, understand the same, and voluntarily sign this form. I further acknowledge that I have received an offer of a copy of this consent form. Dated this ____________ day of (month) ____________, 20 __ _________________ _________________ Signature (thumbprint) of Participant

Signature of Person Obtaining Consent_______________________________
Appendix II: Focus Group Discussion Guide:

Welcome,

Thank you taking the time to be a part of this discussion about health risk management practices among people with hypertension attending the Ashongman community hospital.

My name is Peter Fataw. You have been asked to participate because you have hypertension.

The purpose of the discussion today is to explore your views and beliefs about hypertension and health risk management practices in hypertension.

I would like to stress that there are no right or wrong answers. If your view is different from what someone else says or you want to add to what someone else has said, feel free to disagree or give an example of what you mean. You do not have to respond to all the questions, but your opinions are very important and I am here to ask questions and listen to what you have to say. If you have a lot to say and are talking a lot, I may ask you to let someone else share their thoughts so that everyone has a chance to talk. Everything that is said here today is important, so I’ll be taking notes and taping the session. I may ask you to clarify something you have said, but all of this information is confidential, no names will be included in any reports. There is refreshment available, feel free to get something any time.
**Socio Demographic Information**

1. How old were you on your last

2. Marital status

3. Married-----

4. Single------

5. Divorced---

6. Others -----

Please specify

6. Sex of respondent

Male ---------------

Female --------------

7. Level of education completed

No education----------

Primary-----------

Junior high-------

Senior high---------

College ------------
Vocational sch. --------

7. Religion of respondent

Christian----

Muslim------

other ------

8. What is your occupation?

Farmer ------ ----

Employed- ---------

House wife ---------

Self employed--------

9. Where do you live------------------------?

10. Income level

11. Number of medications used

12. Hypertension control-------------

Controlled--------

Poorly controlled---------

13. Duration of disease
Participants understanding about hypertension

What do you know about hypertension?

What do you think is the cause of hypertension?

What is your experience about hypertension?

Health risk management practices amongst hypertensive people

What do health risk management practices mean to you?

Which health risk management practices do you practice?

Do health risk management practices really help you in controlling your blood pressure?

Do you consider your diet to be important in the management of hypertension?

Which other activities do you consider to be helpful in managing hypertension?

In what ways do you think health risk management impact on your health?

Factors that influence health risk management practices for people with hypertension.

How does your income level affect your practice of health risk management practices?

How does your work influence the health risk management practices you practice?

How does your family/society or religion influence your health risk management practice?

What other socio-economic factors affect your way of engaging in health risk management practice?
Appendix III Ethical Approval

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your study protocol.

<table>
<thead>
<tr>
<th>GHS-ERC Number</th>
<th>GHS-ERC:118/12/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Title</td>
<td>Health Seeking Behaviours among People with Hypertension Attending the Ashongman Community Hospital, Accra</td>
</tr>
<tr>
<td>Approval Date</td>
<td>20th April, 2018</td>
</tr>
<tr>
<td>Expiry Date</td>
<td>19th April, 2019</td>
</tr>
<tr>
<td>GHS-ERC Decision</td>
<td>Approved</td>
</tr>
</tbody>
</table>

This approval requires the following from the Principal Investigator:

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol.

SIGNED: [Signature]
DR. CYNTHIA BANNERMANN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra