Experiences and Perspectives of Patients With Hypertension in Mbarara, Uganda

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Scholarly Report Title: Experiences and Perspectives of Patients with Hypertension in Mbarara, Uganda

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ABSTRACT

Title: Experiences and Perspectives of Patients with Hypertension in Mbarara, Uganda

Purpose: Hypertension is a common cardiovascular risk factor that accounts for a majority of cardiovascular disease burden. We aimed to describe how patients with hypertension in Mbarara, Uganda, experience and perceive hypertension in order to understand the factors that drive patient-centered care of hypertension and contribute to how care is delivered in this setting.

Methods: We purposively enrolled patients with a physician-made diagnosis of hypertension and taking antihypertensive medication for at least 1 month. A trained assistant performed in-depth interviews of 30 participants in outpatient clinics at Mbarara Regional Referral Hospital focusing on the perceptions and experiences with the diagnosis, management, care at the clinic and at home with hypertension. We sampled for equal representation of gender and comorbid conditions (diabetes and HIV) to capture varied experiences. We used a content analysis approach to develop a codebook and identify themes.

Results: Our participants initiated care at various stages of disease, and that variance impacted the understanding of disease, as several expressed a concern of hypertension as a chronic disease that can lead to future complications if not controlled while others attributed other symptoms to the disease. The major barriers to care for patients include inconsistent access to regular medications and difficulty with transport to the clinic, both in time needed and expense. Facilitators to care included family support and accessible clinics, which were consistently identified by participants as major factors for initiating and maintaining treatment. Many participants identified an understanding of the important lifestyle and dietary changes required to control hypertension, especially when endorsing difficulty purchasing medications.

Conclusions: Considering patient factors, including understanding of disease and lifestyle adjustments to prevent complications, in healthcare delivery can help ensure adequate management of hypertension and other NCDs by aligning the clinic structure and resources with patient values and beliefs, such as by counseling family members alongside patients or strengthening outreach and educational resources.

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GLOSSARY OF ABBREVIATIONS

LMICs – low- and middle-income countries

MGH – Massachusetts General Hospital

MRRH – Mbarara Regional Referral Hospital

NCD – non-communicable disease

HTN – hypertension

WHO – World Health Organization

SCHOLARLY PROJECT QUESTION

The specific goal of this project was to explore how patients experience hypertension in a rural setting in Uganda and create a qualitative understanding the factors involved in delivering hypertension care. This project specifically included asking patients about how they are diagnosed, understand the disease and its management, access care (and what specifically influences that access), and how patients manage their hypertension.

My role on the team was to coordinate with my mentors in Boston and Uganda to develop the protocol for the research study, including submitting IRB and ethics approvals prior to travel. Prior to travel, I also trained with Dr. Jessica Haberer in qualitative research methods, gaining valuable skills that I used on the project. Once in Uganda, I helped to create the standard operating procedure documents for the study and train our research assistant on the study goals and protocol prior to initiating interviews. After we initiated the study and started interviewing patients, my main responsibility was to read through the translated interviews for quality checks and to start developing a codebook. Along with Drs. Jessica Haberer and Peter Olds, I developed the codebook and began to iteratively code the interviews as they were conducted. Once the enrollment of participants in the study was complete and all 30 interviews were conducted, I worked with Dr. Haberer to develop key themes that emerged from the interviews and began drafting a manuscript based on the results. I am continuing to finalize the manuscript and prepare it for submission shortly as the first author, and the attached document in **Appendix A1** is the current manuscript draft.

In collaboration for the project with me were four other individuals. Mr. Gabriel Nuwagaba conducted, translated (from Runyankole to English), and transcribed the interviews for participants in the study, as well as offered feedback for the working manuscript. Dr. Samson Okello acted as one of the mentors for the project and helped guide the design and implementation of the project. He also offered feedback for the working manuscript. Dr. Olds helped design the project and offered feedback on the proposals, as well as helped develop the codebook and co-coded the first 10% of interviews. Dr. Haberer provided significant guidance on the design and proposals for the project, training for me in qualitative research methods, and worked with me to develop the codebook and interpret the data. She has also continued to provide guidance on the written manuscript for the study.

APPENDIX

A.1. Manuscript Draft as of February 17, 2020.

The current draft is below, with the intention of submitting the article once internal revisions and draft updates are made among members of the team.

Patient Experience and Perspectives of Hypertension in Mbarara, Uganda: A Qualitative Analysis

Introduction

The global burden of non-communicable diseases (NCDs) is shifting disproportionately toward low- and middle-income countries (LMICs) (1). In 2016, 71% of global deaths were attributed to NCDs, with the largest portion of those attributed to cardiovascular disease (1); hypertension in particular is estimated to cause 12% of annual deaths worldwide (3). In Uganda, the hypertension prevalence is estimated at 26%, but fewer than 10% of patients with hypertension are aware of their disease or access care for management (12). NCDs are responsible for at least a third of all deaths in Uganda, and cardiovascular disease is estimated to cause 10% of all annual deaths in the country (2).

Patients' understanding, adherence, and feelings toward their diagnosis can help shape treatment. Patient-centered care is a form of health delivery in which individual patient needs and desired outcomes are used in conjunction with the care team to tailor decisions and plans (4). This model has been shown to be an effective method for increasing access to treatment and improving clinical outcomes. For instance, prior groups have integrated NCD care so that patients can receive all their care for chronic diseases at once, thus saving them significant time and expenses to obtain care (7, 8, 15). There currently are few coordinated NCD specialty clinics in LMICs. Instead, care is divided among specific specialties. For instance, a patient may see one doctor for hypertension and another doctor for diabetes, even for routine follow-up care.

Among the few prior studies describing patient-centered care in Uganda and similar LMIC settings, most looked specifically at non-adherence or disease management (21, 22, 23). No prior qualitative studies regarding patient-centered NCD care in Uganda were found on literature review, although one quantitative measurement of a patient-centered intervention with patient educational booklets was successfully implemented in Kampala, Uganda (14). A prior study of hypertension medication adherence at the outpatient clinic in Mbarara, Uganda, found that 85% of patients met criteria for low adherence based on a validated adherence scale (17). Including patient perspective of the disease can add valuable insight into methods to focus patient-centered care to support adherence and management of disease.

In this study, we sought to understand a patient-centered approach to outpatient management of hypertension in Uganda. We conducted one-time, in-depth interviews at a regional referral hospital among patients with isolated hypertension as well as those with hypertension and other comorbidities. We specifically explored how patients experience their diagnosis with hypertension, understand the disease and its treatment, access care and the specific factors involved in accessing it, and manage their hypertension.

Methods

Study Setting and Population

Participants for this study were identified from the outpatient hypertension clinic at the Mbarara Regional Referral Hospital (MRRH) in southwestern Uganda, which is located approximately 260 kilometers from the capital, Kampala. This clinic provides care to over 3,000 patients, with an average of 120 patients each week (5). Patients are seen on different days of the week based on disease: renal and neurology patients on Monday, hypertension patients on Tuesday, gastrointestinal patients on Wednesday, diabetes patients on Thursday, and urology patients on Friday. Patients are seen on a first come, first serve basis. Medication at the clinic are provided by government medical stores for free, and patients must buy medications from private pharmacies when out of stock.

In this study, all participants had to have an established diagnosis of hypertension, be 18 or older, and be able to speak either English or the local language (Runyankole) for the purpose of the interview. Pregnant patients were excluded from the study, as hypertension of pregnancy was considered beyond the scope of the project goals. Patients unable to provide informed consent, including impairment from intoxication or psychosis, were also excluded from the study.

Sampling and Recruitment

We recruited participants in conjunction with the clinic staff, who identified potential candidates with similar recruitment of both male and female gender. We recruited participants for a reasonable distribution among participants with hypertension only, hypertension with comorbid diabetes, and hypertension with comorbid HIV. Potential candidates were approached for written informed consent. Recruitment continued until thematic saturation was reached on analysis.

Data Collection

One in-depth, in-person qualitative interview was completed with each participant. The goals of the interviews were to explore how participants experience their diagnosis, their understanding of hypertension and its treatment, factors involved in accessing care, and how they approach managing their disease. Interviews were conducted in a private location using either English or Runyankole following a pre-specified interview guide (see Appendix) by a trained research assistant (author GN) who is fluent in both languages. The Runyankole version of the interview guide had been back translated to confirm consistency with the English version. Interviews were audio-recorded, transcribed in English, and reviewed for quality.

Data Analysis

The qualitative transcripts were analyzed according to conventional content analysis (6). Author AGH reviewed the first 5 transcripts and analyzed content to develop labels. He then created operational definitions and developed a codebook with selected illustrative quotes with significant input from author JEH. Approximately 10% of interviews were double-coded (authors

AGH and PKO), and any discrepancies were discussed until consensus was obtained. The codebook was then refined using an iterative process as further interviews were coded. Following completion of the codebook, the remainder of transcripts were coded using Dedoose software (Version 8.3.11, Los Angeles, CA). These codes were then used to generate themes to create a descriptive analysis of the patient experience of hypertension in this community based on the themes that emerged from the data and the goals of the study. Specific quotes were selected to reflect the specific definition of each category and illustrate these themes.

Ethics Statement

The study was approved by the Mbarara University of Science and Technology Faculty of Medicine Research Ethics Committee; the Partners Health Care Human Research Committee; and the Harvard Medical School (HMS) and Harvard School of Dental Medicine (HSDM) Institutional Review Board, via Reliance. We additionally received approval from the Uganda National Council on Science and Technology.

Results

Participant Characteristics

We screened 55 patients for the study. Of those, 22 were deemed ineligible, mostly from not having a documented diagnosis of hypertension. Three eligible patients who declined participation due to personal time constraints. We enrolled and interviewed 30 participants in the study, of whom 20 were female and 10 were male. The average age of participants was 60 years (range 28-86, standard deviation 14.5 years). Of the participants interviewed, 10 had hypertension only, 10 had hypertension with comorbid diabetes mellitus, 1 had hypertension with comorbid HIV, and 9 had hypertension with comorbid diabetes mellitus and HIV. Interviews averaged 49 minutes (standard deviation 12 minutes) in length.

Overview of Qualitative Interview Results

We identified four categories representing the experience of patients receiving their hypertension diagnosis and their care related to it: (1) connection to care, (2) hypertension as a disease, (3) access to care, and (4) patient management of disease.

Connection to Care

Participants initially accessed care for hypertension at various stages of disease. Many participants noted that they received a diagnosis of hypertension after a presentation to the hospital with symptoms from another disease, typically either diabetes or a common complication of hypertension, such as myocardial infarction or stroke.

> *How I came to know that I have hypertension, the same time I was diagnosed with diabetes, I also used to urinate so much. When I narrated the story to someone, how my situation was because I was not having comfortable sleep, he just told me that I am suffering from diabetes, and indeed it was confirmed that I have diabetes and hypertension when I went for treatment. (Male, age 86)*
>
> *I: When did you realize that you have hypertension?*
> *P: I used to be a very sickly person at school in secondary level. I would even collapse, my heart would at times pump so fast.*
> *I: How old were you by then?*
> *P: What I remember is that I was in form two at the time, about 15 years. They then brought me to this hospital and diagnosed me with hypertension. They treated me from the outpatients department, and from there they directed me to the section of the hypertension clinic. They continuously kept checking my hypertension levels, which kept variations of between 180 and 160. The levels were continuously high. (F, 28)*

We also noted trends among participant characteristics and how they received their diagnosis. Participants with HIV tended to receive their diagnosis of hypertension during a routine check-up for their HIV management. Participants not yet connected for hypertension care typically presented when symptomatic; however, some noted that they were diagnosed after screening during an outpatient appointment or at a local health fair (16).

> *I was attending to my usual routine of HIV treatment, and then they took some tests of hypertension and diabetes, and they found out that I had both diseases. My hypertension was very high at 190. From there, I started taking hypertension medication. (F, 50)*

Participants were typically connected to hypertension care after incidentally being diagnosed upon symptomatic presentation or outpatient care for another disease, although some participants noted screening opportunities that have started to occur.

Hypertension as a Disease

When asked about hypertension as a disease and to explain its meaning, participants expressed a range of understanding. Many associated it with the long-term risk of stroke and stressed the importance of adequate treatment to prevent future events. Those participants who were diagnosed with hypertension either in the outpatient setting during a routine appointment or after symptomatic presentation from a cardiovascular event (e.g., stroke or angina symptoms) tended to recognize hypertension's long term risk of stroke and heart disease.

> *Whenever I come here at the hypertension clinic, I get a chance of meeting people I sometimes who were hit by stroke and got paralyzed because of poor management of hypertension. I have to make sure that I always have enough medication of hypertension in order to avoid being hit by stroke and getting paralyzed too. (F, 50)*

Other participants attributed symptoms of diabetes to hypertension or were unable to differentiate the two diseases, as they were often diagnosed at the same time upon presentation to the hospital with complications of new or poorly controlled diabetes. those who were diagnosed after hospitalization for diabetes or an unrelated illness were more likely to associate hypertension with an array of symptoms.

> *P: Hypertension and diabetes are very hard to describe. I actually understand diabetes more than hypertension. The body generally loses all its abilities to do anything. You*

> *totally feel so weak. You just feel death is grabbing your entire life. At times you get so dizzy, feel confused in the head, the eyes completely become squinted and start looking at everything in doubles.*
>
> *I: Is this hypertension or Diabetes?*
>
> *P: I cannot tell the difference of which is which, I take them as one disease. (F, 71)*

Other participants simply stated that they were unsure how to describe hypertension, whereas several participants described hypertension as a "catch-all" for any unexplained symptoms they may be experiencing.

> *I don't know, because hypertension is so difficult to explain. Sometime I feel a lot of heat that covers me abruptly, and I start sweating seriously all over my body. But I cannot tell you exactly what hypertension is or how it pains not at all. (Female, age 72)*

Despite the range of understanding of what hypertension is, participants consistently understood hypertension as a chronic disease that could not be cured. Even with this idea of a chronic disease, participants demonstrated resilience and acceptance toward the disease. In some, faith played a role in this acceptance of their chronic diseases as well.

> *It is a very important thing to know your hypertension status because you start treating yourself seriously, maybe you can live longer and do wonderful things in life that you have always wished to do. (M, 45)*

> *I just thought about it deeply, and my mind told me, God has a purpose for everything. If this is what he has decided for me, then I will accept it as well. (F, 71)*

Of note, no one mentioned education level achieved and its role on understanding of medical care.

Access to Care

Participants noted systemic and clinic-based factors that contributed to how and when they accessed care, as well as factors that encouraged participants to continue trying to adequately manage their hypertension. Participants endorsed easier access to care when clinics were accessible easily from their home, either by walking or inexpensive, short-distance transport.

> *How I wish the services were extended nearer to the people in the communities. If they are able to test our hypertension levels in the community, it would be one way of easing treatment for us. (M, 74)*

On the other hand, the cost of hiring transport, both with local motorcycles and longer distance taxis, increased the cost for participants to attend the clinic and make scheduled follow-up appointments.

> *The medicine I take is very expensive. I also have to come here with a boda boda [motorcycle], which I must pay, and I have to feed as well. (M, 45)*

Furthermore, the relationship with health workers was indicated as a facilitator to care and encouraged participants to go to the clinic regularly for their care.

> *What I like most is the good relationship we have with these health workers at this hospital. We talk together nicely about health issues. Sometimes, you even forget about the challenges you go through. If they were using bad language, people would not be coming to this health facility. (M, 86)*

Several participants compared the ease of accessing treatment and management of HIV to the difficulties of accessing care for hypertension, with some considering it worse than HIV in certain regards.

> *This disease is more of a risk than HIV. Its rating should be classified as a very dangerous disease. If it is in order, we should be given much more attention than the patients of HIV. These patients of HIV are given counseling, medicine, outreach programs. Really, we should also receive this kind of attention; hypertension is a major risk in families. (F, 35)*

Participants also expressed a balance between strong independence and motivation to manage their own disease with an importance placed on family and community support, including caregiving, transportation, and financial support.

> *My children are now very helpful. Their father is the one who used to take care of me when he was still alive, but when he passed away, they each gave themselves months when they would buy for me medicine...In addition, they engaged a person to take care of my banana plantation. They usually buy for me the food that I cannot afford, for example fish. They show me so much care and love that keeps me at peace. (F, 65)*

Participants repeatedly noted financial strain as a major barrier to care. Decreased available funds, combined with a shortage of the less expensive hypertension medications at the clinic, led to a struggle to purchase medications and a decrease in self-reported adherence.

> *P: They always tell me to go and buy, but I do not have the money.*
>
> *I: How long have you spent without swallowing your hypertension drugs?*
>
> *P: I have spent about four month, but I am not very sure. I think I last swallowed in March. Whenever they tell me to go and get hypertension from the hospital pharmacy, I do not get anything.*
>
> *I: You mean hypertension has never disturbed you?*
>
> *P: It disturbs me a lot. I fail to get peace, and I get tired. They always prescribe the medicine, but the money to buy it is the challenge. (F, 72)*

In addition to accessibility of the clinic impacting care seeking, many participants noted characteristics of the clinic structure that were frustrating and impacted their attitude toward care. All participants were asked about their experience at the clinic as well, with many similar experiences. Many noted having to arrive at the clinic over two hours prior to the clinic day starting.

> *I finished my treatment early today because I woke up so early at around 5:30am. It rained on me, but I wanted to be among the first patient to be treated. In fact, I was the second patient to arrive, and I had to wait. But I made a small mistake when I went out to easy*

> *myself and grab a cup of tea, but the time I came back, I found my position had changed, and I was about the tenth, but still that was not a big problem to me. I do not know whether it is because of the many patients or few doctors, sometimes you wake up early but still you finish your treatment late at around 4:00pm or 5:00pm, when you are very exhausted and tired. (M, 45)*

This variable experience in accessing care shapes patients' abilities to manage disease and their motivation to seek extensive treatment.

Management of Hypertension

Most participants noted that when they had access to medications at home for their disease, they always remembered to take their medications and recognized the importance of regular medication adherence.

> *No I have never missed [taking medication]. It is not easy for me to forget. Wherever I go, I have to make sure that I carry my medicine. If I am to spend a night there, I have to make sure that I carry some. It has really never happened. (M, 72)*

Oftentimes, participants were prescribed medications for hypertension and told to pick up their medications at the hospital pharmacy, only to be told that the medication was unavailable. They were advised to go to a local, non-hospital pharmacy to purchase the medication. With this added expense, several participants noted that they would return home without any medications, as they could not afford to purchase them from an outside pharmacy.

> *Money is the most challenging thing while seeking hypertension treatment, especially in buying medicine. For example, the medicine they have prescribed me today is not available here in the hospital, and I have to go and buy it from the drug shops, and I do not have money to buy it. So that becomes a big challenge. (F, 53)*

Many participants noted an understanding of the necessary dietary and exercise changes that they should make to improve their health and help manage their disease. Most noted some form of counseling they had received during the course of their NCD care, listing normative dietary changes and the importance of exercise.

> *I went tested and was told I had hypertension. The health workers told me what I should and shouldn't do. In case I was drinking alcohol or smoking I should stop, time reached when I was told to stop eating salt. I spent two years without eating it, then later was told to take very little. (F, 65)*

Participants with both HIV and hypertension noted the significant non-pharmaceutical management required with NCDs, often citing the difficulty involved in making lifestyle changes to control hypertension, among others.

> *HIV is very manageable. I used to do my activities as usual, eat all the foods I want, but with hypertension and diabetes, it's very different. They weaken the body and prevent me from doing all my other activities. You become a real patient and very delicate because you become very selective with the foods. Imagine eating food without salt, no eating meat the way you want, milk has to be very watery and tasteless, food has to eaten in phases and make sure you do not get so full up. These make life very difficult. (F, 56)*

Furthermore, participants mostly reported that they did not use alternative therapy, primarily because they had been counseled that the dosing and utility of these therapies were unknown, although some used these therapies in place of the hypertension medication that they could not afford.

> *Most of those herbs are so expensive, and I have seen people who stopped swallowing their hypertension or diabetes drugs, and they die so abruptly and painfully. So, I do not trust such medicines. (F, 53)*

> *I: What happens when you do not have money?*
> *P: I use alternative means. Like I said, I use herbal medicine these days for hypertension because the drugs are very expensive. (F, 56)*

Participants endorsed a significant understanding of lifestyle modifications necessary for NCD management when medications are not necessarily available due to other constraints.

Discussion

In our qualitative study of patients with hypertension in a regional referral hospital in rural Uganda, we found that participant understanding of disease was closely tied to their symptoms at presentation. Financial strain and difficulty traveling to the clinic were among the primary barriers to care, whereas family support and accessible clinics promoted care access. Additionally, although a hypertension diagnosis was accepted and understood to be a chronic, lifelong disease, participants were generally resilient and eager to continue treating and managing their disease. Patients were likely to be connected to care earlier when they had access to health screenings or regular outpatient appointments, presented for care for another disease, or had easy access to a clinic and family support to encourage care. Expenses for travel to the clinic and purchasing medications tend to dissuade patients from receiving care, resulting in a later diagnosis and difficulty maintaining treatment regimens. Given the variance in presentation, there is a reflective variance in understanding of disease, ranging from its visible association with strokes to diabetes-like symptoms to any unexplained ailment, with education level likely playing a role as well. When able to access medications, participants regular endorsed strong adherence to their prescribed regimen. Participants consistently cited the necessary lifestyle adjustments, including diet and exercise alterations, to manage their hypertension.

Considering patient factors in healthcare delivery can help ensure adequate management of hypertension and other NCDs by aligning the clinic structure and resources with patient values and beliefs (15). The World Health Organization considers patient-centered care essential for sustainable NCD management (18). In high-income countries, this approach can include personalized medicine and high-tech solutions, including genetic-based medicine, that can involve patients more in their own individualized, tailored care plan (19, 20). Kruk et al. suggest redesigning care models in LMICs with a focus on patient and community outreach, possibly through community healthcare workers, to increase access to affordable care, and integrating care team services (19). In similar, low-resource settings, other groups have found integrating NCD care with a patient-centered approach helps to reach patients beyond certain barriers to care and prepare clinics for managing these diseases (7, 8).

By integrating NCD care, patients will have decreased travel burden as they receive all of their disease care at once. Further, when managing patients' multiple diseases, time can be allotted to customize treatment approaches that fit particular patient preferences and disease burden. When possible, connecting patients with ways to receive transport or medications at an affordable rate may improve access to care and regular management of disease. More stable patients may benefit from extended time to follow up, as many participants noted having to travel to the clinic several times over the span of a few months, increasing expenses for hiring transport to get to the clinic. Patients in general understood the chronicity of the disease and steps required to prevent long-term outcomes, although it may be difficult to actually follow these steps without support from caregivers and family members. Counseling family members alongside patients, including on topics related to long term outcomes of hypertension and what to expect from treatment, may help bridge this gap.

Strengths of this study include the fact that participants were interviewed with a range of comorbidities and experiences with their hypertension. All participants were seen at the same clinic and could comment on the same care delivery model for hypertension. Furthermore, enrollment continued until thematic saturation was reached. The study was limited in that it only interviewed patients of the clinic, without the perspective of family members or healthcare workers. Additionally, all participants were interviewed from a single clinic which operates as a referral center for the region.

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A.3. Hypertension Patient Interview Guide

Introduction

We are studying what it is like for patients to live with hypertension ("pressure") and receive care at this hospital. We would like to ask you some questions about your experience with "pressure" (high blood pressure) and taking care of it. The interview will take less than an hour, and the interview will be recorded to ensure all of your responses captured without distortion, but the interview will be confidential. You will have the opportunity to stop the interview or skip a question whenever you want.

Key questions for the interview are numbered, and questions in italics are probe questions.

1. Please tell me a little about yourself.

On a typical day, what do you do from the time you wake up until you go to bed?

2. How did you learn that you have "*pressure*" (high blood pressure)?

Where did you learn that you have "pressure" (high blood pressure)?

Who was with you at that time?

How did you feel when you first learned this?

3. Why is it important to know you have "*pressure*" (high blood pressure)?

What does it mean to you?

4. Since being diagnosed with "pressure", how do you take care of yourself?

How often do you visit the health facility?

Do you seek care for "pressure" from other providers, e.g., traditional healers, herbalists, or spiritualists??

What's easy?

What's hard?

5. Other than health care providers, does anyone help you with taking care of your "*pressure*" (high blood pressure)?

Who helps you?

How do they help you?

6. I’d like to know how you take your medication for hypertension. Please tell me how you last swallowed your medication.
7. Tell me about your experiences going to the health facility to seek care for pressure.

How do you get to the health care facility?

How do you feel about the reception and waiting to see a health care provider (nurse, doctor)?

What do you expect when you go to the health care facility?

What do you like about the health care facility?

Are there times when the experience at the health care facility was different from your expectations?

8. On a typical day, what do you eat?

Do you eat or not eat certain foods to help your pressure?

9. Tell me what kinds of physical activities you do in a week.

Is any of it exercise to help your hypertension?

10. Are there any types of support you would like to get for your “*pressure*” (high blood pressure)?

From the health care facility?

From family or friends?

11. Is there anything else you would like to tell me about your “*pressure*” (high blood pressure)?

Thank you for your time.