

For My Family, I Take It': A Phenomenological Study of Antihypertensive Medication Use Among Filipino Adults

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Abstract: Hypertension remains a leading cause of cardiovascular morbidity and mortality. Although effective antihypertensive therapies are available, sustained blood pressure control remains suboptimal due to inconsistent medication use. Most adherence research is quantitative and offers limited understanding of how individuals interpret lifelong treatment within daily life, particularly in culturally grounded contexts. To explore the lived experiences of Filipino adults taking antihypertensive medication. A qualitative study grounded in Heideggerian interpretive phenomenology was conducted. Ten Filipino adults diagnosed with hypertension were purposively recruited from outpatient clinics in Manila, Philippines. In-depth semi-structured interviews were transcribed verbatim and analyzed using the six-step IPA framework. Analysis revealed six interconnected themes describing how participants interpreted and sustained medication use: (1) Diagnosis as Disruption; (2) Medication as Protection and Responsibility; (3) The Paradox of the Silent Illness; (4) Everyday Barriers to Sustained Treatment; (5) Constructing Routine and Adaptive Self-Management; and (6) Family as Anchor within Cultural Contexts. These themes reflected emotional adjustment, symptom-driven adherence, financial and work-related barriers, adaptive coping strategies, and strong family-centered motivation. Medication-taking was experienced as an ongoing negotiation shaped by bodily cues, daily demands, and relational obligations. Conclusion: Antihypertensive medication use is shaped by relational, cultural, and socioeconomic contexts, underscoring the need for family-inclusive and culturally responsive hypertension care.

Keywords: Hypertension; Medication Adherence; Lived Experience; Family Support; Filipino Patients

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1. Introduction

Hypertension remains one of the most pervasive chronic conditions globally and continues to be a leading contributor to cardiovascular morbidity and mortality. Despite the availability of effective antihypertensive therapies, blood pressure control rates remain suboptimal, largely due to inconsistent medication adherence [1,2]. Sustained

adherence to antihypertensive therapy is essential because nonadherence substantially increases the risk of stroke, coronary heart disease, renal complications, and premature mortality [3,4]. Although pharmacologic efficacy is well established, real-world effectiveness depends on patients' long-term engagement with prescribed regimens. Therefore, understanding antihypertensive medication use as a lived and ongoing experience is crucial for strengthening chronic disease management strategies.

Medication adherence is shaped by multifaceted influences that extend beyond biomedical instruction. Patients' beliefs regarding illness severity, perceived necessity of treatment, concerns about adverse effects, and the quality of patient-provider communication significantly affect adherence behaviors [5]. Recent evidence further demonstrates that health literacy and social support play critical roles in promoting sustained medication adherence among individuals with hypertension [6]. It was found that individuals with higher health literacy and stronger social support networks exhibited significantly better adherence behaviors, underscoring the relational and cognitive dimensions of treatment engagement [6]. These findings reinforce that antihypertensive medication use is embedded within broader psychosocial contexts rather than being solely an individual compliance issue.

Within the Filipino context, hypertension prevalence remains substantial, yet sustained adherence to antihypertensive medication continues to present significant challenges. Although systematic reviews have identified determinants of medication adherence among Filipino patients, existing research is largely quantitative and focuses on measurable predictors rather than lived experience [7]. There remains a notable absence of phenomenological inquiry exploring how Filipino adults interpret, negotiate, and sustain long-term antihypertensive therapy within familial, cultural, and socioeconomic contexts. Considering the central role of family systems, communal values, and financial considerations in shaping Filipino health behaviors, deeper qualitative exploration is warranted. Therefore, this study aims to explore the lived experiences of Filipino adults taking antihypertensive medication, with the objectives of identifying emergent experiential themes, examining contextual influences on adherence, and contributing culturally grounded insights to inform more patient-centered and contextually responsive hypertension care.

2. Materials and Methods

2.1. Research Design

This study employed a qualitative design grounded in Heideggerian interpretive phenomenology and utilized Interpretative Phenomenological Analysis (IPA) to explore the lived experiences of adults taking antihypertensive medication. IPA was selected for its emphasis on examining how individuals make sense of significant life experiences through a double hermeneutic process [8]. The approach allows for in-depth exploration of meaning-making within sociocultural and relational contexts, making it appropriate for examining long-term medication use in chronic illness.

2.2. Study Setting and Participants

The study was conducted in selected outpatient clinics in Manila, Philippines, from January to March 2025. A purposive sampling strategy was used to recruit participants who could provide rich experiential accounts. Inclusion criteria included: (1) clinical diagnosis of hypertension for at least one year, (2) current use of prescribed antihypertensive medication, (3) age 20 years or older, and (4) ability to communicate in English or Filipino. A total of ten ($n = 10$) participants were included in the final analysis. Recruitment continued until experiential redundancy was observed across interviews.

2.3. Instrument Development and Pilot Testing

Data were collected using a semi-structured interview guide developed from existing literature on hypertension management and medication adherence. The original interview guide was developed in Filipino to ensure cultural and linguistic appropriateness for the study population. To establish content validity, the instrument underwent expert review by two qualitative research specialists and one clinician with expertise in cardiovascular care. Revisions were made to enhance clarity, cultural sensitivity, and alignment with the study objectives.

Following expert validation, the interview guide was translated into English for documentation and academic reporting purposes. A forward-translation process was conducted, and linguistic equivalence was reviewed by a bilingual expert to ensure semantic accuracy. A pilot interview was conducted with one eligible participant to assess clarity, sequencing, and comprehensibility of the questions; this pilot interview was excluded from the final analysis.

2.4. Data collection

In-depth, face-to-face interviews were conducted in private settings within clinic premises or at participant-preferred locations. Interviews lasted approximately 30 to 60 minutes and were audio-recorded with consent. Field notes were taken to capture contextual observations and non-verbal cues. Interviews conducted in Filipino were translated into English for analysis while maintaining semantic integrity. All interviews were transcribed verbatim.

2.5. Data analysis

Data were analyzed following the six-step IPA framework outlined by [9], including repeated reading, initial noting, development of emergent themes, identification of thematic connections within cases, cross-case comparison, and construction of superordinate themes supported by verbatim quotations. Analysis was iterative and reflexive, allowing continuous engagement with participants' narratives and evolving interpretations.

2.6. Trustworthiness

Rigor was established in accordance with criteria commonly associated with Lincoln and Guba's framework—credibility, transferability, dependability, and confirmability—as discussed in contemporary qualitative scholarship [10]. Credibility was enhanced through prolonged engagement and peer debriefing. Transferability was supported through rich, thick descriptions of participants and context. Dependability was ensured by maintaining an audit trail documenting methodological and analytic decisions. Confirmability was reinforced through reflexive journaling to acknowledge and bracket researchers' assumptions.

2.7. Ethical considerations

Ethical approval was obtained from the St. Paul University Philippines Research Ethics Committee (SPUP_2025_SR_JC) prior to data collection. Written informed consent was secured from all participants before participation. Participants were informed of their right to withdraw at any time without consequence.

To ensure confidentiality and anonymity, participants were assigned alphanumeric codes (P1–P10) in place of their real names. These codes were used in transcripts, analytic memos, and reporting of findings. All audio recordings and transcripts were stored in

password-protected files accessible only to the research team. Identifying information was removed from transcripts prior to analysis to protect participant privacy.

3. Results

A total of ten ($n = 10$) participants were included in the study. Participants ranged in age from 48 to 65 years. Six participants were female and four were male. Employment status varied, with participants either employed full-time, retired, self-employed, or reliant on pension income. Demographic characteristics are presented in [Table 1](#).

Table 1. Participant Demographic Profile

| Participant Code | Age/Sex | Employment Status |
|------------------|---------|------------------------------|
| P1 | 55/F | Employed |
| P2 | 52/M | Employed |
| P3 | 58/F | Self-employed |
| P4 | 60/F | Retired |
| P5 | 65/F | Pensioner |
| P6 | 50/M | Employed |
| P7 | 54/F | Employed |
| P8 | 60/F | Pensioner |
| P9 | 57/M | Self-employed |
| P10 | 48/M | Employed (Shifting Schedule) |

Summary of Themes

Based on interpretative phenomenological analysis, six superordinate themes emerged describing the lived experiences of antihypertensive medication use. These include: (1) Diagnosis as Disruption; (2) Medication as Protection and Responsibility; (3) The Paradox of the Silent Illness; (4) Everyday Barriers to Treatment; (5) Constructing Routine and Adaptive Self-Management; and (6) Family as Anchor within Cultural Contexts. Collectively, these themes demonstrate that antihypertensive maintenance is embedded within emotional response, bodily perception, socioeconomic constraints, and relational dynamics.

3.1. Theme 1: Diagnosis as Disruption – From Shock to Realization

As shown in [Table 2](#), participants described hypertension diagnosis as an emotionally disruptive experience characterized by shock, disbelief, and fear. Under the subtheme Shock and Disbelief, several participants initially resisted the diagnosis because they felt physically well, with P10 expressing surprise and P8 indicating difficulty accepting the condition. The invisibility of symptoms contributed to delayed internalization of illness identity. The subtheme Fear of Complications emerged as participants reflected anxiety about stroke and heart attack, often influenced by family history, as illustrated by P8's fear after witnessing her sister's stroke. Under Realization through Symptoms, seriousness became embodied when participants experienced high blood pressure episodes, headaches, or chest tightness, prompting behavioral change.

These accounts suggest that diagnosis moved from abstract medical information to lived vulnerability through bodily experience. Overall, hypertension diagnosis disrupted participants' perceived normalcy and initiated a gradual process of acceptance.

Table 2. Theme 1: Diagnosis as Disruption

| Subtheme | Illustrative Quotations |
|------------------------------|---|
| Shock and Disbelief | <p>"I was surprised because I felt healthy." (P10)</p> <p>"I did not immediately accept that I had hypertension." (P8)</p> <p>"I felt shocked when they told me I needed lifelong medication." (P1)</p> |
| Fear of Complications | <p>"I was scared that the same thing might happen." (P8)</p> <p>"I was afraid of stroke." (P4)</p> <p>"I was anxious about possible complications." (P2)</p> |
| Realization through Symptoms | <p>"I was frightened after severe headache and dizziness." (P5)</p> <p>"After chest tightness, I became serious." (P10)</p> <p>"When my blood pressure became very high, I realized it was serious." (P8)</p> |

3.2. Theme 2: Medication as Protection and Responsibility

As reflected in [Table 3](#), participants gradually reframed antihypertensive medication from reluctance to acceptance. Under Medication as Protection, participants described feeling safer and more secure when taking medication regularly, indicating that treatment reduced anxiety about complications. The subtheme Responsibility to Family revealed strong relational motivation, as participants associated medication adherence with remaining present for children and fulfilling provider roles, as seen in P8 and P10's accounts. However, Ambivalence and Vulnerability persisted, with participants expressing concern about long-term effects and feeling reminded of aging or dependence. Medication thus carried symbolic meaning beyond blood pressure control, representing both empowerment and acknowledgment of chronic illness. These narratives demonstrate that adherence was rooted not only in medical advice but also in moral obligation and relational identity. Overall, medication was experienced as both a protective safeguard and a marker of vulnerability.

Table 3. Theme 2: Medication as Protection and Responsibility

| Subtheme | Illustrative Quotations |
|-------------------------------|--|
| Medication as Protection | <p>"Medication means protection for my health." (P5)</p> <p>"I feel more secure knowing my blood pressure is controlled." (P8)</p> <p>"It prevents emergencies." (P3)</p> |
| Responsibility to Family | <p>"I want to stay alive longer for my children." (P8)</p> <p>"It allows me to continue working and supporting my family." (P10)</p> <p>"I do not want to become a burden." (P1)</p> |
| Ambivalence and Vulnerability | <p>"Sometimes I still worry about long-term effects." (P8)</p> <p>"It feels like a reminder that I need to slow down." (P10)</p> <p>"I feel dependent on pills." (P2)</p> |

3.3. Theme 3: The Paradox of the Silent Illness – Symptom-Driven Adherence

As illustrated in Table 4, participants' adherence behaviors were shaped by hypertension's asymptomatic nature. Under Reduced Urgency when Asymptomatic, participants admitted relaxing medication intake when feeling physically well, suggesting that absence of symptoms diminished perceived threat. The subtheme Complacency without Immediate Consequences emerged when participants reported skipping doses without experiencing immediate effects, reinforcing inconsistent adherence patterns. However, Learning through Bodily Warning became evident when elevated blood pressure episodes, chest discomfort, or visual disturbances reinstated seriousness and renewed commitment. These accounts reveal a reactive pattern of medication-taking driven by bodily cues rather than preventive consistency. The paradox lies in managing a medically serious yet experientially silent condition. Overall, adherence fluctuated between complacency and vigilance depending on symptom perception.

Table 4. Theme 3: The Paradox of the Silent Illness

| Subtheme | Illustrative Quotations |
|---------------------------------------|---|
| Reduced Urgency when Asymptomatic | <p>"If I feel okay, sometimes I think I do not need it." (P8)</p> <p>"When I feel normal, I relax." (P6)</p> <p>"There are times I stop when I feel fine." (P7)</p> |
| Complacency without Immediate Effects | <p>"Nothing immediate happened." (P10)</p> <p>"When I missed it, nothing happened right away." (P4)</p> <p>"I thought skipping once was okay." (P2)</p> |
| Learning through Bodily Warning | <p>"After my BP spiked, I realized the importance." (P8)</p> <p>"Chest tightness made me serious." (P10)</p> <p>"Blurred vision scared me." (P3)</p> |

3.4. Theme 4: Everyday Barriers to Sustained Treatment

As presented in Table 5, participants described multiple structural and personal barriers that influenced sustained antihypertensive medication use. Under Financial Constraints, several participants reported delaying medication purchase due to limited income, particularly pension-dependent individuals such as P8 and P5, who prioritized essential household expenses when finances were tight. These accounts indicate that adherence decisions were sometimes shaped by economic trade-offs rather than health beliefs alone. The subtheme Work and Routine Disruptions emerged among employed participants, particularly P10, whose shifting schedule contributed to forgetfulness and irregular intake. In addition, Medication Access and Side Effects influenced adherence, as participants noted unavailable brands in local pharmacies and discomfort such as dizziness, dry cough, or frequent urination. Although these side effects were generally described as mild, they contributed to hesitation and occasional inconsistency. Overall, medication adherence was situated within broader socioeconomic realities, daily routines, and bodily responses that competed with treatment regularity.

Table 5. Theme 4: Everyday Barriers to Sustained Treatment

| Subtheme | Illustrative Quotations |
|------------------------------------|---|
| Financial Constraints | <p>“Sometimes I wait for my pension before buying medicine.” (P8)</p> <p>“Fixed pension income.” (P5)</p> <p>“If money is tight, I prioritize food and bills.” (P8)</p> |
| Work and Routine Disruptions | <p>“Because of my shifting schedule, I sometimes forget.” (P10)</p> <p>“Rotating shifts make consistent intake difficult.” (P6)</p> <p>“When I am busy, I forget.” (P8)</p> |
| Medication Access and Side Effects | <p>“The specific brand is not always available.” (P8)</p> <p>“I sometimes feel tired or lightheaded.” (P8)</p> <p>“Frequent urination.” (P10)</p> |

3.5. Theme 5: Constructing Routine and Adaptive Self-Management

As shown in Table 6, participants actively developed strategies to maintain adherence despite challenges. Under Habit Integration, participants embedded medication within daily routines, such as pairing intake with breakfast or coffee, as described by P5 and P8. This integration transformed medication from a separate medical task into part of ordinary life. The subtheme Use of Reminders and Tools was evident in the use of phone alarms, pill organizers, and keeping spare medication at work, particularly among employed participants like P10. Additionally, Spiritual and Motivational Coping emerged as participants described prayer, self-reminders, and reflection on health priorities as means of reinforcing consistency. These strategies reflect intentional efforts to compensate for forgetfulness and competing demands. Rather than passive recipients of prescriptions, participants demonstrated agency in constructing adherence-supportive environments. Overall, routine-building functioned as a stabilizing mechanism in chronic illness management.

Table 6. Theme 5: Constructing Routine and Adaptive Self-Management

| Subtheme | Illustrative Quotations |
|-----------------------------------|--|
| Habit Integration | <p>“It became part of my morning routine together with coffee.” (P5)</p> <p>“I take my medication after eating.” (P8)</p> <p>“I associate it with meals.” (P4)</p> |
| Use of Reminders and Tools | <p>“Phone reminders.” (P10)</p> <p>“I use a pill organizer.” (P5)</p> <p>“I keep extra tablets in my locker.” (P10)</p> |
| Spiritual and Motivational Coping | <p>“I pray and remind myself that my health is important.” (P8)</p> <p>“I think about my grandchildren.” (P8)</p> <p>“I tell myself not to be careless.” (P2)</p> |

3.6. Theme 6: Family as Anchor within Cultural Contexts

As reflected in Table 7, family relationships played a central role in shaping antihypertensive medication experiences. Under Emotional and Practical Support, participants described family members providing reminders, financial assistance, and transportation to appointments, as illustrated by P8’s daughter’s daily calls and P5’s children helping purchase medication. The subtheme Relational Motivation highlights participants’ desire to remain present for family milestones, reinforcing adherence as an act of love and responsibility. However, Cultural Influence and Traditional Beliefs also emerged, particularly when older relatives suggested herbal remedies or alternative approaches, as noted by P10. While these cultural beliefs did not necessarily replace prescribed medication, they introduced tension in health decision-making. Family therefore functioned both as adherence facilitator and cultural context influencing interpretation of treatment. Overall, medication-taking was embedded within strong relational networks that shaped motivation, accountability, and meaning.

Table 7. Theme 6: Family as Anchor within Cultural Contexts

| Subtheme | Illustrative Quotations |
|--|--|
| Emotional and Practical Support | <p>“My daughter calls me every morning.” (P8)</p> <p>“My wife monitors my BP.” (P10)</p> <p>“My children send money for medicines.” (P5)</p> |
| Relational Motivation | <p>“I want to be present for family gatherings.” (P8)</p> <p>“I do not want to become a burden.” (P1)</p> <p>“I need to stay healthy for my family.” (P10)</p> |
| Cultural Influence and Traditional Beliefs | <p>“Older relatives suggest traditional remedies.” (P10)</p> <p>“I thought I could manage it with herbal remedies.” (P8)</p> <p>“They recommend garlic and herbal tea.” (P6)</p> |

Overall Interpretation of Findings

Across all themes, antihypertensive medication use was experienced as a dynamic and evolving process shaped by emotional disruption, symbolic reframing of medication, symptom-driven adherence patterns, socioeconomic constraints, adaptive routine-building, and strong family influence. Participants navigated the paradox of managing a silent yet serious illness within the realities of financial limitations and shifting daily structures. Medication adherence was therefore not simply compliance with medical instruction, but an ongoing negotiation embedded in bodily experience, relational obligation, and cultural meaning. The interplay between invisibility of symptoms and family-centered motivation emerged as a defining experiential dynamic. Collectively, these findings highlight the complexity of long-term antihypertensive maintenance within everyday life contexts.

4. Discussion

This study explored the lived experiences of antihypertensive medication use among Filipino adults and revealed that diagnosis was frequently experienced as emotionally

disruptive. Participants described disbelief, fear, and delayed acceptance, particularly when hypertension was asymptomatic. Similar patterns have been observed in qualitative research where patients struggled to reconcile the absence of symptoms with the necessity of lifelong medication [11, 12]. In rural Bangladesh, likewise reported that limited symptom recognition and delayed healthcare engagement shaped patients' treatment pathways [13]. In the present study, seriousness was internalized primarily after bodily warning signs such as elevated blood pressure or chest discomfort occurred. These findings reinforce that illness perception and embodied experience significantly shape early adherence behaviors across diverse cultural contexts.

Medication was gradually reframed as protective and responsibility-laden, particularly within relational contexts. Participants described antihypertensive therapy as enabling them to fulfill family roles and avoid becoming burdens to loved ones. This relational framing mirrors findings by [14], who identified strong social and familial obligations influencing hypertension management. Similarly, disease acceptance and fear of complications facilitated adherence, reinforcing the motivational role of perceived vulnerability [15]. However, contrasting evidence suggests that negative attitudes toward medication may persist despite clinical advice; skepticism and fear of side effects sometimes undermined sustained adherence [16]. Compared to these findings, participants in the current study appeared to reinterpret medication positively over time, suggesting that relational motivation may mediate early ambivalence.

The paradox of hypertension as a silent illness strongly influenced medication practices. Participants frequently reported reduced urgency when asymptomatic and heightened vigilance following symptom episodes. Perceived susceptibility directly affects engagement in self-management [13], while some patients deprioritize medication when symptoms improve, reflecting a reactive adherence model [17]. In contrast, the role of intentional habit formation strategies—such as environmental cues and structured routines—in sustaining long-term adherence independent of symptom presence [18]. The present findings reveal an oscillation between symptom-driven adherence and routine-based management, highlighting the interpretive and behavioral negotiation involved in chronic illness care.

Socioeconomic and structural barriers further shaped participants' medication experiences. Financial constraints, medication access limitations, and work-related disruptions were recurrent themes. Similarly documented economic hardship and competing domestic responsibilities as significant barriers to adherence in rural populations [19]. Systemic determinant, including affordability and healthcare infrastructure, remain critical drivers of global nonadherence [4]. However, unlike intervention-based contexts where adherence therapy can reshape beliefs and behaviors [20], participants in this study relied primarily on self-developed coping strategies and family support rather than structured behavioral interventions. This contrast underscores the importance of accessible support mechanisms within routine clinical care.

Finally, family support and cultural beliefs emerged as central influences on sustained medication use. Participants described reminders, financial assistance, and emotional encouragement from family members as essential facilitators of adherence. Social support is one of the strongest facilitators across qualitative adherence research [8]. At the same time, traditional remedies and misconceptions may coexist with biomedical treatment, occasionally complicating medication behaviors [20]. In the present study, cultural beliefs did not fully displace prescribed therapy but were integrated into daily life alongside biomedical management. Collectively, these findings demonstrate that antihypertensive medication use is relational, culturally embedded, economically influenced, and dynamically interpreted rather than being a fixed behavioral outcome.

Implications for Practice

Understanding the lived experiences of antihypertensive patients suggests that care should shift beyond prescription alone to include routine assessment of personal beliefs, symptom interpretations, socioeconomic barriers, and family contexts. Clinicians and nurses should integrate culturally sensitive education, co-create medication plans with patients, and engage family networks to strengthen adherence. Proactive support such as reminders, practical strategies, and coping resources should be routinely offered in clinical encounters to enhance long-term treatment sustainability.

5. Conclusions

This study highlights that antihypertensive medication use is experienced as an interpretive process embedded in emotional reactions, bodily perceptions, structural realities, and relational responsibilities. Participants navigated symptom silences and socioeconomic constraints through adaptive strategies and family networks, revealing that adherence is shaped far beyond biomedical prescription. These insights underscore the need for patient-centered, culturally aware approaches that integrate family support and practical self-management into hypertension care. By foregrounding lived experience, healthcare providers can better align treatment plans with patients' realities, ultimately supporting more consistent and meaningful long-term engagement with antihypertensive regimens.

6. Limitations and Recommendations

Despite its contributions, this study has limitations. Firstly, participants were recruited from urban outpatient settings in Manila, Philippines, which may limit transferability to rural or geographically distinct regions. Although the sample achieved thematic saturation, the contextual nuances of rural, remote, or low-resource populations remain unexplored in this study and warrant future qualitative inquiry. Additionally, the cross-sectional design captures experiences at one point in time; longitudinal investigations could illuminate how lived meanings and adherence behaviors evolve over the course of treatment.

Future research should also consider triangulating qualitative findings with quantitative adherence measures and biological markers to strengthen credibility. Strategies such as longitudinal mixed methods design, or participatory action research could deepen understanding of how social, economic, and cultural factors interact to shape adherence trajectories. Moreover, intervention development grounded in these lived experiences — such as community-based support models and family-centered adherence programs — should be tested for effectiveness in improving long-term blood pressure control.

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