Perceived Familial Support and Medication Adherence among Hypertensive Person Deprived of Liberty

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ABSTRACT

Family support improves drug adherence, especially for chronic patients. Emotional, practical, and educational support can help patients continue their treatment plan. However, there is a scarcity of studies involving hypertensive persons deprived of liberty. This quantitative research utilized the descriptive, correlational research design to assess interrelationship among personal characteristics, perceived familial support, and medication adherence among hypertensive persons deprived of liberty in a City Jail in Mandaue City for the first quarter of 2025. Findings revealed that majority were aged 36 to 55 years old while over half were singles. Over a quarter were at the elementary level. Majority had been imprisoned for one to three years and had a primary hypertension. Majority had been diagnosed with hypertension for one to three years and without co-morbidities. Overall, the perceived familial support was high. Emotional aspects of family support was fair while recognition of families' strengths and cognitive were high. Overall, they were moderately adherent to medication. In terms of having a positive attitude towards health care and medication, and active coping with health problems, respondents were highly adherent while in lack of discipline they were highly non-adherent and in terms of aversion towards medication, the respondents were non-adherent. Marital status was correlated with perceived familial support. The personal characteristics were not correlated with adherence to medication. Perceived familial support was significantly correlated with adherence to medication. To address the findings of the study, a medication adherence enhancement plan is proposed.

Keywords: Adherence to medication; Hypertension; Perceived familial support; Persons deprived of liberty.

INTRODUCTION

Hypertension, a prevalent global disease, significantly increases the risk of chronic conditions like heart disease, stroke, and kidney problems (Mills & Stefanescu, 202 as cited in Hossain et al., 2025; Bijani et al., 2020 as cited in Hossain et al., 2025). It also causes substantial mortality among adult population and identified as the third leading cause of deaths worldwide (Bijani et al., 2020 as cited in Hossain et al., 2025). Moreover, about half of the deaths caused by cardiovascular diseases are directly linked to hypertension (Mills & Stefanescu, 202 as cited in Hossain et al., 2025).

Hypertension as one of the diseases is manageable through medications. According to Gutierreez and Sakulbumrungsil (2021), diseases of the heart and vascular system are the leading cause of mortality in the Philippines. Hypertension, the most important modifiable risk factor, has a prevalence rate of 28 percent and a control rate of 20 percent. Despite the proven efficacy of pharmacologic treatment, medication adherence is reported to be as low as 66 percent. Adherence to pharmacological treatments is the key to achieving optimal control of blood pressure. As a result, the risk of morbidities and fatalities connected with the condition will be reduced. In order to successfully manage one's blood pressure levels, it is essential to take antihypertensive medicine as prescribed. There is a correlation between poor adherence to these medications and the development of hypertensive problems as well as an increase in the risk of cardiovascular events, which ultimately results in a reduction in the clinical

outcome. While there are a multitude of studies cnudcted on adherence to medication among hypertensive individuals. There had been very few conducted among hypertensive persons deprived of liberty.

On the other hand, one factor that may affect adherence to medication is familial support. Patients with hypertension may find that their families are a potential source of familial support, which can help them overcome social barriers and carry out illness management duties, particularly with regard to treatment compliance. The promotion of familial support through the use of a social intervention could be a potential way to enhance care for hypertensive patients. This is because the treatment of chronic illnesses presents difficulties for patients who are isolated, but these difficulties could be solved with the assistance of family members. Support from family members is essential for the long-term management of hypertension, which necessitates a change in lifestyle that must be maintained throughout the affected individual's entire life. Having a strong sense of support from their family will boost their sense of self-worth and motivation. It is conceivable that a hypertensive patient who is sufficiently driven will adhere to therapy programs and, as a result, achieve greater control of their blood pressure. In order to improve the function of hypertensive patients and the result of their treatment, it is vital for health care practitioners to ensure that families of patients with hypertension are included in the management of their condition. The situation is even more dire when the sufferer is behind bars.

According to Milandari et al. (2023), adherence to treatment in hypertensive patients is a major aspect in the healing process. In order for the healing process to be realized, it certainly requires cooperation between hypertension sufferers and their families. Family support is one of the factors that determine the level of patient compliance in carrying out the treatment process, the more obedient the patient is in undergoing treatment, the more complications from the disease will be avoided.

One of the researchers being a nurse in the institution has observed some worthy of pondering incidents. While the hypertensive persons deprived of liberty receives support from the government, there seems to be a scarcity of supplies of the medication for hypertension. At times, the supplies come in late and much worst there is no available supplies. This where familial support comes in very importantly. With support from family or significant others, they can provide medications at their own expense and therefore compliance is continued. Further the family member or a significant other would be helpful in reminding them. However, this person is not always available, they can only do this during visits. Establishing this independent data on perceived familial support and adherence to medication is something that is unknown. By knowing these information, specific actions can be done to strengthen familial support and adherence to medication. Also, how personal characteristics influence familial support and adherence to medication as well as how familial support plays a role in adherence to medication is not known as well. These things serve as the research gap of the study. Being able to establish baseline information, on these gaps would allow the researcher to develop an adherence to medication enhancement plan. This way, these gaps will be addressed. The plan also serves to help not only hypertensive persons deprived of liberty but also the institution.

This research work will promote collaboration and implementation of specific activities that will awaken family members or significant others to take active role in the management of hypertensive persons deprived of liberty and play an active role in allowing hypertensive persons deprived of liberty to be strictly compliant with their medications. In the end, this study will be able to promote good health and well-being among hypertensive persons deprived of liberty. Thus, aligning to the third sustainable developmental goals.

Research Objectives

The main purpose of the study was to assess interrelationship among personal characteristics, perceived familial support, and medication adherence among hypertensive persons deprived of liberty in a City Jail in Mandaue City for the first quarter of 2025.

Specifically, the study answered the following queries:

1. What were the personal characteristics of the hypertensive persons deprived of liberty in terms of:

   1.1 age;
   1.2 marital status;
   1.3 educational attainment;
   1.4 years imprisoned;
   1.5 type of hypertension;
   1.6 number of years diagnosed with hypertension; and
   1.7 presence of co-morbidities?

2. What was the perceived familial support as perceived hypertensive persons deprived of liberty by the in terms of:

   2.1 emotional;
   2.2 recognition of familial strength; and
   2.3 cognitive?

3. What was the medication adherence among hypertensive persons deprived of liberty in terms of:

   3.1 positive attitude towards health care and medication;
   3.2 lack of discipline;
   3.3 aversion towards medication; and
   3.4 active coping with health problems?

4. Was there a significant relationship between

   4.1 personal characteristics and perceived familial support;
   4.2 personal characteristics and adherence to medication; and
   4.3 perceived familial support and adherence to medication?

5. What medication adherence enhancement plan was proposed based on the findings of the study?

Statement of Null Hypotheses

Ho1: There was no significant relationship between the personal characteristics and perceived familial support among hypertensive persons deprived of liberty.

Ho2: There was no significant relationship between the personal characteristics and medication adherence among hypertensive persons deprived of liberty.

Ho3: There was no significant relationship between the perceived familial support and medication adherence among hypertensive persons deprived of liberty.

REVIEW OF LITERATURE AND STUDIES

Perceived Familial Support. According to the study of Bhattarai et al. (2023), social support is considered vital for effective management of chronic conditions. It was found that majority of the individuals received moderate to high social support. Participants receiving high social support had a numerically lower proportion of controlled hypertension however not statistically significant. The proportion of good adherence to antihypertensives did not differ between the social support categories. There was no association in overall, family, friends, and significant other sub-scales of social support with controlled hypertension and adherence to antihypertensives. Also, in the

study of Harding et al. (2022), at baseline, the mean age of participants was 50 years and majority were men. During a median follow-up time of 6.9 years, over half of participants developed hypertension. A high level of functional social support was associated with lower risk of incident hypertension, compared with a low level of functional social support. Level of structural social support and satisfaction with social support were not associated with hypertension risk.

The study of Ma et al. (2024) revealed that the total score of physical literacy for young and middle-aged patients with hypertension ranged from 18 to 90, with a mean score of 62.30 ± 13.92, indicating a moderate level. There was a positive correlation between the physical literacy score and the scores of social supports, sense of coherence, and self-efficacy among young and middle-aged patients with hypertension. Furthermore, social support was found to have multiple mediating effects through sense of coherence and self-efficacy on physical literacy. The results of the study of Shen et al. (2022) suggested that the score for social support was positively correlated with the score for medication literacy. The results of CCA demonstrate that older adult patients with hypertension who had more subjective and objective support performed better in knowledge, skills and behavior literacy. Hierarchical linear regression indicated that two dimensions of subjective support and objective support in social support were found to be independent predictors of medication literacy. Social support is positively associated with medication literacy in older Chinese adult patients with hypertension. The study highlights the importance of social support in promoting medication literacy among older adult patients with hypertension.

Results in the study of Thuy et al. (2021) showed that increasing total network size was related to 52 percent higher odds of uncontrolled hypertension. Higher network sizes on the provision of information support related to advice, emotional support related to decisions, and practical support related to sickness were associated with lower odds of uncontrolled hypertension. Every additional 1 percent of the percentage of network members having hypertension decreased 2 percent the odds of uncontrolled hypertension. A 1 percent additional network members who were living in the same household was associated with a decrease of 0.08 point of behavioral adherence score. Meanwhile, a 1 percent increase of network members who were friends on the provision of practical support related to sickness and jobs was related to an increase of 0.10 point and 0.19 point of behavioral adherence score. The current study suggested that further interventions to improve hypertension management should address the potential effects of social network characteristics. In the study of Osamor (2015) most subjects reported receiving some social support from family members and approximately over half of the respondents reported receiving social support from friends. Social support from friends but not from family was significantly associated with good compliance with treatment for hypertension.

Adherence to Medication. In the study of De Tran et al. (2024) revealed that four behavioral factors were identified: negative emotions and beliefs about capabilities, beliefs about consequences, knowledge and skills, and social support. Factor one showed a strongest inverse association with medication adherence. Significantly higher Factor one scores were recorded in hypertensive patients with secondary school or lower education, income less than 4 million VND, who were currently smoking, self-reporting chest pain or discomfort, and of older age. In the study of Sharma et al. (2024) revealed that more than half of the study participants had moderate to high levels of medication adherence. Upon bivariate analysis, there was a significant association between presence of side effects, blood pressure status, forgetfulness, high cost, fear of taking medicine lifelong and irregular follow-up with a low level of adherence. Upon multivariate the logistic regression analysis, forgetfulness, high cost and fear of taking medicines lifelong were found to be associated factors of low level of adherence. There is an urgency to develop evidence-based strategies to improve the level of adherence to antihypertensive medications among patients with hypertension. Strategies like reminder messaging, setting alarms, expanding the scope of national health insurance and proper counselling to reduce fear could help to improve medication adherence. Hence, the feasibility and effectiveness of such intervention should be explored in future studies.

The study of Abdisa et al. (2022) revealed that the level of poor antihypetensive medication adherence was 63 percent. Patients who had no formal education, existing comorbid conditions, self-funded for medication cost, poor knowledge about hypertension (HTN) and its treatment, poor patient–physician relationship and unavailability of

medication showed significant association with poor medication adherence during the pandemic of COVID-19. The types of adherence groups were classified into two groups: an 'adherence group' and a 'non-adherence group'. Furthermore, age, living alone, and depressive symptoms were identified as determinants of medication adherence type among older hypertensive patients. The significant impact of sociodemographic status (age, living alone, and depressive symptoms) on medication adherence among older hypertensive patients indicates the need to establish more specific empirical interventions based on each type's characteristics. It is expected that this study will provide an in-depth understanding of factors associated with medication adherence among older patients with hypertension, which can support interventions tailored to the specific needs of those who are non-adherent (Lee et al., 2022). In the study of Turki et al. (2024) findings revealed that a low and moderate level of medication adherence has been observed in majority of the participants. Uncontrolled blood pressure was detected in majority of cases. Only few have a good level of knowledge about hypertension. Concerning Self-care practices, 48.8% of patients have inadequate practices of maintenance, almost half have inadequate practices of monitoring, and majority have inadequate practices of management. The self-efficacy for managing hypertension was weak in almost half of the participants. In multivariate analysis, low medication adherence was associated with the number of antihypertensive pills/day, side effects, uncontrolled hypertension, insufficient self-efficacy for managing hypertension, and insufficient self-care maintenance.

Medication adherence was good among a quarter of patients and moderate among over one third; over one third patients were nonadherent. Most patients had uncontrolled hypertension. Nearly half were unable to afford monthly medication. In bivariate analysis, nonadherence was associated with female sex and long waiting times in the health care facility; the presence of comorbidities was associated with good adherence. In multivariate analysis, nonadherence was associated with unaffordability of treatment and uncontrolled hypertension. Good adherence determinants included adequate counseling and education (Noreen et al., 2023). The random-effect meta-analysis showed that a pooled national antihypertensive medication adherence among hypertensive patients was 65.1 percent. The highest medications adherence was 83.5 percent occurring in the Somali Region with the lowest medication adherence being 58.5 percent in the Tigray Region. The meta-analysis suggested a significant increase in medication adherence among patients who had good knowledge of hypertension and 2.54 times increase in the odds among patients who had co-morbidities. This meta-analysis also revealed a 51 percent reduction of uncontrolled blood pressure among patients who adhered to an antihypertensive medication regimen. According to Hamrahian et al. (2022), medication adherence can significantly improve with a patient-centered approach, non-judgmental communication skills, and collaborative multidisciplinary management, including engagement of the patients in their care by self-blood pressure monitoring.

Personal Characteristics and Perceived Familial Support. In the study of Pan et al. (2021), it was found that over one third of patients were adherent with their antihypertensive treatments. Gender, duration of antihypertensive drug used, number of antihypertensive drugs used and social support were independently associated with hypertensive treatment adherence. Social support was strongly and positively associated with the hypertensive treatment adherence. Family social support was provided to hypertensive patients mainly through their nuclear family, that is spouses, partner or children. Treatment adherence of hypertensive patients was positively correlated to the three subgroups of social support. It was found that social support provided to patients from social resource had greater impact on treatment adherence than that from kinship and nuclear family. In the study of Savina et al. (2023) it revealed that among people living with HTN, 22.4 percent, 27.0 percent, 21.6 percent and 28.9 percent reported receiving low, medium, high and very high levels of social support respectively. Higher levels of social support were found in female adults, married adults, adults aged over 60, as well as those living in a household of 4 to 5 members and those receiving some or having completed primary education. Participants who received medium and very high levels of social support had two times the odds of receiving treatment for HTN as participants with low levels of support both in the last 12 months and the last 3 months. While, participants who had high level of social support had five times the odds of receiving treatment for HTN (both in the last 12 and 3 months) as participants with low levels of social support.

The study of Hosseini et al. (2021) revealed that the highest levels of perceived availability of informational,

tangible, emotional, and belonging support were significantly associated with the lowest mean level of systolic blood pressure (SBP) but not diastolic blood pressure, independent of known confounders and other support types. However, associations were small, and their directions were more consistent in women. The lowest levels of informational support, relative to the highest, were associated with higher odds of hypertension in women, more so than in men. The lowest levels of emotional support were similarly associated with the odds of hypertension in women, relative to the highest. Larger differences in mean SBP in women, compared with men, were seen for informational support and emotional support. Findings were unaltered by sensitivity analyses. The study of Hossain et al. (2025) revealed that over one third had grade-I and almost a quarter had grade-II uncontrolled hypertension. Most patients displayed moderate adherence, and few showed poor medication adherence. Certain patient subgroups had higher rates of poor adherence: females compared to males, rural residents compared to city-dwellers, and newly diagnosed patients compared to those diagnosed 2–5 years earlier. Multivariable analysis found a strong association between medication adherence and BP control. Compared to poor adherence, moderate adherence and good adherence were associated with better control. Increasing age, rural living, and uncontrolled hypertension were also linked. Comorbidities worsened BP control, and managing multiple medications contributed to poor adherence and grade-II hypertension in patients.

Also in the study of Thirunavukkarasu et al. (2022) revealed that more than one-third of the participants were in the high adherence category group, while the remaining majority of the participants were either low or medium adherence category. The binary logistic regression analysis revealed that low and medium adherence category is significantly associated with age, married participants, residing at village, and participants with monthly family income of 5000 to 7000 SAR. A negligible positive correlation was revealed between illness perception and medication adherence. The factors that were positively associated with adherence were health care system-related factors: good patient-health provider relationship, accessibility of health services, use of specialty clinics and programs for hypertension, and health insurance. The factors found to be negatively associated with adherence are (a) social economic factors: younger age, single civil status, low educational attainment, and unemployment; (b) patient-related factors: low in health literacy and awareness, knowledge on hypertension, attitude towards hypertension, self-efficacy, and social support; (c) therapy-related factors: inconsistent drug regimen schedule, use of Thiazide and complementary and alternative medicines; and (d) condition-related factors: low illness perception, and absence of comorbidities (Gutierrez & Sakulbumrungsil, 2021).

In the study of Asgedom et al. (2018) revealed that majority of the study participants were found to be adherent. More than half of the participants were males and the mean age of the participants was 55.0 ± 12.7 years. Co-morbidity, alcohol intake, getting medications freely, and combination of antihypertensive medications were inversely associated with antihypertensive medication adherence. The study of Abbas et al. (2024) revealed that the mean age 57.1 years, most were married, literate, and living with families, 63% were from Islamabad, and 78.9% were employed. The study found high adherence in behavior-related areas but low adherence due to costs. Gender showed a statistically significant correlation by independent t-test. At the same time, ANOVA tests revealed that educational level, monthly income, family support, and medication costs significantly impacted adherence, while factors like social status, employment status, and smoking did not have a considerable influence. The study of Teshome et al. (2017) revealed that three-quarters of the participants were found to be adherent to their medication therapy. The multivariable logistic regression analysis showed that urban residence (adjusted odd ratio, taking less than two drugs per day, and having knowledge about hypertension (HTN) and its treatment were positively and significantly associated with medication adherence, while age >60 years was negatively and significantly associated with good medication adherence.

The study of Vaingankar et al. (2020) revealed that being married was positively associated with perceived social support in people with and without mental disorders. Results of the SEM partially support mediation by mental state - perceived social support relationship by 'Married' status. The study of Almaghamsi and Alzahrani (2024) revealed high levels of perceived social support. A significant association between medication adherence and perceived social support was found, with moderate adherers having higher social support scores. Socio-demographic factors influencing adherence included marital status, education level, income, and occupation, with significant associations

for each. Married participants and those with higher education and income levels had greater adherence. Government employees showed the highest moderate adherence while the unemployed and homemakers had lower adherence. No significant associations were found between gender or age and adherence.

Familial Support and Adherence to Medication. Tahe study of Zhou et al (2024) revealed that a good level of knowledge, belief, and behavior and adequate social support were facilitators of medication adherence in hypertensive patients. In contrast, lack of medication literacy, difficulty adapting to roles, reduced sense of benefit from treatment, limited access to healthcare resources, and unintentional nonadherence were barriers. Medication adherence in hypertensive patients remains a challenge to be addressed. The study of Jiang et al. (2024) revealed that there was a direct and significantly positive association between social support and medication adherence. Moreover, increased levels of stigma and depression were both associated with a decline in medication adherence. Bootstrapping analysis revealed that the association between social support and medication adherence operated indirectly through stigma. Additionally, social support was indirectly associated with medication adherence through depression. Further analysis indicated that social support had an indirect association with medication adherence through both stigma and depression.

The review of Shahin et al. (2021) revealed statistically significant positive associations between medication adherence and social support were found in nine studies. The review evaluated the impact of social support on medication adherence and highlighted gaps in the literature regarding the impact of social support on adherence. Family members or peer support may promote better adherence in some patient groups. The participants included over one third patients with a low degree of medication adherence and over half patients with a medium/high degree of adherence. Social support directly influenced adherence and indirectly influenced adherence through health literacy. Health literacy directly influenced adherence. Education indirectly affected adherence through both social support and health literacy. Moreover, there was a sequential mediating effect of social support and health literacy on the association between education and adherence. After controlling for age and marital status, similar results were also obtained, indicating a good model fit (Guo et al., 2023). The association between social support and medication adherence and possible mediating effects of mental distress and self-efficacy were tested by structural equation model, with significant demographic and disease-related factors adjusted. The respondents showed a very low level of medication adherence. The level of social support was positively associated with medication adherence, and such association was fully mediated by two indirect pathways: through self-efficacy and through mental distress and then self-efficacy (Yu et al., 2024).

RESEARCH METHODOLOGY

Design. The quantitative research made use of the descriptive, correlational research design. In application to the study, the descriptive design was used in determining the personal characteristics, perceived familial support, and adherence to medication. The correlational design was used to assess the relationship among personal characteristics, perceived familial support, and adherence to medication.

Environment. The study was conducted in a City Jail in Mandaue City. In January 1993 mandaue city jail male dormitory was turned over to DILG – BJMP. It is situated in Brgy. Basak Mandaue City, Cebu. During pandemic the facility was opened on May 7, 2020 as a 150-bed isolation facility Ligtas COVID Center in Cebu province. The facility can further accommodate up to 280 patients. On September 2023, the former warder instructed the health service unit in coordination with the intelligence unit to transfer the all PDL from the old facility to our current facility by batch. Currently housing a total jail population of 1,571 PDL, has a total strength of 105 personnel, with four functioning jail nurses/jail officers, has 28 cells in total and 1 TB isolation cell.

Respondents. Participants of the study were the diagnosed hypertensive persons deprived of liberty in the institution. Currently, there were 115 hypertensive persons deprived of liberty in the institution.

Sampling Design. There was no sampling as a complete enumeration was utilized. By complete enumeration, all those who qualified based on the inclusion and exclusion criteria were invited to participate in the study.

Inclusion Criteria. Included in the study were hypertensive persons deprived of liberty. They should be diagnosed by a physician to be suffering from any type of hypertension regardless of age, religion, marital status, educational attainment, type of hypertension, length of imprisonment and number of years diagnosed with hypertension. Lastly, they should be willing to give voluntary consent to participate in the study.

Exclusion Criteria. Excluded from the study were those not clinically or medically diagnosed hypertensives. They had to be diagnosed at least for six months already.

Instruments. The study made use of a three-part instrument. Part one of the instrument pertained to the personal characteristics of the hypertensive person deprived of liberty. Part two of the instrument was the Iceland-Family Perceived Support Questionnaire (ICE-FPSQ) as developed by Edi et al. (2012). It is a 21-item instrument which can be answered using a five-point Likert-type scale ranging from 1 (almost never) to 5 (all of the time). Parametric score and interpretation: A score of 1.00 – 1.80 is very low, 1.81 – 2.60 is low, 2.61 – 3.40 is fair, 3.41 – 4.20 is high, and 4.21 – 5.00 is very high.

Reliability. The 21 items ICE-FPSQ instrument (Svavarsdottir & Sveinbjarnardottir, 2009) had a total Cronbach's alpha coefficient of $\alpha = .959$ and 3 factors emerging: emotional support ($\alpha = .925$), recognition of families' strengths ($\alpha = .926$), and cognitive support ($\alpha = .841$). In study two the two factor 14 items ICE-FPSQ instrument had Cronbach's alpha coefficient for the total scale of $\alpha = .953$; for the cognitive support factor, the Cronbach's alpha coefficient was $\alpha = .874$, and for the emotional support factor, the Cronbach's alpha coefficient alpha was $\alpha = .937$. In study three the Cronbach's alpha coefficients were as following: for total instrument: $\alpha = .961$; cognitive subscale: $\alpha = .881$ and emotional subscale: $\alpha = .952$.

Part three of the instrument was the Adherence in Hypertension Questionnaire Short Version: Maastricht Utrecht Adherence in Hypertension short version (MUAH-16) developed by Cabral et al. (2018). It is 16-tem questionnaire answered using a seven-point Likert scale where 1 is totally agree and 7 is totally disagree. It is composed of four dimensions with four items each, namely: positive attitude towards health care and medication, lack of discipline (reversely interpreted), aversion towards medication (reversely interpreted), and active coping with health problems.

Reliability. The MUAH-16 presents a lower internal consistency than the original version8 (Cronbach α for MUAH-16 subscales I, II, III, and IV: 0.53, 0.36, 0.59, and 0.51, respectively; Cronbach α for MUAH subscales I, II, III, and IV: 0.75, 0.80, 0.63, and 0.76, respectively). This limitation was expected as a result of the reduction of the number of items for each subscale. Another limitation of this analysis was the impact of test length on the Cronbach α value (Tavakol & Dennick, 2011; Schmith, 1996; Dunn et al., 2014) In shorter scales, measures of unidimensionality, as factor analysis, are equally important to Cronbach α for homogeneity assessment of the instrument. Indeed, internal consistency is a necessary but insufficient condition for measuring homogeneity in a sample of test items (Tavakol & Dennick, 2011). Thus, by reducing the number of items in each subscale to four, a reduction in α values was expected. Nevertheless, the evaluation of confirmatory factor analysis for both models shows that MUAH-16 is a better fit than the original. This finding suggests that MUAH-16 better represents each adherence dimension. The entire instrument was converted to Cebuano for respondents to better respond to the questions being asked.

Data Gathering Procedures. Letters of transmittal were prepared in order to seek clearance from the Dean of the College of Allied Health Sciences as well as the Administrator of the institution where the study was carried out. A panel of experts were present at the design hearing that was conducted for the study. The next phase was the processing of the ethical approval. This signified the beginning of the recruitment process for the first respondent once a notice to proceed had been issued. Given that the individuals who were responding to the questions were the hypertensive persons deprived of liberty and since the researcher worked in the same institution, the researcher personally distributed the questionnaires by face-to-face intercept method. The answering took place in an area where they had privacy. After they had completed the questionnaire, they had to indorsed it right away to the researcher. As soon as the questionnaires were sent back, they were examined to ensure that they were complete.

When a questionnaire was incompletely filled-out, it was returned to the respondent for completion. Until all of the respondents had been recruited, this procedure was performed repeatedly. Following the collection of data, gathered data were compiled in Excel format, and then it was sent to the statistician so that it can be subjected to statistical analysis. Tables were used to present the data, along with interpretations, implications, and supporting literature and studies. The study was presented for a final defense. All of the questionnaires that had been filled out were destroyed or shredded at the end of the study.

Statistical Treatment of Data. The following descriptive and inferential statistics were used to treat the data: (a) Frequency Distribution and Simple Percentage were used to determine the personal characteristics of the respondents in terms of age, marital status, educational attainment, years imprisoned, type of hypertension, number of years diagnosed with hypertension, and co-morbidities; (b) Mean score and Standard Deviation **w**ere used to determine the perceived familial support and the adherence to medication; (c) Chi Square with Cramer's V were used to assess the significant relationship between personal characteristics and perceived familial support and personal characteristics and adherence to medication. The Cramer's V was used to assess the strength of association should there be a significant relationship among variables; and (d) Pearson r was used to assess whether perceived familial support was significantly correlated with adherence to medication.

Ethical Considerations. The ethical committees of both the university and the institution were consulted regarding the research project that was conducted. A request for ethical permission was made before the beginning of the data collection process in order to guarantee that the respondents' well-being were safeguarded appropriately.

Presentation, Analysis, And Interpretation Of Data

Table 1 Personal Characteristics of the Hypertensive Persons Deprived of Liberty

6	*f*	*%*
Age		
18 to 35 years old	16	13.90
36 to 55 years od	82	71.30
56 years old and above	17	14.80
Marital Status		
Single	72	62.60
Married	37	32.20
Separated	5	4.30
Widowed	1	.90
Educational Attainment		
Elementary Level	31	27.00
Elementary Graduate	9	7.80
High School Level	19	16.50
High School Graduate	21	18.30
Vocational	5	4.30
College Level	20	17.40
College Graduate	10	8.70

Years Imprisoned		
1 to 3 years	89	77.40
4 to 6 years	15	13.00
7 to 9 years	3	2.60
10 years and above	8	7.00
Type of Hypertension		
Primary	96	83.48
Secondary	19	16.52
Number of Years Diagnosed with Hypertension		
1 to 3 years	80	69.60
4 to 6 years	23	20.00
7 to 9 years	4	3.50
10 years and above	8	7.00
Co-morbidities		
None	96	83.50
Diabetes Type II	3	2.60
Chronic Kidney Disease	6	5.20
Diabetes Type II uncontrolled, CKD	8	7.00
Others (Diabetes Type II uncontrolled, Hypertensive CVD, CKD and Heart Enlargement)	2	1.70

Note: *n=115.*

The table shows that majority of the respondents were aged 36 to 55 years old, few of them were aged 18 to 35 years old as well as a few of them were 56 years old and above. Over half of them were singles while over one third were married and very few were separated and a single respondent was widowed. Over a quarter of the respondents had an educational qualification at the elementary level. Few were college level, high school level, and high school graduates while very few were distributed to being college graduates, elementary graduate, and graduates of vocational courses.

Majority of the respondents had been imprisoned for one to three years while few were imprisoned for four to six years. Also, very few of the respondents were imprisoned for ten years and above and seven to nine years. Majority of the respondents had a primary hypertension while few had secondary hypertension. Majority of the respondents had been diagnosed with hypertension for one to three years while almost quarter were diagnosed for four to six years. Very few had been diagnosed with hypertension for ten years and above as well as seven to nine years. Majority of the respondents did not have any co-morbidities. Few had Diabetes type II, Chronic Kidney Disease (CKD), and Diabetes type II uncontrolled CKD and very few had a co-morbidity which is a combination of Diabetes Type II uncontrolled, Hypertensive CVD, CKD and Heart Enlargement. These co-morbidities were also recorded and known during their regular check-ups.

The demographics of hypertension (high blood pressure) are affected by a variety of characteristics, including age, gender, race or ethnicity, education level, and socioeconomic situation. The prevalence of this condition is higher

in males, older adults, and members of specific racial and ethnic groups, such as non-Hispanic Black people. As one gets older, the likelihood of developing hypertension rises considerably. Contrary to popular belief, the frequency of hypertension is higher among males than among women; however, this disparity tends to narrow as people get older. When compared to other racial and ethnic groups, such as non-Hispanic white, non-Hispanic Asian, or Hispanic individuals, the prevalence of hypertension on the part of non-Hispanic Black adults is significantly higher. Several studies have demonstrated a correlation between a lower socioeconomic status, which includes lower levels of education, and the prevalence of hypertension.

According to World Health Organization (2023), an estimated 1.28 billion adults aged 30–79 years worldwide have hypertension, most (two-thirds) living in low- and middle-income countries. An estimated 46 percent of adults with hypertension are unaware that they have the condition. Less than half of adults with hypertension are diagnosed and treated. Approximately 1 in 5 adults with hypertension have it under control. Hypertension is a major cause of premature death worldwide. Hypertension (high blood pressure) is when the pressure in your blood vessels is too high (140/90 mmHg or higher). It is common but can be serious if not treated. People with high blood pressure may not feel symptoms. The only way to know is to get your blood pressure checked. Things that increase the risk of having high blood pressure include: older age, genetics, being overweight or obese, not being physically active, high-salt diet, and drinking too much alcohol.

Table 2 Perceived Familial Support among Hypertensive Persons Deprived of Liberty

Dimensions	Mean score	SD	Interpretation
Emotional	3.08	.880	Fair
Recognition of families' strengths	3.74	0.958	High
Cognitive	3.79	1.027	High
Grand mean	3.54	0.771	High

Note: *n=115.*

Legend: A score of 1.00 – 1.80 is very low (almost never), 1.81 – 2.60 is low (rarely), 2.61 – 3.40 is fair (sometimes), 3.41 – 4.20 is high (often), and 4.21 – 5.00 is very high (all the time).

Overall, the perceived familial support was high. High levels of perceived familial support among hypertensives typically indicate that people who have high blood pressure have a stronger sense of having a social network that is supportive of them. Having solid relationships, having the sense that one is valued, and having access to resources and assistance are all examples of this. In addition to better control of blood pressure, increased adherence to therapy, and maybe reduced risks of hypertensive consequences, it is associated with these two outcomes. Supporting this finding, according to the study of Bhattarai et al. (2023), familial support is considered vital for effective management of chronic conditions. It was found that majority of the individuals received moderate to high familial support. Participants receiving high social support had a numerically lower proportion of controlled hypertension however not statistically significant.

In terms of the emotional aspects of family support, this was rated as fair. The respondents believed that the healthcare professionals in the institution often helped family members to draw forth our strengths and resources to support one another and often helped family members recognize that their emotional response was valid and helped them to validate and/or normalize family members' emotional response. Additionally, they often created trust for the open expression of family members' fears, anger, and sadness about their illness experience. However, they believed that healthcare professionals in the institution sometimes encouraged their family to become involved with the healthcare team in the care of their family member and have offered them caregiver support, sometimes encouraged family members to listen to each other's concern and feelings, and sometimes helped family members

understand how their emotional response was related to the family member's illness. Also, the believed that healthcare professionals in the institution sometimes encouraged their family to take a respite from caregiving, sometimes encouraged family members to share their illness narratives—not only stories of illnesses and suffering, but also stories of strength and resilience, sometimes offered them family meetings, and sometimes had been open-minded when their family decided not to use recommendations or education that professionals provided, and then the nurses were curious about what did not fit for their family. Lastly, they believed that the healthcare professionals in the institution rarely emphasized the use of family rituals to promote family members' health. This finding implies that because in order for individuals who have hypertension to have fair emotional support from their families, it is necessary for their families to provide them with understanding, encouragement, and validation, which assists them in coping with the disease. It is essential to have this support in order to effectively manage hypertension since it can result in improved self-care behaviors, medication adherence, and overall improvements in health outcomes. Results in the study of Thuy et al. (2021), higher network sizes on the provision of information support related to advice, emotional support related to decisions, and practical support related to sickness were associated with lower odds of uncontrolled hypertension.

In terms of recognition of families' strengths, the rated this as high. They believed that the healthcare professionals in the institution were often aware of the impact family members can have on one another, on the patient's wellbeing, and on the illness itself, often committed to their family, often drawn out their family strengths and often offered them information and their professional opinion. Moreover, they believed that the healthcare professionals in the institution often commended on their family and individual strengths often looked for the family's strengths and opportunities to commend family members when their strengths have been revealed. In the case of persons who have hypertension, having a high recognition of family strengths indicates that the individual and their family members recognize and make use of the good aspects of their family interactions and dynamics in order to promote the individual's health and well-being. This includes acknowledging and appreciating the family's abilities to provide support, understanding, and collaboration in the management of the condition. Also, in the study of Harding et al. (2022), a high level of functional social support was associated with lower risk of incident hypertension, compared with a low level of functional social support. Level of structural social support and satisfaction with social support were not associated with hypertension risk.

In terms of the cognitive support, this was rated as high. The respondents believed that the healthcare professionals in the institution often provided ideas, information and thoughts in a manner that enabled them to learn from them and reflect on them, they often provided accessible and easy-to-read literature about the health problem, they often looked for reactions and beliefs in my family after we tried new professional resources, and often informed their families about the resources available in the community that have proven to be helpful for families in similar situations. When an individual with hypertension has high cognitive familial support, it indicates that members of the individual's family are actively involved in supporting the individual's mental and emotional well-being, as well as their knowledge of treatment plans and their adherence to them. There is a correlation between this kind of support and improved control of blood pressure as well as better overall health outcomes for people who have hypertension. In the study of Osamor (2015) most subjects reported receiving some social support from family members and approximately over half of the respondents reported receiving social support from friends. Social support from friends but not from family was significantly associated with good compliance with treatment for hypertension. Familial support is important among hypertensive persons deprived of liberty as this can greatly encourage them to take active role in managing their illness. By showing high levels of familial support, they can feel that they are being supported and loved.

Table 3 Adherence to Medication among Hypertensive Persons Deprived of Liberty

Dimensions	Mean score	SD	Interpretation
Positive attitude towards health care and medication	5.34	1.531	Highly adherent
Lack of discipline	2.50	1.332	Highly non-adherent

Aversion towards medication	2.86	1.549	Not Adherent
Active coping with health problems	5.68	1.389	Highly adherent
Grand mean	4.10	.397	Moderately adherent

Note: *n=115.* Legend: A score of 1.00-1.86 – very highly non-adherent (totally disagree), 1.87-2.72 – highly non-adherent (disagree), 2.73-3.58 – not adherent (partially disagree), 3.59-4.44 – moderate adherence (neither agree nor disagree), 4.45-5.30 – adherent (partially agree), 5.31-6.16 – highly adherent (agree), 6.17-7.00 – very highly adherent (totally agree).

Overall, the respondents were moderately adherent to medication. This indicates that the patient fairly adheres to their recommended medication regimen on a consistent basis, which includes taking the appropriate dosage, frequency, and timing of medication as directed by their physician. It is essential for getting the desired therapeutic benefits of treatment and indicates a high degree of compliance with the prescribed treatment schedule. Supporting this finding, in the study of Sharma et al. (2024) revealed that more than half of the study participants had moderate to high levels of medication adherence.

In terms of having a positive attitude towards health care and medication, respondents were highly adherent. They agreed that they felt better taking medication every day and that if they take their medication every day, they felt confident that their blood pressure is under control. However, they neither agree nor disagree that the pros of taking medication weigh up against the cons and that they think they contributed to the improvement of their blood pressure when they take their medication every day. When a person has a high positive attitude regarding healthcare and medication, it typically indicates that they have faith in the efficacy of their prescriptions and trust in the healthcare system. Increased adherence to treatment programs, potential reductions in adverse effects, and overall improvements in health outcomes are all possible outcomes that can result from this. Contrary to the findings, the study of Abdisa et al. (2022) revealed that the level of poor antihypertensive medication adherence was 63 percent.

In terms of lack of discipline, they were highly non-adherent. The respondents did not lack the discipline as they disagreed that they were not sure whether they have taken their tablets, they disagreed that they had a busy life; that is why they sometimes forget to take their medication, they disagreed that during holidays or weekends they sometimes forget to take their medication, and they disagreed that they found it hard to stick to their daily regimen of medication taking. It can be deduced from this that the respondents do not lack the discipline necessary to take their medications. Regardless of the circumstances, they make it a point to take their medications as prescribed. According to Hamrahian et al. (2022), medication adherence can significantly improve with a patient-centered approach, non-judgmental communication skills, and collaborative multidisciplinary management, including engagement of the patients in their care by self-blood pressure monitoring.

In terms of aversion towards medication, the respondents were non-adherent. They did not avert the taking of medications as they disagreed that when their blood pressure is under control during their medical checkups, they wanted to take less medication and that they disagree that they were afraid of side effects. However, they partially disagreed that they dislike taking medication every day and they thought it was not healthy for their body to take medication every day. It is clear from this that they believed the medications would be of significant assistance to them in maintaining control of their blood pressure. And that they make it a point to take their medications as prescribed, regardless of the circumstances whatsoever. Contrary to the findings, in the study of Turki et al. (2024) findings revealed that a low and moderate level of medication adherence has been observed in majority of the participants. Uncontrolled blood pressure was detected in majority of cases. Only few have a good level of knowledge about hypertension. Concerning self-care practices, almost half of patients have inadequate practices of maintenance, almost half have inadequate practices of monitoring, and majority have inadequate practices of management.

In terms of active coping with health problems, respondents were highly adherent. They agreed that they took special

care to do enough exercise to reduce the risk of getting cardiovascular diseases, they ate less fat in order to avoid cardiovascular diseases, they ate less salt in order to avoid cardiovascular diseases, and they gathered information about possibilities to solve health problems. This implies that the respondents are indeed resilient, they tried to cope with their illness despite their condition of being deprived of liberty. They make sure to use of available resources and take the initiative to cope with their condition. Contrary to the findings, in the study of Savina et al. (2023) it revealed that among people living with HTN, reported receiving low, medium, high and very high levels of social support respectively. Higher levels of social support were found in female adults, married adults, adults aged over 60, as well as those living in a household of 4 to 5 members and those receiving some or having completed primary education. Participants who received medium and very high levels of social support had two times the odds of receiving treatment for HTN as participants with low levels of support both in the last 12 months and the last 3 months. While, participants who had high level of social support had five times the odds of receiving treatment for HTN (both in the last 12 and 3 months) as participants with low levels of social support. Following the instructions for taking prescribed medications is essential for maintaining good health since it guarantees that the treatments will work as intended, stops the course of the disease, and improves overall health results. Noncompliance might result in deterioration of conditions, a rise in expenses, and even result in death.

Table 4 Relationship between Personal Characteristics and Perceived Familial Support

Variables	chi value	*p* value	Cramer's V value	Decision	Interpretation
Age	1.779E2	.572	--	Failed to reject Ho	Not significant
Marital status	3.187E2	.030	.961	Reject Ho	Significant
Educational attainment	5.635E2	.293	--	Failed to reject Ho	Not significant
Years imprisoned	2.956E2	.166	--	Failed to reject Ho	Not significant
Type of hypertension	95.163	.382	--	Failed to reject Ho	Not significant
Number of years diagnosed with hypertension	3.059E2	.083	--	Failed to reject Ho	Not significant
Presence of co-morbidities	3.705E2	.8396	--	Failed to reject Ho	Not significant

Legend: Significant if *p* value is < .05. Dependent variable: Perceived Familial Support. Cramer's V values: A value of >0.25 is very strong, >0.15 is strong, >0.10 is moderate, >0.05 is weak, and >0 is no association.

The table shows that *p* value for marital status was lesser than the significant value of .05. This value was interpreted as significant which led to the decision of rejecting the null hypothesis. Thus, marital status was significantly correlated with perceived familial support. There is a higher level of perceived familial support as the person is married. The correlation was very strong. There is a substantial correlation between the marital status of individuals with hypertension and their perceptions of the social support they receive. Individuals who are married have a tendency to report higher levels of perceived social support in comparison to those who are not married. This indicates that marriage has the ability to serve as a source of both structural and social support, which may result in improved health outcomes, including improved control of hypertension.

The perception of social support is substantially impacted by a person's marital status. It has been demonstrated time and again via research that married people have a tendency to have higher levels of perceived social support in comparison to their counterparts who are not married. This distinction is frequently attributed to the one-of-a-kind social relationships and support systems that marriage has the potential to create. Supporting this finding, the study of Vaingankar et al. (2020) revealed that being married was positively associated with perceived social support in people with and without mental disorders. Results of the SEM partially support mediation by mental state - perceived social support relationship by 'Married' status.

However, the table shows *p* values which were greater than the significant value of .05. This means that the personal characteristics of age, educational attainment, years imprisoned, type of hypertension, number of years diagnosed with hypertension, and presence of co-morbidities were not correlated with perceived familial support. These led to the decision of failing to reject the null hypothesis. The personal characteristics do not influence perceived familial support. There can still be a high perceived familial support no matter what age, educational attainment, years imprisoned, type of hypertension, number of years diagnosed with hypertension, and presence of co-morbidities. Contrary to the findings, in the study of Pan et al. (2021), gender, duration of antihypertensive drug used, number of antihypertensive drugs used and social support were independently associated with hypertensive treatment adherence. In the study of Savina et al. (2023) it revealed that higher levels of social support were found in female adults, married adults, adults aged over 60, as well as those living in a household of 4 to 5 members and those receiving some or having completed primary education. Individuals who are deprived of their liberty have a significant requirement for social assistance, regardless of whether or not it is connected to the adherence to medication. They require assistance from family, friends, relatives, or significant others because of the fact that they are incarcerated. This support can come from any of these sources.

Table 5 Relationship between Personal Characteristics and Adherence to Medication

Variables	chi value	*p* value	Cramer's V value	Decision	Interpretation
Age	97.905	.700	--	Failed to reject Ho	Not significant
Marital status	1.418E2	.833	--	Failed to reject Ho	Not significant
Educational attainment	2.991E2	.770	--	Failed to reject Ho	Not significant
Years imprisoned	1.600E2	.462	--	Failed to reject Ho	Not significant
Type of hypertension	39.985	.906	--	Failed to reject Ho	Not significant
Number of years diagnosed with hypertension	1.646E2	.365	--	Failed to reject Ho	Not significant
Presence of co-morbidities	1.780E2	.957	--	Failed to reject Ho	Not significant

Legend: Significant if *p* value is < .05. Dependent variable: Adherence to Medication. Cramer's V values: A value of >0.25 is very strong, >0.15 is strong, >0.10 is moderate, >0.05 is weak, and >0 is no association.

The table reflect *p* values which were greater than the significant value of .05. This means that the personal characteristics of age, marital status, educational attainment, years imprisoned, type of hypertension, number of years diagnosed with hypertension, and presence of co-morbidities were not correlated with adherence to medication. These led to the decision of failing to reject the null hypothesis. The personal characteristics don not influence adherence to medication. There can still be a high adherence to medication no matter what age, marital status, educational attainment, years imprisoned, type of hypertension, number of years diagnosed with hypertension, and presence of co-morbidities.

Contrary to the findings, certainly, demographic characteristics, particularly socioeconomic status and education level, have the potential to influence the degree to which hypertensive persons adhere to their drug regimens. In addition to factors such as age, race, and occupation, more income and education are frequently related with improved medication adherence. Other factors that may play a role include other considerations. Contrary to the findings, the study of Almaghamsi and Alzahrani (2024) revealed socio-demographic factors influencing adherence included marital status, education level, income, and occupation, with significant associations for each. Married participants and those with higher education and income levels had greater adherence.

However, the respondents of the study are persons deprived of liberty. Somehow, being deprived of liberty can pose

positive consequences that while being hypertensives, they can easily be monitored and programs can be implemented since they are confined. This could be the reason behind why their demographic characteristics did not influence at all their adherence to medication because there can still be a high adherence to medication no matter what their demographic profile since they are confined. No matter what the demographic characteristics of the persons deprived of liberty, it is imperative that there should be high adherence of medication. Patients with hypertension who take their medicine as prescribed are more likely to have better control of their blood pressure, which in turn lowers the risk of cardiovascular events and improves their overall health outcomes. In addition to this, it helps to reduce the likelihood of death and morbidity that are consequent to cardiovascular disorders.

Table 6 Relationship between Perceived Familial Support and Adherence to Medication

Variables	r value	*p* value	Decision	Interpretation
Perceived Familial Support vs. Adherence to Medication	.788	.000	Reject Ho	Significant

Legend: Significant if *p* value is < .05. Dependent variable: Adherence to Medication. Pearson r interpretation: A value greater than .5 is strong (positive), between .3 and .5 is moderate (positive), between 0 and .3 is weak (positive), 0 is none, between 0 and –.3 is weak (negative), between –.3 and –.5 is moderate (negative), and less than –.5 is strong (negative).

The table shows that *p* value for correlation between perceived familial support and adherence to medication was lesser than the significant value of .05. This value was interpreted as significant which led to the decision of rejecting the null hypothesis. Thus, perceived familial support was significantly correlated with adherence to medication. The correlation was strong and positive. The higher the perceived familial support, the higher the adherence to medication. This finding implies that the degree to which individuals with hypertension adhere to their medication regimen is substantially impacted by social support, particularly that which comes from family and friends. Patients who are provided with sufficient social support, which may include emotional, informational, and instrumental assistance, are more likely to stick to the pharmaceutical regimens that they have been prescribed. This good influence is the result of a number of different variables, such as encouragement, monitoring of health, and help in the management of the disease. Supporting the findings, the study of Almaghamsi and Alzahrani (2024) revealed a significant association between medication adherence and perceived social support was found, with moderate adherers having higher social support scores.

Also, the study of Pan et al. (2021) revealed that social support was strongly and positively associated with the hypertensive treatment adherence. Family social support was provided to hypertensive patients mainly through their nuclear family, that is spouses, partner or children. Treatment adherence of hypertensive patients was positively correlated to the three subgroups of social support. It was found that social support provided to patients from social resource had greater impact on treatment adherence than that from kinship and nuclear family. Contrary to the findings, in the study of Bhattarai et al. (2023), there was no association in overall, family, friends, and significant other sub-scales of social support with controlled hypertension and adherence to antihypertensives. Both social support and adherence to medication among hypertensive persons deprived of liberty are equally important in the management of their hypertension. These should be equally achieved to gain positive outcomes.

CONCLUSION AND RECOMMENDATIONS

Conclusion. In conclusion, adherence to medication is influenced by perceived social support. The higher the perceived social support, the higher the adherence to medication. Moreover, marital status influences perceived social support. As the person becomes married, the higher the perceived social support. Lastly, personal characteristics do not influence adherence to medication. Adherence to medication can still be high no matter what the personal characteristics of the person. According to the Health Belief Model, the findings on adherence to medication is reflective of the hypertensive persons deprived of liberty having appreciated their perceived

susceptibility, perceived threat, perceived benefits as well as the perceived barriers and appreciation of all these things could also be brought about by the high levels of perceived familial support as explained by the Buffering Theory on Social Support with the respondents receiving sufficient emotional, recognition of familial strength, and cognitive support. To address the findings of the study, a medication adherence plan is proposed.

Recommendations. Based on the findings of the study, the following recommendations are given:

Practice. Initially, the study findings will be discussed with the appropriate stakeholders, including the administrators, local government units and regulating agencies. Following this, the medication adherence enhancement plan will be recommended for use in the city jail. Other city jails may also adopt the said enhancement plan as they deem it appropriate to their organization.

Education. The study findings paved way to being able to provide new insights or knowledge about persons deprived of liberty suffering from hypertension on how familial support plays a role in adherence to their medications, as individual variables and as correlated variables. This will greatly help in the discussion of management of hypertension among special groups such as the persons deprived of liberty. Also, the study can also serve as a generic paper that can be utilized in discussing research methodology along with the statistical treatment of data and ethics in research.

Policy. This may call for the development or crafting of policies among local government units and regulating agencies like the Department of Health in relation to persons deprived of liberty suffering from hypertension to ascertain the provision of medicines or supplies to these group of individuals. This may also bring about internal policies in the city jail itself to advocate for familial support as it influences adherence to medication.

Research. The study will be submitted for publication in any local or international refereed journal. It will also be submitted for either oral or poster presentation in any local or international research congress. Having yielded new research gaps, the following study titles are also recommended for future research studies, to wit:

1. A study in perceived familial support and adherence to medication on all medical conditions in the city jail;
2. A mixed method analysis on the perceived familial support and adherence to medication among hypertensive persons deprived of liberty; and
3. An exploration on the lived experiences on familial support and adherence to medications among persons deprived of liberty suffering from illnesses.

Medication Adherence Enhancement Plan

Rationale

When it comes to the management of hypertension and the prevention of major cardiovascular consequences, regular adherence to antihypertensive medication is absolutely necessary. Insufficient adherence is associated with an increased risk of cardiovascular events such as heart attacks, strokes, and other strokes. To achieve optimal control of blood pressure and to lessen the likelihood of developing long-term health issues, adherence is essential. Moreover, it is essential for people who have hypertension to have social support because it can have a substantial impact on their ability to manage their illness, adhere to treatment plans, and deal with the emotional and psychological issues that come along with living with a chronic disease. There is a correlation between having strong social networks and having a buffer against stress, improved self-efficacy, and increased adherence to healthy activities. Findings of the study revealed that the perceived familial support was high with emotional aspects of family support being fair and recognition of families' strengths and cognitive being high and the adherence to medication being moderate with having a positive attitude towards health care and medication, lack of discipline, and active coping with health problems being high while aversion towards medication being adherent. Thus, the creation of this medication adherence enhancement plan.

General Objectives

This medication adherence enhancement plan is primarily established to provide improvements in both the perceived social support and adherence to medication among hypertensive persons deprived of liberty.

Specific Objectives

Specifically, this plan aims to achieve the following:

a. To further improve the perceived familial support from high to very high;
b. To improve the emotional aspect of familial support from fair to very high;
c. To further improve the recognition of families' strengths and cognitive from high to very high;
d. To further improve the adherence to medication from high to very high;
e. To further improve the having a positive attitude towards health care and medication, lack of discipline, and active coping with health problems being from high to very high; and
f. To improve aversion towards medication from being adherent to very high adherence.

Concerns	Specific Objectives	Activities	Persons Responsible	Resources	Time Frame	Success Indicators
The perceived familial support was high with emotional aspects of family support being fair and recognition of families' strengths and cognitive being high.	. To further improve the perceived familial support from high to very high. . To improve the emotional aspect of familial support from fair to very high. . To further improve the recognition of families' strengths and cognitive from high	**Personally-initiated activities:** · Maintain communication with family member, friends, relatives, and significant others. **Institution-initiated activities:** · Conduct "Family Day" quarterly. · Conduct a seminar on Importance of Social Support to include family, friends, relatives, and significant others. · Enable regular family communication . Improve supply chains by	· Persons deprived of liberty. · Families, Significant other, friends and relatives of the persons deprived of liberty. · Healthcare professionals of the institution (Physician, nurses, etc.) · Non-healthcare professional staffs of the institution. · Heads of the Institution · Administrators of the institution	· Social media platforms. · Internet connectivity. · Desktop · Budget for family day (Php 20,000.00) and seminar (Php 10,000.00) · Instrument to assess perceived familial support.	3rd quarter of 2025 onwards	· Constant communication. · Celebration of Family Day and approved dates and budget. · Certificate of participation in the seminar. · Family Day attendance report. · Re-assessment result – very high perceived familial support in all dimensions.

	to very high.	coordinating with LGU. · Establish family-based health education. · Guarded access to internet solely for connectivity with family, friends, relatives, or significant others only/ · Remind families, relatives, friends, and significant others about the visiting days and hours. · Re-assess perceived social support six months following the implementation of this plan using the same instrument.				
The adherence to medication being moderate with having a positive attitude towards health care and medication, lack of discipline, and active coping with	. To improve the adherence to medication from moderate to very high. . To further improve the having a positive attitude towards health care and medication, lack of	**Personally-initiated activities:** · Secure a pill box with days of schedule of drinking a maintenance medication. · Keep a diary of medication intake. **Institution-initiated activities:** · Conduct health education among	· Persons deprived of liberty. · Families, Significant other, friends and relatives of the persons deprived of liberty. · Local Government Units and Department of Health · Healthcare professionals of the institution (Physician, nurses, etc.) · Non-healthcare	· Budget for the Celebration of Hypertension Awareness Day · Health education visual aides. · BP Monitoring Sheets. · Leaflet. · Memorandum of Understanding (MOU) · Instrument to assess adherence to medication.	3rd quarter of 2025 onwards	· Certificate of participation in the health education. · Monitoring of BP records. · Celebration of Hypertension Awareness Day and approved budget. · Distributed leaflet · Signed MOU · Re-assessment result –

health problems being high while aversion towards medication being adherent.	discipline, and active coping with health problems being from high to very high. . To improve aversion towards medication from being adherent to very high adherence.	hypertensives on the importance of medication adherence. · Scheduled BP monitoring and as necessary. · Provide a leaflet on medication adherence for hypertensives. · Celebrate a day for Hypertension Awareness Day. · Proper coordination with local government units and government agencies on the provision of supplies of medications for hypertension. Making sure that stocks are available for those who cannot afford. · Re-assess adherence to medication six months following the implementation of this plan utilizing the same instrument.	professional staffs of the institution. · Heads of the Institution · Administrators of the institution			very high adherence to medication and in all dimensions.

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