

11-25-2025

Exploring the Experiences of Bahamian Men Diagnosed with Hypertension and Medication Adherence

Bianca Edwards
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>



Part of the [Nursing Commons](#)

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Nursing

This is to certify that the doctoral dissertation by

Bianca Edwards

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Leslie Hussey, Committee Chairperson, Nursing Faculty

Dr. Elizabeth Diener, Committee Member, Nursing Faculty

Chief Academic Officer and Provost

Sue Subocz, Ph.D.

Walden University
2025

Abstract

Exploring the Experiences of Bahamian Men Diagnosed with Hypertension and

Medication Adherence

by

Bianca Edwards

MA, University of The West Indies, 2021

BS, University of The West Indies, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

November 2025

Abstract

Hypertension (HTN) is associated with significant health complications, including stroke, myocardial infarction, heart failure, and kidney disease. Despite advances in the treatment and management of HTN, a lack of medication adherence contributes to the persistence of HTN-related morbidity and mortality affecting men in The Bahamas. The purpose of this qualitative descriptive phenomenological study, guided by Pender's health promotion model and Bandura's social cognitive theory, was to explore the lived experiences of Bahamian men diagnosed with hypertension regarding their adherence to prescribed medications. Using Giorgi's descriptive phenomenological method, in-depth, semistructured interviews were conducted with 11 participants. Data were analyzed through repeated readings, identification of meaning units, transformation into psychologically sensitive expressions, and synthesis into an essential structure that represented shared experiences. The essence of the phenomenon reflected a transformation from reluctance to responsibility, sustained by faith, family influence, and self-discipline. Key recommendations include integrating family-based and faith-informed strategies into clinical practice and addressing male-specific concerns such as sexual side effects. Findings may inform culturally responsive nursing interventions and health education programs that enhance adherence to and management of chronic diseases, thereby improving health outcomes and fostering positive social change within Bahamian communities.

Exploring the Experiences of Bahamian Men Diagnosed with Hypertension and

Medication Adherence

by

Bianca Edwards

MA, University of The West Indies, 2021

BS, University of The West Indies, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

November 2025

Dedication

This research is dedicated to my loving husband, whose unwavering support, patience, and encouragement have sustained me throughout this journey. I also dedicate this study to my daughter, whose love and understanding reminded me daily of the importance of perseverance. You both have been my inspiration and my strength, and I share this accomplishment with you.

Acknowledgments

I wish to thank Almighty God first and foremost for giving me the strength, patience, wisdom, and perseverance to make this dream a reality. I extend heartfelt gratitude to my chair methodologist, Dr. Leslie Hussey, for her steadfast support, patience, and encouragement throughout this journey. I also thank my member content expert, Dr. Elizabeth Diener, for her valuable guidance and insightful feedback, as well as Dr. Carolyn Sipes, who initially served as my chair and whose early mentorship significantly contributed to the development of this work. I am deeply grateful to the Walden faculty for their dedication and support. I also wish to thank Mrs. Suja Philip of the University of the West Indies for her professional courtesy and guidance in locating local and regional health references that complemented my research. I am also grateful to Dr. Laura Hamlett Schlater for her professional editorial support in accordance with Walden University's Form and Style guidelines.

To my husband and daughter, your love and understanding have been my constant motivation. I also extend my appreciation to my family, friends, mentors, and colleagues whose encouragement and assistance sustained me throughout this journey.

Table of Contents

List of Tables	v
List of Figures	vi
Chapter 1: Introduction to the Study.....	1
Background.....	3
Problem Statement.....	4
Purpose of the Study.....	6
Research Question	7
Theoretical Framework for the Study.....	7
Definitions.....	12
Assumptions.....	14
Scope and Delimitations	14
Limitations	16
Significance.....	18
Summary.....	19
Chapter 2: Literature Review.....	21
Literature Search Strategy.....	22
Theoretical Foundation.....	22
Literature Review Related to Key Concepts.....	34
Justification of Key Concepts.....	35
Evolution of Hypertension Research	36
Empirical Findings on Medication Adherence	38

Hypertension Medication Adherence	43
Barriers and Facilitators of Medication Adherence	45
Economic and Systemic Barriers	46
Social Support and Family Involvement.....	47
Healthcare Provider Communication and Patient-Centered Care	48
Cultural Competence and Communication in Medication Adherence	50
The Economic Impact of Nonadherence.....	52
Social Determinants and Stress Impacting Adherence	52
Summary and Conclusions	54
Chapter 3: Research Method.....	56
Research Design and Rationale	56
Role of the Researcher	59
Methodology	61
Participant Selection Logic.....	61
Instrumentation	63
Procedures for Recruitment, Participation, and Data Collection.....	65
Data Analysis Plan.....	67
Issues of Trustworthiness.....	69
Ethical Procedures	70
Summary.....	71
Chapter 4: Results	73
Setting.....	73

Demographics	75
Data Collection	77
Variation in Data Collection Procedure	78
Unusual Circumstances.....	78
Data Analysis	79
Evidence of Trustworthiness.....	82
Results.....	83
Participant 1	84
Participant 2	84
Participant 3	84
Participant 4	85
Participant 5	85
Participant 6	85
Participant 7	85
Participant 8	85
Participant 9	86
Participant 10	86
Participant 11	86
General Psychological Structure.....	86
Essential Psychological Structure	89
Discrepant Cases	89
Summary	90

Chapter 5: Discussion, Conclusions, and Recommendations	93
Interpretation of the Findings.....	94
Confirmation of Existing Knowledge.....	94
Extension of Knowledge.....	95
Challenges to Prior Assumptions.....	96
Conceptual Framework Integration	97
Limitations of the Study.....	98
Recommendations.....	100
Recommendations for Future Research	100
Recommendations for Practice	101
Implications.....	102
Micro Level.....	102
Meso Level.....	102
Macro Level	103
Methodological, Theoretical, and Empirical Contributions	103
Conclusion	104
References.....	107
Appendix A: Demographic Questionnaire and Interview Guide.....	126
Appendix B: Recruitment Materials	128
Appendix C: Letter to the Permanent Secretary	131

List of Tables

Table 1. Participants' Demographic Characteristics.....	76
Table 2. Participants' Medical Information	76
Table 3. Giorgi's Descriptive Phenomenological Analysis Across Participants	80

List of Figures

Figure 1. Health Promotion Model and Social Cognitive Theory Integration 27

Figure 2. Medication Adherence..... 34

Chapter 1: Introduction to the Study

Hypertension (HTN) is associated with significant health complications, including stroke, myocardial infarction, heart failure, and kidney disease (Iqbal & Jamal, 2022). High blood pressure occurs when the systolic blood pressure is 130 mmHg or higher and/or the diastolic blood pressure exceeds 80 mmHg (Iqbal & Jamal, 2022). Despite advances in the treatment and management of HTN, a lack of medication adherence contributes to the persistence of HTN-related morbidity and mortality. According to the World Health Organization (WHO; 2023b), more than 50% of patients prescribed antihypertensive medications fail to adhere to their treatment regimens, which exacerbates the global burden of HTN (Iqbal & Jamal, 2022).

African Americans with HTN face challenges related to health literacy, mistrust in the healthcare system, and socioeconomic limitations, which negatively impact medication adherence (James, 2024). Similarly, Ekechukwu (2022) found that African Americans, particularly men, experienced disproportionately higher rates of HTN with earlier onset and more health complications, contributing to higher cardiovascular mortality. Although these findings were specific to a U.S. setting, they suggested the importance of addressing systemic barriers in populations disproportionately affected by HTN.

In 2019, the Ministry of Health & Wellness in The Bahamas conducted a survey on the WHO STEPwise approach to noncommunicable diseases (NCDs) risk factor surveillance (STEPS). STEPS is a standardized, three-part framework designed to gather comprehensive data and identify and monitor key risk factors associated with NCDs

through a series of steps. The first component focuses on behavioral risk factors, with administrators using questionnaires to collect information on tobacco use, alcohol consumption, dietary patterns, and physical activity levels. The second component involves physical measurements, including anthropometric data such as body mass index, waist circumference, and blood pressure, to assess physical health risks. The third component comprises biochemical assessments. The parameters include blood tests to measure glucose levels and lipid profiles, which are critical for identifying metabolic risk factors. The STEPS framework provides countries, including The Bahamas, with robust, comparable data to design and implement targeted public health interventions to reduce the prevalence and impact of NCDs (WHO, n.d.).

Although the 2019 STEPS survey showed HTN as a leading NCD affecting 38.2% of the Bahamian population, it lacked gender-specific data, particularly on how HTN impacts men. Given that Black men experience higher rates of HTN globally (Ekechukwu, 2022; James, 2024), this omission underscores a critical gap in understanding the lived experiences of Bahamian men, warranting further exploration.

The WHO's STEPS survey found that HTN is one of the leading NCDs affecting the Bahamian population (Ministry of Health & Wellness, 2019). The prevalence of NCDs was 38.2%, well above the regional average of 18%. Although the WHO included risk factors like poor diet, tobacco use, and a sedentary lifestyle, it did not address the influences of medication adherence on HTN.

More research is needed on HTN medication adherence in certain cultures. Understanding Bahamian men's lived experiences could show the barriers and facilitators

affecting their ability to adhere to prescribed regimens. My findings may contribute to a new narrative and public health interventions for Bahamian men with HTN.

In Chapter 1, I discuss medication adherence in the context of HTN, emphasizing the local, regional, and global implications of nonadherence. I also present the research problem, question, purpose, framework, and the study's significance and potential impact on healthcare policy and practice. The study's limitations, scope, and delimitations also receive discussion.

Background

HTN affects over 1.2 billion people worldwide, a number that has increased over the past decades (WHO, 2023b). HTN is an indicator of future risk of cardiovascular disease, including strokes and heart attacks. The WHO (2023b) showed that despite modern treatments for HTN, a significant portion of the population remains unaware of their condition, presenting a substantial obstacle to preventing and mitigating the risks of HTN. Health experts in the Caribbean countries, including The Bahamas, have increasingly recognized the burden of NCDs, including HTN, as a critical challenge to public health and sustainable development (United Nations Economic Commission for Latin America and the Caribbean, 2020). The 2007 Declaration of Port of Spain initiated the island's commitment to combating NCDs, with healthcare leaders in The Bahamas advocating for interventions at the United Nations General Assembly (Legetic et al., 2016). Healthier diets and reorienting healthcare to NCD prevention and management have been significant outcomes. The WHO STEPS survey showed that 98.6% of Bahamians had at least one risk factor for NCDs, with HTN among the most prevalent

(Ministry of Health & Wellness, 2019). Recent data from the Pan American Health Organization (2022) showed that NCDs remained the leading cause of mortality in The Bahamas. The age-adjusted mortality rate for NCDs was 525.4 per 100,000 in 2022, with men disproportionately affected at 623.8 per 100,000 compared to women at 446.5 per 100,000 (Pan American Health Organization, 2022).

The 2019 STEPS (Ministry of Health & Wellness, 2019) survey for The Bahamas showed disturbing HTN trends. Of the 48% of Bahamians living with HTN, 38% were unaware of their condition. Poor dietary habits and excessive salt intake drove the prevalence of HTN and the need to create a culturally appropriate solution to address the disease. Alcohol consumption and sedentary lifestyles also contributed to the high morbidity associated with NCDs in the country. Urhohide et al. (2023) found that hospital systems were overwhelmed by patients admitted for HTN-related complications. There was a gap in the literature regarding medication adherence concerning HTN within Bahamian men. This study was necessary to explore preventive measures, mainly through improving adherence to antihypertensive medications.

Problem Statement

Despite advances in treatment, hypertension (HTN) remains a major contributor to the non-communicable disease (NCD) burden in The Bahamas and across the Caribbean region (PAHO, 2022; Souza et al., 2024). The Pan American Health Organization (PAHO) confirms that cardiovascular diseases, with hypertension, are the top contributors to mortality in the Caribbean region (Souza et al., 2024). The Pan American Health Organization (2022) reported an age-adjusted mortality rate of 623.8

per 100,000 men from NCDs, including HTN, compared with 446.5 per 100,000 in women, highlighting a persistent gender disparity in NCD-related deaths in The Bahamas. This disparity underscores the need to address both behavioral and systemic barriers affecting hypertension control in Bahamian men. According to The Bahamas STEPS report on NCDs (Ministry of Health & Wellness, 2019), 66% of adults aged 30–79 had HTN diagnoses, but only 22% of those receiving treatment had controlled blood pressure. Although gender-specific prevalence data were unavailable in the Bahamas context, global research suggested that men were disproportionately affected by HTN, with higher rates of unawareness or inadequate management compared to women (Ekechukwu, 2022; James, 2024). These data aligned with anecdotal evidence from clinical settings in The Bahamas, where men often presented with advanced complications related to HTN, suggesting unaddressed barriers to their management. A large portion of the population remained at risk of complications due to uncontrolled blood pressure. The Ministry of Health & Wellness's (2019) findings aligned with data from clinical practice of patients requiring urgent care for HTN. Understanding the factors impacting poor HTN management is critical to improving HTN health outcomes in The Bahamas.

Because a significant portion of the population with HTN is unaware of their condition, only about 22% of individuals treated for HTN were consistently and successfully managing their condition (Ministry of Health & Wellness, 2019). The Ministry of Health & Wellness (2019) data aligns with global research, which shows that nonadherence to antihypertensive medications is due to complex factors, including

socioeconomic barriers, cultural beliefs, and personal perceptions of medication effects (Abdul Wahab et al., 2021; Abeasi et al., 2022).

Successful interventions required addressing individual and more complex cultural and systemic obstacles. Patient concerns—particularly erectile dysfunction associated with antihypertensive therapy—have emerged as critical barriers for men, necessitating that healthcare providers address them openly to improve adherence rates (Rashidi et al., 2024). Nonadherence also had a broader impact on society.

Nonadherence contributed to increased hospitalization costs, suggesting that improved medication adherence benefits both individual and economic health (Abbas et al., 2022).

A deeper understanding of the variables impacting HTN management, especially among Bahamian men, was needed. A qualitative approach to nonadherence was necessary to address individual, cultural, and systemic obstacles (Abdalla et al., 2023).

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore the lived experiences of Bahamian men in managing HTN regarding their adherence to prescribed medications. A qualitative approach enabled an in-depth exploration of these experiences, facilitating the identification of culturally appropriate solutions that may lead to improved health outcomes for Bahamian men. I conducted this study in response to the imperative need to address the HTN management gap in The Bahamas. Focusing on the lived experiences of Bahamian men added to the existing literature on HTN management.

Research Question

What are the lived experiences of Bahamian men managing HTN regarding their adherence to prescribed medications?

Theoretical Framework for the Study

The primary theoretical framework was Pender's (2011) health promotion model (HPM). The HPM served as a guide to explain and predict health-promoting behaviors by exploring the complex interplay of individual characteristics, behavior-specific cognitions and affect, and behavioral outcomes (see Gorbani et al., 2020; Pender, 2011). The model provided a comprehensive approach, enabling a better understanding of the personal factors, benefits, self-efficacy, and environmental influences that affect medication adherence. The HPM theoretical framework supported the positive health outcomes of medication adherence, such as reduced risk of HTN-related complications. Understanding benefits could have reinforced the value of adherence among patients (Gorbani et al., 2020; Pender, 2011).

Identifying patient factors is crucial to improving medication adherence. The literature showed cost, side effects, cultural preferences for alternative treatments, self-efficacy, and confidence in following the prescribed protocol (Gorbani et al., 2020). Whereas prior research provided insights into these factors that were barriers to medication adherence, I explored the participants' lived experiences that allowed the emergence of unique or unanticipated barriers and facilitators of medication adherence. Kamran et al. (2015) provided empirical evidence that greater self-efficacy contributed to better medication adherence and medical outcomes. Their research found that self-

efficacy and perceived benefits were inversely correlated with systolic blood pressure. Gaps in the extant literature indicated the need to identify the individual and situational barriers that shaped medication behaviors and medication adherence in Bahamian men

Interpersonal influences, including social support from family, friends, and healthcare providers, played a significant role in encouraging medication adherence behaviors. Positive reinforcement from interpersonal relationships contributed to enhanced adherence (Pender, 2011; Taghadosi & Nouri, 2023). Modifying situational influences, such as healthcare accessibility, availability, and convenience, could have significantly impacted medication adherence. A strong commitment by the individual often translates into more consistent adherence behaviors, particularly when the plan includes practical steps, such as setting reminders or leveraging family support (Pender, 2011).

Bandura's (1986, 2004) social cognitive theory (SCT) served as a secondary framework to HPM to obtain additional insights into the interplay between personal, behavioral, and environmental influences on health behaviors. SCT addresses why self-efficacy could have influenced outcome expectations. Observational learning, where individuals learn behaviors by observing others, provided more context for community members' influence on medication adherence. Although my primary goal was not to deliver interventions, exploring the lived experiences of Bahamian men provided insights that could guide future considerations of treatment strategies in The Bahamas.

The HPM (Pender, 2011) and the SCT (Bandura, 1986, 2004) provided a framework for identifying health behaviors affecting medication adherence.

Compounding the research problem, the lack of medication adherence among Bahamian men was insufficient knowledge of the barriers and facilitators that influenced adherence behaviors within this population. The HPM was a theoretical framework designed to understand and predict health-promoting behaviors. With this model, Pender (2011) emphasized the interaction between individuals and their environment, integrating principles from the expectancy-value theory and SCT. Central to the HPM were constructs such as perceived benefits, barriers, self-efficacy, and interpersonal and situational influences. The HPM suggests that individuals are more likely to engage in health-promoting behaviors when they perceive valuable outcomes and believe in their ability to achieve them. The HPM was appropriate for this study because each person had unique characteristics and experiences that affected their actions. In semistructured interviews, participants shared their perceptions and social contexts that may have influenced their behaviors. HPM was a robust framework for exploring how Bahamian men experienced and understood medication adherence, identifying ways to engage individuals in health-promoting behaviors. The HPM framework provided a valuable lens for examining facilitators and barriers to health-promoting behaviors, particularly in the context of HTN management (Gorbani et al., 2020). The HPM facilitated an exploration of how environments, perceptions, and health challenges influenced Bahamian men's medication adherence behaviors. I provide more detail on the HPM in Chapter 2. The constructs of perceived benefits, perceived barriers, self-efficacy, and interpersonal influences from Pender's (2011) HPM, together with the emphasis on reciprocal interaction and social learning from Bandura's (1986, 2004) SCT, guided the

development of the semistructured interview guide. One central question and five probing questions were designed to elicit participants' lived experiences of medication adherence in ways that reflected these theoretical concepts.

Nature of the Study

I employed a qualitative phenomenological approach to explore Bahamian men's lived experiences regarding medication adherence. This study design enabled me to understand the participants' personal experiences and the factors that may have influenced their medication adherence behaviors. The participants engaged in semistructured individual interviews with open-ended questions to share their stories and experiences in their own words.

I recruited participants from community health clinics, churches, government agencies, and local organizations. Purposive sampling was appropriate to select Bahamian men 35 to 67 years old diagnosed with HTN for at least 6 months and taking prescribed antihypertensive medications. Additional inclusion criteria were individuals who could articulate their experiences in English were willing to participate in an in-depth interview. Following Walden University's Institutional Review Board (IRB) approval, I recruited individuals through flyers posted in community spaces, social media, churches, and government agencies, as well as direct outreach to healthcare providers and word-of-mouth within local networks.

When interested individuals responded, I requested demographic information (see Appendix A) before conducting the interview. Participants provided details about their age group, marital status, and level of education they had completed, and described their

current occupation. In addition to this demographic information, participants also shared contextual details during the interviews about the duration of their hypertension diagnosis and the medications they were currently prescribed. Collectively, this background information enriched the understanding of participants' lived experiences while maintaining confidentiality and adherence to ethical research practices.

The screening questions were as follows: (a) Are you a Bahamian man aged 35 to 67 years old? (b) Have you been diagnosed with HTN for at least 6 months? and (c) Do you take medication for your HTN? Qualifying participants who answered *yes* to all questions received an informed consent form presenting the details of the study and the participant's role. Measures to respect and protect the participants' privacy included deidentifying transcripts and securely storing data in an encrypted format. Each semistructured interview began with a broad, open-ended question, followed by four to five probing questions tailored to the participant's responses. I planned to conduct interviews with 10 to 15 participants until achieving data saturation, when no new themes emerged from continued data collection. Saturation occurred after the 11th interview, after which interviewing ceased. I audio-recorded the interviews with the participants' consent and transcribed the recordings verbatim for analysis.

The data analysis process aligned with the phenomenological design, which involved breaking the data into meaning units and transforming them to reflect the psychological essence of the participants' experiences (Giorgi, 2009). This approach enabled me to identify patterns and themes that informed the medication adherence experience among Bahamian men. The themes presented essential elements related to the

participants' lived experiences with adherence, including facilitators and barriers to consistent medication use.

I used a constant comparative approach to validate the transcripts against the original audio recordings, ensuring accuracy and fidelity to the participants' narratives. Although traditionally associated with grounded theory (Dodgson, 2023), I adapted the constant comparative method to enhance the rigor of qualitative data validation. In coding, I aimed to identify prominent themes related to medication adherence. Leaning on the systematic aspects of coding allowed for the identification of themes without significant human bias overlaying those themes.

To ensure participant confidentiality, I stored all collected data in a secure, encrypted database accessible only to me. Participant pseudonyms were another means to keep all information confidential. I removed all identifiable information from transcripts, and any reports or publications will maintain the participant's confidentiality.

Definitions

Barrier: An element hindering individuals from following recommended health behaviors, such as medication adherence, including social, economic, or psychological challenges (Odedosu et al., 2012).

Facilitator: A person or thing that supports or enables adherence to health behaviors, such as taking medication as prescribed. Facilitators may include access to health care, social support, and effective communication (Odedosu et al., 2012).

Health promotion: The act of enabling individuals and communities to increase their control over improving their health. Health promotion encompasses social,

economic, and environmental interventions that address personal and societal health factors (Pender, 2011).

Hypertension: A chronic medical condition involving persistently elevated blood pressure, typically defined as a systolic pressure of 130 mm Hg or higher and/or a diastolic pressure of 80 mm Hg or higher (Iqbal & Jamal, 2022; WHO, 2023b).

Medication adherence: The extent to which a person's medication-taking behavior corresponds with agreed-upon recommendations from a healthcare provider (WHO, 2023b).

Nonadherence: Patients' inability or unwillingness to follow prescribed medical advice, including medication regimens (Wilkinson et al., 2022).

Perceived barriers: The factors an individual perceives as obstacles to engaging in a health-promoting behavior, such as cost, side effects, or cultural beliefs that may impede medication adherence (Pender, 2011).

Perceived benefits: In HPM, an individual's belief that a specific action, such as medication adherence, will lead to positive health outcomes (Pender, 2011).

Self-efficacy: Individuals' belief in their ability to execute behaviors necessary to produce specific performance attainments (Bandura, 1986).

Social support: The emotional, instrumental, informational, or appraisal assistance provided by others, which may influence health behaviors. Strong social support often facilitates medication adherence and overall health outcomes (Taghadosi & Nouri, 2023).

Assumptions

Several assumptions in this phenomenological qualitative study were fundamental to its design and interpretation. The primary assumption was that all participants provided truthful and thorough accounts of their experiences. Truthfulness is vital to achieving the study's objective. According to Ravitch and Carl (2021), this flexibility allows the researcher to adjust approaches when new insights emerge. Adaptation and honesty are critical for the success of a qualitative researcher seeking to explore the lived experiences of Bahamian men. Another assumption was that Bahamian men with HTN want to control their HTN by adhering to prescribed HTN medications.

Scope and Delimitations

The scope of this study was to explore the lived experiences of Bahamian men diagnosed with HTN concerning medication adherence. The specific focus was in response to the identified gap in research surrounding medication adherence among this population, especially considering the high prevalence of HTN in The Bahamas and its associated health risks (Ministry of Health & Wellness, 2019). Participants included men aged 35 to 67 who resided on one island in The Bahamas, had received HTN diagnoses, and were currently prescribed antihypertensive medications. Exclusion criteria included individuals diagnosed with any other chronic noncommunicable conditions, such as diabetes or kidney disease, ensuring a sole focus on HTN management without confounding factors. Recruitment involved purposive sampling to ensure diverse perspectives on medication adherence.

I used a qualitative phenomenological design to gather rich, descriptive data through semistructured interviews. This approach was appropriate for exploring the complex interplay of cultural, personal, and systemic factors that influence adherence behaviors. I wanted to understand the influences that may inform potential interventions to improve health outcomes for this demographic and to understand the personal and cultural factors influencing medication adherence.

This study had a qualitative phenomenological design. I considered other approaches, such as ethnography and mixed methods research, but rejected them as inappropriate for fulfilling the study's purpose. Ethnography requires prolonged observation of cultural practices, which exceeded the 1-year timeframe for this study. Mixed methods research, a combination of qualitative and quantitative approaches, was inappropriate due to the time and resource demands of integrating both methods. Phenomenology was the most suitable approach for providing an in-depth understanding of participants' lived experiences within the given constraints.

HPM was the foundation for the study's theoretical framework. The SCT provided a complementary framework to address environmental and social influences on health behaviors. I also considered and rejected alternative theories, such as the health belief and transtheoretical models. The health belief model was inappropriate due to its focus on individual perceptions without adequately addressing environmental factors. I did not choose transtheoretical model, as it emphasizes stages of behavior change rather than the holistic interplay of personal, social, and cultural factors influencing adherence behaviors.

Limitations

Qualitative research, particularly phenomenology, enabled me to provide deep, context-specific insights into a particular phenomenon (Patton, 2015). This study's findings were specific to men on a selected island and might not fully represent the experiences of men in other geographical locations or cultural contexts. Another limitation was the complexity of participant recruitment. Challenges in identifying willing and eligible participants might have restricted the scope of the research. Because recruitment took place on a single island, the findings reflect the unique experiences of each participant from that specific location and may not capture the experiences of men from other islands. Although participant differences are a natural aspect of qualitative research, they could have influenced the breadth of perspectives captured in the study. Thus, it was important to interpret the findings within the specific context of the individuals studied.

As a nurse, I had personal experience with the topic, which introduced the potential for bias. There could have been a perceived power dynamic if participants saw me as an authority figure in the field. A researcher's role and identity may have influenced the data collection, especially in sensitive areas such as health care (Rubin & Rubin, 2012). To minimize the potential for bias that might have skewed the findings, I created a neutral interview environment, emphasized my role as a researcher separate from my clinical responsibilities, and assured participants that their responses would not affect their health care. Because safeguarding participants' privacy was critical to maintaining a safe research environment, I used several confidentiality practices to

encourage participants to share their experiences freely, including deidentifying all data during transcription, storing data securely in an encrypted database, and using pseudonyms in place of participant names throughout the research process. A third limitation could have been social desirability bias, which occurs when participants provide socially acceptable responses instead of their authentic lived experiences. Creating a safe environment for participants could have reduced the likelihood of social desirability.

Transferability refers to the extent to which the findings of a study applied to other contexts (Lincoln & Guba, 1985). Given the qualitative nature of the study and the specific focus on a single population within a unique geographical and cultural setting, transferability of the findings is limited. Although the study's scope could have provided insights relevant to individuals of similar demographics, the findings were not intended to be transferable due to the qualitative nature of the research. Qualitative studies focus on unique, context-specific responses that reflect individuals' lived experiences, which are not reproducible. Instead, the determination of transferability lay in the rigor of the method and design, which could have guided future research in similar contexts. I focused on one healthcare system spread across two districts on one island, specifically the public healthcare system in The Bahamas. Recruitment occurred within this system, and findings primarily reflected participants' lived experiences of HTN concerning medication adherence.

Using Pender's (2011) HPM enabled applicability in culturally similar settings by providing a framework to explain health-promoting behaviors through personal, social,

and environmental factors (see Gorbani et al., 2020). However, applying these findings to different populations required caution. I managed the study's inherent limitations to provide credible, trustworthy, and meaningful findings. Considering potential biases, I adopted several strategies to ensure the study's credibility and trustworthiness. First, I maintained a reflective journal to document my thoughts, assumptions, and potential biases throughout the research process. This practice helped me identify and separate personal beliefs from the participants' lived experiences. Second, I created a neutral and supportive interview environment by emphasizing my role as a researcher rather than a nurse or authority figure to mitigate perceived power dynamics. I also used open-ended, non-leading questions to allow participants to freely express their experiences without being influenced by my preconceptions. Last, I followed the constructs of Pender's HPM to explore the participants' perceptions, beliefs, and experiences regarding medication adherence to identify patterns and themes. To ensure data trustworthiness, I employed a constant comparative approach by validating the transcripts against the original audio recordings. This process helped maintain fidelity to the participants' narratives while minimizing potential researcher bias.

Significance

The findings of this study provide a greater understanding of the barriers and facilitators impacting adherence behavior differences by culture, socioeconomic factors, healthcare access, beliefs, patient-provider communication, and personal motivations. Exploring barriers and facilitators within this demographic's distinct cultural and geographical context provided insights into the lived experiences that contributed to

challenges in adherence to HTN medication among Bahamian men. This study's insights provide a more nuanced understanding of the factors that encourage adherence and motivational aspects that promote better treatment adherence. Policymakers and healthcare providers could use this study's findings to address healthcare behaviors in culturally diverse settings, such as The Bahamas, and potentially tailor interventions to better align with cultural and contextual needs (Abdalla et al., 2023). These strategies are crucial for reducing disparities and enhancing health outcomes, particularly in populations with high rates of nonadherence. The findings also provide insight into how health policies could be more effective when considering cultural and economic realities.

The findings contribute to a more in-depth understanding of the barriers and facilitators influencing medication adherence and inform the development of new strategies to improve medication adherence among Bahamian men. Long-term outcomes may include reduced morbidity and mortality associated with HTN in The Bahamas. Additionally, based on the insights gained from this study, healthcare professionals may be better situated to enhance treatment adherence. This positioning is crucial for improving the health of men who often served as primary economic providers in their communities, such as in The Bahamas. Improved health management could result from a better understanding of the behaviors driving medication adherence, which affects positive social change.

Summary

In Chapter 1, I introduced medication nonadherence among Bahamian men, indicating the need for further research to understand the barriers and facilitators specific

to this regional culture. I also reviewed the study's purpose, research question, theoretical framework, and methodology, providing a context for exploring Bahamian men's experiences. In Chapter 2, I present the relevant literature and theoretical models that provided the framework for this study.

Chapter 2: Literature Review

HTN is a leading cause of morbidity and mortality globally, affecting over 1.2 billion people (WHO, 2023b). Despite advancements in treatment, HTN remains poorly controlled in many populations due to low adherence to prescribed regimens. Researchers have identified poor medication adherence as a significant contributor to the increased rates of complications associated with HTN, including cardiovascular disease, stroke, kidney failure, and premature mortality. Li et al. (2021) found that patients with low antihypertensive medication adherence had a 1.75 times higher risk of developing cardiovascular disease compared to those with high adherence. Additionally, low adherence was associated with greater blood pressure fluctuations, a higher blood pressure burden over time, and significantly higher crude incidence rates of cardiovascular disease. These findings indicate the importance of adherence in mitigating HTN-related complications and show the need to explore the barriers to adherence in populations like Bahamian men, who remain underrepresented in existing research.

The purpose of this qualitative phenomenological study was to explore the lived experiences of Bahamian men in managing HTN regarding their adherence to prescribed medications. The objective was to understand the barriers and facilitators that influenced adherence within this demographic. Despite significant research on medication adherence, there remained a gap regarding this specific demographic of Bahamian men. In Chapter 2, I present the seminal work and existing contemporary literature to provide a background, identify the literature gap, and justify the need for the study.

Literature Search Strategy

To conduct the literature review, I accessed several academic databases via the Walden University Library, including PubMed, CINAHL, Scopus, EBSCO, Google Scholar, PsycINFO, and ScienceDirect. The key search terms included *medication adherence, HTN, cultural influences, health belief, health promotion model, Bahamian men, barriers, facilitators, and social determinants of health*. To refine the search, I combined key terms using the Boolean operators of *AND* and *OR*, including *HTN AND medication adherence AND cultural barriers OR facilitators AND HTN*. The search was limited to English-language, full-text, peer-reviewed articles published between 2020 and 2024.

Conducting a literature review is an iterative process. When I found little relevant scholarship related to The Bahamas and Bahamian men, I searched for seminal research to provide evolutionary and foundational knowledge on HTN, medication adherence, and health behavior theories, such as Pender's (2011) HPM and Bandura's (1986, 2004) SCT. Wilkinson et al. (2022) identified access barriers in Uganda that mirrored some of the same healthcare access issues faced by Bahamian men, further validating my search approach.

Theoretical Foundation

This research was grounded in Pender's (2011) HPM and Bandura's (1986, 2004) SCT. Each theory provided a comprehensive framework for understanding health-promoting behaviors and medication adherence among Bahamian men with HTN. Pender developed the HPM in 1982 and revised it in 1996, emphasizing the role of individual

characteristics, behavior-specific cognitions, and behavioral outcomes in shaping health-related decisions. Bandura developed the SCT in 1986 as an evolution of the scholar's earlier work on SLT. The SLT focuses on the dynamic interplay between individual behavior, personal factors, and environmental influences. Using both theories provided a robust foundation for understanding how individuals navigate health-related behaviors within specific cultural and environmental contexts.

The HPM provides a lens for understanding health behaviors through constructs such as perceived barriers, perceived benefits, and self-efficacy. Perceived barriers, perceived benefits, and self-efficacy could show how individuals assess the challenges and advantages of a behavior and their confidence in performing it. The HPM provides a structured framework for understanding the factors influencing health-promoting behaviors, including medication adherence. One of the framework's core constructs is the perceived benefits of action, which refers to the belief that engaging in a specific health-promoting behavior will lead to desired outcomes, such as improved health or reduced disease risks (Pender, 2011). For hypertensive individuals, perceived benefits may include improved blood pressure control and a reduced likelihood of cardiovascular complications, as noted in studies on medication adherence behaviors (Choudhry et al., 2021; Gorbani et al., 2020). In contrast, perceived barriers to action encompass the physical, emotional, or logistical obstacles that hinder individuals from engaging in health-promoting behaviors (Pender, 2011). Barriers such as the cost of medications, fear of side effects, and limited access to tertiary healthcare facilities are especially significant in resource-limited islands, including those in The Bahamas (Choudhry et al., 2021;

Gaddis, 2019). Addressing these barriers through targeted interventions is crucial for promoting adherence in vulnerable populations.

Another critical construct is perceived self-efficacy, which reflects individuals' confidence in their ability to successfully perform a behavior necessary for achieving desired outcomes (Pender, 2011). Research has shown that higher self-efficacy is associated with greater adherence to treatment regimens, as individuals feel more capable of overcoming challenges (Choudhry et al., 2021). Educational initiatives and family support could contribute to enhanced self-efficacy for Bahamian men, empowering them to manage work schedules, financial constraints, and other challenges to medication adherence. Interpersonal influences, such as norms, social support, and the expectations of significant others, play a pivotal role in shaping adherence behaviors (Pender, 2011). Positive interactions with family members, peers, and healthcare providers foster trust and motivation, facilitating adherence to antihypertensive regimens (Gaddis, 2019).

Situational influences, such as the accessibility of medications or the convenience of healthcare services, also impact adherence behaviors. Nematzad et al. (2023) alluded to those environmental and situational factors, such as reliable access to healthcare resources, that significantly enhance adherence rates in populations with limited infrastructure. A commitment to a plan of action is central to the HPM, involving intentions and strategies to engage in health-promoting behaviors (Pender, 2011). As Kobson et al. (2024) noted, structured action plans, such as setting reminders or involving family members, could significantly improve adherence. These constructs collectively

inform the goal of the HPM: health-promoting behavior, which represents actions taken to enhance health and prevent illness (Pender, 2011).

Bandura's (1986, 2004) SCT served as a complementary theory to the HPM (Pender, 2011). The SCT's constructs of observational learning, reciprocal determinism, and outcome expectations are pivotal for understanding health behaviors such as medication adherence. The constructs enable the exploration of how individuals interact with their social and physical environments to influence their behavior.

Observational learning supports the role of modeling in shaping behaviors. Individuals learn by observing the behaviors, attitudes, and outcomes of others' actions. Najjuma et al. (2020) found that family support and community behaviors significantly influenced medication adherence among patients in Uganda. Similarly, Abeasi et al. (2022) emphasized the importance of education and socioeconomic factors, illustrating how exposure to positive adherence behaviors can foster improved health practices.

Reciprocal determinism is the dynamic, bidirectional interaction between personal factors, environmental influences, and behavior. Abdul Wahab et al. (2021) demonstrated how cultural norms, societal beliefs, and interpersonal dynamics can either facilitate or hinder adherence to antihypertensive medications. For example, individuals influenced by cultural beliefs that "natural is safe" may resist prescribed medications, whereas others may find motivation in community or family encouragement. Colgrove et al. (2017) similarly highlighted the interplay of socioeconomic and geographic disparities in HTN management, illustrating how environmental factors affect individual behaviors.

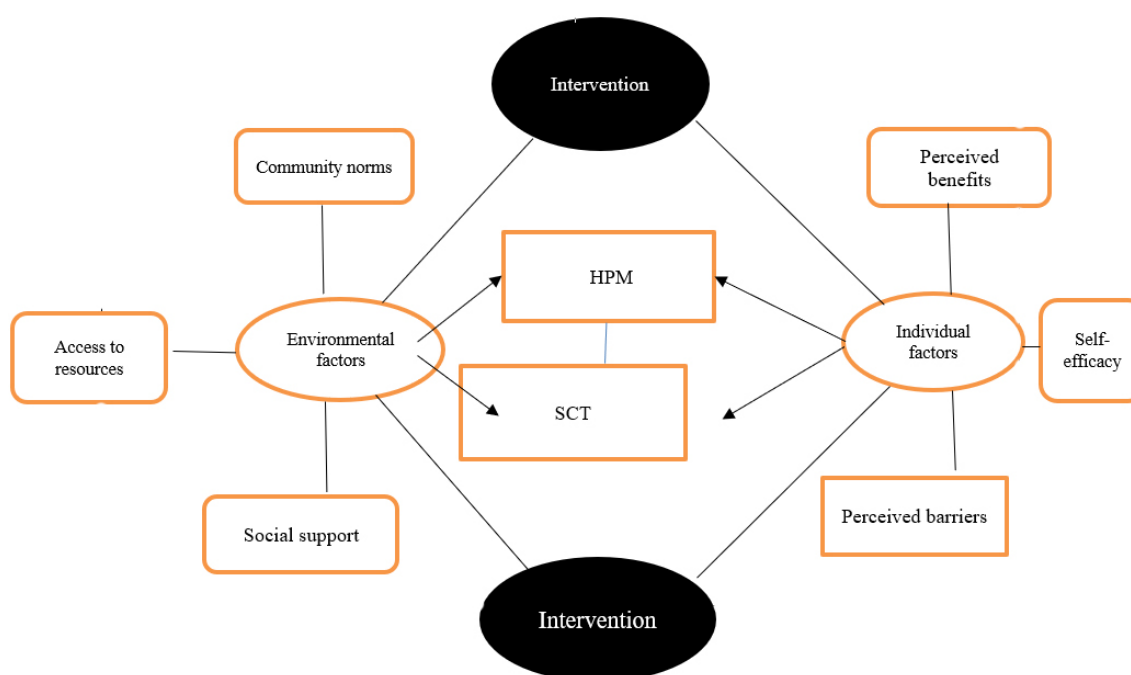
Outcome expectations, another critical SCT construct, focus on the anticipated results of a behavior and how these influence motivation and action. Patients' beliefs in the benefits of controlling HTN—such as reducing cardiovascular risks or improving quality of life—directly impact adherence behaviors, as emphasized by Hamrahian et al. (2022). Conversely, when adverse effects—such as erectile dysfunction linked to antihypertensive medication—are perceived as outweighing the benefits, adherence is likely to decline (Rashidi et al., 2024). These findings reinforce that clear communication about the tangible benefits of medication adherence is critical to fostering positive outcome expectations.

These constructs reflect SCT's strength in addressing the interplay of personal beliefs, social influences, and environmental factors on behavior. Abdalla et al. (2023) noted that addressing these multifaceted barriers requires comprehensive strategies that encompass individual education, social support, and systemic changes. In the context of Bahamian men, interventions that leverage observational learning through community modeling, enhance self-efficacy via targeted education, and address reciprocal determinism by mitigating systemic barriers (e.g., cost and access to medications) may prove highly effective in improving medication adherence. The SCT (Bandura, 1986, 2004) enabled me to explore environmental and social influences, including the roles of community, family, and cultural norms in shaping adherence behaviors. Both frameworks ensure a holistic approach to understanding how individual beliefs, social dynamics, and environmental contexts influence medication adherence behaviors among Bahamian men.

Figure 1 shows the integration of the HPM and SCT in this study. This diagram presents the key constructs of each theory—such as perceived benefits, perceived barriers, self-efficacy, interpersonal influences, observational learning, and reciprocal determinism—and visually represents their interconnected roles in understanding medication adherence behaviors. By mapping these constructs, the framework indicates how individual, environmental, and social factors influence the adherence behaviors of Bahamian men with HTN. The dynamic interplay between personal beliefs, social influences, and systemic barriers supports the comprehensive approach of using both HPM and SCT in this research.

Figure 1

Health Promotion Model and Social Cognitive Theory Integration



The HPM and SCT have received extensive applications in health-related research. Gorbani et al. (2020) and Goudarzi et al. (2020) used the HPM to explore

factors influencing medication adherence in hypertensive patients, identifying self-efficacy and perceived barriers as critical components. Wilkinson et al. (2022) employed SCT to examine how social and environmental factors affected medication adherence in Ugandan patients, highlighting barriers such as limited healthcare access and cultural norms that resonated with the challenges faced by Bahamian men.

The rationale for selecting these theories lies in their complementary focus on individual, social, and environmental factors. The HPM served as the primary theoretical framework for this study due to its emphasis on understanding how individual perceptions and contextual factors influence health-promoting behaviors. Using the SCT allowed me to enhance this understanding by addressing the dynamic interaction between personal beliefs and external influences, such as cultural norms and family support. Both frameworks enabled in-depth exploration of the barriers and facilitators related to medication adherence as they pertained to individual experiences.

By grounding this study in the HPM and SCT, I formulated research questions directly tied to the theoretical framework. I developed queries to investigate how perceived barriers and benefits influenced adherence behaviors, and how interpersonal and situational factors shaped participants' experiences, building on existing theory while addressing gaps in the literature. Both frameworks also guided the exploration of the lived experiences of Bahamian men, providing a structured lens to analyze individual and contextual factors. Ultimately, the combination of HPM and SCT enabled me to produce research findings grounded in a well-established theoretical foundation, while also

potentially offering new insights into the unique cultural and environmental influences on health-promoting behaviors.

The primary constructs of HPM (Pender, 2011) were perceived benefits and barriers to action, self-efficacy, interpersonal influences, situational factors, and commitment to a plan of action. Bandura's (1986, 2004) SCT complemented the HPM with an emphasis on self-efficacy, outcome expectations, and the dynamic interaction between personal, behavioral, and environmental influences in shaping health behaviors. Pender (2011) used a competence- or approach-oriented lens that extended beyond disease prevention. The HPM emphasizes promoting health by addressing individual perceptions, environmental factors, and interpersonal influences that shape behavior and encourage adherence to health-promoting actions (None & Musharyanti, 2021). Because Pender recognized the significance of environmental contexts in shaping health behaviors, something many other theorists did not acknowledge, the HPM was an appropriate framework for this study. The model further supported the role of healthcare partnerships and individualized interventions in promoting adherence to health-promoting behaviors (None & Musharyanti, 2021).

Pender's (2011) HPM provided a comprehensive framework for understanding how various factors influenced an individual's decision to engage in health-promoting behaviors, such as medication adherence. An assumption with the HPM was that people were more likely to engage in health-promoting behaviors when significant others modeled the behavior or provided support, thus enhancing the individual's commitment

to action (Pender, 1996). For example, family and healthcare providers were critical to medication adherence by reinforcing positive behaviors.

Within the HPM, perceived benefits of action related to the belief that medication adherence would lead to positive health outcomes, such as reducing the risk of HTN-related complications. Seeming barriers to action included obstacles that individuals believed hindered their ability to adhere to medication, such as the cost, side effects, or cultural preferences for alternative treatments (Gorbani et al., 2020; Goudarzi et al., 2020; Kobson et al., 2024). Yang et al. (2024) found significant emotional and knowledge barriers among patients, showing the need for personalized interventions to enhance self-management outcomes. Self-efficacy was another component of the HPM, with individuals' confidence central to their ability to successfully adhere to a prescribed medication regimen. Enhancing self-efficacy through educational interventions and supportive strategies could lead to better adherence outcomes, as individuals feel more capable of managing their health (Gorbani et al., 2020; Pender, 2011; Zhou et al., 2023).

Further enriching the theoretical framework was Bandura's SCT and its emphasis on the role of self-efficacy and outcome expectations in regulating behavior. Bandura (2004) argued that individuals with high levels of self-efficacy were more likely to initiate and sustain healthy behaviors, particularly when faced with barriers. Bandura introduced the concept of reciprocal determinism, also known as observational learning. A critical part of SCT, reciprocal determinism, suggests that individuals learned behaviors by observing others; thus, social support and community norms influence healthy medication adherence behaviors. In a systematic review, Kobson et al. (2024)

found that interventions were more acceptable when tailored to individual needs, emphasizing the importance of user involvement and shared decision-making. The SCT aligned with this study, suggesting that self-efficacy and social support were critical factors influencing adherence among hypertensive patients (Shahin et al., 2021; Taghadosi & Nouri, 2023).

Pender's (2011) HPM and Bandura's SCT (1986, 2004) were appropriate for understanding the lived experiences of Bahamian men with HTN and identifying the barriers and facilitators that influenced their adherence to antihypertensive medications. The HPM provided a structured approach to explore how personal beliefs about medication, perceived barriers, self-efficacy, and social influences shaped adherence behaviors. Access to healthcare services and medication availability could have promoted or hindered adherence, as addressed in this model. With a greater commitment to health-promoting behaviors, sustaining over the long term is more manageable, even when barriers exist. Commitment is vital to health-promoting behaviors, such as setting medication reminders. Bandura's (2004) SCT complemented this study by showing the importance of self-efficacy and social learning in health-promoting behaviors. The use of both models enabled a comprehensive understanding of medication adherence.

I focused on medication adherence to the extent to which individuals took their prescribed medications consistently and as directed by healthcare professionals. Medication adherence was a critical health-promoting behavior, particularly in managing chronic conditions like HTN, where it could have prevented serious complications such as strokes and heart attacks (Burnier & Egan, 2019). Pender's (2011) HPM and

Bandura's (1986, 2004) SCT were well-suited for exploring this phenomenon, based on their emphasis on individual cognition, social support, and environmental factors that shape health behaviors. The HPM suggests that when positive emotions are associated with adherence behaviors, such as satisfaction with improved health, there is an increased likelihood of continued commitment (Pender, 1996), in this case, to the medication regimen. Interpersonal influences, such as family support and provider encouragement, were essential for facilitating adherence behaviors.

Pender (2011) identified perceived benefits, perceived barriers, and self-efficacy as instrumental in predicting whether individuals engage in health-promoting behaviors, such as medication adherence. The perception of reduced cardiovascular risks improved medication adherence for Bahamian men (Gorbani et al., 2020; Goudarzi et al., 2020). Conversely, barriers like cost, side effects, and limited access worsened medication adherence (Abdul Wahab et al., 2021; Abeasi et al., 2022; Wilkinson et al., 2022). The fear of side effects, for example, was a common barrier among hypertensive patients—particularly when treatment was associated with sexual side effects like erectile dysfunction linked to antihypertensive use (Rashidi et al., 2024; Taghadosi & Nouri, 2023).

Self-efficacy has consistently been identified as a pivotal factor influencing medication-adherence behavior across populations. For instance, individuals who believe they can manage their medication regimens despite challenges such as work schedules or financial constraints are more likely to comply (Pender, 2011; Wilkinson et al., 2022). Social support from family members, friends, and healthcare providers has also been

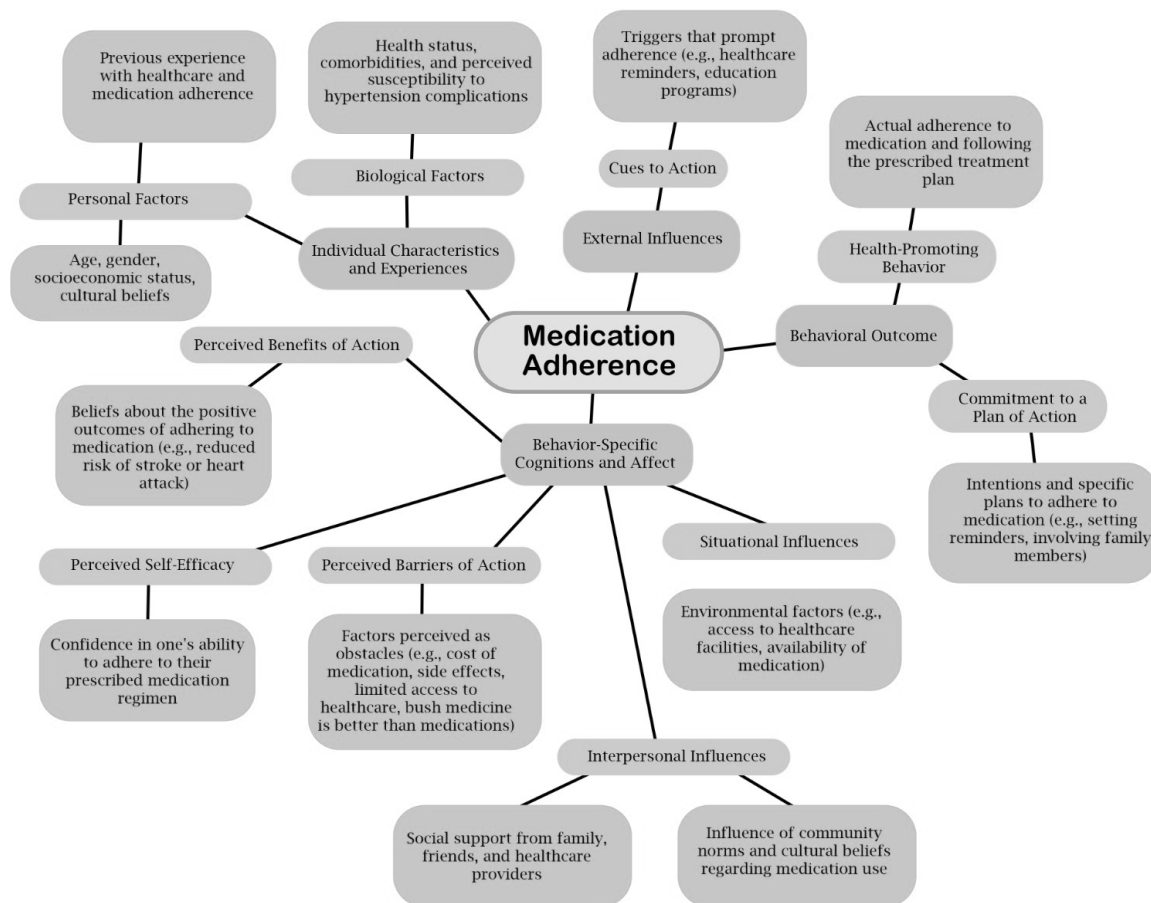
shown to promote adherence through encouragement, reminders, and clear communication (Wilkinson et al., 2022). In contrast, preferences for traditional remedies and distrust of pharmaceuticals have been reported as barriers that undermine adherence in several cultural contexts (Goudarzi et al., 2020). Environmental factors, access to healthcare facilities, and the availability of medications significantly impacted adherence. In The Bahamas, geographic barriers and limited access to healthcare services—particularly in the Family Islands—continue to hinder timely medical attention and continuity of care. The National Health Insurance Authority (NHIA, 2021) acknowledged these disparities and outlined measures such as telehealth expansion, integration of public and private services, and standardized primary care coverage under the Standard Health Benefit to improve access and quality of care nationwide. Situational influences, such as the accessibility of healthcare services and environmental context, may increase or decrease individuals' participation in health-promoting behaviors, depending on how easily patients can engage in care (Pender, 1996). Figure 2 shows how these situational and environmental factors align with key constructs from the HPM and SCT, highlighting their interconnected impact on medication adherence behaviors. Personal, behavioral, and environmental factors contributed to adherence challenges and strategies.

Improving access to healthcare facilities through transportation or telemedicine helped alleviate some barriers and promoted better adherence outcomes (Wilkinson et al., 2022). External influences, such as community health programs and healthcare reminders, served as cues to action that triggered individuals to adhere to their medication. For instance, regular follow-ups or phone calls from healthcare providers and

community health campaigns were reminders for patients to stay on track with their medication regimens (Nematzad et al., 2023).

Figure 2

Medication Adherence



Note. From *Health Promotion in Nursing Practice* (3rd ed.), by N. J. Pender, 2011. Copyright 2011 by SAGE Publications

Literature Review Related to Key Concepts

In the literature on medication adherence, although cultural and economic contexts varied, common global themes emerged as barriers to medication adherence. Despite significant advancements in medication adherence, a lack of qualitative findings

necessitated an exploration of the lived experiences of Bahamian men. Addressing this gap was vital. Sociocultural factors unique to The Bahamas, including healthcare infrastructure, cultural beliefs, and economic disparities, affect adherence in ways not fully captured in broader studies.

Justification of Key Concepts

The key concepts in this study—medication adherence, barriers, facilitators, and self-efficacy—were directly relevant to understanding HTN management behaviors. An association exists between medication adherence, a critical determinant of successful HTN treatment, and improved health outcomes (Abbas et al., 2022; Wilkinson et al., 2022). Bissonnette (2008) identified three elements in the complex multidimensionality of medication adherence: personal, environmental, and systemic. Despite the factors' impact on adherence behavior, a robust framework for understanding the intricacies of medication adherence emerged when examined under a rich lens that acknowledged multidimensionality. Tailored interventions evolved from acknowledging the intricacies of medication adherence. In line with the structured approach proposed by Vrijens et al. (2012), research showed how Bahamian men progressed through the stages of initiation, implementation, and discontinuation. Understanding the barriers (cultural beliefs, costs, and access to care) and facilitators (social support and effective patient–provider communication) is crucial to creating a personalized intervention for Bahamian men. Framing these concepts within the context of health-promoting behaviors supported the use of HPM in understanding how Bahamian men navigated medication adherence (Gorbani et al., 2020; Pender, 2011).

Evolution of Hypertension Research

The field of HTN research has evolved significantly. Early studies focused on global epidemiology regarding HTN, as seen in Mills et al. (2020) and Beaney et al. (2020). These scholars emphasized the importance of addressing HTN through large-scale public health initiatives. In a foundational study conducted in The Bahamas, Conliffe et al. (2015) highlighted the unique geographic and socioeconomic challenges impacting HTN management. Looking at disease management on a global level was no longer appropriate. Conliffe et al. provided a foundation for understanding how cultural and structural factors influenced HTN care in The Bahamas. The researchers identified the need for culturally sensitive strategies, a progressive focus that discouraged making global generalizations. Understanding the behavioral factors influencing HTN management on a local level was important to create interventions for medication adherence.

Researchers shifted their attention toward understanding the behavioral factors influencing HTN management, particularly medication adherence. Recent scholars, such as Zhou et al. (2023), applied Pender's (2011) HPM to explore the relationship between patient-provider interactions and medication adherence. The study found that trust and satisfaction with healthcare providers significantly impacted adherence. The shift in focus indicated increasing awareness of critical psychosocial and behavioral factors in HTN management.

Šabović et al. (2024) used data from more than 11,000 patients across multiple countries, finding that although demographic factors like age, body mass index, and

smoking status differed between men and women, both genders benefited equally from HTN treatment protocols. Even though the global perspective did not account for regional cultural differences, the insights may hold for Bahamian men. Effective treatment strategies used internationally could have also improve adherence in The Bahamas. Goorani et al. (2024) emphasized the multifactorial nature of HTN and alluded to its nature, including its genetic, lifestyle, and socioeconomic components. The authors additionally highlighted the limitations of current treatment approaches in their study. The approaches included lifestyle interventions and pharmacological therapies, while advocating for innovative solutions such as digital health tools and novel drug therapies. Their findings reinforced the importance of addressing the socioeconomic burdens and tailoring interventions to cultural contexts, such as those in The Bahamas.

The historical milestones in HTN research outlined by Kotchen (2011) were crucial in shaping the understanding of HTN management. Acknowledging the historical framework and timeline was crucial in understanding how far the field had come in recognizing that adherence reduced HTN-related complications and emergencies. Kotchen's progressive research was key to the present study of Bahamian men's lived experiences and medication adherence. Historical insights informed adherence strategies tailored to The Bahamas. The literature, including studies by Kotchen (2011), Mills et al. (2020), and Beaney et al. (2020), showed HTN's progress from research to public health priority. Awareness of the historical timeline explained why medication adherence became a priority. Historical insights may inform adherence strategies, particularly among Bahamian men.

The Lancet Regional Health – Americas (2022) report indicated the need for bolder public health interventions across Latin America and the Caribbean. The authors called for systemic changes, including policy interventions, to enhance healthcare access and patient education. The report's findings aligned with the challenges Bahamian men face in HTN management, supporting the need for a multipronged approach to medication adherence.

In addition to behavioral insights, physiological and clinical research on HTN was instrumental in shaping the understanding of the disease. In addition to behavioral insights, physiological and clinical research on HTN was instrumental in shaping the understanding of the disease. Goorani et al. (2024) described how chronic hypertension leads to vascular remodeling, endothelial dysfunction, and organ damage, including kidney and heart failure. The authors discussed how the pathophysiological mechanisms reinforced the importance of long-term pharmacotherapy. Goorani et al. emphasized that poor medication adherence increases the risk of severe complications, including left ventricular hypertrophy and renal damage. Therefore, by linking biological consequences to adherence behavior, the researchers strengthened the rationale for culturally and socially tailored adherence strategies, as they relate to the context of Bahamian men facing similar risks.

Empirical Findings on Medication Adherence

Several scholars have explored the socioeconomic, cultural, and behavioral factors that influence medication adherence. Shen et al. (2020) identified self-efficacy as a significant mediating factor in the relationship between medication literacy and

adherence in hypertensive patients, accounting for 28.7% of the effect on adherence behaviors. This finding was significant for understanding how enhancing self-efficacy could promote adherence behaviors, particularly in populations with lower health literacy, such as in some socioeconomic groups in The Bahamas (Ministry of Health & Wellness, 2019). The Bahamas STEPS survey found that mismatches between health knowledge and healthy behavior practices were common, especially among groups with lower educational attainment, which could affect health literacy and adherence to prescribed treatments.

Abeasi et al. (2022) identified socioeconomic status and education as significant predictors of adherence among hypertensive adults in Ghana, supporting the role of sociodemographic factors in shaping adherence behaviors. This finding may also extend to men in The Bahamas, where similar socioeconomic constraints may have hindered effective HTN management. Chham et al. (2024) explored the role of family social support in Cambodia, showing that higher levels of social support were associated with better adherence, particularly in resource-limited settings. Although these findings were specific to Cambodia, they were relevant to Bahamian men, who often relied on close-knit community and familial support to assist them in adhering to their medication regimen. Culturally appropriate interventions may benefit from these family-centered social structures, as Bahamians have a strong family bond. Jonas (2023) identified sociocultural barriers to medication adherence among hypertensive patients in private practice in Zimbabwe, including distrust of Western medicine and a preference for traditional treatments. This finding is applicable to the Bahamian context, where

traditional and cultural beliefs may have influenced health behaviors. Sociocultural barriers often intersect with economic and access-related challenges to create unique adherence difficulties, particularly in low-resource contexts (Abeasi et al., 2022; Edward et al., 2021; Jonas, 2023; Wilkinson et al., 2022). Edward et al. (2021) explored patient and healthcare provider perspectives on antihypertensive medication adherence in Tanzania. The authors found that medication cost, limited access to care, inadequate provider counseling, and cultural reliance on herbal and faith-based remedies were significant barriers to consistent medication use. Their findings suggested that socioeconomic hardship and cultural beliefs interacted to shape adherence behaviors in low-resource settings, highlighting the need for culturally and economically sensitive strategies to improve hypertension control.

Sekkarie et al. (2024) found that U.S. men, particularly older adults and those of lower socioeconomic status, exhibited higher rates of uncontrolled HTN. Despite a slight increase in antihypertensive medication use between 2017 and 2021, significant disparities remained due to socioeconomic constraints and poor adherence behaviors. These findings are relevant to Bahamian men, who were likely to have faced similar socioeconomic challenges impacting their ability to manage HTN effectively. Although further research is necessary to confirm the application within the Bahamian context, the parallels observed in other populations suggest that socioeconomic barriers similarly affect medication adherence within this group. Sekkarie et al. showed the need for addressing these socioeconomic factors, providing a comparative framework that informed the need for culturally sensitive interventions in Bahamian men with HTN.

Calhoun (2024) highlighted the importance of shared decision-making in improving adherence. Black men with HTN in the United States expressed a strong preference for being actively involved in healthcare decisions, and their involvement positively influenced adherence behaviors. This finding may be relevant for Bahamian men, where patient autonomy and engagement could be crucial in promoting better medication adherence. Calhoun emphasized the importance of developing healthcare models incorporating patient preferences and respecting autonomy to improve treatment outcomes.

Zhou et al. (2024) explored the barriers and facilitators of antihypertensive medication adherence. The authors found that adherence was shaped by interconnected individual, social, and systemic factors, including economic hardship and limitations in the healthcare system. The high cost of medications, lack of insurance coverage, and limited healthcare access were consistent economic and structural barriers across the studies reviewed. Additionally, inadequate follow-up systems, long travel distances to clinics, and poor coordination within healthcare services further hindered adherence. Conversely, family support, trust in healthcare providers, and clear communication were identified as facilitators that improved adherence behaviors. Zhou et al. concluded that medication adherence in hypertension is multifactorial, requiring interventions that simultaneously address financial burden, system-level barriers, and psychosocial influences. These findings are relevant to Bahamian men, whose experiences of adherence may also be affected by similar structural and economic

challenges within geographically dispersed healthcare settings (Edward et al., 2021; Zhou et al., 2024).

Rashidi et al. (2024) identified that erectile dysfunction (ED) is a significant concern among hypertensive men, especially seen in men using beta-blockers. The study reported that more than 80% of participants experienced some degree of ED. The study emphasized that managing sexual side effects could improve adherence to antihypertensive therapy. Similarly, Taghadosi and Nouri (2023) found that fear of medication-related side effects was also a major contributor to treatment discontinuation. Although these findings were from other populations, they are relevant to men in the Bahamas, where similar issues may arise, impacting adherence and overall health outcomes. The psychosocial challenges posed by ED represent a critical area of focus for healthcare providers seeking to improve adherence within this population.

Logistical barriers contribute to nonadherence. Wilkinson et al. (2022) identified logistical challenges such as distance from healthcare facilities and the cost of medications as critical barriers in Uganda. These challenges may mirror what some Bahamian men face, particularly those residing in the Family Islands, which do not have specialists. Improving healthcare access and reducing logistical barriers are vital in addressing these adherence challenges. The insights from Wilkinson et al.'s study supported the need to consider individual and systemic factors when designing interventions to improve adherence rates.

Although researchers have explored medication adherence across different countries and contexts, many have relied on self-report surveys or clinical outcomes,

which introduce the potential for recall bias and may not fully capture the complexity of individual experiences. Abeasi et al. (2022) employed survey methods, which, although valuable, may not have comprehensively uncovered the deeper cultural and personal reasons underlying nonadherence. Wilkinson et al. (2022), Jonas (2023), and Burnier and Egan (2019) focused heavily on logistical barriers without fully exploring their intersection with personal beliefs. With the phenomenological design, I addressed these gaps by directly engaging Bahamian men to explore their lived experiences, ensuring a comprehensive understanding and incorporation of cultural, social, and emotional nuances into the analysis.

Hypertension Medication Adherence

Medication adherence is pivotal to the successful management of HTN. Despite the efficacy of antihypertensive pharmacotherapy in reducing morbidity and mortality, adherence rates remain suboptimal, with studies showing that 38% of hypertensive patients exhibited low medication adherence (Guo et al., 2023). Adherence was not a singular construct, but rather one encompassing multiple stages, including initiation, implementation, and persistence, each playing a critical role in the overall success of HTN management (Vrijens et al., 2017). Medication adherence involved taking prescribed medication, adhering to dosing schedules, and continuing treatment long term. Adherence was particularly challenging for chronic conditions like HTN, where the disease was often asymptomatic, making it easier for patients to discontinue treatment (Burnier & Egan, 2019).

Several factors contributed to nonadherence, including patient-related barriers such as health literacy and social support, as well as systemic issues like access to healthcare and medication costs (Guo et al., 2023). Guo et al. (2023) found that health literacy and social support directly and indirectly affected medication adherence, highlighting their critical role in adherence behaviors. Vrijens et al. (2017) emphasized that complex medication regimens may overwhelm patients, leading to unintentional nonadherence, particularly when polypharmacy is involved. The introduction of fixed-dose combination therapies was shown to simplify treatment regimens and significantly improve adherence rates, indicating the need for healthcare system administrators to adopt strategies that reduce pill burden and minimize treatment complexity. Electronic medication adherence monitoring has emerged as an effective tool for healthcare providers to assess adherence patterns in real-time, enabling timely interventions to prevent adverse outcomes (Burnier & Egan, 2019).

Patient-provider communication was critical to fostering adherence, with studies indicating the importance of trust and engagement in the decision-making process (Beena & Jose, 2011). Patients who were actively involved in their treatment decisions and received clear, culturally sensitive communication were more likely to adhere to prescribed treatments. This finding was particularly relevant in populations with complex socioeconomic and cultural contexts, such as Bahamian men with HTN, where systemic barriers like healthcare access and medication affordability intersected with personal beliefs and healthcare literacy (Brown & Bussell, 2011). As Beena and Jose (2011) noted, addressing both intentional and unintentional nonadherence warrants a multifaceted

approach, including improving health literacy, simplifying regimens, and fostering strong, trust-based relationships between patients and healthcare providers.

Managing HTN through pharmacotherapy requires medication adherence. The multifactorial causes of nonadherence, from individual patient barriers to systemic healthcare challenges, necessitated a comprehensive approach to improving adherence rates and patient outcomes. By addressing the practical barriers to adherence and leveraging tools like fixed-dose combinations and real-time monitoring, healthcare practitioners could have significantly mitigated the burden of HTN-related complications, particularly in vulnerable populations such as Bahamian men.

Barriers and Facilitators of Medication Adherence

The phenomenological approach best suited this exploration of Bahamian men's healthcare journeys. Unlike quantitative studies, which produced broad statistical insights, qualitative research enables a focus on the personal and social realities that shaped medication adherence behaviors. Including unique perspectives in the data indicated the nuanced sociocultural barriers, facilitators, and individual beliefs that influenced adherence to antihypertensive medications (Jonas, 2023; Wilkinson et al., 2022). Various barriers and facilitators, including socioeconomic status, cultural beliefs, healthcare access, and behavioral factors, influence the complexity of medication adherence (Abeasi et al., 2022; Shen et al., 2020). Although these factors impact how individuals manage HTN and maintain adherence to prescribed regimens, they have lacked extensive study, particularly within the Bahamian context (Ministry of Health & Wellness, 2019). Quantitative approaches have historically been key in identifying

adherence trends and patterns (Abbas et al., 2022), yet they are often insufficient to capture the personal and emotional aspects of medication adherence, particularly in smaller or culturally unique communities (Jonas, 2023; Wilkinson et al., 2022).

Researchers, such as Abbas et al. (2022), employed quantitative methodologies to identify adherence and conducted cross-sectional surveys to assess socioeconomic and clinical predictors of adherence behaviors. Jonas (2023) used a qualitative approach to investigate barriers and facilitators among hypertensive patients in Zimbabwe, finding that socioeconomic challenges and cultural influences were often intangible yet significantly impacted adherence. By providing greater insight into Bahamian men's healthcare experiences, this study contributed to existing quantitative results and offered rich, contextualized narratives essential for understanding barriers, facilitators, and health behaviors in the Bahamian context.

Economic and Systemic Barriers

Economic factors were significant obstacles to adherence, particularly in low- and middle-income countries. Abbas et al. (2022) found that nonadherence to antihypertensive medication in Lebanon contributed to increased hospitalizations and healthcare costs. Dhar et al. (2017) identified the cost of medication and access to healthcare as primary barriers in developing countries.

Cultural beliefs and logistical challenges substantially influenced medication adherence. Odusola et al. (2014) highlighted how cultural beliefs about HTN and its treatment in rural Nigeria led to mistrust of modern medicine, contributing to nonadherence. Kisigo et al. (2022) found that logistical barriers, including travel

distances to healthcare facilities and limited access to healthcare, hindered adherence among hypertensive patients in Tanzania.

Health literacy may be another critical barrier to adherence in Bahamian men. Shen et al. (2020) found that self-efficacy mediated health literacy and medication adherence in hypertensive patients. The researchers showed that improved health literacy could enhance adherence behaviors. This finding was particularly relevant in populations with low educational attainment, such as some socioeconomic groups in The Bahamas (Ministry of Health & Wellness, 2019).

Social Support and Family Involvement

Social support was significant in promoting medication adherence among hypertensive patients. Black patients with HTN who had robust family support systems exhibited significantly higher adherence to treatment regimens, as discovered by Flynn et al. (2013). These findings showed that family members played a role in encouraging and monitoring adherence, offering emotional and logistical support, and helping patients navigate healthcare challenges. Bahamian men's adherence outcomes depended on family support. Similarly, Zhou et al. (2023) found that the importance of social support networks in medication adherence applied across diverse global populations. Individuals with access to robust community- and family-based support systems were likelier to have adhered to antihypertensive regimens, suggesting that these networks supported medication adherence.

Wu et al. (2024) explored how the involvement of functional family units contributed to better managing chronic diseases like HTN and diabetes. The study

showed that individuals who reported strong family cohesion and support exhibited improved adherence behaviors compared to those from less supportive environments, suggesting that family members played a significant role in medication adherence. Familial caregiving roles are prevalent in the Bahamas, and leveraging these relationships is crucial for enhancing adherence among hypertensive patients.

In Ghana, Byiringiro et al. (2024) found a direct association between the accessibility of community and familial support networks and better blood pressure control outcomes. Patients with strong social ties and support structures reported fewer barriers to adherence and more consistent medication-taking behaviors. Several factors contributed to nonadherence, including patient-related barriers such as health literacy and social support, as well as systemic issues like access to healthcare and medication costs (Guo et al., 2023). Guo et al. (2023) highlighted that health literacy and social support directly and indirectly affected medication adherence, emphasizing their critical role in adherence behaviors.

Healthcare Provider Communication and Patient-Centered Care

Healthcare providers' and patients' communication effectiveness has been a consistent finding to improve medication adherence, particularly in managing chronic conditions like HTN. In a comprehensive review, Hamrahian et al. (2022) identified several key barriers and facilitators to medication adherence that clinicians should take into consideration. Clear, patient-centered communication had a positive impact on adherence. Engaging patients in shared decision-making and providing individualized attention significantly enhanced trust, leading to improved adherence behaviors. Results

also showed that building a strong rapport with patients to ensure they felt involved and valued in their care decisions was significant in medication adherence.

Patients who trusted their healthcare providers adhered to prescribed treatments, which mitigated the risks of complications such as hypertensive emergencies. Hamrahian et al. (2022) found that fostering a strong patient–provider relationship resulted in better treatment outcomes because patients were likelier to have disclosed their concerns about medication side effects and other treatment barriers. Trust was a critical mechanism to facilitate adherence, especially in populations that had historically faced barriers to healthcare access.

Feedback interventions were an effective strategy for improving patients' adherence to long-term medication treatments for HTN (Kobson et al., 2024). By integrating regular feedback, patients were able to monitor their progress and felt supported by their healthcare providers, which in turn improved adherence rates. Wilkinson et al. (2022) found that effective communication, taking into account a patient's cultural background, may significantly improve adherence. Chen et al. (2024) emphasized the role of health literacy and education in fostering self-management behaviors, while Wazir et al. (2024) highlighted the importance of trust in the patient–doctor relationship and social support as a moderating factor in adherence.

Strong patient–provider relationships, clear communication, and consistent feedback are essential for enhancing medication adherence. Providers using these interventions improved clinical outcomes and encouraged patients to be active in managing their health, which was particularly important in resource-limited settings like

The Bahamas. The literature indicates that consideration of cultural factors has a significant impact on medication adherence.

Cultural Competence and Communication in Medication Adherence

S. C. Williams (2011) examined how cultural values impacted medication adherence among Bahamian women, finding impacts of cultural competence and effective communication in health care in the same geographic region. Global guidelines, such as those proposed by Unger et al. (2020), showed the critical role of cultural competence in HTN management and how patient-centered care could have improved adherence. Schoenthaler et al. (2017) found that poor patient–provider communication significantly increased the risk of medication nonadherence. This was evident when providers failed to engage patients in discussions about their social and contextual circumstances—elements that align with culturally competent, patient-centered care. Kohrman et al. (2024) found that community-based interventions in family settings, such as barbershops, improved adherence. Social trust and culturally familiar environments played a key role in adherence, showing the importance of cultural competence in medication adherence, especially for underserved communities. Kohrman et al. (2024) highlighted the importance of culturally competent care for Bahamian men. Ogunniyi et al. (2021) investigated the intersection of race and ethnicity with HTN management, indicating cultural beliefs and ethnic diversity shaped adherence behaviors and how that applied to Bahamian men.

Brown et al. (2022) explored how cultural and religious beliefs in Jamaica influenced adherence to pharmacotherapy for NCDs, underscoring the need for culturally

competent care. Because Jamaica and The Bahamas share religious and cultural contexts, Brown et al.'s study supported the need to understand how beliefs impacted Bahamian men's adherence to HTN medications. Mansoor et al. (2024) investigated the differences in prescription patterns and medication adherence by gender and age. Middle-aged and older men were particularly vulnerable to nonadherence, indicating a link to societal norms regarding masculinity and health-seeking behaviors. These findings showed the importance of gender-specific approaches to culturally competent care,

Williams (2021) explored the medication beliefs and behaviors of hypertensive Caribbean immigrants in New York City, finding skepticism of Western medicine to be a significant barrier to adherence. Crucial concerns shaping adherence behaviors in the Caribbean immigrant population were side effects and medication efficacy, which suggested the need for healthcare providers to address these apprehensions directly. Cultural and individual beliefs about medication were significant barriers to adherence, requiring culturally addressed interventions.

Chang et al. (2021) emphasized the importance of trust and satisfaction with healthcare providers in promoting adherence, which is particularly crucial for Bahamian men, given the complexities of cultural and social factors that complicate communication. Pettersen and Candelaria (2024) explored patients' perspectives on medication adherence. By implementing communication strategies to consider cultural backgrounds, individual patient concerns, and patient-provider trust, healthcare providers fostered better adherence outcomes.

The Economic Impact of Nonadherence

The economic burden of nonadherence is well-documented. According to Abbas et al. (2022), nonadherence among hypertensive patients in Lebanon resulted in higher hospitalization costs. Nonadherence impacted patient health and placed a financial burden on healthcare systems. Mahmood et al. (2020) identified the cost of medications as a significant barrier to adherence among low-income patients in Pakistan. Patients often forewent treatment in regions where financial constraints limited access to necessary medications, resulting in more severe health outcomes and increased healthcare costs.

Although researchers have identified socioeconomic factors as barriers to adherence, the challenge is more pronounced in rural and underserved areas. Rural regions have limited healthcare infrastructure, making it difficult for patients to obtain preventive care and daily medications (Escobar & Barrios, 2021). Escobar and Barrios (2021) proposed a new approach to HTN management, focusing on enhancing infrastructure and access to care. Addressing financial constraints and the structural barriers that hindered medication adherence was essential. Given the economic and infrastructural challenges in rural areas identified by Escobar and Barrios (2021), Bahamian men in similar contexts experienced comparable barriers to adhering to medications.

Social Determinants and Stress Impacting Adherence

Alvarez et al. (2021) emphasized the significant role of social determinants such as stress and discrimination in medication adherence. External pressures like economic

challenges, work-related stress, and social inequalities influenced medication adherence. Comprehensive interventions addressing the physical aspects of health and the psychological and social challenges patients faced were necessary.

Brown et al. (2022) explored how cultural and religious beliefs in Jamaica influenced medication adherence for NCDs. The study found that patients often perceived illness as symptomatic, leading to poor adherence when symptoms subsided. Additionally, reliance on traditional remedies and religious beliefs resulted in patients prioritizing alternative treatments over prescribed medications. These findings suggested that culturally sensitive healthcare strategies were imperative, particularly in rural areas where such beliefs were prevalent.

Systemic challenges further complicated adherence to HTN management. The Lancet Regional Health – Americas (2022) found that addressing systemic inequalities in healthcare access was critical for improving health outcomes, particularly in the Caribbean region. Limited access to healthcare services, economic disparities, and healthcare inequalities compounded patients' everyday stress. Addressing systemic barriers, such as healthcare infrastructure gaps and provider distrust, reduced HTN-related stress and improved adherence rates in underserved populations, including Bahamian men (Bhattarai et al., 2023). Despite previous quantitative studies of medication adherence, qualitative scholars demonstrated the broader sociocultural factors involved. However, there was insufficient research that has captured the lived experiences of Bahamian men who live with HTN. The present qualitative study

addressed this gap by generating data to better understand the unique barriers and facilitators affecting adherence among this population.

Summary and Conclusions

Sociocultural and economic factors significantly influenced medication adherence, demonstrating the essential role of effective communication and cultural competence—the complex interplay between personal, social, and environmental determinants of health behavior—in treating HTN in Bahamian men. Despite considerable progress, a notable gap remains in research on Bahamian men with HTN. I addressed this gap by exploring the lived experiences of Bahamian men, seeking insights to inform culturally sensitive interventions and improve adherence and health outcomes within this demographic.

Pender's (2011) HPM and Bandura's (1986, 2004) SCT provided a framework to identify the factors impacting medication adherence among Bahamian men with HTN. Researchers have used the theories to understand how individual characteristics, perceived benefits and barriers, self-efficacy, interpersonal influences, and situational factors shape health behaviors. I extended the use of HPM and SCT frameworks by applying them to a specific cultural and social context and identifying unique challenges and facilitators within the focus population.

The literature shows that socioeconomic, cultural, and systemic barriers are central to the challenges of managing HTN and promoting medication adherence. The Lancet Regional Health – Americas (2022) and Brown et al. (2022) emphasized the need for individualized care approaches and broader systemic interventions that accounted for

specific cultural contexts, such as those in The Bahamas. The literature indicates the importance of a comprehensive, multifaceted approach that incorporates cultural, economic, and social factors when addressing medication adherence among Bahamian men.

I emphasized the importance of exploring the sociocultural context of Bahamian men to gain deeper insights into how these factors influence health behaviors and medication adherence. Presenting seminal and contemporary research was necessary to understand the multiple variables impacting adherence in this population. Public health strategies that were more effective and culturally tailored emerged as an outcome of this research to reduce the burden of HTN in The Bahamas. The literature showed the need for local research to explore Bahamian men's experiences with HTN, particularly regarding medication adherence (Jonas, 2023; The Lancet Regional Health – Americas, 2022; S. C. Williams, 2011). This qualitative phenomenological study offers insights into the personal, cultural, and socioeconomic barriers affecting adherence, providing a foundation for developing culturally sensitive interventions that improve health outcomes and reduce HTN-related morbidity in The Bahamas. The findings could lead to improved medication adherence interventions and health outcomes among patients in The Bahamas.

In Chapter 3, I present the research methodology and design, my role as the researcher, participant recruitment, the data collection and analysis plans, and ethical procedures.

Chapter 3: Research Method

The purpose of this qualitative phenomenological study was to explore the lived experiences of Bahamian men in managing HTN regarding their adherence to prescribed medications. Chapter 3 provides an in-depth overview of the research design and rationale, emphasizing the importance of a qualitative approach to explore the nuanced experiences of Bahamian men. The role of the researcher, potential biases, and strategies to ensure the study's integrity and credibility receive close attention. I address participant selection, the data collection instrument, procedures for collecting and analyzing data, and the ethical considerations related to my study. There is a discussion of the issues of trustworthiness: credibility, transferability, dependability, and confirmability.

Research Design and Rationale

The primary research question guiding this study was “What are the lived experiences of Bahamian men with HTN regarding medication adherence?” The central phenomenon was medication adherence, defined as the extent to which a person's behavior, taking medication, following a diet, or making lifestyle changes, corresponded with healthcare provider recommendations (see WHO, 2023b). I explored the lived experiences of Bahamian men as they navigated adherence to prescribed antihypertensive medications through shared stories. I employed qualitative methodology with a phenomenological design. A qualitative approach was suitable for capturing participants' feelings and experiences, enabling a nuanced understanding of their behaviors and motivations to emerge. Phenomenology was a suitable design for understanding how individuals made sense of their experiences in a specific context, such as managing HTN

through medication adherence. This research approach is appropriate to explore how personal, social, and cultural factors influenced individuals' behaviors and decisions regarding their health (Ravitch & Carl, 2021)

My findings provided rich, descriptive insights into the phenomenon of interest by focusing on the participants' lived experiences. This phenomenological approach was a way to understand Bahamian men's perceptions, motivations, and challenges in adhering to prescribed treatments. I intended for a sample size of 10 to 15 participants, aiming to achieve saturation and facilitate an in-depth exploration of individual experiences. The number of participants depends on data saturation, a key principle in qualitative research that involves continued data collection until no new themes or information emerges (Hossain et al., 2024). As Hossain et al. (2024) noted, smaller sample sizes in phenomenological studies were appropriate for gathering rich, detailed narratives without overwhelming data analysis. Eleven participants provided sufficient data to achieve saturation with manageable data collection and analysis.

I collected data through semistructured interviews with open-ended questions, allowing participants' narratives to emerge freely. I used purposive sampling to select Bahamian men diagnosed with HTN for at least 6 months who were currently taking prescribed antihypertensive medication. Recruitment involved distributing flyers at community health clinics, churches, and other local organizations, as well as posting on Facebook and other social media platforms. I coordinated with public health clinics, nurses in charge, and chronic NCD (CNCD) coordinators to promote participant engagement. Following IRB approval from Walden University, I obtained formal

approval from the permanent secretary through the nursing department to facilitate participant engagement. Subsequently, I submitted the research proposal to the Public Hospital Authority/University of the West Indies Research Ethics Committee of the Commonwealth of The Bahamas IRB for ethical review. Upon receiving ethical clearance from the institutions, I obtained authorization to conduct the study from the permanent secretary within the Ministry of Health and Wellness. Once approvals were secured, I conducted the interviews via Zoom (audio only) with participants' consent and recorded the sessions. I later transcribed the data verbatim for analysis. This multitiered approval process ensured adherence to international and national ethical standards, safeguarding participant rights while ensuring the research occurred within established regulatory frameworks.

Data analysis followed Giorgi et al.'s (2017) phenomenological method, which involved breaking the data into meaning units and transforming them to reflect the essential meanings of participants' lived experiences. This approach enabled the identification of patterns and themes that informed the medication adherence experience among Bahamian men. I found essential elements related to the participants' lived experiences with adherence, including facilitators and barriers to consistent medication use. Exploring how Bahamian men interpreted and navigated their medication adherence experience while capturing their behaviors in context presented culturally relevant insights that enhanced public health interventions in this area.

Role of the Researcher

My role as a researcher was that of an observer-participant. This role enables researchers to actively collect data while maintaining a level of detachment, ensuring the authentic capture of participants' experiences (Patton, 2015). As an observer-participant, I conducted semistructured interviews, recorded and analyzed data, and interpreted the participants' experiences related to medication adherence.

My 18 years of work as a registered nurse and midwife provided valuable insight into the challenges faced by Bahamian men with HTN, particularly concerning adherence to antihypertensive medications. Due to my dual roles as a healthcare professional and researcher, managing potential biases and power dynamics was crucial. I acknowledge that participants may have viewed me as an authority figure, which could have affected the data they shared. This possibility was particularly relevant because I work within the healthcare system where participants received care. To mitigate this risk, I did not recruit participants from the clinics where I was currently employed, a recommendation made by Ravitch and Carl (2021) to reduce the potential for conflicts of interest or feelings of coercion. During the consent process, I emphasized my role as a researcher, reassuring the participants that participating in the study would not affect their health care or relationship with any medical provider.

Mitigating researcher bias required careful consideration and management. As a healthcare provider, I held preconceptions about the factors influencing medication adherence that could have shaped the interpretation of participant responses. I regularly reflected on my biases and maintained a research journal to document my thought

processes during data collection and analysis, as suggested by Patnaik (2013). I practiced reflexivity to avoid misconstruing the participants' lived experiences through assumptions and biases.

Ethical considerations, particularly confidentiality and consent, were central to this study. Given the personal and sensitive nature of the shared health information, participants may have felt vulnerable discussing their health behaviors. Confidentiality was essential, necessitating the use of pseudonyms to protect participants' identities. Participants were aware of their right to withdraw from the study at any time without penalty. The data remained securely stored on a password-protected, encrypted drive accessible only by me.

Another potential conflict of interest was my professional connection to the healthcare system, where the recruitment flyers were distributed. Although I am employed within the public health system, I did not conduct the study within my workplace or include individuals under my care. Clinics were only used as community recruitment sites to display flyers and share information about the study. This separation of roles minimized the risk of power imbalances and reduced ethical concerns related to conducting research within one's work environment (Ravitch & Carl, 2021).

Informed consent is a requirement for research involving human subjects. Participants received detailed consent forms that outlined the study's purpose, the researcher's role, and participants' rights, ensuring the study's ethical conduct. As a token of appreciation, participants received blood pressure machines to support their ongoing health management. I intended this token to promote health awareness and self-

monitoring among participants, aligning with the study's focus on HTN management. I provided the blood pressure machines without obligation, ensuring that participation remained voluntary and free from coercion. I created a trusting research environment by actively managing potential biases, power dynamics, and ethical concerns. I ensured that participants felt comfortable sharing their experiences freely without fear of judgment or consequence. Attending to ethical considerations ensured that the data collected authentically reflected participants' lived experiences and contributed to understanding the barriers and facilitators of medication adherence among Bahamian men.

Methodology

The purpose of this qualitative phenomenological study was to explore Bahamian men's lived experiences with HTN regarding medication adherence. The section provides details on participant selection, data collection, and the data analysis plan. I followed ethical guidelines in collecting data to provide valuable insights into the phenomenon of medication adherence concerning Bahamian men. Data collection involved audio-only Zoom interviews, as was the participants' preference. This approach ensured accessibility and comfort for participants, particularly given the island's geographical context.

Participant Selection Logic

The inclusion criteria of Bahamian men aged 35 to 67 enabled a focus on the working-age population, where medication adherence may have intersected with employment demands, lifestyle factors, and healthcare access. Men over 67 were ineligible due to the potential for age-related cognitive decline or multimorbidity to confound the focus on HTN-specific adherence behaviors. Participants had been

diagnosed with HTN for at least 6 months, were currently taking at least one antihypertensive medication, were able to articulate their experiences in English, and were willing to take part in an in-depth interview. Purposeful sampling ensured the selection of participants who had experience with the studied phenomenon, medication adherence, to obtain diverse and knowledgeable perspectives. Purposeful sampling is appropriate in qualitative research to obtain in-depth and related information in accordance with the established inclusion criteria (Creswell & Creswell, 2018; Patton, 2015). Participant selection occurred based on *yes* responses to three screening questions: (a) Are you a Bahamian man between the ages of 35–67? (b) Have you been diagnosed with HTN for at least 6 months? and (c) Do you take medication for your HTN?

I recruited participants from health clinics, churches, government agencies, and other local organizations. The focus was on individuals who could articulate their experiences in English and were willing to participate in an in-depth interview. I sent formal letters to local organizations, including Rotary, Kiwanis, Lodges, churches, and government agencies, outlining the purpose of the study and the inclusion criteria and requesting their voluntary participation. Following IRB approval, I obtained formal written approval from the permanent secretary within the Ministry of Health & Wellness to conduct my research. This approval permitted me to engage CNCDC coordinators solely for the purpose of sharing IRB-approved research flyers and to post recruitment flyers only within clinic settings located in Eleuthera. No data collection occurred at the

healthcare facilities, and no CNCD coordinator was involved in any aspect of the data collection process.

I posted flyers in community spaces, sharing and encouraging recruitment via word-of-mouth referrals within local networks (See Appendix B). Interested individuals contacted me directly using the information on the flyer, and those who met the study criteria received a consent form. I contacted participants who responded to the recruitment efforts and scheduled a mutually convenient time for the semistructured interviews, ensuring privacy and comfort during the virtual Zoom platform. The interview process began by obtaining informed consent, ensuring that participants fully understood the study. The participants received information on confidentiality procedures, including the deidentification of transcripts and the secure storage of data in an encrypted format, to respect and protect their privacy. Each interview began with a broad, open-ended question, followed by four to five probing questions tailored to the participants' responses. Although I had planned to recruit 10 to 15 participants to achieve data saturation, no new themes emerged from the 11th interview. I audio-recorded all interviews with the participants' consent and transcribed the recordings verbatim for analysis.

Instrumentation

The instrument for this study was the semistructured interview, which I designed to explore Bahamian men's lived experiences with hypertension (HTN) and medication adherence (see Appendix C). The open-ended interview questions encouraged participants to describe their personal experiences freely, while allowing me to probe for

clarification and deeper meaning when necessary. In line with the exploratory nature of phenomenological studies, qualitative researchers may make adjustments and probe for more details based on participants' responses. Semistructured interviews are particularly effective in phenomenological research because they allow for the in-depth exploration of individual perspectives while maintaining a flexible structure (Smith et al., 2009).

Pender's (2011) HPM guided the development of the interview content and structure. The questions explored the perceived benefits of medication adherence, perceived barriers, self-efficacy, and the role of social and family support in managing HTN among the participants. Prior studies on medication adherence and health-promoting behaviors (Abbas et al., 2022; Wilkinson et al., 2022) informed the framing of the interview guide, ensuring that the content reflected both theoretical constructs and real-world influences identified in the literature. Collecting demographic information (age, gender, and employment; see Appendix A) before the interviews provided contextual details that supported analysis of how background factors shaped the participants' experiences.

All interviews were conducted virtually via Zoom. With participants' permission, I recorded the sessions to ensure accurate capture of verbal responses. I took field notes during each interview to document nonverbal cues, emotional expressions, and contextual observations that enriched interpretation. This comprehensive and interactive approach to data collection supported the phenomenological commitment to understanding the essence of lived experiences (Beck, 2021).

The interview structure reflected the principles of Pender's (2011) HPM. It was conceptually linked to Bandura's (1986, 2004) SCT, which emphasizes self-efficacy and reciprocal interactions between personal, behavioral, and environmental factors. These complementary frameworks allowed the interview to explore how beliefs, interpersonal relationships, and environmental contexts influenced adherence behaviors. One central question guided the interviews, while additional probing questions were used flexibly based on each participant's responses to elicit deeper insight into their lived experiences. The focus remained on what participants contributed through their narratives rather than imposing predetermined or forced-choice questions that would align with a quantitative design. This flexible use of probes aligns with the phenomenological approach, which emphasizes allowing meaning to emerge naturally from participants' descriptions rather than constraining responses within predefined categories. The in-depth exploration of participants' perspectives ensured a robust understanding of the phenomenon of medication adherence among Bahamian men with HTN and contributed to both theoretical and practical insights (Saglam, 2024).

Procedures for Recruitment, Participation, and Data Collection

The means of recruitment was via flyers at community health clinics, churches, government agencies, and local organizations after receiving permission from the Permanent Secretary (see Appendix B). CNCDC coordinators and clinic staff posted the IRB-approved flyer in public clinic areas only after obtaining site permission. They did not identify, screen, or refer any potential participants. In addition to flyers, I shared the recruitment invitation on social media platforms using the following IRB-approved flyer.

Some participants also learned of the study through word of mouth after flyers were displayed publicly. All participants in this study were self-referred men who independently contacted the researcher using the information provided on the recruitment materials.

When an interested individual contacted me, I asked three qualifying questions: (a) Are you a Bahamian man between the ages of 35–67? (b) Have you been diagnosed with HTN for at least 6 months? and (c) Do you take medication for your HTN? Respondents who answered *yes* to all three questions were eligible for the study. Meeting the inclusion criteria ensured that the participants had direct, lived experiences with the phenomenon of medication adherence being explored. The inclusion criteria were critical in obtaining data that reflected the experiences of Bahamian men in managing HTN. Individuals answering *no* to any question received appreciation for their interest and the reason for their ineligibility. All eligible participants received and completed an electronic consent form outlining the study’s details, risks, and right to withdraw at any time in advance. Participants who were not computer literate obtained a printed copy of the document. Respondents provided signed consent or responded to the email with “I consent” to confirm participation.

After receipt of each consent form, I arranged a time for the online Zoom meeting. Although I anticipated each interview would take between 30 and 60 minutes, the actual lengths ranged from 12 to 21 minutes, depending on the participant’s responses. Before the interview, I explained the process and associated risks and let the participants know they were free to stop the interview at any time if they were

uncomfortable. I began the interview upon obtaining each participant's consent for audio recording. Neither the participants nor I turned on the cameras, and the interviewees did not identify themselves by name. Audio recording allowed for verbatim transcription and accurate data analysis.

Data Analysis Plan

To analyze data, I followed Giorgi's (Giorgi et al., 2017) descriptive phenomenological method, which was well-suited for exploring the lived experiences of medication adherence among Bahamian men with HTN. Giorgi's method enabled an understanding of the complexity of participants' experiences rather than relying on single data points. Descriptive phenomenological analysis was appropriate to explore medication adherence among Bahamian men, providing a more realistic narrative of the participants' experiences. Giorgi's method comprises four critical steps: reading the entire dataset to gain a sense of the whole, identifying meaning units within the data, transforming the meaning units into phenomenologically sensitive expressions, and synthesizing the transformed meaning units into a coherent narrative structure.

The first step involved reading the interview transcripts in-depth to gain a deeper understanding of the participants' experiences. Giorgi (Giorgi et al., 2017) identified this phase as crucial for researchers to immerse themselves in the data and capture the overall context of the participants' narratives. I listened to the recordings while reading the transcripts to confirm their accuracy. Next, after immersing myself in the transcripts, I broke the data into smaller, more meaningful units relevant to medication adherence,

perceived barriers, or facilitators. I identified and isolated aspects of the participants' narratives that provided insight into medication adherence.

After identifying meaning units, I transformed them into psychological insights. According to Giorgi (2020), this process enables researchers to move beyond the literal content of the narrative and interpret the underlying and less obvious psychological elements, such as participants' beliefs, motivations, and emotions regarding medication adherence. The final step involved synthesizing the meaning units into broader themes to identify commonalities and differences across participants' narratives. Through phenomenological transformation of meaning units, patterns such as perceived barriers, facilitators, and individual motivations for medication adherence emerged. Coding in qualitative research requires an iterative review, where the data are continuously compared to refine the emerging themes (Rubin & Rubin, 2012).

I employed a comparative approach to promote accuracy throughout data analysis, focusing on original recordings only and ensuring that themes emerged from the data, rather than from assumptions or biases. This approach involved maintaining consistency across the data. As the researcher, I remained attentive to deviations from the participants' narratives, comparing them only to the original recordings to ensure fidelity to the participants' lived experiences. The iterative comparative method aligns with Giorgi's (2020) approach to remaining faithful to the participants' descriptions of their lived experiences, without influence from the researcher's assumptions or biases. Careful interpretation served as an additional strategy to resolve any ambiguities in meaning. The findings could inform culturally relevant public health interventions.

Issues of Trustworthiness

Due to the subjective nature of qualitative research, ensuring trustworthiness was paramount. Guba and Lincoln's (1981) four criteria—credibility, transferability, dependability, and confirmability—served as fundamental guidelines for establishing trustworthiness in qualitative research. In studies exploring lived experiences, achieving trustworthiness means that the findings accurately represent the data set.

To enhance the credibility of this study, I achieved sufficient engagement with participants through in-depth semistructured interviewing and iterative probing. Ensuring credibility involved maintaining fidelity to the original recordings throughout the data analysis process. If I identified any discrepancies between the transcripts and the recordings, I revisited and clarified them to ensure accuracy and uphold the integrity of the findings. Thick, rich descriptions of participants' experiences allowed others to assess the transferability of the findings (Ahmed, 2024). Throughout the study, I maintained an audit trail to document decisions and actions, which increased dependability and allowed others to replicate the study method and design. Reflexivity and the separation of roles further reduced researcher bias, enhancing confirmability (Ahmed, 2024).

Maintaining a thick, rich description of each part of the study enables others to assess the transferability of the findings (Ahmed, 2024). Ahmed (2024) emphasized that reflexivity, or critically examining one's biases and assumptions, is vital to qualitative research. To minimize researcher bias and enhance confirmability, I employed practices such as role separation and reflexivity. These strategies enhanced the trustworthiness of the findings while maintaining rigor in the research process.

Ethical Procedures

Ethical procedures guided the study. I obtained informed consent from all participants and adhered to stringent confidentiality practices. The interviewees were aware of their rights as participants and the voluntary nature of the study. The interviews were conducted using a phenomenological approach that emphasized neutrality and openness, ensuring that questions were phrased in an unbiased, open-ended manner to allow participants to describe their lived experiences freely. Before I began data collection, I obtained approval from the Walden University IRB (Approval number: 05-30-25-0418479). In addition, I received formal written approval from the Permanent Secretary of the Ministry of Health & Wellness in The Bahamas to conduct the study and to post recruitment flyers in each community clinic space in Eleuthera (see Appendix D).

I took deliberate measures to maintain participant confidentiality. The recordings remained securely stored and accessible only by me. The Zoom interviews took place without cameras or participant names, which served as additional steps to maintain confidentiality and minimize participant risk and discomfort.

After transcribing the interviews, I reinforced the confidentiality of the data by securely storing all recordings and transcripts. By doing so, I maintained ethical rigor and respected participants' trust throughout the research process. Participants received a reminder of their right to withdraw from the debriefing interview at any point without consequences. I securely stored all data in my password-protected Walden University OneDrive account, which provided secure, end-to-end encryption and controlled access. I

transferred the data to a password-protected iStorage encrypted USB drive with AES 256-bit hardware encryption. I was the sole person handling the data.

Privacy and confidentiality were paramount throughout the study. Providing an informed consent form in advance allowed participants to understand the study's purpose and their roles. The form included measures taken throughout the study to protect their confidentiality, making them feel comfortable in the environment and alerting them to their right to withdraw from the study at any time. Using the informed consent form to communicate clear ethical standards helped participants feel more comfortable and aware of their rights throughout the study. These ethical standards ensured that interviews occurred with transparency and respect for the participants' welfare.

Summary

In Chapter 3, I outlined the methodological framework and procedures used to explore the lived experiences of Bahamian men with hypertension regarding their medication adherence. The qualitative phenomenological design was appropriate for capturing the depth and complexity of these experiences, allowing participants to describe their realities in their own words. The use of purposive sampling ensured that only individuals who directly experienced the phenomenon were included. This enhanced the richness and relevance of the data. The semistructured interview instrument and the use of probing questions created space for reflection and meaning making, supporting the study's alignment with Giorgi's descriptive phenomenological method.

I also demonstrated how rigor and trustworthiness were achieved through reflexivity, prolonged engagement, and maintaining fidelity to the participants' original

accounts. Ethical integrity was upheld through informed consent, confidentiality, and adherence to Walden University and The Bahamas' ethics approval procedures.

Collectively, these methodological choices created a structured yet flexible process that safeguarded participant rights while ensuring authentic representation of their lived experiences.

In Chapter 4, I present the findings that emerged from this methodological process, including themes that reflect Bahamian men's perceptions, barriers, facilitators, and motivations related to medication adherence.

Chapter 4: Results

The purpose of this qualitative phenomenological study was to explore the lived experiences of Bahamian men with hypertension regarding their adherence to prescribed antihypertensive medication. The guiding research question was: What are the lived experiences of Bahamian men managing hypertension regarding their adherence to prescribed medications? I present the pilot study, including the research setting, participant demographics, data collection, data analysis, and evidence of trustworthiness, followed by the study results. In line with Giorgi's descriptive phenomenological analysis method (Giorgi, 2020; Giorgi et al., 2017) and following Koivisto et al. (2002) application in nursing research, the results appear in two levels: the specific situated structures for each participant (P1–P11), and the general psychological structure, which integrates invariants, variations, and the final essence of the phenomenon.

Setting

I conducted this qualitative study with Bahamian men residing on the island of Eleuthera who were diagnosed with hypertension and prescribed antihypertensive medications. Eleuthera was a convenient selection because it is the island where I live and work. To avoid any conflict of interest, I did not recruit participants from the clinic where I work or from any of my current patients. Participant recruitment focused on men from the central and southern districts of the island, where residents may have known me as a nurse, but there were no provider–client relationships.

I obtained IRB approval to conduct the study. I also received permission from the Ministry of Health & Wellness in The Bahamas to engage ministry-employed chronic

non-communicable disease coordinators to share research flyers, post the IRB-approved recruitment flyer in the Eleuthera clinic setting, and conduct interviews with qualified participants who voluntarily responded to the recruitment flyer. After obtaining approval from the appropriate individuals, I posted recruitment flyers in community spaces, including health clinics, churches, civic groups, government agencies, and social media forums. In churches, for example, it is customary for moderators to read announcements aloud at the close of Sunday service, which provided a culturally appropriate way to share research invitations. Chronic noncommunicable disease coordinators and clinic staff posted flyers in waiting areas but were not involved in identifying or referring individuals.

Interested participants contacted me directly using the email address on the recruitment flyer. I responded via email with three prequalifying questions: (a) Are you a Bahamian man aged 35 to 67? (b) Have you been diagnosed with hypertension for at least 6 months? and (c) Are you currently prescribed antihypertensive medication? I emailed all eligible participants the informed consent form, which detailed that the study was voluntary and that they could decide at any time not to participate or complete the interview. I scheduled semistructured interviews after the participants replied with the words, "I consent." All interviews took place from July through the second week of August 2025, primarily via Zoom audio calls, a format the participants identified as convenient and private. Although in-person interviews in a private, approved conference room used for community seminars were an option, all participants selected virtual interviews.

Demographics

The participants were 11 Bahamian men ranging in age from 35 to 67 years. The age group breakdowns were as follows: 35–40 ($n = 1$), 41–50 ($n = 3$), 51–60 ($n = 6$), and 61–67 ($n = 1$). Educational backgrounds ranged from some high school to college degrees, and occupations represented diverse sectors, including public service, skilled trades, hospitality, and business ownership (see Table 1).

The years since diagnosis with hypertension ranged from 1 to 2 years to more than 30 years. Participants had received prescriptions for a range of antihypertensive medications, and their follow-up practices varied from routine monthly visits to rarely seeking provider care and relying on self-monitoring. The duration of hypertension diagnoses varied considerably across participants. Some reported receiving diagnoses more than 30 years ago, whereas others had lived with the condition for 10 to 20 years. A few participants described their date of diagnosis in broader terms, such as “since early career,” “since age 18,” or simply “a few years.” This variation showed the range of lived experiences, from men who had managed hypertension across most of their adult lives to those with more recent diagnoses (see Table 2).

Table 1*Participants' Demographic Characteristics*

Participant ID	Age group	Education level	Occupation
P1	61–67	Some college	Skilled trade
P2	51–60	Some high school	Skilled trade
P3	41–50	High school	Other/generalized
P4	41–50	High school	Public service
P5	51–60	High school	Public service
P6	51–60	College degree in Electrical	Skilled trade
P7	61–67	College degree in Business Administration	Public service
P8	51–60	High school and international/technical training	Other/generalized
P9	41–50	College	Hospitality/business owner
P10	51–60	High school	Public service/security
P11	35–40	High school	Skilled trade

Note. Self-reported data; occupations generalized to protect participant confidentiality.

Table 2*Participants' Medical Information*

Participant ID	Years since HTN diagnosis	Current medication(s)	Frequency of provider visits
P1	32 years	Co-Diovan, Diovan 160mg, amlodipine 5mg	Every 6 months
P2	20 years	Preterax 1.5mg, Nifedipine 30mg	Yearly
P3	Since 2022 (~1–2 years)	Amlodipine, previously Co-Diovan 180	As needed
P4	Few years	Valcard 160mg, Crestor 10mg	Rarely; only when necessary
P5	10–12 years	Natrilix, previously Preterax	Not specified
P6	15+ years	Triplixam 5mg (previously Diovan)	Monthly or every 2–3 months
P7	11–12 years	Amlodipine, Preterax	Every 3 months
P8	10 years	Co-Diovan	Monthly
P9	Since 2008 (~15+ years)	Lisinopril (previously Zestoretic)	Every 3 months
P10	Since early career (~20+ years)	Diovan 320, Amlodipine 5mg, water tablet (previously Exforge)	Hardly ever
P11	Since age 18 (~15–20 years)	Lisinopril (previously another, unknown med)	Rarely; self-monitors daily at home

Note. Medical history details based on participants' self-reported information during the interviews.

Data Collection

Data collection entailed conducting semistructured interviews with open-ended questions to elicit the participants' lived experiences with hypertension and medication adherence. Each participant received an email containing a link to the password-protected Zoom waiting room, along with the IRB-approved informed consent form. Participants responded to the email with "I consent" or signed and returned a paper copy of the form before their scheduled interview.

The audio-only interviews took place in quiet, private settings to ensure confidentiality and minimize interruptions. I obtained each participant's consent to audio-record the conversations. At the start of each session, I reminded participants of the study's purpose, confidentiality protections, and right to withdraw at any time. Participants were aware that I would de-identify and transcribe the interviews for research purposes only, subsequently analyzing the data and writing the results.

The interviews began with demographic queries, followed by questions to explore facilitators, barriers, and perspectives on treatment adherence. I stored the audio files on a password-protected device in an encrypted folder accessible only to me. I transcribed each recording verbatim, removing names and other personal identifiers. I shared the transcripts and data analysis steps with my dissertation committee as part of the review process to ensure accuracy and transparency. Interviews lasted between 12 and 21 minutes, with an average of about 15 minutes. Although shorter than expected, the participant interviews provided sufficient depth and richness to achieve data saturation.

Raw audio and transcripts remained in the institutional OneDrive account, in accordance with IRB approval. As a backup, I mirrored the files to a password-protected, AES-256–encrypted USB drive. No external parties had access to the data.

A pretest of the Zoom audio-recording feature found that the process was reliable; therefore, no backup device was necessary. I kept field notes to capture salient observations during each session. Each participant was interviewed once, using the same semistructured interview guide to ensure consistency across cases. All interviews took place between July and the second week of August 2025.

Variation in Data Collection Procedure

There were minor adjustments to the scheduling and logistics. Some participants rescheduled due to work obligations or working late, and others required preinterview reminders. When one participant had difficulty connecting to Zoom, we rescheduled his interview for an evening when his wife would be home and able to assist. Similarly, another participant was not familiar with Zoom and required his wife’s help to set up the session. Despite these adjustments, all 11 interviews took place. By the 10th interview, the descriptions provided sufficient depth and variation to capture the essential structures of the phenomenon. No new essential structures emerged in the eleventh interview, supporting the adequacy of the sample size.

Unusual Circumstances

No participants withdrew after providing consent. There was a delay in one participant’s interview due to a temporary internet disruption caused by a power outage. I used a mobile hotspot to reconnect and completed the interview without loss of data.

Effectively managing brief interruptions did not compromise the integrity of the data. Overall, the data collection process proceeded smoothly, and no unusual or significant circumstances occurred.

Data Analysis

I followed the data analysis process using Giorgi's descriptive phenomenological method (Giorgi, 2020; Giorgi et al., 2017), which involved moving from participants' raw transcripts to meaning units, transformed expressions, and then synthesizing themes (see Table 3). I first read each transcript in its entirety to gain a sense of the whole. Next, I identified meaning units within each narrative that directly addressed the phenomenon of medication adherence. I transformed these units into phenomenologically sensitive expressions, highlighting underlying beliefs, emotions, and contextual influences. Finally, I synthesized the transformed expressions into essential structures (invariants) and variations across participants. Common emergent themes included family support, masculinity concerns, fear of illness, bush medicine use, lifestyle and work-related challenges, and spirituality. At the same time, variations in individual accounts showed the unique ways in which the men balanced cultural practices, occupational demands, and personal responsibility in managing hypertension.

Table 3*Giorgi's Descriptive Phenomenological Analysis Across Participants*

Participant	Meaning unit (raw excerpt)	Transformed expression	Step 4: Structural notes	Invariant/ variation
P1	I have my own machine and take my [blood] pressure twice a day.	Regular self-monitoring creates a sense of control and responsibility.	Invariant: Monitoring + lifestyle adjustments → adherence	Invariant
P1	Too many men stop taking their pills because of sex drive concerns.	Masculinity beliefs influence adherence decisions.	Variation: Not all participants raised sexuality	Variation
P2	Sometimes I skip a day if my readings are good.	Medication adherence is adjusted based on self-monitoring rather than provider advice.	Invariant: Self-regulation seen across participants	Invariant
P2	My wife cooks healthy meals, and I use bush teas.	Family support and cultural remedies shape adherence practices.	Variation: Greater reliance on bush medicine than some others	Variation
P3	The pills make us feel weak in our manhood.	Sexual side effects perceived as threats to masculinity → reduced adherence.	Invariant: Masculinity concerns present	Invariant
P3	My wife and son keep me on track.	Family reminders act as external adherence motivators.	Invariant: Family as facilitator	Invariant
P4	I didn't want to go on medication at first... but with a baby on the way, I decided.	Family transitions motivate adherence.	Variation: Parenthood as adherence motivator	Variation
P4	My faith... my body is God's temple.	Spiritual belief informs adherence.	Variation: Religious framing	Variation

Participant	Meaning unit (raw excerpt)	Transformed expression	Step 4: Structural notes	Invariant/ variation
P5	I ran out or simply forgot... I tried apple cider vinegar and lemon juice.	Forgetfulness and alternative remedies lead to inconsistent adherence.	Invariant: Bush medicine use across participants	Invariant
P6	Nurse said I'd be on medication for life, but after changing my diet, I can skip days.	Self-efficacy and lifestyle change reduce perceived dependence on meds.	Variation: Stronger emphasis on diet as a substitute	Variation
P6	Doctors are qualified and there to help... If you want to get better, you need to listen to them.	Trust in medical authority reinforces adherence despite experimentation with self-regulation.	Invariant: Trust in provider advice	Invariant
P7	My wife reminds me.	Spousal support sustains adherence.	Invariant: Family as key facilitator	Invariant
P7	My doctor asked, 'Are you ready to die?' That stuck with me.	Fear-based provider message influences adherence.	Variation: Provider communication impact	Variation
P8	When I skip, I feel tingling, so I return.	Embodied awareness signals adherence need.	Invariant: Physical sensations guide decisions	Invariant
P8	My wife sets up my pill organizer and checks in by phone.	Spousal involvement institutionalizes adherence behaviors.	Invariant: Family as facilitator	Invariant
P9	My work schedule makes me forget.	Occupational demands hinder adherence.	Variation: Work as barrier	Variation
P9	I don't want to die... I'm motivated by wanting to live a long life.	Mortality awareness motivates adherence.	Invariant: Fear of death motivates adherence	Invariant
P10	Sometimes I skip to avoid bathroom trips when I work late.	Side effects + work routines shape adherence.	Variation: Practical barriers differ	Variation

Participant	Meaning unit (raw excerpt)	Transformed expression	Step 4: Structural notes	Invariant/ variation
P10	I don't want another stroke.	Fear of recurrence motivates adherence.	Invariant: Fear of illness motivates adherence	Invariant
P11	I neglected medication because of sexual performance concerns.	Masculinity concerns influenced adherence.	Invariant: Male identity theme	Invariant
P11	I almost had a stroke once... had to get IV meds.	Crisis experience reinforces importance of adherence.	Variation: Lived near-death reinforced adherence	Variation

Note. Transcript excerpts are anonymized. Invariants represent shared meanings across participants; variations reflect contextual differences.

Evidence of Trustworthiness

To ensure rigor, I employed Lincoln and Guba's (1985) four criteria for trustworthiness: credibility, transferability, dependability, and confirmability. Achieving credibility entailed engaging participants in in-depth, semistructured interviews that allowed them to describe their lived experiences in detail. I maintained fidelity to the raw transcripts during analysis, with meaning units compared to the original recordings to preserve accuracy. I also considered discrepant cases that did not align with dominant themes, ensuring the representation of all voices (Creswell & Creswell, 2018; Giorgi, 2009).

Thick, rich descriptions of participants' backgrounds, occupations, and medication practices contributed to transferability, enabling readers to assess applicability to other contexts. Although the findings are not generalizable beyond Eleuthera, they may resonate with men in other Caribbean or small-island contexts who share similar cultural and health challenges. The in-depth experiences strengthen the trustworthiness of the

study by providing a basis for readers to make informed judgments about the transfer of insights.

Dependability was maintained using an audit trail to document recruitment, consent, data collection, and data analysis. All interviews occurred following the same guide and process. Giorgi's structured phenomenological steps were used, which included identifying meaning units, transforming them into phenomenological expressions, and synthesizing them into situated, general, and essential structures.

Reflexivity and methodological transparency strengthened confirmability. As a nurse and a researcher, I was mindful of potential bias and documented reflections in a research journal. By separating my professional role from my researcher role and adhering to ethical safeguards, I ensured that findings arose from participants' narratives rather than my assumptions. Secure data storage and transparent analysis further reinforced confirmability.

Results

The purpose of this descriptive phenomenological study was to explore the lived experiences of Bahamian men with hypertension regarding their adherence to prescribed antihypertensive medication. Following Giorgi's steps of data analysis, the analytic process progressed from the development of specific, situated structures for each participant to the articulation of a general psychological structure that captured both invariant and variant aspects, and finally to the synthesis of an essential psychological structure that expressed the essential meaning of the phenomenon.

Situated structures illuminated how antihypertensive adherence manifested in each case, reflecting the participants' unique lived experiences. I transformed the structures into phenomenological language supported with direct quotations. Eleven situated structures follow.

Participant 1

P1 accepted adherence from the beginning, grounded in trust in physicians and reinforced by observing peers who became disabled from neglect. He explained, "I been taking my medication from the doctor straight ... I see men who didn't, and now they can't walk." P1 structured his practices through fixed dosing, refills, and home blood pressure checks. He occasionally drank bush tea but never in place of prescribed pills, and he often encouraged peers not to neglect their treatment.

Participant 2

P2 was ambivalent about adherence, frequently adjusting intake based on self-monitored readings. He admitted, "Sometimes I check my pressure and if it low, I don't take them." A work-related collapse served as a turning point, and his wife's reminders and dietary control played a central role in sustaining adherence.

Participant 3

P3's resistance aligned with fears of sexual dysfunction. He said, "These pills ... have us as males get us 'lil weak in our manhood ... I still young, I ain' old." Observing strokes among peers and reminders from his wife and son eventually shifted his practice toward consistent adherence.

Participant 4

P4 resisted medication for years until critically high blood pressure and the birth of his child served as decisive motivators: “When my baby born, I realize I have to take it ... I can’t leave my child.” He structured adherence around evening dosing and a blood pressure log, framing his body as “God’s temple.”

Participant 5

P5 described his adherence as an obligation: “No motivation ... I just have to take them.” He experimented with substituting apple cider vinegar and lemon juice, but a physician’s stern warning reframed adherence as a matter of survival.

Participant 6

Philosophical resistance to lifelong medication prompted P6’s deliberate self-testing by skipping doses. He remarked, “I wanted to see if that true ... so I stop for 3, 4 days.” He also relied on garlic- and ginger-infused water. Ultimately, P6 described adherence as obedience to both medical authority and divine wisdom.

Participant 7

Initially, P7 framed his condition as “borderline” until a physician’s stark question— “Are you ready to die? ... You can just fall out and die”—became a turning point. He maintained a daily morning routine of prayer, water, and medication, driven by a desire to live long enough to see his grandchildren.

Participant 8

P8’s early negligence shifted following an episode of Bell’s palsy, which he suspected was stroke related. The participant recalled, “My face drop one side ... I know

it was serious.” His wife organized his medications in a cartridge system, and although he reported reduced sexual drive, he continued his adherence because he believed the medication preserved his life.

Participant 9

P9’s demanding work as a chef disrupted his adherence. He admitted, “Sometimes when I travel, I forget them home.” He avoided taking pills on an empty stomach, which sometimes led to delays. Fear of a sudden collapse in the kitchen motivated P9 to continue treatment.

Participant 10

P10, who had been prescribed antihypertension medication for several years, occasionally missed doses due to nocturia when dosing late. He explained, “If I take it late, I up all night using the bathroom.” Following a stroke in 2018, P10 became vigilant, admitting, “After the stroke, I ain’t miss no more.”

Participant 11

Diagnosed as a teenager, P11 practiced conditional adherence. He explained, “If my pressure high, I take it. If it low, I don’t bother.” After the participant experienced a hypertensive crisis that required hospitalization, his orientation shifted, though concerns about sexual performance and episodes of neglect persisted.

General Psychological Structure

As shown in Table 3, the cross-participant analysis indicated invariants that were consistent across participants and variations that reflected contextual differences. From the situated structures, shared essences and nuanced variations emerged. These general

structures represent how Bahamian men commonly lived and made sense of adherence to antihypertensive medications.

Across participants, initial ambivalence was evident. Many men hesitated at the beginning, citing disbelief in the need for lifelong medication or concerns about side effects. This was particularly seen in those who voiced concerns about affecting sexual performance and masculinity. Despite this reluctance, decisive turning points redirected men toward adherence. These junctures included health crises such as strokes or hypertensive emergencies, strict physician warnings framed in terms of life and death, and significant family milestones, particularly the birth of children or the desire to remain present for grandchildren.

The participants described structured practices that sustained their routines after establishing adherence. Their actions included daily schedules, pillboxes, home monitoring, and reminders from spouses. Some participants deeply ritualized their practices, such as combining prayer, hydration, and medication at a fixed time each day.

Motivations for adherence consistently reflected three central anchors: fear, family, and faith. Fear of complications or death served as a powerful motivator, as did responsibility toward children and grandchildren. Faith provided meaning and reinforced discipline, with some men framing their bodies as temples of God or describing medical authority as divinely inspired.

Despite these commitments, participants continued to face persistent barriers. Barriers such as work demands, irregular schedules, and frequent travel created interruptions. Forgetfulness or negligence contributed to lapses that sometimes lasted

several days. Side effects—including dizziness, cough, gout, frequent urination, and diminished sexual drive—shaped attitudes toward medication in varied ways, leading some to experiment with alternatives. The participants experienced hypertension through symptoms such as tingling, dizziness, and headaches, consistently describing medication as restorative and life-preserving.

Variation across participants also reflected cultural context and personal framing. The participants widely acknowledged the use of bush medicine and home remedies. Some participants used bush medicine in addition to their prescriptions, while others substituted it for them. Some sources of motivation differed. They ranged from spousal encouragement to children, grandchildren, and spiritual stewardship. The participants framed adherence variously as discipline, fear, obligation, or divine obedience. Some men became advocates, encouraging peers to adhere, whereas, others-maintained privacy or practiced conditional adherence.

Together, these invariant and variant structures show that adherence was not a static behavior but an active and ongoing negotiation. Participants continuously balanced medical prescriptions with cultural remedies, personal fears with family obligations. This was also evident in the structured routines, which often encountered barriers in everyday life. The findings underscore that adherence cannot be understood as simply following prescriptions, but rather as a process of ongoing adjustment within the context of participants' lived experiences.

Essential Psychological Structure

The essential structure of adherence among the participants was a movement from reluctance to responsibility. Although many participants initially had ambivalence or resistance, they were reoriented toward adherence at decisive turning points. Once committed, men organized their lives around structured practices that combined medical treatment with personal and cultural meaning. Once committed, men organized their lives around structured practices that combined medical treatment with personal and cultural meaning.

The primary motivations of each participant's adherence to antihypertensive medication were the fear of death or serious health complications, a strong sense of responsibility to care for their families, and the belief that maintaining their health was part of fulfilling a God-given purpose. The disruption from work schedules, side effects, forgetfulness, and cultural skepticism about pills played a role in adherence becoming vulnerable to participants. The men experienced hypertension through embodied symptoms and medication as restoration and survival. Ultimately, adherence was not simply compliance with a prescription but a daily act of negotiation—balancing fear and faith, autonomy and obligation, medical prescriptions and cultural practices—in pursuit of preserving life and fulfilling responsibilities to family and community.

Discrepant Cases

The shared experience across participants reflected a movement from initial reluctance toward structured and consistent adherence; three participants described accounts that diverged from this shared structure. Rather than interpreting nonadherence

as a lapse or failure, P2, P5, and P6 framed it as a form of intentional self-management. P2 explained, "Sometimes I skip a day if my readings are good," while P5 reported using alternatives such as apple cider vinegar and lemon juice in place of prescriptions. Similarly, P6 described deliberately withholding medication for several days at a time to test his body's response, relying on garlic- or ginger-infused water and diet adjustments. These perspectives contrasted with those of most participants, who emphasized the dangers of missing doses and the importance of maintaining daily routines.

Including these discrepant perspectives illustrates the fluid and negotiated nature of adherence. On the other hand, the widely shared structure emphasized the importance of consistency for survival. Participants 2, P5, and P6 perceived occasional nonadherence as a controlled and acceptable response. This response was related to bodily feedback, cultural practices, or personal experimentation. These contrasting accounts enhance the credibility of the study by representing the full complexity of the phenomenon, including the perspectives of a few participants who challenged the shared pattern of adherence.

Summary

I presented the results of a descriptive phenomenological analysis of Bahamian men's lived experiences of adherence to antihypertensive medication. The findings emerged from Giorgi's data analysis method, progressing from specific, situated structures for each of the 11 participants to a general structure and an essential statement that captured the phenomenon in its entirety.

Nine of the 11 participants (82%) initially expressed ambivalence or resistance toward medication, often related to skepticism about lifelong use or fears of potential side

effects. There were several decisive turning points. Some were hypertensive crises, dire physician warnings, and family milestones that redirected participants toward adherence. Once committed, participants sustained adherence through structured practices that included daily routines, pillboxes, home monitoring, and spousal reminders. Motivations were consistently centered around the fear of death or disability, a sense of responsibility toward family, and faith in God's purpose.

Despite this shared experience, antihypertensive medication adherence remained susceptible to compliance barriers. These barriers included demanding work schedules, forgetfulness, and medication side effects. Participants experienced hypertension through the presence of somatic symptoms and perceived medication as restorative and life-preserving. Variations emerged in how the men framed adherence, whether as discipline, obligation, fear, or spiritual obedience, and how they integrated or substituted cultural remedies for prescriptions.

Discrepant cases added further nuance. Three of the 11 participants (27%) reframed their occasional nonadherence as intentional self-management rather than failure. The participants highlighted the fluid and negotiated nature of adherence, showing that antihypertensive medication adherence among Bahamian men was neither consistent nor absolute but varied according to personal beliefs, cultural practices, and life circumstances. Overall, the essence of the phenomenon was a shift from reluctance to engage in consistent antihypertensive medication use to a sense of responsibility for one's health and family. Adherence was not a passive act. It was an ongoing negotiation that

balanced medical prescriptions with cultural practices, fear with faith, and obligation with autonomy.

In Chapter 5, I provide an interpretation of the findings in relation to the existing literature and the study's conceptual framework. I show how the results confirm, extend, or challenge prior research on medication adherence among men, with a focus on small-island and Caribbean contexts. In addition, I address implications for nursing practice, health education, and health policy, and conclude with recommendations for future research and social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative descriptive phenomenological study was to explore the lived experiences of Bahamian men diagnosed with hypertension regarding their adherence to prescribed medications. This study was a way to address a significant gap in the literature, as previous research and national health surveys in The Bahamas lacked gender-specific data and insights into men's adherence behaviors. Based on in-depth interviews with 11 participants, the findings present the lived realities and experiences shared by participants, including the challenges and supports that shaped adherence in a small-island context.

Key findings showed that adherence followed a trajectory of reluctance that eventually gave way to a sense of responsibility. Although participants initially resisted or questioned the need to remain on medication for the rest of their lives, decisive turning points, including health crises, stern warnings from physicians, and family milestones, eventually prompted and led to adherence. Once committed, the participants-maintained adherence through structured practices. These practices included using medication pillboxes, at-home blood pressure monitoring, and daily routines often tied to prayer. For example, P7 explained that his morning routine consisted of "prayer, water, and medication," a sequence that reinforced both health and spiritual discipline.

Three central motivators—fear, family, and faith—supported adherence, whereas side effects, occupational demands, and forgetfulness posed ongoing challenges. Instead of bush medicine emerging as a barrier, participants described it as a cultural practice.

Bush medicine was integrated alongside prescribed medications, which offered comfort and continuity with tradition while maintaining reliance on pharmacological treatment.

Interpretation of the Findings

This study provided confirmation, extension, and challenges to previous literature regarding adherence to antihypertensive medications. Participants' descriptions resonated with global evidence and revealed unique, culturally embedded insights into the lived experience of adherence in The Bahamas on a small island.

Confirmation of Existing Knowledge

My findings support existing research showing that men face unique barriers to medication adherence. The participants consistently cited sexual dysfunction as a concern. The findings align with Rashidi et al. (2024), who found that many hypertensive men experienced erectile difficulties while taking antihypertensive medications. The medications taken were particularly beta-blockers, and these effects often influenced their willingness to continue treatment. This finding also reflects Abdi et al. (2024), who documented erectile dysfunction as a key barrier to adherence among hypertensive men in Ethiopia, further validating the salience of sexual health concerns in male populations.

Participants also emphasized occupational barriers, such as shift work, travel, and fatigue, which align with prior studies indicating that socioeconomic and work-related demands disrupt consistent medication use (Abdul Wahab et al., 2021; Abeasi et al., 2022). These findings align with those of Jonas (2023) in Zimbabwe, who reported that work stressors and socioeconomic pressures directly impact the ability of hypertensive patients to adhere to treatment regimens.

Family support emerged as a strong facilitator, echoing Taghadosi and Nouri's (2023) findings that spousal involvement improves adherence behaviors. Similarly, participants who routinely monitored their blood pressure and followed structured medication practices demonstrated high self-efficacy. This confirms Kamran et al.'s (2015) assertion that confidence in self-management correlates with better outcomes. The finding of family support aligns with Shahin et al. (2021) and Wu et al. (2024), who highlighted the importance of social support and family networks as crucial facilitators of adherence across diverse cultural contexts. These consistencies suggest that Bahamian men's experiences, while locally specific, mirror broader patterns identified in global health research.

Extension of Knowledge

The findings extended prior research in several ways. Firstly, despite broad acknowledgment of cultural reliance on alternative medicine (Abdul Wahab et al., 2021; Abeasi et al., 2022), this study showed that Bahamian men integrated bush medicine into their routines rather than wholly substituting it for prescription medications. Participants' descriptions challenged the binary assumption that bush medicine replaces pharmaceutical treatment. Instead, the participants described combining cultural and traditional remedies with prescribed medication, reflecting both approaches to managing hypertension. This finding extends the work of Brown et al. (2022), Williams (2011), and Williams (2021), who found that Caribbean cultural and religious beliefs significantly influence adherence behaviors, often involving a blend of pharmacological and traditional practices.

Although general health promotion literature often references the role of spirituality (Pender, 2011), the present findings supported faith as a central anchor of adherence. Participants described prayer-based routines, framing medication adherence as an act of stewardship over their health and as a way to honor their bodies as God's temple. This finding extends the work of Abdul Wahab et al. (2021), Najjuma et al. (2020), and Herrera et al. (2016), who identified religiosity and spirituality as key influences on patients' adherence decisions, but did not highlight faith as a daily anchor integrated into routines.

My findings suggest the importance of turning points, such as a stroke or a physician's life-or-death warning, which decisively shifted men from a state of reluctance to one of responsibility. Participants described these moments as catalysts that redefined adherence not as optional but as necessary for survival and family responsibility. My findings confirm those of Lie et al. (2021), who found that low adherence significantly increases cardiovascular risk, illustrating how men lived experiences of crisis translated statistical risk into personal motivation.

Challenges to Prior Assumptions

My findings did not support assumptions that nonadherence is always neglect; instead, some men described conditional adherence as a form of self-management rooted in embodied knowledge. A minority of participants described conditional adherence, skipping medication when their blood pressure was low, not as failure but as self-management. These men explained that their decisions were deliberate, shaped by bodily awareness and contextual judgment, rather than a simple lapse in discipline or a

knowledge deficit. This perspective provides a challenge to the binary framing of adherence versus nonadherence and suggests a more nuanced understanding of men's agency in medication practices. Herrera et al. (2016) similarly found that nonadherence is often a deliberate, value-driven decision, motivated by autonomy and personal meaning-making, rather than ignorance or neglect.

Conceptual Framework Integration

The findings aligned closely with Pender's (2011) HPM and Bandura's (1986, 2004) SCT. Participants' lived experiences supported HPM's constructs of perceived benefits, perceived barriers, self-efficacy, and interpersonal influences.

Study participants consistently cited perceived benefits (avoiding stroke, maintaining family roles) as motivators. Several men noted that they took their medication because they feared a collapse or stroke that would prevent them from providing for their families. In contrast, barriers such as sexual side effects, nocturia, work conflicts, and financial strain posed frequent disruptions to the men's adherence. Self-efficacy was evident in the use of medication pillboxes, prayer-linked routines, and at-home blood pressure monitoring, which indicated participants' belief in their ability to manage adherence effectively. This finding aligns with Gorbani et al. (2020), Goudarzi et al. (2020), and Shen et al. (2020), who confirmed that self-efficacy is a strong predictor of adherence behaviors in hypertensive populations. Interpersonal influences were equally important. Spousal reminders, children's encouragement, and stern physician warnings reinforced adherence, reflecting HPM's emphasis on the role of social support.

From the SCT perspective, the findings reflected Bandura's concepts of observational learning, outcome expectations, and reciprocal determinism. Observational learning was clear when participants described peers who became disabled by stroke as cautionary models that motivated their own adherence. Outcome expectations were apparent in fears of disability, death, or the inability to care for family. Faith also shaped outcome expectations, as men expressed confidence that adherence aligned with honoring God's temple would result in better long-term outcomes. Reciprocal determinism was evident in the interaction among environmental factors (shift work, access to medications, and cultural practices), personal beliefs (faith, masculinity, and responsibility), and behaviors (conditional adherence and structured routines).

Together, these interpretations suggest that Bahamian men's adherence was not a matter of isolated choice but a culturally embedded negotiation. The data supported the relevance of HPM and SCT, extending both frameworks by showing faith and masculinity as central cultural influences.

Limitations of the Study

This research had several limitations. First, the study comprised 11 participants residing on a small island in The Bahamas. Although Eleuthera provided an appropriate setting for exploring lived experiences, the geographic focus limits the transferability of the findings to other Bahamian islands or broader Caribbean contexts. As Lincoln and Guba (1985) emphasized, qualitative research produces context-specific insights, rather than broad generalizations. As with all phenomenological research, this study's findings

offer depth over breadth. Transferability depends on providing a thick description, allowing readers to assess the relevance of the findings to their own contexts.

Second, the interviews took place via Zoom audio calls, with durations ranging from 12 to 21 minutes. Although participants provided rich accounts that reached saturation, the relatively brief nature of the interviews may have constrained opportunities for deeper narrative exploration. The audio-only format, chosen for privacy and convenience, also restricted the capture of nonverbal cues that might have enriched the interpretation of participants' experiences.

Third, as with all self-reported data, there is a potential for recall bias or social desirability bias. Some participants may have underreported lapses in adherence or emphasized socially acceptable behaviors rather than sharing their experiences candidly. Although open-ended questions and reassurances of confidentiality helped mitigate this risk, it was not possible to eliminate the possibility of bias.

Fourth, as a nurse living and working on Eleuthera, I had professional knowledge of hypertension care and community health. Although I took steps to avoid recruiting participants from my own clinic and maintained a reflective journal to minimize bias, it is possible that participants perceived me as an authority in health. This dynamic may have shaped their responses..

Finally, participant recruitment occurred through flyers and self-referral, which may have attracted men already motivated to share their experiences. This possibility creates the potential for selection bias, as men who were less engaged in their health or more reluctant to discuss adherence may have lacked representation. Despite these

limitations, I applied rigorous phenomenological methods, ensured data saturation, and provided thick descriptions to support the trustworthiness of the findings.

Recommendations

Recommendations for Future Research

Future research should expand beyond Eleuthera to include participants from other Family Islands and across The Bahamas. Broader sampling could enable comparison across different cultural, economic, and geographic contexts, which would help determine whether the findings of this study are similar for men living in other small-island communities. Qualitative longitudinal researchers could follow men across critical junctures, such as after a stroke, the birth of a child, or retirement. Follow-up interviews would allow exploration of how adherence behaviors evolve. Such studies could provide insight into the durability of adherence after establishing commitment.

Further researchers should examine the role of faith and spirituality in adherence more explicitly. The study found faith as a central anchor of adherence, yet existing literature has not fully addressed its significance. Future scholars could evaluate how spiritual beliefs and religious practices influence adherence behaviors and whether faith-based health promotion strategies are effective in small-island contexts.

Finally, researchers should consider interventions designed for men who face occupational barriers or experience sexual side effects. These areas remain understudied in this context but were salient in the current findings. Future scholars could evaluate targeted adherence interventions that address male-specific concerns, such as counseling

protocols for sexual health, work schedule–friendly medication regimens, or culturally congruent integration of bush medicine with pharmacological care.

Recommendations for Practice

The findings also suggest several practice-level recommendations. Health care providers in The Bahamas should consider incorporating family members, particularly spouses, into adherence counseling and education. I found that wives played an active role in supporting adherence by providing reminders, preparing meals, and organizing and distributing medications. Structured programs that engage families may enhance men’s consistency with treatment. This recommendation aligns with the findings of Shahin et al. (2021) and Wu et al. (2024), who also found that social and family support networks play a central role in improving adherence.

Clinicians should be prepared to address men’s concerns about sexual side effects directly and without stigma. Providing open, culturally sensitive counseling regarding side effects, along with strategies to manage them, may reduce nonadherence driven by fears of diminished sexual performance. This finding supports Hamrahian et al. (2022), who emphasized that patient-centered discussions about side effects are critical to sustaining adherence.

Ultimately, adherence support needs to accommodate men’s work schedules and cultural practices. Providers might encourage the use of pill organizers, reminders linked to daily routines, or blood pressure self-monitoring to strengthen self-efficacy. Acknowledging and respectfully discussing the use of bush medicine, while reinforcing

the importance of prescribed medications, can validate cultural practices while maintaining pharmacological adherence.

Implications

The results of this study suggest important implications for positive social change at the micro, meso, and macro levels.

Micro Level

At the individual level, participants' experiences showed that they sustained adherence through structured routines, anchored in a fear of complications, a sense of responsibility to their families, and faith in God. By understanding these motivators, health professionals could design personalized interventions that integrate medication into men's daily routines, such as linking pill-taking to prayer or self-monitoring practices. These strategies could help strengthen self-efficacy and empower men to manage their hypertension actively, ultimately improving health outcomes and reducing preventable complications (Kamran et al., 2015).

Meso Level

At the meso level, the study indicated the central role of spouses and family members in adherence behaviors. Wives, in particular, played a crucial role as facilitators by organizing pillboxes, preparing healthy meals, and offering reminders. Programs that intentionally involve family members in adherence support may strengthen treatment consistency and reduce the burden of hypertension on households. At the organizational level, CNCD clinics could offer flexible appointment times outside of regular working hours, provide culturally relevant education sessions, and address male-specific concerns

such as sexual side effects. Such adaptations would create more responsive and supportive healthcare environments for men, ensuring that interventions resonate with men's lived realities.

Macro Level

At the macro level, the findings have implications for national health policy and public health initiatives. The Ministry of Health & Wellness could integrate faith-based organizations into adherence campaigns to leverage men's spiritual motivations. Policy-level strategies might also include ensuring reliable access to medications on the Family Islands. Actions may involve preventing stock-outs of essential drugs, offering subsidies to increase affordability, enabling 90-day refills, and expanding the use of fixed-dose combination therapies. These implications align with those of the WHO (2023a) and Pan American Health Organization (2022), both of which emphasized access to medication and culturally sensitive adherence strategies as essential to reducing the burden of NCDs in Caribbean contexts. At the societal level, recognizing and respecting the use of bush medicine while reinforcing pharmacological treatment could enhance culturally congruent care, ultimately reducing hypertension-related morbidity and mortality across The Bahamas.

Methodological, Theoretical, and Empirical Contributions

Methodologically, this study's findings showed that Giorgi's descriptive phenomenological method is suitable for small-island contexts, particularly in exploring men's health behaviors. Theoretically, the study extends Pender's HPM and Bandura's SCT by finding faith and masculinity as significant cultural influences on adherence.

Empirically, the study contributes to filling the knowledge gap on Bahamian men's lived experiences of hypertension management, providing insights that may inform interventions across the Caribbean and other small-island settings.

Conclusion

The purpose of this phenomenological study was to explore the lived experiences of Bahamian men diagnosed with hypertension regarding their adherence to prescribed medications. Eleven participants shared their narratives, providing insight into the barriers, facilitators, and turning points that shaped their adherence behaviors. The findings showed that adherence was not a linear or passive act of compliance but an ongoing negotiation in which men balanced medical prescriptions, cultural practices, family responsibilities, and personal beliefs.

The study found three central anchors of adherence: fear, family, and faith. The participants expressed fears of disability or death, responsibility to spouses and children, and spiritual beliefs that framed the body as God's temple. All of the anchors motivated men to persist with prescribed treatments. At the same time, side effects, occupational demands, forgetfulness, and reliance on bush medicine presented ongoing challenges. Bush medicine, however, was described not as a barrier but as a cultural complement, integrated alongside prescribed medications in a way that reflected both continuity with tradition and commitment to pharmaceutical treatment. Structured routines, such as integrating pill-taking into daily rituals of prayer and home blood pressure monitoring, supported men's sense of control and responsibility. Importantly, the findings also

indicated that health crises and stern provider warnings often served as decisive turning points, transforming reluctance into a sense of responsibility.

The implications of this study extend across micro, meso, and macro levels of social change. At the micro level, physicians and families need to empower men to adopt culturally congruent routines that sustain adherence and improve health outcomes. At the meso level, families and health organizations could support adherence through spousal engagement, flexible clinical services, and culturally responsive counseling. At the macro level, national health policymakers could integrate faith-based initiatives, ensure reliable access to medication on the Family Islands, and promote family-centered approaches to chronic disease management. Methodologically, this study supported the value of Giorgi's descriptive phenomenological method in small-island contexts. Theoretically, the findings extend the HPM and SCT by emphasizing faith and masculinity as cultural influences. Empirically, the research fills a critical gap in knowledge about Bahamian men's experiences with hypertension management.

This study contributes to a more nuanced understanding of medication adherence among Bahamian men, moving the conversation beyond simple notions of compliance and noncompliance. Adherence emerged as a daily negotiation—anchored in fear, sustained by family, and infused with faith. By acknowledging these lived realities, healthcare providers, policymakers, and communities can design interventions that resonate with men's values and lived experiences. The essence of the findings is that when men receive support in balancing cultural practices, family obligations, and faith

commitments, adherence becomes more than compliance—it becomes stewardship over health, family, and community.

References

- Abbas, H., Hallit, S., Kurdi, M., & Karam, R. (2022). Non-adherence to antihypertensive medications in Lebanese adults hospitalized for hypertensive urgency and its cost. *BMC Cardiovascular Disorders*, 22, Article 456. <https://doi.org/10.1186/s12872-022-02907-z>
- Abdalla, M., Bolen, S. D., Brettler, J., Egan, B. M., Ferdinand, K. C., Ford, C. D., Lackland, D. T., Wall, H. K., & Shimbo, D. (2023). Implementation strategies to improve blood pressure control in the United States: A scientific statement from the American Heart Association and American Medical Association. *Hypertension*, 80(10), 143–157. <https://doi.org/10.1161/HYP.0000000000000232>
- Abdi, D., Misgana, T., Asefa, A., Bete, T., Temesgen, A., Zewudie, A., Asefa, H., Tilahun, S., & Dereje, J. (2024). Erectile dysfunction and associated factors among adult hypertensive patients attending outpatient care at public hospitals in Harari Regional State, Eastern Ethiopia. *Research Square*. Preprint (version 1). <https://doi.org/10.21203/rs.3.rs-4886768/v1>
- Abdul Wahab, N. A., Bakry, M. M., Ahmad, M., Mohamad Noor, Z., & Mhd Ali, A. (2021). Exploring culture, religiosity, and spirituality influence on antihypertensive medication adherence among specialised population: A qualitative ethnographic approach. *Patient Preference and Adherence*, 15, 2249–2265. <https://doi.org/10.2147/PPA.S319469>

- Abeasi, D. A., Abugri, D., & Akumiah, P. O. (2022). Predictors of medication adherence among adults with hypertension in Ghana. *Journal of Client-Centered Nursing Care*, 8(1), 23–32. <https://doi.org/10.32598/JCCNC.8.1.396.1>
- Ahmed, S. K. (2024). The pillars of trustworthiness in qualitative research. *Journal of Medicine, Surgery, and Public Health*, 2, Article 100051. <https://doi.org/10.1016/j.glmedi.2024.100051>
- Alvarez, C., Hines, A. L., Carson, K. A., Andrade, N., Ibe, C. A., Marsteller, J. A., & Cooper, L. A. (2021). Association of perceived stress and discrimination on medication adherence among diverse patients with uncontrolled hypertension. *Ethnicity & Disease*, 31(1), 97–108. <https://pmc.ncbi.nlm.nih.gov/articles/PMC7843046/pdf/ethndis-31-97.pdf>
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice-Hall.
- Bandura, A. (2004). Health promotion by social cognitive means. *Health Education & Behavior*, 31(2), 143–164. <https://doi.org/10.1177/1090198104263660>
- Beany, T., Schutte, A. E., Stergiou, G. S., Borghi, C., Burger, D., Charchar, F., Cro, S., Diaz, A., Damasceno, A., Espeche, W., Pulikkottil Jose, A., Khan, N., Kokubo, Y., Maheshwari, A., Marin, M. J., More, A., Neupane, D., Milsson, P., ... Poulter, N. R. (2020). May measurement month 2019: The global blood pressure screening campaign of the International Society of Hypertension. *Hypertension*, 76(2), 333-341. <https://doi.org/10.1161/HYPERTENSIONAHA.120.14874>

- Beck, C. T. (2021). *Introduction to phenomenology: Focus on methodology*. SAGE Publications.
- Beena, J., & Jose, J. (2011). Patient medication adherence: Measures in daily practice. *Oman Medical Journal*, 26(3), 155–159. <https://doi.org/10.5001/omj.2011.38>
- Bhattarai, S., Bajracharya, S., Shrestha, A., Skovlund, E., Åsvold, B. O., Mjølstad, B. P., & Sen, A. (2023). Facilitators and barriers to hypertension management in urban Nepal: Findings from a qualitative study. *Open Heart*, 10, Article e002394. <https://doi.org/10.1136/openhrt-2023-002394>
- Bissonnette, J. M. (2008). Adherence: A concept analysis. *Journal of Advanced Nursing*, 63(6), 634–643. <https://doi.org/10.1111/j.1365-2648.2008.04745.x>
- Brown, M. T., & Bussell, J. K. (2011). Medication adherence: WHO cares? *Mayo Clinic Proceedings*, 86(4), 304–314. <https://doi.org/10.4065/mcp.2010.0575>
- Brown, R., Bateman, C. J., & Gossell-Williams, M. (2022). Influence of Jamaican cultural and religious beliefs on adherence to pharmacotherapy for non-communicable diseases: A pharmacovigilance perspective. *Frontiers in Pharmacology*, 13, Article 858947. <https://doi.org/10.3389/fphar.2022.858947>
- Burnier, M., & Egan, B. M. (2019). Adherence in HTN: A review of prevalence, risk factors, impact, and management. *Circulation Research*, 124(7), 1124–1140. <https://doi.org/10.1161/circresaha.118.313220>

- Byiringiro, S., Hinneh, T., Commodore-Mensah, Y., Masteller, J., Sarfo, F. S., Perrin, N., & Himmelfarb, C. R. (2024). Exploring patient-, provider-, and health facility-level determinants of blood pressure among patients with hypertension: A multicenter study in Ghana. *PLOS Global Public Health*, 4(7), Article e0002121. <https://doi.org/10.1371/journal.pgph.0002121>
- Calhoun, S. F. (2024). *Examining the shared decision-making preferences of adult Black men with hypertension in the U.S. Mid-South region: A mixed methods approach* [Doctoral dissertation, University of Tennessee Health Science Center]. UT Health Science Center Dissertations. <http://dx.doi.org/10.21007/etd.cghs.2024.0654>
- Chang, T.-J., Bridges, J. F. P., Bynum, M., Jackson, J. W., Joseph, J. J., Fischer, M. A., Lu, B., & Donneyong, M. M. (2021). Association between patient-clinician relationships and adherence to antihypertensive medications among Black adults: An observational study design. *Journal of the American Heart Association*, 10, Article e019943. <https://doi.org/10.1161/JAHA.120.019943>
- Chen, Z., Chen, M., Gong, L., Tian, Y., Chang, C., & Cao, W. (2024). Health literacy, social support, and health education as factors associating with self-management behaviors among elderly patients with hypertension in China: A structural equation model. *PLOS ONE*, 19(9), Article e0308402. <https://doi.org/10.21203/rs.3.rs-4568125/v1>

- Chham, S., Buffel, V., Ir, P., Ku, G. M., Chhim, S., Van Damme, W., Van Olmen, J., & Wouters, E. (2024). Understanding the role of social support in adherence to hypertension treatment in Cambodia. *Research Square*.
<https://doi.org/10.21203/rs.3.rs-4918588/v1>
- Choudhry, N. K., Kronish, I. M., Vongpatanasin, W., Ferdinand, K. C., Pavlik, V. N., Egan, B. M., Schoenthaler, A., Houston Miller, N., Hyman, D. J., & American Heart Association Council on Hypertension; Council on Cardiovascular and Stroke Nursing; and Council on Clinical Cardiology . (2021). Medication adherence and blood pressure control: A scientific statement from the American Heart Association. *Hypertension*, 79(3), 434–450.
<https://doi.org/10.1161/HYP.000000000000203>
- Colgrove, P., Connell, K. L., Lackland, D. T., Ordunez, P., & DiPette, D. J. (2017). Controlling hypertension and reducing its associated morbidity and mortality in the Caribbean: Implications of race and ethnicity. *The Journal of Clinical Hypertension*, 19(10), 1010–1014. <https://doi.org/10.1111/jch.13056>
- Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). SAGE Publications.
- Dhar, L., Dantas, J., & Ali, M. (2017). A systematic review of factors influencing medication adherence to hypertension treatment in developing countries. *Open Journal of Epidemiology*, 7(3), 211–250.
<https://doi.org/10.4236/ojepi.2017.73018>

- Dodgson, J. E. (2023). Phenomenology: Researching the lived experience. *Journal of Human Lactation*, 39(3), 385–396. <https://doi.org/10.1177/08903344231176453>
- Edward, A., Campbell, B., Manase, F., & Appel, L. J. (2021). Patient and healthcare provider perspectives on adherence with antihypertensive medications: An exploratory qualitative study in Tanzania. *BMC Health Services Research*, 21, 834. <https://doi.org/10.1186/s12913-021-06858-7>
- Ekechukwu, B. C. (2022). *A clinical practice guideline to promote medication adherence among adult African Americans with hypertension* (Publication No. 29397472) [Doctoral dissertation, Walden University]. ProQuest Dissertations and Theses Global.
- Escobar, C., & Barrios, V. (2021). Revisiting hypertension in rural areas: A new approach is required. *American Journal of Hypertension*, 34(9), 910–911. <https://doi.org/10.1093/ajh/hpab078>
- Flynn, S. J., Ameling, J. M., Hill-Briggs, F., Wolff, J. L., Bone, L. R., Levine, D. M., Roter, D. L., Lewis-Boyer, L., Fisher, A. R., Purnell, L., Ephraim, P. L., Barbers, J., Fitzpatrick, S. L., Albert, M. C., Cooper, L. A., Fagan, P. J., Martin, D., Ramamurthi, H. C., & Boulware, L. E. (2013). Facilitators and barriers to hypertension self-management in urban African Americans: Perspectives of patients and family members. *Patient Preference and Adherence*, 2013(7), 741–749. <https://doi.org/10.2147/PPA.S46517>

- Gaddis, L. A. (2019). *Association of social support and patient-provider communication and medication adherence* (Publication No. 13810161) [Doctoral dissertation, Walden University]. ProQuest Dissertations and Theses Global.
- Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Duquesne University Press.
- Giorgi, A. (2020). In defense of scientific phenomenologies. *Journal of Phenomenological Psychology, 51*(2), 135–161. <https://doi.org/10.1163/15691624-12341375>
- Giorgi, A., Giorgi, B., & Morley, J. (2017). The descriptive phenomenological psychological method. In C. Willig & W. S. Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (Vol. 0, pp. 176–192). SAGE Publications. <https://doi.org/10.4135/9781526405555>
- Goorani, S., Zangene, S., & Imig, J. D. (2024). A continuing public healthcare issue. *International Journal of Molecular Sciences, 26*(1), Article 123. <https://doi.org/10.3390/ijms26010123>
- Gorbani, F., Mahmoodi, H., Sarbakhsh, P., & Shaghghi, A. (2020). Predictive performance of Pender's health promotion model for hypertension control in Iranian patients. *Vascular Health and Risk Management, 2020*(6), 299–305. <https://doi.org/10.2147/VHRM.S258458>

- Goudarzi, H., Barati, M., Bashirian, S., & Moeini, B. (2020). Determinants of medication adherence among hypertensive patients using the Pender's health promotion model. *Journal of Education and Health Promotion*, 9(1), Article 89. https://doi.org/10.4103/jehp.jehp_687_19
- Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. Jossey-Bass.
- Guo, A., Jin, H., Mao, J., Zhu, W., Zhou, Y., Ge, X., & Yu, D. (2023). Impact of health literacy and social support on medication adherence in patients with hypertension: A cross-sectional community-based study. *BMC Cardiovascular Disorders*, 23, Article 93. <https://doi.org/10.1186/s12872-023-03117-x>
- Hamrahian, S. M., Maarouf, O. H., & Fülöp, T. (2022). A critical review of medication adherence in hypertension: Barriers and facilitators clinicians should consider. *Patient Preference and Adherence*, 2022(6), 2749–2757. <https://doi.org/10.2147/PPA.S368784>
- Hossain, M. S., Alam, M. K., & Ali, M. S. (2024). Phenomenological approach in the qualitative study: Data collection and saturation. *ICRRD Quality Index Research Journal*, 5(2), 147–172. <https://doi.org/10.53272/icrrd.v5i2.4>
- Iqbal, A. M., & Jamal, S. F. (2022). Essential hypertension. In *StatPearls*. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK539859/>

- James, D. L. C. (2024). *Strengthening medication adherence in African Americans diagnosed with hypertension* [Doctoral practice project, Jacksonville State University]. JSU Digital Commons.
https://digitalcommons.jsu.edu/etds_nursing/123
- Jonas, J. (2023). *Exploring barriers and facilitators for medication adherence in hypertensive patients in private practice, Zimbabwe* [Unpublished Master's mini-thesis, University of the Western Cape].
- Kamran, A., Azadbakht, L., Sharifirad, G., Mahaki, B., & Mohebi, S. (2015). The relationship between blood pressure and the structures of Pender's health promotion model in rural hypertensive patients. *Journal of Education and Health Promotion, 4*(1), 29–29. <https://doi.org/10.4103/2277-9531.154124>
- Kisigo, G. A., Mcharo, O. C., Robert, J. L., Peck, R. N., Sundararajan, R., & Okello, E. S. (2022). Understanding barriers and facilitators to clinic attendance and medication adherence among adults with hypertensive urgency in Tanzania. *PLOS Global Public Health, 2*(8), Article e0000919.
<https://doi.org/10.1371/journal.pgph.0000919>
- Kobson, B., Paterson, R., Hanley, J., Mair, A., & Dima, A. (2024). Patients' perspectives on feedback interventions to support adherence to long-term medications: A systematic review with thematic synthesis. *International Journal of Clinical Pharmacy*. Advance online publication. <https://doi.org/10.1007/s11096-025-01958-4>

- Kohrman, N., Rashid, M., Flores, R., Blyler, C., Barragan, N. C., Kuo, T., Inkelas, M., Chen, S., Rader, F., Cheng, S., Albert, C., Bello, N. A., & Ebinger, J. (2024). A qualitative analysis of post-hoc interviews with multilevel participants of a randomized controlled trial of a community-based intervention. *PLOS ONE*, *19*(5), Article e0303075. <https://doi.org/10.1371/journal.pone.0303075>
- Koivisto, K., Janhonen, S., & Väisänen, L. (2002). Applying a phenomenological method of analysis derived from Giorgi to a psychiatric nursing study. *Journal of Advanced Nursing*, *39*(3), 258–265. <https://doi.org/10.1046/j.1365-2648.2002.02272.x>
- Kotchen, T. A. (2011). Historical trends and milestones in hypertension research: A model of the process of translational research. *Hypertension*, *58*(4), 522–538. <https://doi.org/10.1161/hypertensionaha.111.177766>
- Legetic, B., Medcalf, M., Berbari, A., Ordunez, P., & McLean, D. (2016). *The Declaration of Port of Spain: The potential for a paradigm shift* (Technical report). Pan American Health Organization.
- Li, J., Zhang, Z., Si, S., Wang, B., & Xue, F. (2021). Antihypertensive medication adherence and cardiovascular disease risk: A longitudinal cohort study. *Atherosclerosis*, *320*, 24-30. <https://doi.org/10.1016/j.atherosclerosis.2021.01.005>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications.

- Mahmood, S., Jalal, Z., Hadi, M. A., & Orooj, H. (2020). Non-adherence to prescribed antihypertensives in primary, secondary, and tertiary healthcare settings in Islamabad, Pakistan: A cross-sectional study. *Patient Preference and Adherence*, *14*, 73–85. <https://doi.org/10.2147/PPA.S235517>
- Mansoor, H., Manion, D., Kucharska-Newton, A., Delcher, C., Lo-Ciganic, W.-H., Jicha, G., & Moga, D. C. (2024). Sex differences in prescription patterns and medication adherence to guideline-directed medical therapy among patients with ischemic stroke. *Stroke*, *56*(2). <https://doi.org/10.1161/STROKEAHA.124.048058>
- Mills, K. T., Stefanescu, A., & He, J. (2020). The global epidemiology of hypertension. *Nature Reviews Nephrology*, *16*(4), 223–237. <https://doi.org/10.1038/s41581-019-0244-2>
- Ministry of Health & Wellness. (2019). *Bahamas STEPS 2019 report: Non-communicable diseases and risk factors in the Bahamian Society*. Pan American Health Organization. <https://cdn.bahamas.gov.bs/tenant/tenantministryofhealth/documents/All%20Documents/Bahamas-Steps-2019-Report---Non-communicable-Diseases-and-Risk-Factors-in-the-Bahamian-Society-Volume-1-20240425020020.pdf>
- Najjuma, J. N., Brennaman, L., Nabirye, R. C., Ssedyabane, F., Maling, S., Bajunirwe, F., & Muhindo, R. (2020). Adherence to antihypertensive medication: An interview analysis of Southwest Ugandan patients' perspectives. *Annals of Global Health*, *86*(1), 1–11. <https://doi.org/10.5334/aogh.2904>

- National Health Insurance Authority (NHIA). (2021). *National Health Insurance Primary Care Transformation Initiative (PCTI): Public consultation feedback report*. Nassau, Bahamas: NHIA. <https://www.nhibahamas.gov.bs/wp-content/uploads/PCTI-Public-Consultation-Feedback-Release.pdf>
- Nematzad, P., Pourghane, P., Besharati, F., & Gholami-Chaboki, B. (2023). Effects of health belief model in promoting self-care behaviors among hypertensive older adults. *Journal of Education and Health Promotion, 12*(1), Article 208. https://doi.org/10.4103/jehp.jehp_689_22
- None, F. L., & Musharyanti, L. (2021). Health promotion in efforts to increase medication compliance in hypertensive patients: A literature review. *Journal Keperawatan Respati Yogyakarta, 8*(3), 174–182. <http://nursingjurnal.respati.ac.id/index.php/JKRY/index>
- Odedosu, T., Schoenthaler, A., Vieira, D. L., Agyemang, C., & Ogedegbe, G. (2012). Overcoming barriers to hypertension control in African Americans. *Cleveland Clinic Journal of Medicine, 79*(1), 46–56. <https://doi.org/10.3949/ccjm.79a.11068>
- Odusola, A. O., Hendriks, M., Schultsz, C., Bolarinwa, O. A., Akande, T., Osibogun, A., Agyemang, C., Ogedegbe, G., Agbede, K., Adenusi, P., & Haafkens, J. A. (2014). Perceptions of inhibitors and facilitators for adhering to hypertension treatment among insured patients in rural Nigeria: A qualitative study. *BMC Health Services Research, 14*, Article 624. <https://doi.org/10.1186/s12913-014-0624-z>

- Ogunniyi, M. O., Commodore-Mensah, Y., Himmelfarb, C. D., Allen, N., & Boutin-Foster, C. (2021). Race, ethnicity, hypertension, and heart disease. *Journal of American College Cardiology*, 78(24), 2460–2470.
<https://doi.org/10.1016/j.jacc.2021.06.017>
- Pan American Health Organization. (2022). *Noncommunicable diseases in the Americas: Regional and country-specific data*. Pan American Health Organization.
<https://hia.paho.org/en/country-profiles/bahamas>
- Pan American Health Organization. (2022). *The Bahamas: Country health profile 2022*.
<https://hia.paho.org/en/countries-22/bahamas-country-profile>
- Patnaik, E. (2013). Reflexivity: Situating the researcher in qualitative research. *Humanities and Social Science Studies*, 2(2), 98–106.
- Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). SAGE Publications.
- Pender, N. J. (2011). *Health promotion model manual*. University of Michigan.
- Pender, N. J., Murdaugh, C. L., & Parsons, M. A. (2011). *Health promotion in nursing practice* (6th ed.). Pearson.
- Pettersen, T. R., & Candelaria, D. (2024). Beyond testing: Understanding the patient perspective of medication adherence in hypertension. *European Journal of Cardiovascular Nursing*, 23(8), e189–e190.
<https://doi.org/10.1093/eurjcn/zvae131>

- Rashidi, M., Ghorbani, S., Heidari, M., & Faraji, R. (2024). Erectile dysfunction and adherence to antihypertensive medication: A challenging correlation. *The Journal of Sexual Medicine*, 21(1), 56–64. <http://dx.doi.org/10.7717/peerj.18596>
- Ravitch, S. M., & Carl, N. M. (2021). *Qualitative research: Bridging the conceptual, theoretical, and methodological* (2nd ed.). SAGE Publications.
- Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data* (3rd ed.). SAGE Publications.
- Šabović, M., Pejkov, H., Kovačević-Preradović, T., Kušljugić, Z., Kuprešak, D., Jatić, Z., Urinov, O., Caraus, A., Bajraktari, G., Gruev, I., Vintila, V. D., Csanádi, Z., & Batjargal, S. (2024). Comparison between women and men in the treatment of hypertension: The real-world observational prospective data from the DISCOVERY study. *Journal of Hypertension*, 42(Suppl_1), e312–e313. <https://doi.org/10.1097/01.hjh.0001022748.01678.f6>
- Saglam, Y. (2024). Which data gathering method is superior: An open-ended questionnaire or a semi-structured interview? *International Journal on Studies in Education*, 6(3), 375–386. <https://doi.org/10.46328/ijonse.220>
- Schoenthaler, A., Knafl, G. J., Fiscella, K., & Ogedegbe, G. (2017). Addressing the social needs of hypertensive patients: The role of patient–provider communication as a predictor of medication adherence. *Circulation: Cardiovascular Quality and Outcomes*, 10(8), e003659. <https://doi.org/10.1161/CIRCOUTCOMES.117.003659>

- Sekkarie, A., Fang, J., Hayes, D., & Loustalot, F. (2024). Prevalence of self-reported hypertension and antihypertensive medication use among adults—United States, 2017–2021. *Morbidity and Mortality Weekly Report*, 73(9), 192–199.
<https://doi.org/10.15585/mmwr.mm7309a1>
- Shahin, W., Kennedy, G. A., & Stupans, I. (2021). The association between social support and medication adherence in patients with hypertension: A systematic review. *Pharmacy Practice*, 19(2), Article 2300.
<https://doi.org/10.18549/PharmPract.2021.2.2300>
- Shen, Z., Shi, S., Ding, S., & Zhong, Z. (2020). Mediating effect of self-efficacy on the relationship between medication literacy and medication adherence among patients with hypertension. *Frontiers in Pharmacology*, 11, Article 569092.
<https://doi.org/10.3389/fphar.2020.569092>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE Publications.
- Souza, K. M., Giron, N., Vallini, J., Hallar, K., Ordunez, P., Rosende, A., Ramírez Loya, B., Debrott Sánchez, D., & Lim, C. (2024). Barriers to access to antihypertensive medicines: Insights from the HEARTS initiative in Latin American and Caribbean region. *Journal of Pharmaceutical Policy and Practice*, 17(1), 2379045.
<https://doi.org/10.1080/20523211.2024.2379045>
- Taghadosi, M., & Nouri, H. (2023). The effect of education based on “Pender health promotion model” on adherence to treatment of patients with hypertension. *Journal of Health Promotion Management*, 12(1), 69–80.

<https://doi.org/10.22034/JHPM.12.1.69>

The Lancet Regional Health – Americas. (2022, May). Latin America and Caribbean’s path to improve hypertension control: Time for bolder, tougher actions. *The Lancet Regional Health – Americas*, 9, Article 100278.

<https://doi.org/10.1016/j.lana.2022.100278>

Unger, T., Borghi, C., Charchar, F., Khan, N. A., Poulter, N. R., Prabhakaran, D., Ramirez, A., Schlaich, M., Stergiou, G. S., Tomaszewski, M., Wainford, R. D., Williams, B., & Schutte, A. E. (2020). 2020 International Society of Hypertension Global Hypertension practice guidelines. *Journal of Hypertension*, 38(6), 982–1004. <https://doi.org/10.1097/HJH.0000000000002453>

United Nations Economic Commission for Latin America and the Caribbean. (2020). *Addressing the adverse impacts of non-communicable diseases on the sustainable development of Caribbean countries*. United Nations.

<https://repositorio.cepal.org/handle/11362/46714>

Urhoghide, E., Onyechi, N. P., Okobi, O. E., Odoma, V. A., Okunromade, O., Moevi, A. A., Louise-Oluwasanmi, O., Ojo, S. A., Harry, N. M., Awoyemi, E., Sike, C. G., Nwatamole, B. C., Agbama, J. A., & Evbayekha, E. O. (2023). A cross-sectional study of the trends in cardiovascular mortality among African Americans with hypertension. *Cureus*, 15(6), Article e40437. <https://doi.org/10.7759/cureus.40437>

Vrijens, B., Antoniou, S., Burnier, M., de la Sierra, A., & Volpe, M. (2017). Current situation of medication adherence in hypertension. *Frontiers in Pharmacology*, 8, Article 100. <https://doi.org/10.3389/fphar.2017.00100>

- Vrijens, B., De Geest, S., Hughes, D. A., Kardas, P., Demonceau, J., Ruppard, T., Dobbels, F., Fargher, E., Morrison, V., Lewek, P., Matyjaszczyk, M., Mshelia, C., Clyne, W., Aronson, J. K., & Urquhart, J. (2012). A new taxonomy for describing and defining adherence to medications. *British Journal of Clinical Pharmacology*, 73(5), 691–705. <https://doi.org/10.1111/j.1365-2125.2012.04167.x>
- Wazir, F., Maqsood, S., Salman, F., Junaid, M., Ilyas, H., & Maqsood, F. (2024). Navigating antecedents and consequences of patient–doctor relationship in chronic care patients. *History of Medicine*, 10(2), 264–282. <https://historymedjournal.com/index.php/medicine/article/view/790/646>
- Wilkinson, R., Garden, E., Nanyonga, R. C., Squires, A., Nakaggwa, F., Schwartz, J. I., & Heller, D. J. (2022). Causes of medication nonadherence and the acceptability of support strategies for people with hypertension in Uganda: A qualitative study. *International Journal of Nursing Studies*, 126, Article 104143. <https://doi.org/10.1016/j.ijnurstu.2021.104143>
- Williams, N. A. (2021). *Medication beliefs and behaviors of hypertensive Caribbean immigrants living in New York City* [Doctoral dissertation, Walden University]. Walden Dissertations and Doctoral Studies Collection. <https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=12670&context=dissertations>
- Williams, S. C. (2011). *Cultural influences on medication adherence among Bahamian women: A study using Pender's health promotion model* [Unpublished doctoral dissertation, Barry University].

World Health Organization. (n.d.). *STEPwise approach to NCD risk factor surveillance (STEPS)*. World Health Organization.

<https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/steps>

World Health Organization. (2023a). *Bahamas: Hypertension profile*.

https://cdn.who.int/media/docs/default-source/profiles/hypertension/hypertension-2023/hypertension_bhs_2023.pdf?sfvrsn=29254723_5&download=true

World Health Organization. (2023b, September 19). *First WHO report details devastating impact of hypertension and ways to stop it*.

<https://www.who.int/thailand/news/detail/19-09-2023-first-who-report-details-devastating-impact-of-hypertension-and-ways-to-stop-it>

Wu, Y., Xiong, S., Zhu, G., Chen, X., Zhang, M., Gong, E., Li, C., Jia, P., Østbye, T., & Yan, L. L. (2024). Patient, family, and community factors associated with medication adherence among people with hypertension or diabetes: A cross-sectional analysis. *Exploratory Research in Clinical and Social Pharmacy*, 15, Article 100482. <https://doi.org/10.1016/j.rcsop.2024.100482>

Yang, J., Zeng, Y., Yang, L., Khan, N., Singh, S., Walker, R. L., Eastwood, R., & Quan, H. (2024). Identifying personalized barriers for hypertension self-management from the TASKS framework. *BMC Research Notes*, 17, Article 224. <https://doi.org/10.1186/s13104-024-06893-7>

Zhou, J., Li, Z., Li, H., Du, W., Liu, M., Jiang, C., Chen, L., Chen, Z., & Wu, Y.

(2024). Barriers and facilitators of medication adherence in hypertension patients:

A meta-integration of qualitative studies. *Journal of Patient Experience*, *11*, 1–

17. doi:[10.1177/23743735241241176](https://doi.org/10.1177/23743735241241176)

Appendix A: Demographic Questionnaire and Interview Guide

Interview Guide/Questions

Introduction to the Interview

Hi, thank you for agreeing to participate in this study. I'm here to learn about your experiences with high blood pressure and taking your medication. There are no right or wrong answers—just your story.

This interview will take about 30 to 60 minutes. Everything you share will stay confidential. If you feel uncomfortable, you can skip any question or stop at any time. Do you have any questions before we start?

Section 1: Demographic and Medical History Questions

Demographics:

Before we start, I'd like to ask a few simple questions about you. These will help me understand your background and experiences better. Your answers will stay confidential.

1. Which age group are you in? (35–40, 41–50, 51–60, 61–67)
2. What is the highest level of school you finished? (For example, primary school, high school, or college)
3. What kind of work do you do now, or what type of work have you done before?
4. When did you first find out you had high blood pressure?
5. What medications are you using to manage your pressure?
6. Have you ever changed your medicine or how you take it without talking to your doctor? If yes, why?
7. How often do you see a doctor or nurse about your blood pressure?

Section 2: Interview Questions***Main Question:***

Tell me about your experiences living with high blood pressure.

Possible Probing Questions:

1. Tell me about the medicines you may have used.
2. Tell me about any changes you may have made to your medications
3. Tell me about any challenges you've faced.
4. Have you ever missed a dose or gone days without taking your prescribed medicine? Can you tell me why? If you started taking it again, what made you decide to do that?
5. Can you tell me what helps or motivates you to keep taking your medication?
6. Tell me about any positive effects you've noticed.

Closing Question

Is there anything else you'd like to share about your story or experience?

Thank you so much for sharing your story with me today. Your experiences are very important, and they will help me better understand how to support others living with high blood pressure. If you have any questions or need to reach out to me, feel free to contact me. I really appreciate your time and for sharing your experiences today. I want to remind you that all information obtained here today will remain confidential. Thank you again!

Appendix B: Recruitment Materials

Good Morning/Afternoon,

You are invited to participate in an interview for my study, “Exploring the Experiences of Bahamian Men With HTN and Medication Adherence.” This research is part of my doctoral program in nursing. The goal of this study is to learn about the experiences of Bahamian men living with high blood pressure and taking their prescribed medications. Your help in this study is important.

Interview Details

I would like your permission to record an interview that will last about 30 to 60 minutes. During the interview, I will ask about your experience managing high blood pressure and taking your medication. We can meet in person at a location we agree on or talk using Zoom without video, whichever is easier for you.

The interview will be written word-for-word to help me understand what you share. If you would like, you can ask for a copy of the recording or written transcript.

Your Choice to Participate

Joining this study is completely your choice. You can decide to stop at any time, even after you begin. You can skip any question if you don't want to answer it. There are no penalties for stopping or skipping questions.

Risks and Benefits

This study is safe and does not involve risks beyond those in your daily life. While there are no direct benefits to you, your input may help improve healthcare services for men like you who are managing high blood pressure.

Privacy

Your privacy is very important to me. All recordings and written transcripts will be stored safely in a protected system that I can access. I will remove any information that could identify you to keep your identity private. The information I collect will be used only for this study and for any related presentations or reports. All recordings and transcripts will be destroyed five years after the study ends.

Questions or Concerns

If you have questions about the study or would like more information, you can contact me, Bianca Edwards, a Doctoral Candidate, PhD in Nursing.

Your Agreement

If you agree to take part in this study after reading this form, please reply to this email with the words: "I consent."

Thank you for your time and help. Your participation is greatly appreciated.

Sincerely,
Bianca Edwards
Doctoral Candidate, PhD Nursing

SEEKING PARTICIPANTS TO SHARE THEIR EXPERIENCES

A Walden University Doctoral student is doing a research study about how Bahamian men manage high blood pressure and take their medicine. You are invited to share your experience in a private interview.

YOU MAY QUALIFY IF YOU: ABOUT THE INTERVIEW:

- ARE A BAHAMIAN MAN BETWEEN AGES 35–67
- HAVE HAD HIGH BLOOD PRESSURE FOR 6 MONTHS OR MORE
- TAKE MEDICATION FOR IT NOW
- SPEAK ENGLISH
- TAKES 30–60 MINUTES (YOUR CHOICE OF IN-PERSON OR ZOOM)
- AUDIO ONLY (NO VIDEO OR CAMERA)
- YOU WILL RECEIVE A FREE BLOOD PRESSURE MACHINE AS A THANK-YOU
- YOUR NAME WILL NOT BE SHARED. ALL ANSWERS ARE PRIVATE AND SAFELY STORED

THIS IS PART OF A DOCTORAL STUDY AT WALDEN UNIVERSITY AND HAS IRB APPROVAL.

TO JOIN, CONTACT:

BIANCA EDWARDS, DOCTORAL CANDIDATE
EMAIL: BIANCA.EDWARDS@WALDENU.EDU

Appendix C: Letter to the Permanent Secretary



MINISTRY OF HEALTH AND WELLNESS
P. O. BOX N-3729
MEETING AND AUGUSTA STREETS
NASSAU, BAHAMAS
PHONE: (242) 502-4700, FAX: (242) 322-6604

June 4, 2025

Ms. Libby Munson
Research Ethics Support Specialist
Research Ethics, Compliance, and Partnerships
Walden University
100 Washington Avenue South, Suite 1210
Minneapolis, MN 55401

Dear Sir/Madam:

RE: Site-Level Approval for Research Study – "Exploring the Experiences of Bahamian Men with Hypertension and Medication Adherence"

This letter serves as formal notification that the Ministry of Health & Wellness grants permission for Mrs. Bianca Edwards, PhD Nursing Candidate at Walden University, to conduct her approved research study entitled "*Exploring the Experiences of Bahamian Men with HTN and Medication Adherence.*"

This approval permits Mrs. Bianca Edwards to:

1. Engage Chronic Non-Communicable Disease (CNCD) Coordinators employed by the Ministry to share research flyers.
2. Post IRB-approved recruitment flyer within the clinic setting in Eleuthera.
3. Conduct interviews with participants who voluntarily respond to the recruitment efforts in alignment with the procedures outlined in her Walden IRB-approved protocol (#05-30-25-0418479).

Please note that this approval is contingent upon the following:

1. Strict adherence to all ethical standards as described in the IRB-approved application.
2. Assurance that the research will not collect data within Ministry facilities or use Ministry staff for data collection.

.../2

-2-

We understand that Mrs. Edwards' study has received Institutional Review Board (IRB) approval from Walden University and that she is actively enrolled and in good academic standing. The Ministry supports research that enhances our understanding of chronic disease management and aligns with national health priorities.

We wish Mrs. Edwards success in her research and look forward to reviewing the outcomes upon its completion.

Sincerely,



Colin Higgs
Permanent Secretary
Ministry of Health & Wellness
Government of The Bahamas