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# Strategies for Controlling Hypertension Among Parents in Asari-Toru Local Government Area of Rivers State

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## ABSTRACT

Hypertension is a major and rapidly expanding noncommunicable disease risk because it is common, often symptomless, and strongly associated with stroke, heart failure, kidney disease, and premature death. Although effective prevention and treatment options exist, control remains suboptimal in many low and middle income settings due to weak lifestyle adoption, late detection, and inconsistent follow up. This study assessed parents' perceptions of hypertension control strategies in Asari-Toru Local Government Area, Rivers State, across primary, secondary, tertiary, and integrated measures. A descriptive survey design was adopted. The target population comprised parents in Asari-Toru LGA. Using a multistage sampling procedure, respondents were selected from five autonomous communities. Data were collected with a self-developed structured questionnaire covering demographic characteristics and four domains of hypertension control strategies. The instrument was validated by experts and achieved a test-retest reliability coefficient of 0.89. Data were analysed using descriptive statistics (frequency, percentage, and grand mean). Findings (N = 800) showed low overall acceptance of recommended strategies across domains, with strongest agreement for tertiary measures. Summary results indicated that 37% agreed with primary strategies, 31.4% agreed with secondary strategies, 46.1% agreed with tertiary strategies, and 26.6% agreed with integrated strategies. Prevention behaviours had particularly weak support, including stress reduction (12.5%) and weight reduction (25%), suggesting major feasibility and perception barriers among parents. It was concluded that parents in Asari-Toru LGA demonstrated stronger preference for clinically framed and complication oriented actions than for prevention and integrated approaches, underscoring the need for locally practical hypertension control programming. A priority recommendation is to institutionalize routine community-based blood pressure screening linked to structured counselling and follow up through primary health centres and community health workers.

**Keywords:** Control strategies, Hypertension, Integrated control, Primary control, Secondary control, Tertiary control

## INTRODUCTION

Hypertension remains one of the fastest growing noncommunicable disease risks worldwide because it is common, often symptomless, and strongly linked to stroke, heart failure, kidney disease, and premature

death. Global evidence shows that the number of adults living with hypertension has risen sharply over recent decades, driven by population growth, ageing, urbanisation, dietary transitions, and sedentary living (NCD Risk Factor Collaboration, 2021; World Health Organization, 2023). Despite expanding knowledge about prevention and treatment, control remains poor in many settings because diagnosis is late, long term follow up is inconsistent, and medicines or healthy lifestyle options are not always affordable or accessible (World Health Organization, 2023, 2025). These trends matter for parents, who often sit at the centre of household food decisions, stress exposure, and care seeking, meaning their beliefs and day to day practices can either reduce or reinforce risk within families and communities.

In hypertension practice, “control strategies” refer to the coordinated actions used to prevent hypertension, detect it early, treat it effectively, and reduce disability or complications when it is established. Globally, best practice combines lifestyle change with risk based clinical care, including routine blood pressure measurement, appropriate laboratory assessment, consistent medication use when indicated, and patient centred follow up (World Health Organization, 2021, 2023). Across Africa, the challenge is not only high prevalence but also lower rates of awareness, treatment continuity, and control, which are shaped by health system constraints and social barriers that make prevention behaviours difficult to sustain (Adeke et al., 2022; World Health Organization, 2023). In Nigeria, national evidence similarly highlights a substantial burden alongside gaps in awareness, treatment, and control, reinforcing the need for strategies that are both clinically sound and culturally feasible (Adeloye et al., 2021; Odili et al., 2020). In this context, hypertension control can be organised across four levels of measures: primary, secondary, tertiary, and integrated approaches.

Primary measures target the upstream drivers of high blood pressure before hypertension develops or worsens, mainly through lifestyle and risk factor reduction. International guidance consistently prioritises healthier diets (especially lower salt intake and improved overall dietary quality), maintaining healthy weight, physical activity, avoiding tobacco, moderating alcohol, and addressing stress and sleep as part of prevention and long term control (World Health Organization, 2021, 2025). Yet adoption is rarely straightforward, particularly in low resource environments where healthy foods may cost more, work patterns reduce time for exercise, and stressors such as economic insecurity and caregiving burdens are persistent. For parents, prevention behaviours are also embedded in household routines, cultural food norms, and shared decision making, so individual knowledge does not automatically translate into practice. Nigerian and broader African studies repeatedly report that lifestyle counselling is often received but not consistently adopted, partly because perceived barriers outweigh perceived benefits, and because supportive environments for sustained change are limited (Adeloye et al., 2021; Lawal & Kantaris, 2024). Secondary measures focus on early detection and prompt management to prevent progression and complications. This includes screening, regular blood pressure checks, clinical assessment, and timely initiation of treatment and follow up. Globally, the logic is simple: if hypertension is detected early and monitored consistently, it becomes easier to start treatment at the right time, adjust therapy, and reduce long term cardiovascular risk (World Health Organization, 2023). In Nigeria, national data and policy discussions emphasise that missed opportunities for screening and weak follow up systems contribute to poor control, even when people have some contact with health services (Odili et al., 2020; Ogungbe et al., 2024). Community oriented screening and referral models, especially those supported by trained frontline workers, have shown promise in improving linkage to care in African settings, but their effectiveness depends on continuity of services, affordability of care, and trust that a diagnosis will lead to meaningful support (Baldrige et al., 2022; Mengesha et al., 2024).

Tertiary measures aim to reduce disability, manage complications, and improve quality of life for people already living with hypertension related damage or long term illness. This level includes sustained medication adherence, monitoring for complications, rehabilitation where needed, and support for long term self management. Current guidelines emphasise structured follow up, simplified treatment protocols, and task sharing to improve continuity and outcomes, especially in resource constrained primary care systems (World Health Organization, 2021; Moran et al., 2023). In Nigeria, clinical and implementation research shows that improving the organisation of care, ensuring reliable medicine supply, and strengthening patient tracking can improve treatment experiences and control rates in public primary

healthcare settings (Ojji et al., 2022; Ogungbe et al., 2024). For parents, tertiary measures also interact with family responsibilities, because managing a chronic condition competes with time, income, and caregiving obligations, making practical support and clear, simple care pathways essential.

Integrated measures combine population level prevention with service level detection, treatment, and continuity, linking households, communities, and primary healthcare into a single pathway. Federal Ministry of Health and Social Welfare guidance and Nigeria's national hypertension direction increasingly reflect this integrated logic: standardised protocols, routine measurement, team based care, and stronger follow up systems within primary care, aligned with global best practice (Federal Ministry of Health and Social Welfare, 2023; Ogungbe et al., 2024). Global scale up efforts such as Resolve to Save Lives and WHO HEARTS also stress that integration works best when it is practical: clear algorithms, reliable medicines, patient registers, missed visit follow up, and health education that fits people's realities (Moran et al., 2023; World Health Organization, 2019). The implication is that integrated strategies are not only "more activities," but a redesign of how prevention and care are delivered, so that families can move from awareness to action with fewer drop offs across the pathway.

Existing studies in Nigeria have provided strong evidence on prevalence, awareness, treatment, and control, and have also evaluated programme based improvements in primary healthcare, including protocol driven care models (Adeloye et al., 2021; Baldrige et al., 2022; Odili et al., 2020). However, there is still limited place specific evidence that centres parents as a priority group and compares how they perceive and accept the full range of control strategies across primary, secondary, tertiary, and integrated levels within a single local government context. This gap matters in Asari-Toru because perceptions shape whether families adopt prevention behaviours, accept screening, remain in care, and sustain long term management. Therefore, this study aims to provide an evidence informed picture of parents' views on hypertension control strategies across the four levels, to guide more feasible community education, primary healthcare planning, and locally responsive hypertension control efforts.

### **Research questions**

The following research questions were posed to guide the study:

1. What are the primary approach strategies for controlling hypertension among parents in Asari-Toru Local Government Area of Rivers State?
2. What are the secondary approach strategies for controlling hypertension among parents?
3. What are the tertiary approach strategies for controlling hypertension among parent?
4. What are the integrated approach strategies for controlling hypertension among parents?

### **METHODOLOGY**

The study used a descriptive survey design to collect and describe data systematically from a defined population. This approach was considered suitable because it enables the researcher to identify what exists in the population at a particular time and to report patterns in participants' responses. The research was conducted in Asari-Toru Local Government Area of Rivers State, with headquarters in Buguma. The area is largely inhabited by people of Kalabari ethnic nationality and includes several towns and villages within multiple communities. The local economy is mainly fishing, net making, and subsistence farming, with additional income opportunities linked to natural resources such as oil, sand, and gravel.

The target population comprised all parents in the LGA, estimated at 9,000, while the accessible population covered parents across the autonomous communities within reach of the researcher. A sample of 800 parents was selected using a multi-stage sampling procedure. First, five autonomous communities were chosen through simple random sampling. Next, respondents were stratified by gender. Then parents were selected through a household-based approach using random procedures, with both male and female parents interviewed in sampled households.

Data were collected using a self-developed structured questionnaire based on the study objectives and informed by related literature. The instrument had five sections covering demographic information and four categories of hypertension control strategies: primary, secondary, tertiary, and integrated approaches. Items were close-ended and rated on a modified Likert scale. Validity was ensured through review by the supervisor and three public health lecturers, whose feedback informed revisions. Reliability was

established through a test–retest method with a similar population outside the study area, producing a high reliability coefficient of 0.89. For data collection, community entry was secured through official permission from community leaders, and trained research assistants supported administration, including interpretation for non-literate respondents. Data were analysed using descriptive statistics (frequency, percentage, and grand mean).

## RESULTS

**Research Question 1:** *What are the primary approach strategies for controlling hypertension among parents Asari-Toru L.G.A of Rivers State?*

**Table 1: Responses on Primary Approach Strategies for controlling Hypertension Among Parents.**

| S/N | Primary Approach strategies for controlling Hypertension | Responses on Strategies |              |             |
|-----|--|-------------------------|--------------|-------------|
|     |  | Agreed                  | Disagreed    | Total       |
| 1   | Salt intake reduction                                    | 300 (37.5%)             | 500 (62.5%)  | 800         |
| 2   | Moderate fat intake                                      | 318 (39.75%)            | 462 (60.25%) | 800         |
| 3   | Avoidance of excessive alcohol intake                    | 230 (28.75%)            | 570 (71.25%) | 800         |
| 4   | Taking less fatty meals and animal protein               | 400 (50%)               | 400 (50%)    | 800         |
| 5   | Restriction of energy intake to appropriate body used    | 435 (54.4%)             | 365 (45.6%)  | 800         |
| 6   | Weight reduction   | 200 (25%)               | 600 (75%)    | 800         |
| 7   | Regular aerobic exercise                                 | 284 (35.5%)             | 516 (64.5%)  | 800         |
| 8   | Stress reduction   | 100 (12.5%)             | 700 (87.5%)  | 800         |
| 9   | Avoidance smoking  | 260 (32.5%)             | 540 (67.5%)  | 800         |
| 10  | Learning to check blood pressure by oneself              | 430 (43.75%)            | 370 (46.25%) | 800         |
|     | <b>Total</b>   | <b>2957</b>             | <b>5043</b>  | <b>8000</b> |
|     | <b>Grand percentage</b>                                  | <b>(37%)</b>            | <b>(63%)</b> |             |
|     | <b>Mean</b>  | <b>296</b>              | <b>504</b>   |             |

Table 1 revealed that 300 (37.5%) of the respondents agreed while 500 (62.5%) disagreed on salt intake reduction as a primary approach strategy of controlling hypertension. Three hundred and eighteen (39.75%) agreed while 482(60.25%) disagreed on moderate fat intake as a primary approach strategy for controlling hypertension. To say that avoidance of excessive alcohol intake is a primary approach strategy for controlling hypertension, 230(28.75%) agreed while 570(71.25%) disagreed on the same issue. Four hundred (50%) of the respondents agreed while 400(50%) disagreed on taking less fatty meals and animal protein as a primary approach strategy for controlling hypertension. Four hundred and Thirty-Five (54.4%) of the respondents agreed while 365(45.6%) disagreed on restriction of energy intake to appropriate body need as a primary approach strategy for controlling hypertension. Two hundred (25%) of the respondents agreed while 600 (75%) disagreed on weight reduction as a primary approach strategy for controlling hypertension.

Two hundred and Eighty-Four (35.5%) of the respondents agreed while 516(64.5%) disagreed on regular aerobic exercise as a primary approach strategy for controlling hypertension. One hundred (12.5%) of the respondents agreed while 700(87.5%) disagreed on stress reduction as a primary approach strategy for controlling hypertension. To say that avoidance of. Smoking is a primary' approach strategy for controlling hypertension/ 260(32.5%) of the respondents agreed while 540(67.5%) disagreed on the same issue. Four Hundred and thirty (53.75%) of the respondents agreed while 370 (46.25%) disagreed on learning to check blood pressure by oneself as a primary approach strategy for controlling hypertension

from the response breakdown, 2957(37%) with mean of 296 agreed while 5043 (63%) with mean of 504 disagreed on primary approach strategies for controlling hypertension.

**Research Question 2:** *What are the secondary approach strategies for controlling hypertension among parents in Asarttory L.G.A of Rivers State?*

**Table 2 Responses on Secondary Approach Strategies for Controlling Hypertension among Parents.**

| S/N | Secondary Approach strategies for controlling Hypertension | Responses on Strategies |                |             |
|-----|--|-------------------------|----------------|-------------|
|     |  | Agreed                  | Disagreed      | Total       |
| 1   | Early case detection by screening                          | 281 (85.5%)             | 510 (64.5%)    | 800         |
| 2   | Clinical examination and investigation                     | 309 (61.4%)             |                | 800         |
| 3   | Treatment with drugs and sustained follow-up               | 732 (91.5%)             |                | 800         |
| 4   | Regular blood pressure checking                            | 610 (76.25%)            |                | 800         |
| 5   | Identification of potential stressors                      | 600 (75%)               |                | 800         |
| 6   | Keeping of record log book                                 | 347 (43.4%)             |                | 800         |
|     | <b>Total</b>   | <b>1504</b>             | <b>3296</b>    | <b>4800</b> |
|     | <b>Grand percentage</b>                                    | <b>(31.3%)</b>          | <b>(68%.7)</b> |             |
|     | <b>Mean</b>  | <b>251</b>              | <b>549</b>     |             |

Data in table 2 above revealed that 284 (35.5%) of the respondents agreed while 516 (64.5%) disagreed on early case detection by screening as a secondary approach strategy for controlling hypertension. Three hundred and nine (38.6%) of the respondents agreed while 419 (61.4%) disagreed on clinical examination and investigation as a secondary approach strategy for controlling hypertension. sixty-eight (8.5%) of the respondents agreed while 732 (91.5%) disagreed on treatment with drugs and sustained follow-up as a secondary approach strategy for controlling hypertension. To say that regular blood pressure checking is a secondary strategy for controlling hypertension, 190 (23.75%) agreed while 610 (76.25%) disagreed on the same issue. Two hundred (25%) of the respondents agreed while 600 (75%) disagreed on the identification of potential stressors as a secondary approach strategy for controlling hypertension. Four hundred and Fifty-Three (56.6%) of the respondents agreed while 347 (43A%) disagreed on keeping of record log book as a secondary approach strategy for controlling hypertension. From the responses breakdown, 1504 (31.3%) with mean of 251 agreed while 3296(68.7% with mean of 549 disagreed on secondary approach strategies for controlling hypertension.

**Research Question 3:** *What are the tertiary approach strategies for controlling hypertension among parents in Asari-Toru L.G.A. OF Rivers State?*

**Table 3: Response on Tertiary Approach Strategies for Controlling Hypertension among parents**

| S/N | Tertiary Approach strategies for controlling Hypertension | Responses on Strategies |                |            |
|-----|---|-------------------------|----------------|------------|
|     |   | Agreed                  | Disagreed      | Total      |
| 1   | Early case detection by screening                         | 404 (50.5%)             | 396 (49.5%)    | 800        |
| 2   | Clinical examination and investigation                    | 329 (40%)               | 480 (60%)      | 800        |
| 3   | Treatment with drugs and sustained follow-up              | 432 (54%)               | 368 (46%)      | 800        |
| 4   | Regular blood pressure checking                           | 487 (76.25%)            | 313 (39.1%)    | 800        |
| 5   | Identification of potential stressors                     | 200 (75%)               | 600 (75%)      | 800        |
|     | <b>Total</b>  | <b>1843</b>             | <b>2157</b>    | <b>800</b> |
|     | <b>Grand percentage</b>                                   | <b>(46.1%)</b>          | <b>(53.9%)</b> |            |
|     | <b>Mean</b>   | <b>369</b>              | <b>431</b>     |            |

Table 3 above revealed that 404(50.5%) of the respondents agreed while 396(49.5%) disagreed on limitation of disability as a tertiary approach strategy for controlling hypertension. Three hundred and twenty (40%) of the respondents agreed while 480(60%), disagreed on management of complications as a tertiary approach strategy for controlling hypertension. Four hundred and Thirty-Two (54%) of the respondents agreed while 368 (46%) disagreed on rehabilitation of patients is a tertiary approach strategy for controlling hypertension. To say that re-integration as a tertiary approach strategy for controlling hypertension, 487(60.9%) agreed while 313(39.1%) disagreed on the same issue. Two hundred (25%) of the respondents agreed while 600(75%) disagreed on patient's compliance with medical advice as a tertiary approach strategy for controlling hypertension. From the responses breakdown, 1843(46.1%) with mean of 369 agreed while 2157(53.9%) with mean of 431 disagreed on tertiary approach strategies for controlling hypertension.

**Research Question 4 :** *What are the integrated approach strategies for controlling hypertension among parents in Asari-toru L.G.A. of Rivers State?*

**Table 4: Response on Integrated Approach Strategies for Controlling Hypertension among Parents**

| S/N | Integrated Approach strategies for controlling Hypertension  | Responses on Strategies |                |            |
|-----|--|-------------------------|----------------|------------|
|     |  | Agreed                  | Disagreed      | Total      |
| 1   | Early case defection cases by screening and tracking         | 180 (22.5%)             | 620 (77.5%)    | 800        |
| 2   | Tracking prevailing risk factors in society at the same time | 100 (12.5%)             | 700 (87.5%)    | 800        |
| 3   | Blood pressure health education and awareness programmes     | 210 (26.25%)            | 590 (26.25%)   | 800        |
| 4   | Lifestyles modifications                                     | 260 (32.5%)             | 540 (67.5)     | 800        |
| 5   | Anti-hypertensive drug therapy                               | 317 (39.6%)             | 483 (60.4%)    | 800        |
|     | <b>Total</b>   | <b>1067</b>             | <b>2933</b>    | <b>800</b> |
|     | <b>Grand percentage</b>                                      | <b>(26.7%)</b>          | <b>(73.3%)</b> |            |
|     | <b>Mean</b>  | <b>213</b>              | <b>587</b>     |            |

Table 4 revealed that 180(22.5%) of the respondents agreed while 620(77.5%) disagreed on early defection of cases by screening and tracking as an integrated approach strategy for controlling hypertension. One hundred (12.5%) of the respondents agreed while 700(87.5%) disagreed on tackling prevailing risk factors in the society at the same time as an integrated approach strategy for controlling hypertension. Two hundred and ten (26.25%) of the respondents agreed while 590(73.75%) disagreed on blood pressure health education and awareness programmes as an integrated approach strategy for controlling hypertension. Two Hundred and Sixty (32.5%) of the respondents agreed while 540(67.5%) disagreed on lifestyle modification as an integrated approach strategy for controlling hypertension. Three hundred and seventeen (39.6%) of the respondents agreed while 483(60.4%) disagreed on anti-hypertension.

### **DISCUSSION OF FINDINGS**

The findings across the four strategy domains show a clear pattern: respondents were generally less receptive to prevention focused lifestyle actions than to clinically framed actions. Primary strategies that require sustained day to day behaviour change, especially stress management, regular exercise, weight control, alcohol moderation, and smoking avoidance, attracted the weakest support, suggesting that many parents may not see these actions as realistic, urgent, or personally actionable in their current living context. Secondary and integrated approaches also drew limited support, particularly where they implied

routine screening, tracking of risks, structured health education, and coordinated follow up. By contrast, tertiary strategies received comparatively stronger acceptance, implying that respondents were more comfortable with approaches that sound like management of established illness and complications rather than early prevention or multi sector coordination.

This pattern is supported by recent global and implementation evidence showing that hypertension control improves when prevention advice is paired with practical delivery systems, trusted health workers, and consistent follow up. The World Health Organization's guideline and technical approaches emphasise that effective control depends on both lifestyle counselling and accessible, protocol driven treatment delivered through primary care teams, including nurses and other trained professionals (World Health Organization [WHO], 2021; Campbell et al., 2022). Evidence on self measured blood pressure also shows that home monitoring works best when combined with co interventions such as counselling, medication support, and structured follow up, rather than being provided as a standalone tool (Khoong et al., 2022; Sheppard et al., 2020). In African settings, community health worker supported models that reduce the burden of frequent facility visits and strengthen linkage to care have also demonstrated improved outcomes, reinforcing the value of well designed integrated delivery even when initial community acceptance is low (Hickey et al., 2025).

At the same time, some recent studies explain why these results can look “non supportive” of prevention and integrated strategies in real communities. The WHO's global report highlights that hypertension remains under detected and poorly controlled in many countries, particularly in low and middle income settings, where routine screening and sustained treatment pathways are often weak or fragmented (WHO, 2023; Kario et al., 2024). Nigerian evidence also continues to report gaps in awareness, treatment continuity, and the practical adoption of lifestyle modification, shaped by financial constraints, cultural food practices, competing priorities, and limited access to supportive environments for exercise and stress management (Lawal & Kantaris, 2024; Ibitoye et al., 2025). In that context, low endorsement of screening, tracking, and health education can reflect low trust in follow up benefits, not simply rejection of the ideas themselves.

The findings align well with behaviour change theory and help explain the gap between what guidelines recommend and what people accept. From a Health Belief Model perspective, weak support for lifestyle measures suggests perceived barriers are outweighing perceived benefits, while low support for screening and tracking suggests limited cues to action and low confidence that detection will lead to meaningful help (Rosenstock, 1974; Glanz et al., 2015). Social ecological thinking further suggests that individual level choices are constrained by family income, food availability, neighbourhood safety, work schedules, and health system responsiveness, so “knowledge” alone rarely produces sustained change (McLeroy et al., 1988). The relatively stronger acceptance of tertiary strategies fits a common risk perception pattern: actions feel more necessary when illness is viewed as already present or severe, while prevention can feel optional when hypertension is seen as a silent, non urgent condition (WHO, 2023).

Practically, public health action in Asari Toru should prioritise making prevention doable, visible, and rewarding. Community outreach should combine blood pressure checks with brief, culturally grounded counselling on salt reduction, healthier cooking swaps, physical activity that fits daily routines, and stress coping skills, while strengthening referral pathways so screening leads to care. Home blood pressure monitoring can be promoted, but only with structured follow up, coaching, and clear escalation steps, consistent with current evidence (Khoong et al., 2022; Sheppard et al., 2020). Primary care should adopt simple treatment protocols and team based roles, which aligns with WHO guidance and recent Nigerian implementation work on scaling structured hypertension services (WHO, 2021; Obiezu Umeh et al., 2025; Sambo et al., 2025). Key limitations should be acknowledged: the results are based on self reported agreement rather than observed behaviour or measured blood pressure outcomes, and some internal inconsistencies in the tables suggest the need for careful data cleaning and verification before drawing firm conclusions for policy.

## **CONCLUSIONS**

This study examined strategies for controlling hypertension among parents in Asari-Toru Local Government Area of Rivers State across primary, secondary, tertiary, and integrated measures. The findings suggest that many parents were less inclined toward prevention-focused lifestyle actions and system-led approaches such as routine screening, tracking, and structured health education, indicating possible gaps in awareness, perceived importance, and feasibility of these strategies in everyday life. Acceptance appeared stronger for measures that align with managing established illness and complications, which may reflect a tendency to respond when risks feel immediate rather than preventive. Overall, the pattern underscores the need for community-responsive interventions that reduce practical barriers, strengthen knowledge, and build trust in primary healthcare pathways for early detection and sustained follow-up. Addressing hypertension in this context requires combining behaviour change support with accessible and reliable health services, so that parents can move from awareness to consistent practice and improved long-term cardiovascular health outcomes.

## **RECOMMENDATIONS**

To strengthen hypertension prevention and control among parents in Asari-Toru LGA, the following actions are recommended:

1. The Rivers State Primary Health Care Management Board, working with the Asari-Toru LGA health authority and community leaders, should run regular community health education sessions in churches, markets, schools, and town halls that teach parents practical ways to reduce salt, improve diet quality, build simple daily physical activity, and manage stress, because low acceptance of lifestyle measures is often driven by limited understanding and high perceived barriers, and this can be improved by using local language messaging, cooking demonstrations, peer educators, and take-home reminders.
2. Primary health centres in Asari-Toru, supported by the LGA health department, should institutionalise routine blood pressure screening for parents during immunisation days, antenatal and postnatal clinics, outpatient visits, and community outreach days, because early detection reduces late complications and improves long-term control, and this can be achieved by setting fixed screening points, using standard recording registers, issuing referral slips, and ensuring follow-up calls or home visits for those with raised readings.
3. The Rivers State Ministry of Health and local facility managers should strengthen access to affordable hypertension care by ensuring uninterrupted supply of essential antihypertensive medicines, basic investigations, and counselling services at primary care level, because inconsistent availability and cost barriers weaken treatment adherence and trust in care, and this can be done through better forecasting and procurement, subsidised pricing where feasible, and clear dispensing and refill schedules linked to patient tracking.
4. Community health workers and trained volunteers, supervised by nurses at primary health centres, should deliver an integrated follow-up system that supports home blood pressure monitoring, medication adherence, and appointment keeping among parents, because ongoing support improves sustained control beyond one-off clinic visits, and this can be implemented through brief training, simple monitoring logbooks, reminder calls or messages, household follow-up for missed visits, and escalation protocols for urgent symptoms or persistently high readings.

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