

Adherence to Lifestyle Modification Practices and Its Associated Factors Among Hypertensive Patients in Bahir Dar City Hospitals, North West Ethiopia [Letter]

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Dear editor

I have read a research article entitled “Adherence to Lifestyle Modification Practices and Its Associated Factors Among Hypertensive Patients in Bahir Dar City Hospitals, North West Ethiopia” by Geremew et al,¹ recently published in Journal of Integrated Blood Pressure Control. I congratulate the authors on this successful article and make some contributions. This study has three notable strengths: Firstly, it used validated tools to comprehensively measure multiple factors related to lifestyle behaviors, knowledge, social support, and the patient-physician relationship among hypertensive patients. This allowed the study to gain useful insights into various personal and social influences on adherence. Secondly, the study provided an overview of adherence to lifestyle modifications in the target population by assessing the current status in the study area. This broad snapshot gives useful baseline information. Lastly, the study investigated an important research topic of adherence to lifestyle changes among hypertensive patients. Exploring modifiable factors associated with adherence can help improve hypertension management strategies.

However, I have also discovered several limitations that need to be addressed in future research namely: 1) The study was conducted in a single city of Ethiopia so findings may not be generalized to other settings. 2) Additionally, lifestyle behaviors were assessed at a single time point and may not reflect long-term adherence patterns. 3) Self-reported data was conducted which can be subjected to recall and social desirability biases. 4) Some other individual factors like mental health and motivation that could impact adherence were not included in the analysis.

To obtain better results, I recommend that research carried out by 1) Develop longitudinal intervention studies to test strategies for enhancing modifiable factors found to be associated with adherence, such as knowledge, social motivation, and the patient-doctor bond.

This could help determine causal relationships and identify the most effective approaches. 2) Consider multicenter studies involving both urban and rural hospitals across different regions of Ethiopia. This would allow for a more nationally representative assessment of adherence rates and influential contextual factors. Comparisons across diverse settings could provide insights into the scalability of successful local programs.

3) Should use objective as well as self-reported measures when evaluating lifestyle behaviors over time. Objective indicators such as clinical measurements of blood pressure, weight reduction, limiting sodium intake, increasing physical exertion, quitting smoking, and avoiding alcohol and help validate adherence levels.² Using both types of measures would generate more robust data for guiding the development of culturally sensitive and sustainable lifestyle modification programs in Ethiopia.

In conclusion, this study makes a significant contribution to understanding adherence to lifestyle modification practices and its associated factors among hypertensive patients in Ethiopia, and emphasizes the need for awareness and advice regarding lifestyle changes for hypertension patients.

Disclosure

The author reports no conflicts of interest in this communication.

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