SUMMARY

Background: The prevalence and morbidity of hypertension is greater among the elderly who often have additional multiple co-morbidities. The involvement of the family and sound mental health may be important in achieving and maintaining optimal blood pressure control in them. The family physician is at the forefront of management of the elderly at all levels of care and has been equipped to identify problems related to their mental and physical health.

Objectives: The study assessed the relationship between family support, psychological well-being and blood pressure control of elderly patients with hypertension attending the Geriatric Care Centre UCH. It also assessed the association between co-morbidities and blood pressure control.

Methodology: The study through a comparative cross sectional study design over a period of three months, recruited 400 consenting elderly patients with established hypertension of at least one year duration between 1st February and 30th April 2014. Controlled blood pressure was taken as average of blood pressure readings of systolic < 140 mmHg and diastolic < 90 mmHg. An interviewer administered questionnaire was used to obtain data on socio-demography, family characteristics, perceived social support, psychological well-being, medication adherence and medical history. Perceived social support- family scale was used to assess family support, WHO (Five) Well-being Index for psychological well-being and medication adherence with modified Morisky predictor scale. The level of significance of analysis was set at p < 0.05.

Results: The mean age of respondents was 70.5 ± 6.8 years and the sex ratio (Male: Female) was 1:2. The median duration of hypertension was 5 years. Majority of the participants (52.5%) spent more than ₦2,500.00 monthly on medications and were on two or more antihypertensive
Adherence to antihypertensive medication was good in 84.0% of respondents. Majority of the elderly patients with hypertension had strong/good perceived family support (95.8%) and good psychological well-being (84.5%), but both were not statistically related to blood pressure control. The predictors of good psychological well-being in the respondents were having formal education (p=0.043), married in monogamous family (p=0.014), less than 40 years of marriage (p=0.026), household size less than 5 (p=0.021), receiving ₦5,000.00 or less from other sources (p=0.036) and cumulative monthly income above poverty line (p=<0.001). Respondents with uncontrolled blood pressure had osteoarthritis (p=0.043) more than controlled participants, while there was better blood pressure control in respondents with refractive error (p=0.037). However, the predictors of blood pressure control were amount spent on medications, body weight and presence of refractive error. Respondents who spent more than ₦2,500.00 monthly on medications (OR=0.620, CI=0.402–0.955) and those with refractive error (OR=0.547, CI=0.301–0.994) have better blood pressure control. Each unit rise in BMI increased the odds of uncontrolled blood pressure by 6.1% (OR=1.061, CI=1.020–1.103).

**Conclusions:** The elderly in this environment had good family support and psychological well-being; however, these two factors did not affect their blood pressure control. The co-existence of other chronic morbidities however affected their blood pressure control positively (refractive error) and negatively (BMI). The Family Physician who provides longitudinal, comprehensive and coordinated care has knowledge of each patient’s medical condition, family history and lifestyle practice. She/he is uniquely positioned to identify patients having challenges in managing their blood pressure and proffer practical solutions to this, including management of multiple chronic morbidities in the elderly.