

Exploring the Influence of Marital Status on Treatment Adherence Among Hypertensive Patients in Primary Healthcare Settings: A Quantitative Cross-Sectional Study

Felix Fiavor¹, Divine kumordzie², Orji-Okafor, Euphemia Cheta³, Oigene Sunday Michael⁴, Gandu Ahmadu Aminu⁵

¹Catholic University of Ghana

²Ho Municipal Hospital

³University of Nigeria, Enugu Campus (UNEC)

⁴Medical Department, federal polytechnic kaura Namoda.

⁵Defence Headquarters Medical Centre, Mogadishu Cantonment, Asokro, Federal Capital Territory, Abuja.

Abstract: This study investigates the influence of marital status on treatment adherence among hypertensive patients in primary healthcare settings in Ghana. Hypertension, a leading contributor to cardiovascular disease and premature mortality, requires strict adherence to treatment regimens for effective management. While previous research has examined demographic and behavioral predictors of adherence, the role of relational status remains underexplored, particularly within African contexts. Employing a quantitative cross-sectional design, data were collected from 220 hypertensive patients using a structured questionnaire comprising socio-demographic variables and Likert-scale measures assessing emotional, financial, and practical partner support. Descriptive statistics revealed that married individuals exhibited higher rates of self-reported adherence (65.4%) compared to single, divorced, or widowed counterparts. However, chi-square analysis found no statistically significant association between marital status and treatment adherence ($\chi^2 = 8.24$, $df = 4$, $p = 0.083$). Emotional support emerged as the most influential dimension, with a mean score of 3.61, indicating that perceived spousal encouragement contributes meaningfully to adherence behavior. Although marital status alone did not predict adherence, findings suggest that the quality and type of partner support play a pivotal role in facilitating consistent medication use. These results highlight the need for healthcare providers to assess patients' relational contexts and promote family-inclusive adherence interventions. The study contributes to a deeper understanding of the social dimensions of chronic disease management and calls for culturally tailored strategies to support adherence across all marital categories, especially for patients lacking immediate partner support.

Keywords: Hypertension, treatment adherence, marital status, social support, primary healthcare

Date of Submission: 09-08-2026

Date of Acceptance: 21-08-2026

I. INTRODUCTION

Hypertension remains a major public health concern globally and is among the leading causes of cardiovascular morbidity and mortality. According to the World Health Organization (2021), more than 1.28 billion adults worldwide suffer from hypertension, with a significant proportion residing in low- and middle-income countries, including Ghana. Despite increasing awareness and improvements in healthcare delivery, adherence to antihypertensive treatment regimens remains suboptimal in many settings, leading to poorly controlled blood pressure and increased risk of complications such as stroke, renal failure, and heart disease (Burnier & Egan, 2019). Treatment adherence among hypertensive patients is influenced by a complex interplay of individual, social, and structural factors. While demographic characteristics such as age, gender, education, and income have been widely studied in relation to medication adherence, the role of marital status and spousal support is gaining increased attention in recent years. Marital relationships often provide both emotional and instrumental support, which may enhance an individual's motivation to adhere to long-term treatment plans (Molokwu et al., 2022). Spouses may serve as reminders, caregivers, and sources of encouragement, which are critical for sustaining health-related behaviors, particularly in chronic illness management.

Several studies have demonstrated that individuals who are married or in stable partnerships tend to exhibit better health outcomes, including higher rates of medication adherence and lower levels of psychological distress (Tadesse et al., 2020; Wulifan et al., 2022). Conversely, individuals who are single, divorced, or widowed often experience limited social support, which may adversely affect their ability to maintain regular

treatment routines. However, the association between marital status and treatment adherence is not always straightforward, and findings remain mixed. For example, some studies have found that the quality of marital relationships may be more critical than marital status per se (Uchendu et al., 2020), while others highlight that spousal support is particularly effective when it involves both emotional reassurance and tangible assistance with treatment management (Gellad et al., 2021). In Ghana, where family structures and social networks are integral to individual well-being, understanding the role of marital status in shaping treatment adherence is especially important. Although hypertension is prevalent and growing among the adult population, empirical research on how marital dynamics influence adherence behaviors in Ghanaian contexts remains limited. The current study seeks to fill this gap by quantitatively examining the association between marital status and treatment adherence among hypertensive patients in primary healthcare settings. By identifying whether certain marital groups are at higher risk of non-adherence, this research can inform targeted interventions that leverage social and relational resources to enhance chronic disease management.

II. RELATED STUDIES

Understanding treatment adherence among hypertensive patients requires a multidimensional exploration of both clinical and non-clinical factors, particularly those grounded in social relationships. Among these, marital status has emerged as a key variable in predicting how consistently individuals follow their prescribed treatment regimens. Existing literature reveals that being in a stable marital relationship may facilitate better adherence to chronic illness management by providing emotional, financial, and logistical support. However, the strength and direction of this relationship remain contested, with variations across cultural, socioeconomic, and gender lines. While several studies have confirmed a positive association between marriage and improved adherence, others argue that it is the quality and context of marital relationships rather than marital status alone that significantly determine patient behavior. Furthermore, research from both high-income and low- to middle-income countries, including those in sub-Saharan Africa, suggests that spousal involvement can either reinforce or hinder health-seeking actions depending on how roles and expectations are socially constructed.

Marital Status as a Predictor of Hypertension Treatment Adherence

Multiple studies have identified marital status as a significant predictor of adherence to chronic disease treatment, particularly in the management of hypertension. DiMatteo's (2004) seminal meta-analysis on social support and treatment adherence found that married individuals exhibited higher adherence levels compared to unmarried ones, attributing this to both emotional encouragement and logistical support often present in marital relationships. This observation was further confirmed by Lee and Rhee (2020), who noted that spouses frequently serve as informal caregivers by reminding patients to take medication, accompanying them to clinical appointments, and encouraging health-promoting behaviors. In Ghanaian and other Sub-Saharan African contexts, where communal and familial structures play a vital role in healthcare decisions, marriage can provide a stable environment that facilitates adherence to lifelong medication regimens.

For instance, Wulifan et al. (2022) reported that married patients demonstrated significantly higher adherence to antihypertensive medications, largely due to support in managing treatment schedules, sharing responsibilities, and providing emotional comfort. However, these benefits are not universal. In a study conducted by Chan et al. (2020), no statistically significant association was found between marital status and adherence among hypertensive patients in Hong Kong. The authors argued that other factors, such as individual health beliefs, autonomy, and access to healthcare resources, might outweigh marital status in influencing adherence behaviors. These findings highlight the complexity of adherence behavior, suggesting that while marital status may provide a supportive framework for better disease management, it is only one of many interacting factors. Cultural expectations and spousal roles within different societal systems can either enhance or undermine this association. Thus, a deeper understanding of how marriage functions within specific socio-cultural contexts, such as those in Ghanaian primary healthcare settings, is essential for tailoring interventions that aim to improve treatment adherence among diverse patient groups.

Quality of Marital Relationships and Its Influence on Adherence

While marital status has been widely studied in relation to treatment adherence, recent research emphasizes that the quality of the marital relationship may be an even more critical determinant of health behaviors than the legal status of the relationship. Molokwu et al. (2022) conducted a comprehensive analysis and discovered that individuals in high-quality, emotionally supportive marriages were significantly more likely to adhere to prescribed hypertension treatments than those in strained or conflict-laden relationships, regardless of their marital status. This aligns with Heisler et al. (2008), who found that patients with mutually respectful and communicative partners were more involved in decision-making and more consistent in following medical

advice. Such couples often share healthcare responsibilities, encouraging each other to maintain treatment regimens. On the contrary, individuals in dysfunctional marriages may experience stress, emotional neglect, or even active sabotage of their treatment efforts, which can directly undermine adherence. Karami et al. (2021) supported this argument, noting that the presence of domestic conflict and lack of mutual concern contributed to non-adherence and poorer health outcomes. These findings are significant in low- and middle-income countries, including Ghana, where marriage is often seen as both a cultural expectation and a practical partnership in economic and health-related matters. Yet, the assumption that all marriages are inherently supportive may obscure the negative experiences of individuals in troubled unions. Emotional abuse, neglect, or lack of involvement by a spouse may render the marital relationship more harmful than helpful. Therefore, healthcare providers should consider not just the marital status of their patients but also the quality of those relationships when assessing support systems. Incorporating relationship counseling or partner-inclusive health education programs could improve adherence outcomes, especially in cases where marital discord is identified as a barrier. Understanding the emotional dynamics within marriages adds depth to policy and program interventions targeting hypertension control in marital households.

Gendered Dimensions of Spousal Support in Hypertension Management

Gender plays a critical role in how spousal support is received and utilized in hypertension treatment adherence. Several studies have pointed to distinct gender differences in the nature of support provided within marriages. DiMarco et al. (2019) observed that men are more likely to receive direct caregiving from their wives, including medication reminders, meal preparation, and appointment scheduling. In contrast, women tend to receive emotional support, which, although beneficial, may not always translate into tangible assistance with treatment adherence. Ogedegbe et al. (2012) further demonstrated that men who received emotional and practical support from their spouses showed better adherence to antihypertensive therapy. However, married women, particularly in African settings, often face dual burdens of caregiving for children and elderly relatives, which can negatively impact their own health management. Akinlua et al. (2017) documented that in Nigerian households, women often prioritize family health over their own, skipping doses or delaying treatment due to time constraints or financial limitations. This gendered disparity underscores the need to evaluate the direction and effectiveness of spousal support, rather than assuming uniformity based on marital status alone. In Ghana, traditional gender roles often position women as caregivers and men as providers, which may further complicate support dynamics. If women are expected to be self-sufficient and manage multiple domestic roles, they may not receive adequate spousal support, even within marriage. Therefore, public health interventions must be gender-sensitive, ensuring that both male and female patients receive appropriate forms of support. Programs that encourage mutual caregiving and challenge stereotypical roles could promote more balanced health outcomes. Understanding these gender dynamics within marital settings can inform targeted strategies that improve adherence by promoting equitable sharing of health responsibilities and encouraging joint participation in disease management.

Cultural and Socioeconomic Contexts in the Marital-Adherence Nexus

The influence of marital status on hypertension treatment adherence is not uniform across societies; it is deeply shaped by cultural norms and socioeconomic realities. In many African contexts, marriage functions not only as a personal relationship but also as a communal institution, often involving extended family networks and socially constructed expectations about gender roles, caregiving responsibilities, and household authority. Akinlua et al. (2017) emphasized that in Nigerian households, societal expectations placed on men to be economic providers and on women to be primary caregivers significantly influenced adherence behaviors. Married male patients often reported higher adherence rates due to the practical assistance they received from their spouses, including help with medication schedules, meal planning, and clinic attendance. Conversely, married women reported difficulties in adhering to treatment because of the multiple roles they played in caring for children, elderly relatives, and even their husbands. These caregiving burdens, coupled with limited control over household finances, often restricted women's ability to prioritize their own health needs. In Ethiopia, Tadesse et al. (2020) found similar patterns, noting that although marriage offered some level of emotional support, the socioeconomic demands within households often created competing priorities that undermined consistent medication use. These findings are echoed by Addo et al. (2019) in Ghana, who observed that low-income households, regardless of marital status, were more likely to default on hypertension treatment due to high out-of-pocket costs and limited access to health insurance. Thus, while marital status may serve as a conduit for support, it does not immunize individuals from the structural barriers that impede adherence. In fact, for some, marriage may add to the burden if the relationship is characterized by financial dependence, inequity, or emotional stress.

III.METHODOLOGY

This outlines the methodological approach adopted to investigate the influence of marital status on treatment adherence among hypertensive patients in primary healthcare settings. The methodological structure was guided by the study's objectives and the need to establish empirical relationships between socio-demographic variables particularly marital status and self-reported adherence behaviors. A quantitative cross-sectional design was deemed appropriate to capture a snapshot of how marital status correlates with treatment compliance among patients currently receiving care. This chapter provides detailed descriptions of the research design, population, sampling procedures, data collection tools and processes, analytical techniques, ethical considerations, limitations, and delimitations of the study. Each section is developed to ensure the study's validity, reliability, and ethical rigor, thus strengthening the credibility of the findings and supporting their application in public health policy and practice. The methodology adopted in this study not only aligns with existing empirical literature but also responds to the local context and healthcare realities of Ghana.

Research Design

This study employed a quantitative cross-sectional survey design to examine the influence of marital status on treatment adherence among hypertensive patients attending primary healthcare facilities. The cross-sectional nature of the design enabled the researcher to collect data at a single point in time, making it possible to assess the relationship between marital status and adherence patterns within a clearly defined time frame. The rationale for choosing this design lies in its capacity to provide a snapshot of current behaviors and perceptions among diverse marital categories without the need for long-term follow-up. Quantitative methodology was chosen for its objectivity, generalizability, and suitability for analyzing numerical patterns, such as frequency distributions, correlations, and statistical associations. This allowed the use of structured questionnaires, Likert-scale metrics, and statistical software to derive meaningful conclusions from the data. Furthermore, a cross-sectional design is cost-effective and efficient, particularly for studies in low-resource settings where extensive longitudinal tracking may be unfeasible.

This design was especially relevant given the research objectives, which sought to determine whether variations in marital status (e.g., single, married, cohabiting, divorced, widowed) are significantly associated with differences in self-reported adherence to antihypertensive treatment. Because adherence can be influenced by psychological, emotional, social, and economic factors that change over time, capturing data at a single point reduces the influence of confounding variables associated with temporal change. Although this approach limits the ability to infer causality, it provides sufficient statistical power to detect significant associations. Moreover, the design aligns with previous related studies in sub-Saharan Africa, which have utilized cross-sectional frameworks to explore social determinants of chronic illness management. Ultimately, this design was chosen to enable a robust analysis of the hypothesized relationships between marital status and treatment adherence, grounded in empirical and statistical evidence derived from the target population in the primary healthcare context.

Study Population

The study population consisted of adult hypertensive patients attending selected primary healthcare facilities in the target municipality. These individuals had been clinically diagnosed with hypertension and were either currently on antihypertensive medications or enrolled in ongoing hypertension management programs. The inclusion criteria required participants to be 18 years of age or older, capable of providing informed consent, and to fall within one of the recognized marital categories: single, married, cohabiting, divorced, or widowed. The selection of this population was critical for exploring the research objective, which focused on understanding how marital relationships or the absence thereof influence the capacity of individuals to adhere to treatment protocols for chronic conditions like hypertension. Primary healthcare settings were chosen as the study sites because they typically serve as the first point of contact for patients managing long-term conditions in Ghana's public health system. These facilities are often more accessible and affordable to the general population compared to secondary or tertiary institutions, thereby attracting a more diverse and representative clientele. Moreover, these settings allowed the researcher to reach patients across various socio-economic backgrounds, ensuring the inclusion of individuals from both urban and peri-urban locations. The study population thus represented a broad cross-section of Ghanaian hypertensive patients, capturing variability in age, gender, education level, occupation, income, and relational status. The rationale for focusing on hypertensive individuals is grounded in the disease's high prevalence and the critical role of sustained medication adherence in preventing complications such as stroke, heart disease, and kidney failure. The decision to include only those actively engaged in treatment ensured the relevance of questions related to spousal support and behavioral adherence. Overall, the selected population provided a rich context for exploring the social determinants of health, particularly the role of marital structures, within the real-world environment of Ghanaian primary care.

Sample Size and Sampling Technique

The sample size for this study was 220 hypertensive patients, carefully selected to ensure representativeness and adequate statistical power for analysis. This number was based on considerations from similar cross-sectional studies conducted in sub-Saharan Africa exploring health behaviors and treatment adherence, where sample sizes ranging from 150 to 300 were commonly utilized to detect medium effect sizes with 95% confidence and a 5% margin of error. A sample of 220 was deemed sufficient to capture variability across the marital status categories of interest single, married, cohabiting, divorced, and widowed while also accounting for potential non-response or incomplete data. Moreover, this sample size aligns with chi-square requirements for categorical data analysis, especially when subgroups such as cohabiting or widowed participants are relatively small. A stratified purposive sampling technique was employed. First, the study population was stratified according to marital status to ensure proportional representation from each category. This stratification was crucial in enabling comparative analysis between different relational groups, a core objective of the research. Within each stratum, respondents were selected purposively based on their attendance at outpatient clinics during the data collection period. This approach allowed the researcher to include individuals with ongoing engagement in hypertension care, ensuring that the topic of adherence was contextually relevant. Although not probabilistic, purposive sampling was appropriate given the specific inclusion criteria and the need to explore social determinants of health in a targeted manner.

Data Collection Instrument

The primary data collection instrument for this study was a structured questionnaire designed to capture quantitative information on respondents' demographic characteristics, marital status, and treatment adherence behaviors. The questionnaire was divided into three key sections. The first section focused on socio-demographic variables such as age, gender, educational attainment, occupational status, and monthly income, which are known to influence health behaviors and access to care. This section provided background context for understanding the socio-economic positioning of each respondent, which could mediate or moderate the relationship between marital status and adherence. The second section was dedicated to marital characteristics, including current marital status, duration of the relationship, and perceived quality of the relationship. This was important for distinguishing between legal marital status and relational experience, thereby providing richer insights into how intimate partnerships affect adherence. The third and most crucial section employed a six-item Likert scale to measure the perceived influence of marital and partner support on hypertension treatment adherence. Statements addressed emotional, financial, and practical support dimensions. For example, participants were asked to rate their agreement with statements such as "My spouse/partner helps me remember to take my medication" or "Lack of support from my partner makes it difficult to follow treatment." Responses were scored from 1 (Strongly Disagree) to 5 (Strongly Agree), allowing for the quantification of perceptions and the calculation of mean scores and standard deviations. The instrument was reviewed by public health experts and pre-tested with a small sample of 20 patients to assess clarity, relevance, and internal consistency. Feedback from the pilot informed minor adjustments in wording for better comprehension. The reliability coefficient (Cronbach's alpha) for the Likert scale items was 0.81, indicating high internal consistency. This ensured that the tool was appropriate for the local context and capable of capturing nuanced information about marital dynamics and adherence behaviors in a standardized format.

Data Collection Procedure

The data collection process was carried out over a four-week period in selected primary healthcare facilities within the study municipality. Prior to the commencement of data collection, ethical clearance was obtained from the appropriate institutional review board, and administrative permission was secured from the management of the health facilities involved. Trained research assistants were recruited and briefed extensively on the objectives of the study, ethical standards, and data collection protocols. These assistants were fluent in both English and the predominant local language, ensuring effective communication with participants from varying educational backgrounds. Upon arrival at the outpatient department, patients meeting the inclusion criteria were approached individually and invited to participate in the study. The purpose of the research was explained in detail, and informed consent was obtained verbally and in writing before administering the questionnaire. To preserve confidentiality and encourage honest responses, interviews were conducted in private consultation areas or other quiet locations within the clinic premises. Each interview lasted approximately 20 to 30 minutes, depending on the participant's familiarity with the questions and comfort level. Participants were assured that their responses would remain anonymous and would not influence their medical treatment. Research assistants followed a checklist to ensure that all questionnaire sections were completed systematically. Any ambiguities or non-responses were addressed promptly during the interview. Completed questionnaires were collected daily and reviewed by the principal investigator for completeness and accuracy. This daily review allowed for real-time corrections and minimized data entry errors. All collected data were securely

stored in a locked cabinet and later entered into a password-protected database for analysis. This structured and ethically grounded data collection procedure ensured the integrity and validity of the responses while respecting the dignity and privacy of participants.

Data Analysis Techniques

The data collected were processed and analyzed using the Statistical Package for the Social Sciences (SPSS) version 26. Prior to analysis, all questionnaires were carefully checked for completeness and consistency, and data were cleaned to remove any anomalies or missing values. Descriptive statistics were first employed to summarize the demographic characteristics of the respondents. Frequencies, percentages, means, and standard deviations were calculated to provide a comprehensive overview of variables such as age, gender, income, educational level, and marital status. These descriptive measures helped to identify patterns and distributions across the sample, setting the stage for more advanced analyses. To assess the influence of marital status on treatment adherence, inferential statistics were used. Specifically, the Chi-square (χ^2) test of independence was applied to examine whether a significant association existed between marital status and levels of treatment adherence (categorized as high or low adherence). The Chi-square test was suitable given that both variables were categorical. A p-value of less than 0.05 was considered statistically significant. In addition, Likert scale responses related to spousal support were analyzed using measures of central tendency (mean scores) and variability (standard deviations), allowing the researcher to interpret how participants perceived different dimensions of partner support and its effect on their adherence behaviors.

Ethical Considerations

This study adhered strictly to the ethical principles of research involving human subjects, including respect for persons, beneficence, and justice. Ethical approval was obtained from the relevant institutional ethics review board before data collection commenced. Participants were fully informed about the purpose, scope, and procedures of the study. They were assured that their participation was entirely voluntary and that they had the right to withdraw at any stage without any consequences to their ongoing healthcare or relationship with the facility. Informed consent was obtained in writing from each participant, with explanations provided in both English and the local language to ensure comprehension. Confidentiality was maintained throughout the research process. No personal identifiers such as names or medical record numbers were collected. Each questionnaire was assigned a unique identification code, and all data were stored in locked cabinets or password-protected digital files accessible only to the research team. During data entry and analysis, care was taken to ensure anonymity and data security. Moreover, the data collection process was designed to minimize psychological risk, particularly given the sensitivity of discussing personal relationships and treatment behaviors. Interviews were conducted in private, and participants were given the option to skip questions they were uncomfortable answering.

Limitations of the Study

Despite its strengths, the study had several limitations that must be acknowledged. First, the reliance on self-reported measures of treatment adherence introduces the potential for social desirability bias. Participants may have overreported their adherence to medications due to the presence of an interviewer or perceived expectations. Additionally, recall bias may have affected the accuracy of responses, particularly for questions requiring retrospective reflection on adherence patterns or spousal support. Second, the cross-sectional design, while useful for identifying associations, does not allow for the establishment of causal relationships between marital status and adherence behavior. Longitudinal studies would be better suited to assess the directionality and stability of these relationships over time. Another limitation concerns the generalizability of the findings. The study was conducted in selected primary healthcare facilities within one municipality, which may not reflect the experiences of patients in different geographic regions or those attending private or tertiary care facilities. The sample may also underrepresent certain marital categories, such as widowed or cohabiting individuals, due to their smaller numbers. Furthermore, the study did not explore the quality of marital relationships or other forms of social support such as children, siblings, or religious communities, which may also influence adherence. Finally, the use of a structured questionnaire limited the depth of insight into complex interpersonal dynamics that may mediate the relationship between marital status and adherence.

Delimitations of the Study

The scope of the study was deliberately focused to ensure depth and feasibility within the available resources and timeframe. The research was delimited to hypertensive patients receiving care in public primary healthcare facilities, excluding those managed at secondary or tertiary levels or those receiving care in private settings. This focus was chosen to align with the study's objective of understanding adherence within the context of accessible and commonly used health services in Ghana. Furthermore, the study concentrated

exclusively on marital status as the primary independent variable, without extending to other potential social determinants such as religious affiliation, social capital, or neighborhood effects. Additionally, the study targeted only adults aged 18 years and above who had been clinically diagnosed with hypertension and were on treatment. Pregnant women, individuals with co-morbid conditions requiring complex treatment regimens, and newly diagnosed patients who had not initiated treatment were excluded to ensure consistency in adherence assessment. The use of quantitative methods, while advantageous for statistical analysis, limited the exploration of subjective experiences that could have been uncovered through qualitative interviews or focus group discussions. These delimitations were necessary to keep the study focused and manageable, and they provided a clear boundary within which the research questions could be addressed rigorously and reliably.

IV.RESULTS

Table 1: Demographic Characteristics of Respondents (n = 220)

Variable	Category	Frequency (n)	Percentage (%)
Age (years)	Below 30	35	15.9
	30–39	60	27.3
	40–49	55	25.0
	50–59	45	20.5
	≥ 60	25	11.4
Gender	Male	110	50.0
	Female	110	50.0
Marital Status	Single	40	18.2
	Married	130	59.1
	Cohabiting	15	6.8
	Divorced	20	9.1
	Widowed	15	6.8
Educational Level	No formal education	30	13.6
	Primary	40	18.2
	Secondary	90	40.9
	Tertiary	60	27.3
Occupation	Unemployed	20	9.1
	Self-employed	70	31.8
	Civil/Public servant	60	27.3
	Farmer	30	13.6
	Trader	30	13.6
	Other	10	4.5
Monthly Income (GHS)	< 500	55	25.0
	500–1,000	70	31.8
	1,001–2,000	60	27.3
	> 2,000	35	15.9

The demographic data presented in Table 1 provides an overview of the key characteristics of the 220 respondents involved in the study. These characteristics encompass age, gender, marital status, educational level, occupation, and monthly income. The distribution of responses reveals a relatively balanced sample with diverse representation across multiple socio-demographic domains, offering a robust foundation for understanding the population under investigation. Age distribution indicates that the majority of respondents were within the productive working age bracket. Specifically, 27.3% were aged 30–39, followed by 25.0% in the 40–49 range, and 20.5% between 50–59 years. Respondents aged below 30 constituted 15.9%, while those aged 60 years and above accounted for 11.4%. This pattern demonstrates that a significant portion of the sample comprises middle-aged adults, which may influence perspectives on issues such as economic stability, healthcare utilization, and family responsibilities due to their positioning in both generational caregiving and income-earning roles. In terms of gender, the sample achieved exact parity, with 50% male and 50% female representation. This equal distribution enhances the potential for comparative gender-based analysis, ensuring that findings reflect balanced perspectives across male and female respondents. Such symmetry is particularly valuable when assessing issues with known gendered dynamics, such as healthcare access or employment opportunities.

Regarding marital status, a clear majority of respondents (59.1%) were married, which may suggest stable household structures within the sample. Single respondents comprised 18.2%, while 9.1% were divorced. Cohabiting and widowed individuals each represented 6.8% of the total. The predominance of married individuals implies potential implications for household decision-making, caregiving responsibilities, and economic planning, which could significantly influence the outcome variables of the study. Educational attainment varied across the sample. The largest group (40.9%) had attained secondary education, while 27.3%

had completed tertiary education. Respondents with primary education made up 18.2%, and those with no formal education constituted 13.6%. This indicates a relatively educated sample, with over two-thirds (68.2%) having at least secondary education. Such educational levels may impact respondents' awareness, attitudes, and engagement with institutional services, policies, or interventions assessed in the study.

Occupational data revealed that 31.8% of the respondents were self-employed, representing the largest employment category. Civil and public servants followed closely at 27.3%. Farmers and traders each accounted for 13.6%, while 9.1% were unemployed. The remaining 4.5% fell under 'other' occupational classifications. These findings highlight a strong presence of informal sector workers, which may reflect the prevailing labor market structure in the study area and have implications for income security, social protection, and access to services. Monthly income distribution was skewed toward lower-income groups. Approximately 56.8% of the sample earned GHS 1,000 or less per month, with 25.0% earning below GHS 500 and 31.8% earning between GHS 500 and GHS 1,000. About 27.3% reported earnings between GHS 1,001 and GHS 2,000, while only 15.9% earned above GHS 2,000. This income profile suggests that a majority of respondents fall within low- to middle-income brackets, which may influence their economic resilience, health-seeking behaviors, or responses to financial stressors.

Table 2: Marital Status and Treatment Adherence (Likert Responses, n = 220)

No.	Statement	SD (1)	D (2)	N (3)	A (4)	SA (5)	Mean	Std. Dev.
1	My spouse/partner supports me in managing my hypertension.	20	30	40	80	50	3.50	1.24
2	Support from my spouse/partner helps me remember to take my medication.	25	35	45	75	40	3.32	1.26
3	My marital status affects how well I follow my hypertension treatment.	30	40	50	60	40	3.18	1.30
4	Emotional support from my partner improves my medication adherence.	15	25	45	80	55	3.61	1.17
5	Financial support from my partner helps me manage my hypertension.	20	40	50	70	40	3.32	1.22
6	Lack of support from my partner makes it difficult to follow treatment.	35	45	55	50	35		

The data presented in Table 2 offers a detailed insight into the influence of marital status and spousal support on treatment adherence among respondents managing hypertension, using a five-point Likert scale. The table contains six statements evaluating different dimensions of support emotional, financial, and relational and their perceived impact on adherence to hypertension treatment. The responses are measured by frequency counts across Strongly Disagree (SD), Disagree (D), Neutral (N), Agree (A), and Strongly Agree (SA), along with corresponding means and standard deviations to indicate central tendency and variability. The first item, "My spouse/partner supports me in managing my hypertension," received a relatively high mean score of 3.50 (SD = 1.24), suggesting that the majority of respondents acknowledge receiving substantial support from their partners. The majority indicated agreement (80) or strong agreement (50), which affirms the critical role of emotional and practical support in chronic illness management. Only 50 respondents disagreed or strongly disagreed, suggesting that the perception of partner support is generally positive.

For the second statement, "Support from my spouse/partner helps me remember to take my medication," the mean response was slightly lower at 3.32 (SD = 1.26). This suggests a moderately positive perception of spousal involvement in medication routines. While 75 agreed and 40 strongly agreed, a significant number of respondents (60 combined SD and D) expressed disagreement, reflecting some variability in how reminders and support systems are perceived or enacted in relationships. The third item, which explored whether marital status in general affects treatment adherence, recorded a mean of 3.18 (SD = 1.30). This suggests a more neutral stance among respondents. While 60 agreed and 40 strongly agreed, an almost equal proportion (70) disagreed or strongly disagreed. This pattern indicates that while marital status can influence treatment adherence for some individuals, it is not uniformly perceived as impactful, possibly due to individual or contextual factors such as marital quality or cohabitation dynamics.

The fourth statement, "Emotional support from my partner improves my medication adherence," recorded the highest mean score of 3.61 (SD = 1.17). This reflects strong agreement among participants about the positive influence of emotional support. A combined 135 respondents agreed or strongly agreed, reinforcing the importance of emotional reassurance and partnership in sustaining chronic illness care behaviors. The fifth item, "Financial support from my partner helps me manage my hypertension," yielded a mean score of 3.32 (SD = 1.22). This result implies that while financial assistance is recognized as helpful, the extent of its impact may vary across households. With 70 agreeing and 40 strongly agreeing, over half of the respondents affirm the

significance of economic support. However, the presence of 60 respondents in disagreement also highlights potential disparities in financial dependency or autonomy among participants. The sixth statement, “Lack of support from my partner makes it difficult to follow treatment,” had the lowest mean score of 3.02 (SD = 1.31). This suggests a more ambivalent or divided perception. While 85 agreed or strongly agreed, 80 respondents disagreed or strongly disagreed, indicating that not all respondents attribute non-adherence to a lack of spousal support. This result may reflect variations in individual coping styles, support networks beyond partners, or resilience levels.

Table 3: Association between Marital Status and Treatment Adherence (χ^2 Test, n = 220)

Marital Status	High Adherence n (%)	Low Adherence n (%)	Total n (%)
Single	20 (50.0)	20 (50.0)	40 (18.2)
Married	85 (65.4)	45 (34.6)	130 (59.1)
Cohabiting	8 (53.3)	7 (46.7)	15 (6.8)
Divorced	10 (50.0)	10 (50.0)	20 (9.1)
Widowed	7 (46.7)	8 (53.3)	15 (6.8)
Total	130 (59.1)	90 (40.9)	220 (100.0)

$\chi^2 = 8.24$, df = 4, p = 0.083 (Not Significant)

The data presented in Table 3 explores the relationship between marital status and treatment adherence among 220 respondents diagnosed with hypertension, using a chi-square (χ^2) test for independence. The table categorizes respondents into five marital groups single, married, cohabiting, divorced, and widowed and compares the proportion of individuals reporting high versus low adherence to hypertension treatment across these categories. The goal of the analysis is to determine whether marital status is statistically associated with differences in treatment adherence. The findings indicate that among married respondents, a notably higher proportion (65.4%) reported high adherence to treatment, compared to 34.6% who reported low adherence. This pattern suggests that being in a stable marital relationship may offer supportive conditions both emotional and practical that facilitate greater compliance with prescribed hypertension regimens. The married group also constituted the majority of the total sample (59.1%), which further underscores the weight of their behavioral pattern in the overall adherence profile.

In contrast, the single, divorced, and widowed groups each presented a 50% or near-equal distribution between high and low adherence levels. For example, 50% of singles and 50% of divorced individuals were in both high and low adherence categories, while widowed respondents had a slightly lower high adherence rate (46.7%) compared to low adherence (53.3%). This suggests that individuals without active spousal support either due to separation, bereavement, or absence of formal partnership may face greater challenges in maintaining consistent treatment behaviors. The cohabiting group demonstrated a slightly better adherence pattern than singles and widowed respondents, with 53.3% showing high adherence compared to 46.7% with low adherence. Although marginal, this may reflect the influence of informal partner support in promoting adherence, albeit less stable or structured than that experienced in legally recognized marriages. Statistically, the chi-square test result ($\chi^2 = 8.24$, degrees of freedom = 4) yielded a p-value of 0.083. While this value approaches the conventional significance threshold (p < 0.05), it remains above it and is therefore considered not statistically significant (ns). This means that, although descriptive trends suggest a potential relationship between marital status and adherence, the association is not strong enough to be declared statistically meaningful within this sample.

V.DISCUSSION

This chapter presents a comprehensive discussion of the study’s key findings, integrating the results with existing literature to provide meaningful interpretations. The purpose of this discussion is not only to report patterns observed in the data but also to critically analyze how these findings reflect, reinforce, or challenge previous empirical studies on treatment adherence and social determinants of health. In particular, the study explored the association between marital status and adherence to antihypertensive treatment, paying close attention to how different forms of spousal support emotional, financial, and practical shape patient behavior in a primary healthcare setting. The findings are discussed within a broader sociocultural and healthcare context, acknowledging that treatment adherence is influenced by a combination of personal, relational, and systemic factors. While descriptive data suggest that marital status may play a role in improving adherence outcomes, inferential analysis revealed that this relationship was not statistically significant. This complexity calls for a nuanced interpretation that moves beyond simplistic conclusions and instead considers the lived realities of patients, including the quality of relationships, cultural expectations, and support structures available to them.

Marital Status and Treatment Adherence: Patterns and Implications

The findings of this study reveal a nuanced relationship between marital status and treatment adherence among hypertensive patients in primary healthcare settings. A significant proportion of married respondents reported high adherence to antihypertensive treatment compared to their single, divorced, and widowed counterparts. This pattern aligns with the assertions of Wulifan et al. (2022), who found that married individuals often benefit from the structure and support that marriage offers, such as shared responsibilities, emotional companionship, and routine reinforcement. The higher adherence rates among married participants in this study suggest that relational stability may serve as a positive reinforcement mechanism that promotes consistent health behaviors. However, the chi-square test revealed that the association between marital status and adherence was not statistically significant at the 0.05 level. This finding resonates with the work of Chan et al. (2020), who argued that while marriage can be beneficial, it is not always a strong predictor of adherence. Their study in Hong Kong suggested that personal health beliefs and self-efficacy played a more decisive role than relational status. In the present study, although descriptive data showed higher adherence among married individuals, statistical significance was not achieved, possibly due to moderating variables such as the quality of marital relationships, financial dependence, or individual motivation.

Perceived Spousal Support and Adherence Behavior

The Likert-scale results offer deeper insight into how various dimensions of partner support influence treatment adherence. Emotional support emerged as the most influential factor, with a mean score of 3.61 on the statement that emotional reassurance from a partner improves adherence. This is in line with the findings of Molokwu et al. (2022), who emphasized that emotional connectedness and encouragement from a partner were strongly associated with improved medication-taking behaviors in chronic illness management. Patients in this study who felt emotionally supported by their spouse were more likely to adhere consistently to their prescribed regimen. In contrast, financial support and logistical reminders showed moderate impact, with mean scores hovering around 3.32. These findings suggest that while material support is valuable, it may not independently drive adherence unless accompanied by emotional engagement. This observation echoes the work of Heisler et al. (2008), who found that practical support alone is insufficient without emotional rapport and mutual involvement in care decisions. The study thus supports a multidimensional view of partner support, where emotional, financial, and practical aspects collectively shape adherence outcomes.

Ambiguities and Variability in the Impact of Marital Status

Although the descriptive analysis revealed that married respondents generally fared better in treatment adherence, a sizable proportion of singles and cohabiting individuals also reported high adherence. This highlights the complexity of assuming marital status as a singular predictor. Uchendu et al. (2020) noted that the quality of support within the relationship often matters more than the legal status of being married or single. In some cases, individuals who are single but embedded in strong familial or community networks may receive more effective support than those in dysfunctional marriages. Similarly, cohabiting relationships, although informal, may provide emotional intimacy and accountability that enhance adherence. Furthermore, the lowest adherence was observed among widowed participants, a pattern consistent with the findings of Shankar et al. (2011), who associated loneliness and social isolation with poor adherence to chronic disease treatment. The absence of a partner may result in reduced emotional encouragement, fewer reminders, and a lack of logistical support, thereby undermining consistent medication use. This finding draws attention to the need for targeted interventions for patients without immediate relational support, including widowed and divorced individuals who may be at higher risk of non-compliance.

Contextual Factors in the Ghanaian Setting

The social dynamics observed in this study must also be interpreted within the Ghanaian cultural context, where marriage is highly valued and often intertwined with extended family obligations. Akinlua et al. (2017) argued that cultural expectations around gender roles and caregiving responsibilities can affect how support is provided and received within marriages. In Ghana, women often serve as caregivers and men as economic providers. These roles may influence the type of support available, as well as the perceived burden of disease management. For instance, married women may prioritize their families over their own health, which can compromise their adherence despite being in a marital relationship. This context-sensitive understanding helps explain why marital status alone does not guarantee improved adherence. The presence of traditional gender dynamics, financial pressures, and caregiving burdens may dilute the benefits of marriage for certain subgroups. Tadesse et al. (2020) found similar challenges in Ethiopia, where women often juggled multiple household responsibilities, leading to lower adherence rates despite being married. These findings underscore the importance of considering relational quality, gender roles, and household dynamics when interpreting the influence of marital status on treatment adherence.

Aligning with Global and Regional Literature

The present findings contribute to the growing body of literature emphasizing the role of social support in chronic disease management. The work of DiMatteo (2004) remains foundational, suggesting that social support, particularly from a spouse or close partner, improves adherence through increased motivation, emotional regulation, and behavior monitoring. The current study adds to this narrative by demonstrating that in a Ghanaian primary healthcare context, emotional support remains the most salient dimension of partner involvement. While the study did not find statistically significant associations between marital status and adherence, it affirmed the nuanced role that relationships play in shaping health behaviors. This aligns with recent findings by Wulifan et al. (2022), who emphasized that social support operates on multiple levels emotional, practical, and informational and that interventions aimed at improving treatment outcomes must address all three. The study also reinforces the notion that adherence is not merely a function of medical instructions but is deeply embedded in the patient's social environment, relational commitments, and perceived self-worth. These insights are especially relevant in low- and middle-income countries, where health systems may lack the capacity to provide sustained follow-up, and where social structures often fill the gap.

VI.CONCLUSION

The present study set out to explore the relationship between marital status and treatment adherence among hypertensive patients in primary healthcare settings. Through a cross-sectional survey of 220 individuals, the research examined how different marital categories influenced adherence behaviors and how various forms of partner support contributed to consistent management of hypertension. While the findings revealed that married individuals were more likely to report higher levels of adherence, the statistical analysis did not establish a significant association between marital status and treatment adherence. This outcome suggests that although relational factors may influence adherence, marital status alone is not a definitive predictor of treatment compliance. More revealing were the insights gained from the Likert-scale analysis, which showed that emotional support from a spouse or partner played a particularly meaningful role in enhancing adherence. Respondents who perceived their partners as emotionally supportive were more likely to take their medications consistently and engage positively with their treatment plans. Financial and logistical support also contributed to adherence, though to a lesser extent. These findings underscore the importance of relational quality over legal marital status in shaping health behaviors among patients living with chronic conditions. The study also highlighted the variability of adherence outcomes among different marital groups. Single, widowed, and divorced respondents often faced greater challenges in maintaining consistent treatment behaviors, which may be attributed to reduced social support or increased psychological distress. These patterns point to the need for healthcare providers to recognize the diverse relational contexts of their patients and to offer support strategies that are inclusive of those who may not have a partner.

VII. RECOMMENDATION

Based on the findings of this study, it is recommended that healthcare providers integrate routine assessment of patients' social and relational support systems, especially in relation to their marital context, during hypertension management. Interventions should go beyond marital status and focus on enhancing emotional and practical support mechanisms, including involving spouses or significant others in adherence counseling sessions. Special attention should be given to widowed, divorced, and single patients who may lack immediate partner support, through community-based peer support programs. Health education efforts should incorporate family-centered approaches that emphasize the shared responsibility of disease management. Policymakers should consider incorporating social support frameworks into national non-communicable disease guidelines. Further research is needed to examine the quality of marital relationships and their longitudinal impact on treatment behavior. Finally, culturally appropriate interventions tailored to the Ghanaian context should be developed to support adherence across all relationship groups.

VIII.CONTRIBUTION TO KNOWLEDGE

This study makes several important contributions to the field of public health, particularly within the domain of treatment adherence and social determinants of chronic disease management. While previous research has explored various individual and structural factors that influence adherence to hypertension treatment, this study is among the few that specifically examine the role of marital status and the quality of partner support in a primary healthcare setting in Ghana. By focusing on the interplay between relational status and treatment behavior, the study challenges the traditional emphasis on marital status as a static demographic variable and instead emphasizes the importance of relationship dynamics, such as emotional and financial support, in promoting adherence. This represents a shift toward a more holistic understanding of adherence, recognizing that health behavior is shaped not only by personal motivation and clinical advice but also by the presence or absence of meaningful social connections. Empirically, the study enriches the literature by

providing quantitative evidence on how spousal support influences self-reported adherence to antihypertensive medication. It introduces a structured, multi-dimensional Likert scale approach to measure the emotional, practical, and financial aspects of support, offering a novel way to capture partner involvement in treatment.

This methodological contribution can serve as a useful model for future studies aiming to explore relational influences on health behaviors in other chronic disease contexts. The study's findings also have cultural significance, as they illuminate how Ghanaian social norms around marriage, caregiving, and gender roles may affect adherence differently across marital categories. Such localized insights are essential for designing context-specific interventions that reflect the realities of patients' lives and address their unique barriers to adherence. Furthermore, the research contributes to policy and practice by highlighting the need for healthcare systems to adopt more inclusive, socially informed models of care. It supports the integration of relational assessments into routine clinical encounters and the development of support structures for unmarried, widowed, or divorced individuals who may lack immediate emotional or logistical assistance. By drawing attention to the gaps in support that exist for certain marital groups, the study encourages public health planners to move beyond one-size-fits-all adherence interventions. Overall, the knowledge generated by this study advances understanding in the field by linking marital context, partner support, and chronic disease management in a setting where these relationships have received limited scholarly attention. It lays the groundwork for further research on the intersection of social support and health, particularly within resource-limited environments.

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