

Self-Care Behaviour Practices and Related Factors among Hypertensive Men and Women in Delhi

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Abstract: A descriptive cross sectional study was undertaken to assess and compare the self-care behaviour practices and related factors such as perceived health status, knowledge about hypertension related aspects, physical exercise patterns, and food intake among hypertensive men and women in Delhi. A total of 80 hypertensive subjects; 40 men and 40 women between 45-59 years of age constituted the study sample. Questionnaire-cum-interview schedule was used to collect data on general profile, perceived health status, knowledge about hypertension related aspects, and physical exercise patterns of the subjects. Food intake data were gathered using 24-hour diet recall method. Behavioural practices on six self-care activities were assessed using an adapted Hypertension Self-Care Activity Level Effects Scale (H-SCALE). Results revealed that as compared to women, men had relatively better awareness about causes and consequences of hypertension; and methods of controlling blood pressure. On the subscales of H-SCALE, females scored slightly better than the males in terms of medication adherence, weight management, and consumption of low-salt low-fat diets though the difference between the two groups was not statistically significant ($p \leq 0.05$). Males had significantly higher scores ($p \leq 0.001$) than females for only smoking and alcohol consumption, which were negative indicators and connoted greater risk for hypertension. The study indicated that the male subjects had relatively better knowledge about hypertension related aspects while the female subjects followed slightly better self-care behaviour practices. Moreover, there was a lot of scope for improvement in knowledge about hypertension as well as the self-care behaviour practices of both men and women to effectively control their blood pressure levels.

Key words: Hypertension, Self-care behaviour, Physical exercise pattern, Food intake

Introduction

Hypertension, a major cause of cardiovascular and cerebrovascular morbidity and mortality is a significant public health problem in many developing countries. It is estimated that 16% of ischemic heart disease, 21% of peripheral vascular disease, 24% of acute myocardial infarctions and 29% of strokes are attributable to hypertension in India (Mohan et al., 2011). Furthermore, hypertension has been estimated to be attributable for nearly 10% of all deaths (Patel et al., 2011).

According to WHO 2008, the prevalence of raised blood pressure among Indian men and women was 21.3% and 21.0% (WHO, 2014). The number of people with hypertension in India is projected to increase from 118 million in 2000 to 214 million in 2025, with nearly equal numbers of men and women (Reddy, 2009). A recent study has reported the overall prevalence of hypertension in India to be 29.8% with significant differences in rural (27.6%) and urban (33.8%) regions (Anchala et al., 2014).

Age, alcohol, smoking and chewing tobacco, Body Mass Index (BMI), central obesity (defined as waist circumference >90 cm in men and >80 cm in women), low consumption of vegetables/ fruits, high consumption of dietary fat and salt, and sedentary activity have been identified as the

significant risk factors for hypertension among Indian patients (Anchala et al., 2014). Majority of hypertensive subjects still remain undetected and the control of hypertension is also inadequate. This calls for urgent prevention and control measures for hypertension in India (Mohan et al., 2007).

Hypertension is a chronic but preventable disease; and thus adequate knowledge of the disease, lifestyle modification and correct dietary approaches are important features in its effective control and management. While it is difficult or impossible to change demographic and personal characteristics, cultural norms and socioeconomic status, increasing knowledge (Magadza et al., 2009) and improving self-care behaviour can positively influence patients' beliefs about medicines and management of hypertension. Researchers have emphasized that compliance with hypertension self-care guidelines such as weight reduction, smoking cessation, a low sodium diet, and physical activity can contribute substantially to regulating blood pressure (Kojuri & Rahimi, 2007; Park et al., 2011; Logan et al., 2012).

Most of the studies focus only on the adverse effects of non-compliance to medication regimens. There are very few studies that address the issue of compliance and recommendations for a healthy lifestyle that are equally essential in controlling

hypertension. With this background, an attempt was made in the present study to assess the self-care behaviour practices and related factors such as knowledge about hypertension related aspects, physical exercise patterns and food intake among hypertensive men and women (45 – 59 years) in Delhi.

Materials and Methods

This study was carried out in communities of Delhi inhabited by families belonging to middle-income group. Based on purposive sampling technique, a total of 80 hypertensive adults (45-59 years), 40 males and 40 females were selected to constitute the study sample. The subjects were selected based on the inclusion criteria viz. 1) patients with known hypertension for not less than a year, and 2) patients willing to participate and assuring full cooperation. The patients who had undergone any major cardiac or other surgery and those suffering from any other serious health complications were excluded from the study.

Blood pressure (BP) measurements of the subjects were taken with a digital sphygmomanometer (Omron Automatic Blood Pressure Monitor) using the recommended technique. The same instrument was used for all the subjects to eliminate error. Classification of blood pressure given by the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC7) (U.S. Department of Health and Human Services, 2004) was used to categorize the subjects into different grades of hypertension.

A questionnaire-cum-interview schedule was designed to gather data on general profile, perceived health status, knowledge about hypertension related aspects and physical exercise patterns of the subjects. Food intake data was gathered using 24-hour dietary recall method for one typical day. The subjects were asked to recall and report details of all the food items and beverages that they had consumed in the previous day and also their ingredients and serving sizes in household measures. Those were then translated into raw weights and the total food group intake was calculated for all male and female subjects. The mean intake of different foods by the subjects was then compared with the intake recommendations for the same foods given by ICMR, 2011 for sedentary males and females.

Self-care behaviour practices of the subjects were assessed using a suitably adapted Hypertension Self-Care Activity Level Effects, or H-SCALE. This tool is designed to measure the recommended self-care activities in a way that would facilitate examining the theoretical dose-response relationship between adherence to the expected

behaviours and better control of blood pressure (Warren-Findlow & Seymour, 2011; Warren-Findlow et al., 2013). JNC7 recommends that people with hypertension should engage in six self-care activities: adhering to antihypertensive medication regimens, maintaining or losing weight, following a low-salt diet, limiting alcohol, engaging in regular physical activity, and eliminating tobacco use (U.S. Department of Health and Human Services, 2004). The H-SCALE measures the six self-care activities recommended by JNC7 (Warren-Findlow & Seymour, 2011). For the six self care activities in the present study, scores were given as directed which ranged as - medication adherence (0 - 21), weight management (10 - 30), low fat low salt diet (0 - 84), physical activity (0 - 14), smoking (0 - 7) and alcohol intake (0 - 21). The scores for each of the self-care activities were calculated for all subjects followed by calculation of mean scores for the male and female subjects. All the data obtained were coded, entered into the computer and analyzed using Statistical Package for Social Sciences (SPSS) version 16.0.

Results and Discussion

General Profile

The data on general profile of the subjects (Table 1) showed that a significantly higher percentage (45%) of women were hypertensive at younger age (45-50 years) as compared to a greater percentage (50%) of hypertensive men at the age of 56 to 59 years. However, there was no significant difference between the percentages of hypertensive males and females in different stages of hypertension when classified as per JNC7. As the duration of suffering from a disease could affect an individual's self-care activities, an attempt was made to find out the total duration for which the subjects had been suffering from hypertension. Significantly higher percentages of men (22%) were found to be suffering from hypertension for more than 10 or 15 years as compared to only 2% women ($p \leq 0.001$). Most of the women (98%) had hypertension for less than 10 years.

The male subjects in the study sample had a comparatively better educational status than the female subjects. While a large percentage of men (77%) were employed either in government or private set ups, most of the women (75%) were self-employed and this category included homemakers also. Although higher numbers of male subjects in the study were more educated and gainfully employed outside homes, greater monthly expenditure on food and medicines was reported by significantly higher percentage of women ($p \leq 0.05$). Expenditure on health services varied on a monthly basis for higher percentages of men (73%) and women (52%) (Table 1).

Table 1: Distribution of the subjects according to their general profile

Parameter	Group/Category	Male (N=40) N (%)	Female (N=40) N (%)	Total (N=80) N (%)	χ^2
Age (years)	45-50	11 (28)	18 (45)	29 (36)	6.70*
	51-55	9 (22)	8 (20)	17 (21)	
	56-59	20 (50)	14 (35)	34 (43)	
#Stages of hypertension	Normal	2 (5)	3 (7)	5 (6)	2.40
	Prehypertensive	13 (32)	9 (23)	22 (28)	
	Stage 1	17 (43)	18 (45)	35 (44)	
	Stage 2	8 (20)	10 (25)	18 (22)	
Duration of hypertension	<10 years	31 (78)	39 (98)	70 (88)	19.60***
	10-15 years	4 (10)	1 (2)	5 (6)	
	>15 years	5 (12)	0 (0)	5 (6)	
Educational status	Upto Class X	12 (30)	22 (55)	34 (43)	13.88***
	Class XII	5 (13)	2 (5)	7 (9)	
	Graduate	23 (57)	16 (40)	39 (48)	
Occupation	Employed	31 (77)	10 (25)	41 (51)	66.42***
	Self-employed	7 (18)	30 (75)	37 (46)	
	Not employed	2 (5)	0 (0)	2 (3)	
Monthly expenditure on food (Rs)	5,000-10,000	17 (42)	10 (25)	27 (33)	6.90*
	10,001-15,000	8 (20)	12 (30)	20 (25)	
	>15000	15 (38)	18 (45)	33 (42)	
Monthly expenditure on health services (Rs)	<1000	9 (22)	16 (40)	25 (31)	9.44**
	1001-3000	2 (5)	3 (8)	5 (6)	
	Variable	29 (73)	21 (52)	50 (63)	
Monthly expenditure on medicines (Rs)	<1000	33 (83)	27 (68)	60 (65)	6.51*
	1001-3000	3 (7)	4 (10)	7 (9)	
	Variable	4 (10)	9 (22)	13 (16)	

*significant at $p \leq 0.05$, **significant at $p \leq 0.01$, ***significant at $p \leq 0.001$

#Normal-($<120/<80$), Prehypertensive-($120-139/80-89$), Stage 1-($>140-159/90-99$) and Stage 2-($\geq 160/\geq 100$)

Health profile and knowledge about hypertension related aspects

Subjects were categorized as per their response for their perceived health status and knowledge about hypertension related aspects and the results obtained have been presented in Table 2. Higher percentages of both men (73%) and women (67%) perceived their health to be 'good'. A significantly lower number of male subjects (20%) as compared to 35% of female subjects reported that they had a family history of hypertension. Further, a statistically significant difference was observed between the male and female subjects in terms of their knowledge about family history of hypertension ($p \leq 0.05$). Guddad et al. (2012) in a study on hypertensive patients in Karnataka, India also reported that 50% of the subjects did not have a family history of hypertension. About one-third (34%) of the total subjects (40% males and 27% females) reported that they had blood pressure monitors at home. However, only 5% men and 2% women 'regularly' monitored their blood pressure at home while 35% men 'sometimes' did that as compared to 25% women (Table 2). Beth et al. (2012) in their study on hypertensive subjects also reported that only 32.3% respondents monitored their blood pressure at home; and 18.4% respondents did this as they were aware of the complications of hypertension. Further, it was observed in the present study that higher percentage (45%) of males as compared to 38% females practiced self-medication but this was practiced for some common illnesses only.

Table 2: Distribution of the subjects as per perceived health status and knowledge about hypertension related aspects

Parameter	Group/Category	Male (N=40) N (%)	Female (N=40) N (%)	Total (N=80) N (%)	χ^2
Self perception about health	Poor	10 (25)	13 (33)	23 (29)	1.52
	Good	29 (73)	27 (67)	56 (70)	
	Excellent	1 (2)	0 (0)	1 (1)	
Family history of hypertension	Present	8 (20)	14 (35)	22 (28)	5.64*
	Absent	32 (80)	26 (65)	58 (72)	

Knowledge about family history	Present	17 (43)	10 (25)	27 (34)	8.10*
	Absent	9 (22)	9 (23)	18 (22)	
	Did not know	14 (35)	21 (52)	35 (44)	
Measured blood pressure at home	Sometimes	14 (35)	10 (25)	24 (30)	3.00
	Regularly	2 (5)	1 (2)	3 (4)	
	Never	24 (60)	29 (73)	53 (66)	
Self medication	Practiced	18 (45)	15 (38)	33 (41)	1.00
	Not practiced	22 (55)	25 (62)	47 (59)	
Knowledge about meaning of hypertension	Correct	24 (60)	22 (55)	46 (58)	1.22
	Partially correct	3 (7)	2 (5)	5 (6)	
	No idea	13 (33)	16 (40)	29 (36)	
Knowledge about causes of hypertension	Yes	30 (75)	14 (35)	44 (55)	12.93***
	No	10 (25)	26 (65)	36 (45)	
Knowledge about consequences of hypertension	Yes	21 (53)	17 (43)	38 (48)	0.80
	No	19 (47)	23 (57)	42 (52)	
Knowledge about methods of maintaining normal BP	Yes	27 (68)	20 (50)	47 (59)	2.53
	No	13 (32)	20 (50)	33 (41)	
Knowledge about salt intake in hypertension	Yes	33 (82)	35(87)	68 (85)	1.05
	No	7 (18)	5 (13)	12 (15)	
Knowledge about physical exercise in hypertension	Yes	26 (65)	19 (48)	45 (56)	1.23
	No	14 (35)	21 (52)	35 (44)	

*significant at $p \leq 0.05$, ***significant at $p \leq 0.001$

The data on knowledge about hypertension among the subjects revealed that 33% males and 40% females had no idea about the term 'hypertension' though they themselves suffered from it. They identified their problem as that of increased blood pressure but were not aware of its medical terminology. Only 60% male and 55% female subjects knew the term and its meaning correctly and no significant difference was found between this knowledge among males and females (Table 2). Similar finding was reported by Bhandari et al. (2012) in their study on hypertensive patients that showed only 56% hypertensive patients were aware of the meaning of the term 'hypertension'.

A significantly higher percentage of male subjects reported to be aware of at least some causes of hypertension (Table 2). High salt intake and stress were cited as the most common causes of hypertension by maximum number of both male and female subjects. The knowledge about consequences of hypertension and methods of maintaining normal blood pressure was higher among the male subjects though the difference between the two groups was not found to be statistically significant (Table 2). Heart attacks were listed as the most common consequence of

hypertension by maximum number of males and females. Restricting salt intake and doing physical exercises emerged as the most common methods of controlling blood pressure in the study group. This was in consonance with the commonly listed causes for hypertension by these subjects.

The subjects were specifically asked about their knowledge regarding the role of salt and physical exercise in hypertension. Majority of the male (82%) and female (87%) subjects reported that they were aware that high salt intake could increase their blood pressure levels. A study by Shaikh et al. (2012) on hypertensive patients in Pakistan also reported that 76% of the patients knew that salt was not good for hypertension. The fact that physical exercises could lower BP values was reported by 65% male and 48% female subjects in the present study. Further, it was found that a slightly higher percentage of females were concerned with the salt intake while more males were aware of the correct role of exercises in hypertension though the difference in the knowledge of males and females about these aspects was not statistically significant (Table 2).

Salt intake and physical exercise pattern

Salt consumption and physical exercise patterns of the male and female subjects have been presented in Table 3. Salt consumption patterns of subjects in both the groups were found to be similar. Maximum male and female subjects reported low consumption of salt (65% each). Only 2% males reported that they consumed high amounts of salt in their diet as otherwise their food did not taste good. Furthermore, majority of the male and

female subjects (95% each) reported that they consumed normal iodized salt; and 5% subjects each reported that they consumed low sodium salt to maintain normal blood pressure levels. Majority of the males (90%) and almost all the female subjects (98%) reported that they 'never' added extra salt in the cooked food while eating. But among the subjects who added extra salt, significantly higher percentage (10%) was of the male subjects.

Table 3: Salt consumption and physical exercise pattern of the subjects

Parameter	Group/Category	Male (N=40) N (%)	Female (N=40) N (%)	Total (N=80) N (%)	χ^2
Salt consumption	Low	26 (65)	26 (65)	52 (65)	0.52
	Medium	13 (33)	14 (35)	27 (34)	
	High	1 (2)	0	1 (1)	
Extra salt on cooked foods	Always	1 (2)	1 (2)	2 (2)	6.63*
	Sometimes	3 (8)	0 (0)	3 (4)	
	Never	36 (90)	39 (98)	75 (94)	
Physical exercise	Performed	29 (73)	22 (55)	51 (64)	7.03**
	Not performed	11 (27)	18 (45)	29 (36)	
Frequency of exercise	Daily	22 (76)	16 (73)	38 (75)	7.36*
	2-3 times/week	2 (7)	4 (18)	6 (12)	
	Once a week	5 (17)	2 (9)	7 (13)	
Duration of exercise per episode	20-30 min	16 (55)	14 (63)	30 (59)	1.78
	>30-60 min	9 (31)	6 (28)	15 (29)	
	>60min	4 (14)	2 (9)	6 (12)	

*significant at $p \leq 0.05$, **significant at $p \leq 0.01$

A significantly higher number of males (73%) reported to be performing regular physical exercises as compared to 55% female subjects. Those who did not exercise regularly reported that they either did not have time for them or were not keeping well enough to perform them. Similar to our findings, Bhandari et al. (2012) also reported that 64% of the hypertensive patients performed regular exercises. Of those who exercised regularly, 83% males and 86% females reported that they went for a brisk walk; and 17% males and 14% females performed yoga as the physical exercise. Guddad et al. (2012) in their study on hypertensive patients also reported that exercise in the form of walking was practiced by 63% and yoga by 18% of subjects; and 36% subjects did not do any form of exercise.

Around three-fourths of the subjects who performed physical exercises reported that they exercised daily (76% males and 73% females). Further, 55% male and 63% female subjects performed exercises for about 20-30 minutes at a stretch; and another 31% males and 28% females did exercises for 30 minutes to one hour each time (Table 3). Overall, the study group seemed to be conscious of the benefits of exercising and a large number of them did some physical exercise as frequently as possible. Misra et al. (2009) among other forms of physical activities have also recommended aerobic physical exercise which

includes brisk walking for 30 minutes for 5 days a week for adults suffering from obesity and metabolic syndrome. In the present study, it was observed that many of the subjects were performing these simple exercises for the recommended duration.

Intake of different food groups by the subjects

A higher percentage of male subjects (65%) were non-vegetarian as compared to 43% female subjects (43%). Data for intake of different food groups by male and female subjects has been given in Table 4. Results indicate that the mean intake of cereals by male and female subjects was significantly low as compared to the recommended cereal intake of 375g and 270g respectively. Female subjects consumed significantly higher amount of pulses (56.7 ± 38.0 g) when compared with the recommended amounts for non-vegetarian females. National Family Health Survey (NFHS-3, 2007) has also reported higher daily consumption of pulses by women. However, as more than half of the female subjects reported to be vegetarians in the present study, their intake of pulses was actually almost similar to the recommended intake. In males, pulse intake was higher than the recommended, however, the difference was not

statistically significant. Consumption of milk by both groups of subjects was lower than recommended intakes but the difference was not significant. The intake of meat/chicken/fish/eggs/poultry, green leafy vegetables, other vegetables and sugar by male as well as

female subjects was significantly lower than that recommended by ICMR, 2011. The mean intake of fruits and visible fat by male and female subjects was similar to the recommended intakes for these foods (ICMR, 2011).

Table 4: Mean daily intake (g/ml) of different food groups by the subjects in comparison with recommended daily intake (ICMR, 2011)

Food Group	Recommended intake for Males (g/day)	Male (n=40) Mean \pm SD (g)	t value	Recommended intake for Females (g/day)	Female (n=40) Mean \pm SD (g)	t value
Cereal	375	189.1 \pm 59.7 (60-300)	-19.67***	270	165.8 \pm 44.6 (60-255)	-14.74***
Pulse	45 ^o	56.8 \pm 43.3 (0-210)	1.73NS	30 [@]	56.7 \pm 38.0 (0-160)	4.4 ***
Milk	300	257.3 \pm 143.2 (60-690)	-1.88NS	300	273.3 \pm 158.3 (54-700)	-1.06NS
Meat	50	19.0 \pm 45.4 (0-180)	-4.3 ***	50	11.0 \pm 26.8 (0-130)	-9.1***
Green leafy vegetables	100	37.0 \pm 59.1 (0-220)	-6.73***	100	47.1 \pm 71.3 (0-310)	-4.68***
Other vegetables	200	88.0 \pm 76.3 (0-270)	-9.27***	200	75.1 \pm 75.7 (0-290)	-10.42***
Root and tubers	200	193.6 \pm 89.3 (0-375)	-0.4NS	200	166.0 \pm 96.5 (0-565)	-2.22*
Fruits	100	118.8 \pm 72.4 (25-355)	1.64NS	100	120.1 \pm 69.3 (25-285)	1.83NS
Visible fat	25	27.0 \pm 11.7 (7-65)	1.07NS	20	22.1 \pm 8.8 (12-55)	1.6 NS
Sugar	20	9.4 \pm 6.22 (0-25)	-10.71***	20	13.0 \pm 8.8 (0-40)	-4.98***

Figures in parentheses denote range; ^o75g for Vegetarian Males; [@]60 g for Vegetarian Females; *significant at $p \leq 0.05$, ***significant at $p \leq 0.001$, NS: Not significant

The subjects, however, needed to be cautious about their intake of fat in visible forms as well as invisible forms because any negligence could have resulted in higher intakes and increased their risk to hypertension. They also needed to continue adequate consumption of fruits and increase their intake of vegetables and other foods, which were low fat and were being consumed in insufficient amounts by them.

Self-care behavior of the subjects

Self-care behaviour helps in the management of blood pressure in hypertensive individuals. In this study, an attempt was made to gather information regarding self-care behaviour of hypertensive males and females using Hypertension Self-Care Activity Level Effects, or H-SCALE, which is a self-report assessment designed to measure the recommended self-care activities (Warren-Findlow et al., 2013). The results have been consolidated according to the six self-care activities recommended by JNC7 (U.S. Department of Health and Human Services, 2004) and focus upon the total scores for each activity, for both male and female subjects.

As indicated in Table 5, the mean medication adherence score of female subjects was slightly higher (11.4 \pm 7.6) as compared to the males (10.1 \pm 7.4) though the difference was not significant ($p \leq 0.05$). Moreover, the mean score was almost 50% lower than the maximum score the subjects could have attained on this sub-scale. Warren-Findlow et al. (2013) reported a mean score of 17.64 \pm 5.32 on medication adherence subscale in their study that primarily comprised hypertensive women. Weight management scores of male and female subjects were 16.8 \pm 3.03 and 18.15 \pm 3.5 respectively. The scores for weight management in both groups of subjects were also much lower than the maximum attainable score on this subscale. Scores on consumption of low salt, low fat diet by the males (16.8 \pm 3.32) and females (20.1 \pm 3.5) subjects were very poor in comparison with the maximum achievable score of 84, though there was no significant difference observed between the two study groups ($p \leq 0.05$). Contrary to the findings in the present study, Warren-Findlow et al. (2013) in their study on hypertensive patients in North Carolina reported higher mean scores of 57.73 \pm 11.98 for low salt, low fat DASH (Dietary Approaches to Stop Hypertension) diet subscale.

Lack of enough knowledge about hypertension and its control in the subjects in the present study could have attributed to their low scores on these subscales.

On physical activity subscale too, scores for both the groups of subjects were lower by more than 50% of the maximum achievable score of 14 (Table 5). Warren-Findlow et al. (2013) also reported similar findings of mean score of 6.59 ± 4.88 on physical activity subscale for patients suffering from hypertension.

Scores on smoking and alcohol consumption are actually negative indicators where a higher score on these subscales indicates a greater risk to hypertension. In the present study, scores on smoking subscale were significantly higher for male subjects (1.6 ± 2.9) as compared to the females (0.17 ± 0.6) ($p \leq 0.001$). None of the females in the study group reported to be smoking but as the subscale included a response for 'how many days in the past 7 days did you stay in a room or ride in an enclosed vehicle while someone was smoking', a few females responded in affirmative and a small score was calculated for them (Table 5). With regard to alcohol consumption, females scored a zero as none of them consumed alcohol. A

significantly higher score of 1.92 ± 3.54 ($p \leq 0.001$) was obtained by the male subjects in comparison with the females (Table 5), though it was heartening to note that this score was almost negligible compared to the maximum achievable score of 21. The habit of not indulging in smoking and drinking by the Indian women due to traditions and societal norms decreases their risk to hypertension and related disorders to some extent. Similar scores were reported by Warren-Findlow et al. (2013) on subscales for smoking and alcohol intake.

Overall, it was observed that on the subscales of Hypertension Self-Care Activity Level Effects Scale or H-SCALE, females were doing slightly better than the males in terms of medication adherence, weight management and consumption of low salt, low fat diets though the difference between them was not statistically significant. In terms of smoking and alcohol consumption, males had significantly higher scores than females but these higher scores indicated a greater risk to hypertension. The findings indicated that the females were following a slightly better self-care regimen as compared to men.

Table 5: Mean self-care behaviour scores of male and female subjects

Self-care activities (Subscales of H- SCALE)	Scores (Range)	Mean Score		t value
		Male (n=40)	Female (n=40)	
Medication adherence	0-21	10.1 ± 7.4 (0-21)	11.4 ± 7.6 (0-21)	0.75NS
Weight management	10-30	16.8 ± 3.03 (13-25)	18.2 ± 3.5 (13-25)	1.82NS
Low fat, low salt diet	0-84	16.8 ± 3.32 (12-27)	20.1 ± 3.5 (13-28)	4.30NS
Physical activity	0-14	6.4 ± 5.7 (0-14)	5.4 ± 6.1 (0-12)	0.78NS
Smoking	0-14	1.6 ± 2.9 (0-12)	0.17 ± 0.6 (0-3)	3.08***
Alcohol consumption	0-21	1.9 ± 3.54 (0-12)	0.0 ± 0.00 (0)	3.43***

***significant at $p \leq 0.001$, NS: Not significant

Conclusion

From the findings of the present study, it could be concluded that though the male subjects seemed to have relatively better knowledge about hypertension and related aspects, the female subjects were following slightly better self-care regimens and had better practices as compared to men. However, there seemed a need for both hypertensive men and women for greater improvement in their knowledge about aspects related to hypertension and their self care behaviour practices to maintain normal blood

pressure levels and prevent themselves from the adverse consequences of hypertension.

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