Vol. 14 December 2014
PRINT ISSN: 1908-4358
doi: http://dx.doi.org/10.7828/sgsrjldcu.v14i1.676

Employees' Health-Promoting Lifestyle and System Stressors as Predictors of Health and Well-Being in a State University, in Northern Mindanao

KHANDY LORRAINE B. GUERRERO
ORCID No. 0000-0003-2127-305
guerrero_kl@gmail.com
Liceo de Cagayan University
Cagayan de Oro City

ABSTRACT

This study described the health-promoting lifestyle, the level of health practices compliance and the system stressors, and determined the level of health and well-being and of MSU-IIT faculty. A non-experimental descriptive, mixed (qualitative and quantitative) research design was used. Thirty- three faculty respondents answered an 8-sectioned questionnaire describing their health promoting lifestyle, the level of health practices compliance and system stressors while the dependent variable was health and well-being of a hypertensive faculty. The intervening variables were the demographic data (age, gender, marital status, religion, highest level of educational attainment, length of experience, amount of duties and heredofamilial diseases). Using Pearson Product-movement, T-test and chi-square correlations, the following conclusions were derived: 1) there are positive and negative correlations between the independent and dependent variable; and 2) there is an intervening effect between the independent and dependent variables with the intervening variables. This study increases understanding of the deleterious effects of hypertension towards health and awareness of lifestyle and behavior that enhance well-being.

Keywords **-** hypertensive faculty, health-promoting lifestyle, health practices compliance, system stressors

INTRODUCTION

Hypertension, or generally known as high blood pressure, is a medical condition wherein an individual's blood pressure is re currently elevated. Hypertension is an important contributor to morbidity and mortality from cardiovascular disease. It is an independent risk factor for diseases such as stroke, myocardial infarction, renal failure, congestive heart failure, progressive atherosclerosis, dementia, coronary artery disease and peripheral vascular disease. Hypertension affects approximately 50 million individuals in the United States and approximately 1 billion individuals worldwide, As the population ages, the prevalence of hypertension will increase even further broad and effective preventive measures are implemented (Chobasian et al., 2003) . The Philippines, 9.6 million people are hypertensive and 15.4 million are predisposed to be hypertensive among adults, 20 years and over (Dans et al., 2003). Unfortunately, about half of those who have hypertension are not aware that they have the condition, only 13.1% of them have been treated and 19.3% has been controlled (Dans et al, 2007). Since hypertension may be present in an individual in years without noticeable symptoms, it is otherwise known as " The Silent Assassin" according to Macropedia Britannica (1993) in the Philippines, for over 5 years, hypertension ranks as the fifth leading cause of morbidity (Department of Health, 2003). A nationwide survey on hypertension was conducted in January through April of 2007 which involved a base population of 3,901. The prevalence of hypertension in the adult population in the Philippines is 21% of whi9ch 16% (or 76% of these base hypertensive population) were aware and 5% (or 24% of the base hypertensive population) were unaware. The prevalence was equal among males and females. Hypertension prevalence was highest in Metro Manila and lowest in Western Visayas; higher in urban areas than in rural areas; highest among the age groups 60-69 years and 70 years and above; higher among males up to age 49 years and among females 50 years old and above (progressive with advancing age). Treatment rate was 65% of which 66% were compliant (or 43% of all hypertensive subjects with or without treatment). BP control rate was 20% (13% of treated and untreated hypertensive subjects) (Sison, et al, 2007). This implies that hypertension is a chronic problem or condition of the country and perhaps not much has been done on its control and prevention.

Prolonged and uncontrolled hypertension is very dangerous. Unhealthy lifestyles which include cigarette smoking, unmanaged stress, salty food consumption, physical inactivity, or being overweight are the common modifiable risk factors to having hypertension. Non-modified factors include

genetic predisposition to hypertension and other disease condition like diabetes, heart and kidney disease, high cholesterol level, or stroke and an increasing age.

Mindanao State University- Iligan Institute of Technology (MSU-IIT) is one of the prestigious universities in the Philippines. It composes of (9) colleges with 572 faculty members. According to a source who is clinic personnel, hypertension is quite rampant among the faculty but most of them do not visit the clinic because they are too busy to do it. "I am afraid to come late in my class," says one faculty member. Moreover, the said clinic personnel also added that there are only a few (about 24 faculty members) who regularly visit the clinic for blood pressure monitoring. Because of this, the researcher wants to conduct a study relating to the effects of maintaining a healthy lifestyle to achieve optimal health. The general objectives of this study are to describe the health-promoting lifestyle and determine the level of health and well-being of MSU-IIT Faculty members with hypertension.

FRAMEWORK

This study made use of Nola Pender's Health Promotion Model.

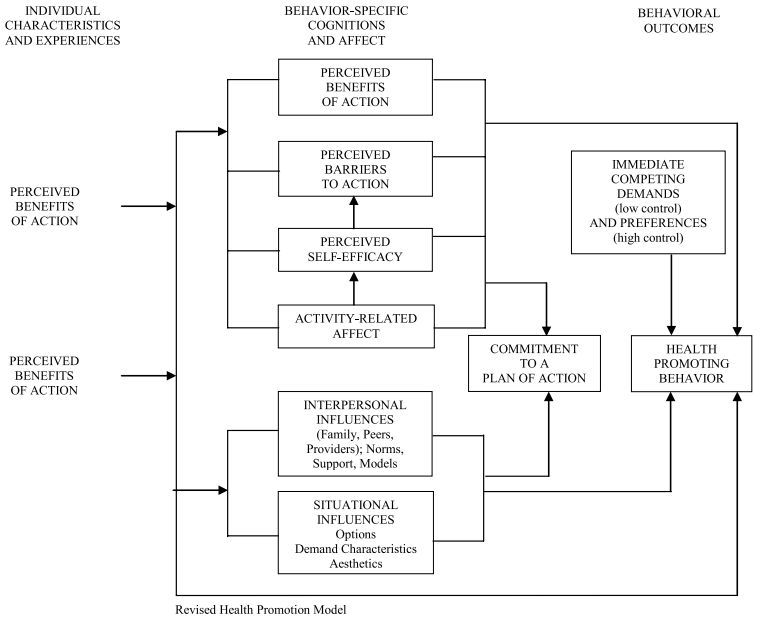

Figure 1. Pender's Health Promotional Model

Pender, Murdaugh, and Parsons (2002) described the health promotion framework as a guide used for exploring the bio psychosocial processes, which motivated patients to participate in behaviors directed toward enhancing health.

The Health promotion was defined as the activities that directed the development of resources to enhance a patient's well-being. The Health promotion Model was designed to assess the areas of poor health practices or habits within the patient's environment and to construct a plan to create healthy bio psychosocial adjustments.

The Health Promotion Model is composed of three main categories. The first category, Individual Characteristics and Expenses, assessed the personal characteristics and experiences that affect action (Pender et, al., 2002). Then individual Characteristics and Expenses category focused on two areas: prior related behavior and personal factors. Prior-related behavior is proposed to have an effect on the likelihood of participating in health-promoting behaviors. Smoking is described as a prior-related behavior. The other area of this category was personal factors. Personal factors were biologic, psychologic, or sociocultural factors. Race, gender and self-motivation were described as personal factors.

The next consecutive category of the Health Promotion Model was Behavior-Specific Cognitions and Affect (Pender et al., 2002). This category contained six different areas: perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences, and situational influences. The Health-Promoting Lifestyle Profile Behavior II (HPLP II) incorporated all six areas of the Behavior-specific cognitions and Affect category into its statements.

The Health Promotion Model defined the six areas.

Perceived benefits of action are defined as indirect or direct motivational behavior, which determined the extent of commitment to the plan by the patient (Pender et al., 2002).

Perceived Barriers to Action

Perceived barriers to action are defined as the patient's anticipated barriers to health-promoting behavior (Pender, et, al., 2002).

Perceived Self-Efficacy.

Perceived self-efficacy is defined as judgment of personal capability to create, organize, or complete a particular action (Pender, et al., 2002).

Activity-Related Affect.

Activity-related affect is described as the subjective feelings that happened prior to, during, and following the activity (Pender et al., 2002).

Interpersonal Influences.

Interpersonal influences are defined as the concerns that an individual has about other feeling, beliefs, and attitudes (Pender et al., 2002).

Situational Influences.

Situational influences are described as personal perceptions about a situation that promoted or impeded behavior (Pender, et al., 2002).

The last category was Behavioral Outcomes (Pender et al., 2002). This category included the last portions of the Health Promotion Model, Commitment to a plan of action and Health-promoting behavior. The behavioral outcomes incorporated the knowledge gained in the first two categories, individual Characteristics & Experiences and Behavior- Cognitions & Affect, to create a commitment to a plan of action for health-promoting behavior. Commitment to a plan of action started a behavioral event. The commitment propelled the individual into and through the behavior. Pender et al. (2002) stated.

> "Commitment to a plan of action implies the underlying cognitive processes
>
> (1) Commitment to carry out a specific action at a given time and a place and with specified persons or alone, irrespective of competing preferences; and (2) identification of definitive strategies for eliciting, carrying out and reinforcing the behavior."

Once the commitment was established, the endpoint or action outcome is the positive health-promoting behavior. (Pender et al., 2002) further described health- promoting behaviors as"… continuing activities that must become an integral part of individual's life style." For example, people with chronic hypertension require daily medication in order tom maximize their hypertension control. In this context, hypertension control enhances the person's quality of life. Adherence to a daily medication regimen requires the individual to develop behaviors which support it. In that sense, medication compliance can be seen as a health- promoting behavior. Moreover, the desire to develop health- promoting

behaviors is rooted in cognitive processes and is influenced by the values placed on these behaviors by the individual. Pender refers to the cognitive-perceptual factors as primary motivating mechanisms. Current state of illness or wellness, self-esteem, the ability to understand the need for these behaviors and the desire to undertake them, all influence the individual's likelihood of making choices about whether or not to adopt a healthy life style (Pender, et al., 2002).

OBJECTIVES OF THE STUDY

This study aimed to (1) present the profile of the respondents in terms of age, gender, marital status, religion, highest level of educational attainment, length of teaching experience, amount of duties, and heredofamilial diseases, (2) determine the status of the respondents in terms of their Health-Promoting Lifestyle as to Health Responsibility, Stress Management, Spiritual Growth, Interpersonal relationships, Nutrition, Physical Activity, (3) identify the level of health practices of the respondents in terms of Exercise, Lifestyle, Diet, Medication, (4) analyze the status of the respondents in terms of Demands at work, Managerial Support, Colleague Support, Role, Relationships, (5) determine the level of health and well-being of the respondents in terms of Blood Pressure, and Number of Years suffering from hypertension, (6) measure the significant relationship between the independent variables and the dependent variables, and (7) measure the intervening effect of the respondents profile to the relationship between the independent variables and the dependent variables.

METHODOLOGY

This study made use of non-experimental descriptive, mixed (qualitative and quantitative) design to be able to describe the Health-promoting lifestyle, the level Health practices compliance and the MSU-IIT Faculty with hypertension. The total expenses of this study amounted to PhP 10,000.00 which covered the printing of the questionnaires and this paper, jeepney and bus fares, and tokens given to the respondents and the research panel.

Research locale

This study was conducted in Mindanao State University-Iligan Institute of Technology (MSU-IIT).

The respondents of the study were the faculty of MSU-IIT. They must

be working as a full time faculty. Faculty members who serve as lecturers and consultants were not included in the study. No sampling method (Complete Remuneration) was used since all hypertensive faculty listed at the school clinic participated on the study.

The questionnaire was divided into eight (8) parts: Part I, demographic data; Part II, Blood Pressure Monitoring; Part III, Health-Promoting Lifestyle II (HPLP II) questionnaire; Part IV, Exercise activities; Part V, Lifestyle, Part VI, Dietary Habits, Part VII, Medication Adherence; and Part VIII, Work related Questionnaires. The Demographic data questionnaire was adapted from the Health-Promoting Lifestyle Profile II (HPLP II) demographic section (Porter et al., 2005). However it has been modified to be applicable to the subject set-up. Part I includes age, gender, marital status, religion, highest level of educational attainment, length of teaching experience, and blood pressure average. Some items were added like the amount of duties in the college the respondent is currently connected to.

Part II was the Blood Pressure Monitoring Questionnaire adapted from the medical/health Questionnaire created by Porter (2005). It served as an assessment on how well the respondent is currently monitoring his or her blood pressure at home. The family history was also included in this section.

Part III was a set of questions relating to health-promoting lifestyle. The questionnaire was adapted from the Health-Promoting Lifestyle Profile II (HPLP II), which was created by Walker, Sechrist, and Pender in 1987. The HPLP was finally derived from the lifestyle and Health Habits Assessment developed by Pender. The HPLP has been further redefined over the last 10 years to a 52-item instrument. The latest version available is in HPLP II, which has six dimensions to measure a health-promoting lifestyle. The six dimensions were as follows: Health Responsibility, Physical Activity, Nutrition, Spiritual Growth, Interpersonal Relations, and Stress Management. The HPLP II is a 52-item Likert scale instrument intended to measure the major components of a healthy Lifestyle.

The HPLP II helped determine whether or not subjects with hypertension more frequently or less frequently performed health-promoting behaviors.

Part IV was the exercise activities questionnaire, also adapted from the Medical/health questionnaire created by Porter (2005). It described the respondent's exercise patterns.

Part V was the Lifestyle Check Questionnaire, also a part of the Medical/health questionnaire created by Porter (2005). It described the general of lifestyle

of the general of lifestyle of the respondent in terms of smoking and alcohol drinking.

Part VI was the Dietary Habit Questionnaire, a part of the Medical/health questionnaire, created by Porter (2005). It described the everyday food intake of the respondent including the foods and beverages they eat for their snacks.

Part VII was a questionnaire adapted from a research conducted by Dr. Marvin Moser and Franklin Stanley (2007) on hypertension management. It consisted of a set of behaviors relating to therapeutic lifestyle changes which is recommended to control hypertension and its associated complications.

Part VIII was the Work-Related Questionnaire also called as the Health and Safety Executive (HSE) Indicator Tool (Cousins et al., 2004). This questionnaire was originally made to identify the health and safety of employees at work.

A letter of consent to conduct the study was given to the College Deans and the Institute Clinic Head for approval. The list of the names of hypertensive faculty was taken from the Institute Clinic. Another letter of consent was made exclusively for the thirty-three (33) respondents who would be participating in the study.

The data was analyzed using statistical package for the Social Sciences (SPSS) research.

RESULTS AND DISCUSSION

Objective 1. To present the profile of the respondents in terms of age, gender, marital status, religion, highest level of educational attainment, length of teaching experience, amount of duties, and heredofamilial diseases.

This section presents the results and discussion of the respondents in terms of age, gender, marital status, and highest level of educational attainment, length of teaching experience, amount of duties, and heredofamilial diseases.

Majority of the respondents (39.4%) belonged to the age bracket 52-59 years old. This implies that most of the faculty who are suffering from hypertension was at their 50s. It signifies that as we age, the incidence of hypertension increases (Williams and Hopper, 2007). This is basically due to the structural and functional changes in the heart and blood vessels that may contribute to blood pressure increase as we age, (Smeltzer et al., 2008).

With regards to gender, most of the respondents (54.5%) are females

Although men are more prone to have hypertension the result may not be related to this. In the academe, females as a group are more drawn than men to careers that involve working with students and teenagers (Anderson, 2010). Therefore, it is expected that females generally dominate the teacher population. In fact, as reported by Dr. Caesar Saloma (2010), the male-to-female ratio for state college and universities in the Philippines is 1:1.57.

For marital status, the larger population (87.9%) composed of married respondents. The result infers that people generally wants to get married. This is basically due to the fact that God created women to be a suitable partner for men (Genesis 2:18, CEV). Moreover, there have been a lot of researchers implying that people do get married because of the numerous benefits of marriage including an increase of life expectancy (Clay, 2009). However, this is not always the case because the quality of the relationship also matters (BBC News, 2010). Therefore, those who do not have marital satisfaction still have a higher risk of having certain disorders such as cardiovascular diseases including hypertension.

As to religion, most of the respondents (39.4%) were Roman Catholics. As reported by BBC News (2005), the Roman Catholic Church is the largest branch of Christianity in the world. Moreover, according to Prof. Susan Russell (2010), the Philippines is approximately 85% Christian (mostly Roman Catholic), 10% are Muslims, and only 5% "other" religions. On the other hand, only one (3.0%) said that he has no specific religion but he believed in God. The above results implies that majority (97%) of the respondents do believe on the importance of religion on one's health and overall well-being.

Majority of the respondents (75.8%) were MA graduates (See Appendix E, page 134). This strongly infers that most of the faculty members have already obtained MS and MA degrees. According to Prof. Chloe D. Jondonero, Dean of the College of Nursing, the initial requirement that must be satisfied when entering MSU-IIT is at least an MA or MS graduate. However, if the applicant is a BS degree graduate, he or she must be at the top of the class (summa-, magna-, cum laude) of a prestigious university. Moreover, as reported by Dr. Caesar Saloma (2010), only 9.08% pf the faculty of various state universities and colleges in the Philippines are PhD degree holders while 30.63% are MS degree holders.

For the length of teaching experience, about 27.3% have already served MSU-IIT for 10-17 years and 15.2% has served for 26-33 years. This signifies that majority of the respondents were already exposed to the long-lasting stress of teaching of teaching. Because of the nature of work, Teaching is one profession

that is considered a factor for an increased risk of hypertension and other cardiovascular diseases (Tao et al., 2007).

Since most academics are expected to be involved in both the generation of new knowledge (research) and the transmission of knowledge (teaching) (Coaldrake & Stedman, 1999), the teaching load, administrative load, research advisories and committee memberships were also included as part of the profile of the respondents.

For the teaching load, most of the respondents were given 9-17 units while only 3% have 0-8 units. This implies that most of them were carrying regular teaching loads. As stipulated in the Faculty Manual, the regular teaching load is 12-15 units/ teaching load above 15 units were considered as teaching overload. Those who have various positions will be deloaded according to the position they hold: 1.5-3 units deloaded for any committee memberships, 9 units deloaded for assistant Deans and Department Chairpersons, and 12 units deloaded for School/College Deans.

For the administrative load, majority of the respondents have 0 to 3 units (84.8%) Administrative load while only 15.2% have administrative load. The 15.2% comprises of 2 faculty who are members of the Institute Academic Planning Committee (consisting of the College/Schools Dean with 12-unit deload) and a faculty who is a member of the Institute Academic Scholarship Committee (with 3-units deload). This implies that some faculty are being elected or appointed to handle administrative functions aside from teaching and research.

As to research advisories, most of the respondents were handling 0-2 research advisories while only 21.2% are handling 3-5 research advisories in the undergraduate level. Most of the respondents (84.8%) also do not have any advisories on the masteral level. Lastly, only one respondent (3.0%) had accepted an advisory on the doctorate level. This implies that most faculty members prefer to have research advisories in the undergraduate level. According to them, Masteral theses and PhD dissertations need a lot of intellectual thinking and more pressure because they could be so preoccupied with the activities that they do not have time to exercise and may also have the tendency to forget taking their medications. They added that the number of research advisories also have an impact on their blood pressure. The more research advisories they have, the more their blood pressure cannot be controlled. Thus, the number of research advisories may as well affect their health and well-being. However, some of them prefer not to involve themselves on any research activities to decrease their

exposure to stress and control their blood pressure.

With regards to committee memberships, majority of the respondents (90.9%) were not given any special duty aside from teaching. Per interview, most of them do not want to be elected or appointed on different department, college or institute positions because of the impact of stress to their health. Therefore, this signifies that membership from various institution committees may affect the blood pressure.

Lastly, for heredofamilial diseases, most of the respondents (78.8%) have a familial disease of hypertension. About 48.5% have a familial disease of DM, 30.3% have Heart Attack, 27.3% have a High Cholesterol, and 24.2% have Stroke. This implies that a family history of hypertension strongly predisposes one to develop hypertension almost twice the risk of developing it (Williams and Hopper, 2007). Having DM also increases the risk of getting hypertension because the increase sugar levels can cause structural changes in the arteries causing atherosclerosis, leading to hypertension (Grossman & Messerli, 2008).

Objective 2. To determine the status of the respondents in terms of their health-promoting lifestyle as to health responsibility, stress management, spiritual growth, interpersonal relationships, nutrition, and physical activity.

For health responsibility, although the respondents have different answers to each statement (CV: 12.868), the results imply that the respondents were "somewhat" responsible in terms of their health with an over-all mean of 3.4613. The therapeutic regimen is actually a basic responsibility of the client in collaboration with the health care provider (Smeltzer et al. 2008).

With regards to physical activity, the over-all mean of 2.4512 implies that the respondents do not frequently involve themselves on some activities as stated on the questionnaire. This could have an impact towards blood pressure control. Sedentary lifestyle does contribute to having hypertension. Having regular exercise schedule helps prevent and control hypertension by reducing weight, decreasing peripheral resistance, and decreasing body fat.

As to nutrition, the respondents still have different responses (CV: 23.0173). With an overall-weighted mean of 3.7239, the results implies that almost all statements above were "somewhat" being done by them. The impact of this to health is very positive.

For spiritual growth, the over-all mean of 4.3636 signifies that all statements mentioned in the questionnaire were "very characteristic" on them. To them,

spiritual growth is highly significant to their lives. The implication of this to health is positive. Several studies had demonstrated to the physiological effects of meditation to the body systems (Astin, 2000). Moreover, according to a study conducted by O'Connor et al. (2005), those who pray had more favorable health-related behaviors, preventive service use, and satisfaction with care. Therefore, this can greatly contribute to controlling blood pressure.

As to interpersonal relationships, the over-all mean (3.9596) implies that they have goof interpersonal relationships with their family and friends since all statements reflected under this section of the questionnaire most likely being done by them.

Lastly, for stress management, the over-all mean of 3.6869 signifies that the respondents were employing stress management techniques as stated on the questionnaire. Other specific stress management techniques being identified by them were watching TV (45.5%), engaging on some recreational activities like dancing (42.4%), praying to God (21.2%), talking with grandchildren (15.2%), involving in church activities (15.2%), playing with grandchildren (15.2%), sleeping (12.1%), reading books (12.1%), hanging out with friends (6.1%), involving in community activities (6.1%) and going to the mall (6.1%).

Objective 3. To identify the level of health practices of the respondents in terms of exercise, lifestyle, diet, medication.

Table 1. Frequency distribution for health compliance in terms of exercise

Exercise (in minutes)	Mean	Std.dev
4.1 On the average, how many times do you exercise per week?	1.55	1.502
4.2 On the average, how long do you exercise?	18.94	13.99
4.3 Encircle the range as shown below how intense is your typical workout. Very easy 1 2 3 4 5 6 7 8 10 Very Intense	2.79	2.15
4.4 Exercise Activity Running/Jogging	2.7273	7.74000
Walking	14.5455	11.98069
Bicycling	3.7121	8.50370
Weight training	.3030	1.74078
Attending Aerobic classes	2.4242	7.91766
Swimming	.4545	2.61116
Playing Racquet Sports	1.8182	10.44466
Yoga/Martial Arts	.0000	.00000

Table 1 shows the respondents' compliance to having exercise activities. The average mean for the number of times they exercise per week is 1.55. The average mean in minutes for how long they have their exercise activities in minutes is 18.94. The intensity of their exercise is almost very easy with a mean of 2.79 minutes. Most respondents prefer walking as their exercise activity than running or jogging, bicycling, attending aerobic classes, playing racquet sports, swimming and weight training, respectively,

The average mean for the number of times the respondents exercise per week was not enough to control blood pressure. The advisable frequency is 3 to 5 times per week (Wallace, 2003). The time frame on how long they do their exercise activities in minutes is also not enough. The advisable number of minutes a hypertensive client must perform aerobic exercises is at least 20 to 60 minutes.

Table 2. Frequency distribution for health practices in terms of lifestyle

Smoking	No		Yes		Total
	Freq	%		%	
1. Are you a cigarette smoker?	33	100.0	0	0.0	100.0
2. Previously a cigarette smoker? If yes, when did you quit: 2000 How many years have your smoked or did you smoked before quitting? 13 years	32	97.0	1	3.0	100.0
3Please rate your daily stress levels (Select one):					
Stress Level		Freq		%	
Low		1		3.0	
Moderate		9		27.3	
High: I enjoy the challenge		5		15.2	
High: Sometimes difficult to handle		16		43.5	
High: Often difficult to handle		1		3.0	
Total		33		100.0	
Alcohol Drinking	No	%	Yes	%	Total
4. Do you drink alcohol?	22	67.6	11	33.3	100.0
5. How would you rate your consumption on a scale of 1 to 10? 1 = 1 glass of wine 1 2 3 4 5 6 7 8 9 10 10 = 1 liter bottle of wine					
Consumption Scale		Frequency		%	
0		21		636	
1		1		3.0	
2		4		12.1	
3		1		3.0	
4		3		9.1	
6		2		6.1	
8		1		3.0	

Table 2 shows the respondent's compliance practices in terms of their lifestyle. All of the respondents were not smoking. However, one in faculty admitted that he was once a smoker for 13 years and only decided to quit smoking 2000. Quitting smoking as early as possible has a positive impact on the hypertensive client's level of health (Sommers et al., 2007). In terms of stress levels, majority of them (54.5%) have a high stress level and only almost half of them (48.5%) perceived that sometimes the stress they had was difficult to handle. What made them hypertensive were stress at work (60.6%), financial problems (48.5%), and sleepless nights (42.4%), kids that do not go home early (12.1%), bad news seen on television (12.1%), their kid's problems in school (9.1%), noisy environment (9.1%), and long research hours (3.0%). In addition, elements in school that made them hypertensive are having delinquent students (63.6%), sleepless nights (39.4%), poor interpersonal relationships with colleagues (33.3%), no rest periods (24.2%), hectic schedule (21.2%), successive appointments or meetings (15.2%), extracurricular activities (15.2%), warm classrooms (15.2%), poor interpersonal relationships with students (12.1%), too much research-related activities (9.1%), beating deadlines (9.1%), and delayed salary (6.1%). These stressors identified by the respondents can definitely affect their blood pressure.

Table 3. Frequency distribution for health practices compliance in terms of diet

Diet Pattern	Yes	%	No	%
I seldom consume red or high fat meats.	13	39.40	20	60.60
I pursue a low-fat diet	12	36.40	21	63.60
I eat at least 5 servings of fruit/vegetables per day	19	57.60	14	42.40
I almost always eat a full, healthy Breakfast	15	45.50	18	54.50
My diet includes many high-fiber foods	16	48.50	17	51.50
I rarely eat sugar or high fat desserts.	14	42.40	19	57.60

Table 3 shows the respondents' health practices compliance in terms of diet. As shown, most of the respondents (39.4)% have a lesser consumption of red or high fat meat. They also do not prefer to have a low-fat diet accounting to 63.6% of the total population. Most of them (57.6%) also liked to eat at least 5 servings of fruits and vegetables every day. More than half of the population (54.5%)

was not always eating a full, healthy breakfast. It is also sad to note that only more than half of the population (48.5%) included high fiber foods in their diet. Lastly, most of them (57%) favored eating sugar or high fat desserts.

Table 4. Frequency distribution of typical meal for breakfast, lunch, dinner, and snack

Meals	Yes		No	
	Freq	%	Freq	%
Breakfast				
Rice	29	87.90	4	12.10
Eggs	16	48.50	17	51.5
Hotdogs	9	27.30	24	72.70
Fried Fish	5	15.20	28	84.80
Fish	9	27.30	24	72.70
Vegetable	13	39.40	20	60.60
Fruits	8	24.20	25	75.80
Milk	2	6.10	31	93.90
Meat	6	18.20	27	81.80
Toccino	1	3.0	32	97.00
Coffee	8	24.20	25	75.80
Bread	1	3.0	32	97.00
Lunch				
Rice	32	97.00	1	3.00
Vegetables	22	66.70	11	33.30
Meat	23	69.70	10	30.30
Vegetable with meat strips	11	33.30	22	66.70
Fruit juice	3	9.10	30	90.90
Fish	9	27.30	24	72.70
Fruits	6	18.20	27	81.80
Fruit Salad	1	3.00	32	97.00

Dinner				
Rice	31	93.90	2	6.10
Vegetable	22	66.70	11	33.30
Meat	24	72.70	9	27.30
Vegetable with meat strips	12	36.40	21	63.60
Fruit Juice	4	12.10	29	87.90
Fish	5	15.20	28	84.80
Fruits	7	21.20	26	78.80
Snacks				
Coffee	17	51.50	16	48.50
Tea	6	18.20	27	81.80
Softdrinks	9	27.30	24	72.70
Sandwich	7	21.20	26	78.80
Arrozcaldoi	5	15.20	28	84.80
Benignit	2	6.10	31	93.90
Crackers	7	21.20	26	78.80
Bread	10	30.30	23	69.70
Fruit salad	10	30.30	23	69.70
Sweetened Dessert Cake	5	15.20	28	84.80

Table 4 shows that the respondents; typical foods eaten for breakfast, lunch, dinner and snacks. Almost all the respondents prefer to have rice in their meals except for the snacks. For breakfast, they like to have eggs (48.5), and vegetables (39.4%). For lunch, most of them go for meat (69.7%) and vegetables (66.7%). For dinner, majority want to have vegetables (66.7%) and meat (72.7%) as their viands. More than half of the respondents (51.5%) prefer to have coffee for their snacks.

Table 5. A Frequency distribution for health practices in terms of medication adherence

Medication Adherence	Yes		If yes, Why?	No	
	Freq	%		Freq	%
1. Did you ever forget to take your Medication/s?	18	54.50	Busy (42.4%) Don't like it to take (6.1%) Forget to buy (6.1%), Not yet adapted to taking it, (3.0%)	15	45.50

2. Were you careless at times about taking your medication/s?	8	24.20	Takes more when BP is high (6.1%), No money (6.1%), Don't like it to take (6.1%), Busy (3.0%), Forget where I place my meds (3.0%)	25	75.80
3. When you felt better, did you sometimes stop making your medication/s?	14	42.40	Tends to forget (24.2%) No reasons to take it (6.1%), Forgets when feels good (6.1%), Believes that meds are bad for the vital organs (6.1%), Not taking anything (3.0%)	19	57.60
4. Sometimes, if you felt worse when you took your medication/s, did you stop taking it?	15	45.50	Don't like the discomfort (39.4%), Not taking them (6.1%), Not effective (3.0%)	18	54.50

Table 5 shows the respondents adherence to medication regimen. Most of the respondents (54.5%) have the tendency to forget taking their prescribed medications because they were busy, or just plainly forgets, or was not used to taking it or was not taking anything at all. However, majority of them (57.6%) were not careless when taking their maintenance medications. It was noted that more than half of them (57.6%) stop taking the medications whenever they felt better because they tend to forget or have no reasons for taking it, and hence were taking were anything at all. Lastly, more than half of the populations (54.5%) also stops taking their medications when they felt worse upon taking their medications because they do not like the discomfort, the medications were not effective or preferred not taking them.

Table 6. Frequency distribution of prescribed maintenance medications.

Medication	Not taking		Taking	
	Freq	%	Freq	%
Dyslipidaemic Agents				
Lipitor (Atorvastatin)	29	87.9	4	12.10

Simvastatin	32	97.00	1	3.00
ACE Inhibitors				
Norten (Imidapril)	28	84.8	5	15.2
Accupril (Quinapril)	26	78.80	7	21.20
Norplus (Imidapril + Hydrochlorothiazide)	24	72.70	9	27.30
Diuretics				
Lasix (Furosemide)	31	93.9	2	6.10
Calcium Channel Blockers				
Norvasc (Amlodipine)	23	69.70	10	30.3
Amvasc (Amlodipine)	31	93.90	2	6.10
Adalat (Nifedipine)	28	84.8	5	15.2
Angiotensin II Receptor Blockers				
Cozaar (Losartan)	29	87.90	4	12.10
Anzar (Losartan)	31	93.90	2	6.10
Diovan (Valsartan)	30	90.90	3	9.10
Beta Blockers				
Betaloc (Metoprolol)	31	93.90	2	6.10
Neobloc (Metoprolol)	32	97.00	1	3.00
Vitamin Supplements				
Enervon	29	87.90	1	12.10
Clusivol	29	87.90	4	12.10
Stresstabs	32	97.00	1	3.00

Table 6 shows that the respondents were maintaining, if not one drug, a combination of antihypertensive medications. For dyslipidaemic agents, only 12.10% of the respondents were taking it. Dyslipidaemic agents lower down blood lipids, specifically cholesterol levels (Lantin, 2008). About 27.3% were taking Norplus.

Angiotensin Converting Enzyme (ACE) Inhibitors dilates peripheral blood vessels to reduce vascular resistance, thus lowering down blood pressure levels (Lantin, 2008). Only 6.10% are maintaining Lasix. Lasix (Furosemide) is a diuretic which is effective in excreting excess volumes of fluids via the kidneys to decrease blood pressure (Lantin, 2008). 30.3% of them were taking Norvasc (Amlodipine), a calcium-channel blocker which is effective in producing relaxation over the coronary vascular smooth muscles, decreasing the incidence

of chest pain brought about by hypertension, about 12.10% were maintaining Cozaar (Losartan), an Angiotension II Receptor Blocker (ARB). ARBs were found to be effective in lowering down blood pressure since it prevents the activation of angiotension II, a potent vasoconstrictor (Lantin, 2008). 6.10% were taking Betaloc (Metoprolol), a Beta Blocker. Beta Blockers block sympathetic nerve responses to decrease myocardial contractility, causing a decreasing in blood pressure (Lantin, 2008).

Objective 4. To analyze the status of the respondents in terms of demands at work, managerial support, colleague support, role, relationships.

For the demands at work, the over-all result (Mean: 2.2841) implies that the respondents almost have no problems with regards to their demands at work (See Appendix J, page 143). The demands such as workload, work patterns, and the working environment may affect blood pressure levels (Cousins et al., 2004). Since the responses range from seldom to never, this infers that they were able to cope up with their demands at work. This could somehow contribute in controlling their blood pressure.

For colleague support, most of the respondents (Mean: 4.3939) were able to receive the respect they deserve from their colleagues always. With regards to the roles at work, majority of the respondents (Mean: 4.6364) knows how to get their jobs done always. With responses ranging from often to always, this signifies that the respondents most likely have no problems with regards to their job description and their roles in their respective departments.

Lastly, for relationships at work, with an over-all mean of 2.0303, this result signifies that the respondents do seldom experience relationship problems at work. The presence of this type of problem between relationships at work could be a factor to the increasing blood pressure of a respondent.

Objective 5. To determine the level of health and well-being of the respondents in terms of blood pressure, and number of years suffering from hypertension.

Table 7. Percentage distribution of blood pressure

Stage	Frequency	%
Prehypertension	13	39.4
Hypertension Stage 1	19	57.6
Hypertension Stage 2	1	3.0
Total	33	100.0

As shown in Table 7, a bigger portion of the population (57.6%) was diagnosed with hypertension stage 1 while 39.4% are on their Pre-hypertension Stage. Only 3% of them are on the Stage 2 Hypertension. This implies that being in the academe exposes oneself to long-lasting stress which put the teaching profession a risk for hypertension and cardiovascular diseases, considering the nature of work (Tao et al., 2007).

Table 8. Descriptive Statistics for the Number of Years Suffering from Hypertension

Years Suffering from Hypertension	Mean	Std. Dev.
	7.21	4.3139

Table 8 shows the descriptive statistics for the number of years the respondents were suffering from hypertension. The average mean was 7.21 years. This signifies that the average number of years they were already suffering from hypertension is seven years. According to Marcell Pick (2010), unstable high blood pressure can shorten the lifespan by 10-20 years and is strongly linked to women of the most entrenched degenerative problems like DM Type 2 and Coronary Heart Diseases (CHD). Therefore, the respondents must always engage in healthful activities to combat hypertension to lengthen their lifespan.

Objective 6. To measure the significant relationship between the independent variables and the dependent variables.

Table 9. Test of relationship of health promoting lifestyle and the health and well-being of the hypertensive faculty (Blood Pressure Category)

Health Promoting Life Style	Somer's D	P-values	Remarks
Health Responsibility	-.003	.953	Not significant

Physical Activity	-.165	.272	Not significant
Nutrition	.137	.422	Not significant
Spiritual Growth	.062	.741	Not significant
Interpersonal Relations	-.310	.025	Significant
Stress Management	-.424	.010	Highly significant

Table 9 shows the test of relationship between the variables for health promoting lifestyle to the health and well-being of the respondents in terms of blood pressure. Based on the results, there is a significant negative relationship between interpersonal relations to their blood pressure and very highly significant negative relationship between stress management and blood pressure.

Interpersonal relations can somehow be a factor for the changes in the blood pressure of the respondents. Some of the respondents verbalize that an increase to their blood pressure is due to poor interpersonal relationships with students and colleagues.

Table 10. Test relationship of health promoting lifestyle and the health and well-being of the hypertensive faculty (Number of years suffering from hypertension)

Health Promoting Life Style	Pearson r Correlation Coefficients	P-Values	Remarks
Health Responsibility	.013	.945	Not significant
Physical Activity	-.168	.350	Not significant
Nutrition	.115	.526	Not significant
Spiritual Growth	.049	.788	Not significant
Interpersonal Relations	-.417	.016	Significant
Stress Management	.000	.996	Not significant

Table 10 shows the test of relationship between the variables for health promoting lifestyle to the health and well-being of the respondent in terms of the number of years they are suffering from hypertension. As reflected, there is a significant relationship between interpersonal relations and the number of years they we're suffering from hypertension.

Table 11. Test of relationship of health practices compliance and the health and well-being of the hypertensive faculty

(Blood Pressure Category)

Health Practices Compliance	Somer's d	P-values	Remarks
Exercise			
Frequently of exercise per week	-.142	.291	Not significant
Length of time for the exercise	-.072	.543	Not significant
Intensity of typical workout	-.06	.651	Not significant
Lifestyle			
Cigarette smoker	.375	.311	Not significant
Previously a cigarette smoke	.375	.311	Not significant
No. of years smoking/smoke before quitting	.166	.294	Not significant
Daily stress levels	-.133	.418	Not significant
Drinking alcohol	-.101	.515	Not significant
Diet			
Seldom consume red or high fat meats	.308	.064	Not significant
Pursue a low fat diet	.143	.433	Not significant
Eat at least 5 servings of fruits/vegetables per day	.09	.602	Not significant
Almost always eat a full, healthy breakfast	.03	.867	Not significant
Diet includes many high-fiber foods	-.044	.802	Not significant
Rarely eat sugar or high fat desserts	.226	.184	Not significant
Medication Adherence			
Forget to take medications	.281	.089	Not significant
Careless at times about taking medications	-.06	.996	Not significant
Stop taking medications when felt better sometimes	.226	.184	Not significant
Stop taking medications if felt worse sometimes	.148	.390	Not significant

Table 11 shows the test of relationship of the variables under health practices compliance and the health and well-being of the hypertensive faculty in terms of blood pressure. As reflected, there is no significant relationship between the health practices compliance as to exercise, lifestyle diet and medication adherence to the blood pressure of the respondents.

Table 12. Test of relationship of health practices compliance and the health and well-being of the hypertensive faculty (Number of years suffering from hypertension)

Health Practices Compliance	Somer'sD	P-values	Remarks
Exercise			
Frequently of exercise per week	-.331	.016	Significant
Length of time for the exercise	-.261	.082	Not significant
Intensity of typical workout	-.229	.109	Not significant
Lifestyle	Likelihood Ratio Chi-square		
Cigarette smoker			
Previously a cigarette smoke	8.962	.030	Significant
No. of years smoking/smoke before quitting	8.962	.030	Significant
Daily stress levels	13.368	.574	Not significant
Drinking alcohol	11.349	.078	Not significant
Consumption scale of alcohol	20.224	.320	Not significant
Diet			
Seldom consume red or high fat meats	4.627	.201	Not significant
Pursue a low fat diet	1.428	.695	Not significant
Eat at least 5 servings of fruits/vegetables per day	2.01	.572	Not significant
Almost always eat a full, healthy breakfast	1.271	.736	Not significant
Diet includes many high-fiber foods	1.514	.679	Not significant
Rarely eat sugar or high fat desserts	3.095	.377	Not significant
Medication Adherence			
Forget to take medications	1.591	.583	Not significant
Careless at times about taking medications	3.119	.374	Not significant
Stop taking medications when felt better sometimes	5.511	.138	Not significant
Stop taking medications if felt worse sometimes	1.271	.736	Not significant

Table 12 shows the test of relationship of the variables under health practices compliance and the health and well-being of the hypertensive faculty in terms of the number of years the respondents were suffering from hypertension. Based on the results, there is a significant relationship between the frequency of exercise per week to the number of years the respondent is suffering from hypertension. In addition, being a cigarette smoker also has a significant relationship towards the span of time suffering from hypertension.

Table 13. Test of relationship of work-related factors and the health and well-being of the hypertensive faculty (Blood Pressure Category)

Work Related Factors	Somer's D	P-values	Remarks
Demands of Work	.041	.781	Not significant
Managerial Support	-.058	.704	Not significant
Colleague Support	-.203	.219	Not significant
Role	-.809	.156	Not significant
Relationships	-.157	.334	Not significant

Table 13 shows the test of relationship of work-related factors and the health and well-being of the hypertensive faculty in terms of blood pressure. As reflected above, there is no significant relationship between work-related factors (demands at work, managerial support, colleague support, role and relationships) and the blood pressure of the respondents.

Table 14. Test of relationship of work-related factors and the health and well-being of the hypertensive faculty (Number of years suffering from hypertension)

Work Related Factors	Pearson Correlation Coefficients	P-values	Remarks
Demands of Work	-.066	.716	Not significant
Managerial Support	-.132	.464	Not significant
Colleague Support	-.056	.757	Not significant
Role	-.101	.575	Not significant
Relationships	-.266	.144	Not significant

Table 14 shows the test of relationship between work-related factors and the health and well-being of the hypertensive faculty in terms of the number of years they were suffering from hypertension. Based on the results, work-related factors (demands at work, managerial support, colleague support, role, and relationships) have no effect towards the number of years the respondents were suffering from

hypertension.

Objective 7. To measure the intervening effect of the respondents profile to the relationship between the independent variables and the dependent variables.

The last problem that the researcher wanted to find out is the intervening effect between the independent variables (individual's health promoting lifestyle and health practices compliance, and system's demands at work, managerial support, colleagues support, role and relationships) and dependent variable (health and well-being of a hypertensive faculty) with the intervening variables (age, gender, marital status, religion, highest level of educational attainment, length of experience, amount of duties and family history). This can be shown by investigating if the respondents' profile significantly influences the independent and dependent variables.

Table 15. Pearson Correlation Coefficients on the effect of the intervening variable (profile) with the independent variables (health promoting lifestyle)

Profile	Health Responsibility/ prob.	Physical Activity/prob.	Nutrition/ prob.	Spiritual Growth/ prob.	Interpersonal Relations/ prob.	Stress Mgt/prob.
Age	.336/.056	.204/.26	.467**/.006	.237/.184	-.29/.102	.114/.529
Teaching Experience	.392*/.023	.053/.776	.476**/.005	.190/.289	-.343/.05	.170/.343
Teaching Load	-.027/.881	-.091/.6161	0.16/.928	-.143/.426	.126/.485	-.074./.68
Administrative Load	-.166/.351	-.232/.195	.265/.137	-.204/.254	-.139/.439	-161/.37
Research Advisees (Undergrad)	.158/.379	-.128/.478	-.073/.688	-.034/.852	-.206/.25	.17/.344
Research Advisees (Masteral)	-.025/.891	.185/.304	-.062/.991	-.076/.218	-.209/.244	.151/.40
Research Advisees (PhD)	.223/.211	.158/.379	.159/.378	-.245/.112	-.187/.298	-.206/.25
Committee Membership	-.104/.566	-.086/.634	.029/.874	-.131/.469	-.265/.136	-.023/.098
Gender	.015/.934	.041/.831	-.022/.898	.111/.511	.193/.262	-.096/.547
Civil Status	-.621*/.020	-.172/.542	-.690*/.044	-.405/.156	.276/.302	-.405/.191
Religion	-.067/.124	.156/.314	-.084/.492	-.316**/.001	-.050/.667	-.124/.248
Educational Attainment	.342*/.038	.352*/.031	.279/.112	.027/.888	-.269/.168	.256/.246

*Significant at .05 level

Table 15 shows the correlation coefficients on the effect of the respondents' profile to their health promoting lifestyle. There is a positive correlation of age to nutrition. As their age increases, their nutritional intake is more favourable. Teaching experience has a positive correlation towards health responsibility and nutrition. The higher the teaching experience, the more responsible is the respondent towards his health and nutrition. There is a negative correlation of civil status to health responsibility and nutrition. On this study, since most of the respondents were married, this implies that being married is more inclined to taking lesser responsibility towards health and nutritional intake. In terms of religion, it has a negative correlation towards spiritual growth. This means that religious affiliations have only minimal effects towards spiritual growth. Lastly, educational attainment has a positive correlation towards health responsibility and physical activity. Educational attainment has influence to being responsible to health as well as engaging to some physical activities.

The positive correlation of age to nutrition is brought about by the effects of aging to nutritional intake. The effects of aging are inevitable, therefore, individuals were encouraged to take healthy steps to limit the damages and live a healthy life (Abraham, 2010). Moreover, dietary intake is lower among older individuals (Shahar et al., 2003). According to a respondent, he likes to read articles regarding achieving and maintain optimum health. This hereby has a positive effect towards his nutritional intake.

Teaching experience has positive correlation towards health responsibility according to Wilson (1984), "The teacher is key personal in all school-health activities." Teachers always reinforce "optimal health" to their students in class. The health education will only be effective if they themselves also will follow their teachings to their students. Therefore, since teachers serve as "role models" in schools, the more they work in schools, the more they are responsible to their health (Griew et al, 2010).

For the negative correlation on civil status to health responsibility and nutrition, the results of this study contradicts to several studies conducted regarding the effects of being married to health and nutrition. In a study conducted by Markey et al (2005) and Hughes et al (2008), their results ruled out that marriage and health responsibility are associated. Having a spouse to monitor one's behavior may encourage healthier living habits such as a better diet (Markey et al, 2005; Wood et al., 2007, Hughes, 2008). However, on this study, it has been found out that being married does not necessarily imply more responsibility towards health and nutritional intake.

In terms of religion, it has been found out that religion has a negative correlation to a spiritual growth. According to Howe (2001), at a personal level religion fulfils the role of accounting for a lack of knowledge and offering hope in the face of difficulties. However, since personal attributes are too easily swamped by its societal consequences, it can be reasonably argue that religion could actually lead an individual in the opposite direction (Howe, 2001). Therefore, religion does not always affect the spiritual growth of the respondent.

Educational attainment has a positive correlation towards health responsibility and physical activity. According to Higgins et al (2008), those with more education are likely to have a greater knowledge of health conditions and treatment regimens and have better self-management skills than those with less education. Self-management skills include proper diet, good stress coping strategies, regular physical activity and healthy lifestyle. Limited health literacy is associated with increased health care costs, higher rates of hospitalization and greater use of health care services (Higgins et al., 2008). Therefore, the level of educational attainment could influence an individual to be more responsible to his or her health as well as engage on regular exercise activities.

Table 16. Pearson correlation coefficients in the effect of the intervening variable (profile) with the independent variable (work-related factors)

Profile	Demands of Work	Managerial Support	Colleague Support	Role	Relationship
Age	-.163/.366	.259/.145	.279/.145	.304/.086	-.277/.118
Teaching Experience	-.054/.764	.254/.154	.223/.212	.261/.132	-.162/.369
Teaching Load	.377*/.031	-.379*/.03	-.244/.171	-.381*/.029	.406*/.019
Administrative Load	.428*/.013	-.262/.141	-.153/.394	-.235/.189	.247/.167
Research Advisees (Undergrad)	.197/.272	-.002/.992	.044/.809	.159/.377	-.034/.851
Research Advisees (Masteral)	.141/.443	-.087/.631	-.143/.427	-.177/.324	.207/.248
Research Advisees (PhD)	.214/.233	-.069/.703	-.065/.719	-.166/.357	.120/.504
Committee Membership	.215/231	-.194/.28	-.284/.109	-.116/.522	.070/.698
Gender	.156/.422	-.078/.678	.000/1.000	-.030/.870	.096/.63
Civil Status	.474/.230	-.379/.236	-.517/.146	-.362/.221	.207/.459
Religion	.361**/.009	-.325**/.007	-.268*/.022	-.079/.535	.347**/.008
Education	.064/.794	.187/.380	.046/.831	.050/.799	.274/.107

*Significant at 0.5 level **Significant at .01 level

Table 16 shows the effect of the respondents' profile to their work-related factors (demands at work, managerial support, colleague support, role and relationship). Teaching load has a positive and significant correlation towards demands and relationship at work. This means that the higher the teaching load, the greater is the demands of work. Moreover, a higher teaching load could also create favorable working relationships. However, there is a negative correlation of it to managerial support and role at work. The higher the teaching load, the lesser they get managerial support and the more perplexing is their role at work. Administrative load has a positive and significant correlation towards demands of work. This means that if the respondent is handling some administrative load, the demands of work will increase. Religion has a positive and significant correlation towards demands and relationship at work. This means that the respondents' religion has a positive effect towards their demands at work. They also can have good working relationships with their colleagues. However, there is a negative correlation towards managerial and colleague support. This means that religion has no influence having support from managers and colleagues.

The number of teaching units has a significant positive correlation towards the demands and relationship at work. Teaching is a complex profession. Depending on the type of college or university, teachers may be juggling many responsibilities such as teaching a number of course overloads, fulfilling teaching and research requirements. Even more demanding than the complexity of teaching is the fact that teaching can also generate a high level of stress, fatigue, and lead to burnout (King, 2002). Therefore, this strongly implies that the higher the number of teaching units, the higher is the demands at work. In addition, the increasing demands at work results to less time interacting with colleagues and students (Easthope & Easthope, 2000). This can especially be the case when teachers are too pressured to carry out many of the caring activities they perceive as part of their professional identity (King, 2002). Therefore, the results of this study contradicted King's (2002) and Easthope & Easthope (2000) studies with regards to the positive correlation between the number of teaching units and relationship at work.

The number of teaching units has a negative correlation to managerial support and role at work. Managerial support can be a reduction in teaching load if educators will involve themselves on other scholarly activities aside from teaching like research (Soliman, 1999). However, the results of this study strongly negated

Soliman's results. Nonetheless, the results of this study strongly supports the idea that the more teaching load one has, the more unclear is the role at work (Soliman, 1999; Easthope & Easthope, 2000; King 2002).

The handling of administrative loads has a positive correlation towards the demands of work. Administrative loads are considered as workloads outside of the classroom. According to King (2002), workloads outside of the classroom will increase the demands at work. Therefore, handling administrative loads may strongly contribute to unstable blood pressure levels.

Religion has a positive and significant correlation towards the demands and relationship at work. Recent studies have already identified several life benefits of spirituality, religiosity, and faith towards one's work or occupation and relationship with others. To name a few, that has been found out that the religion can make individuals enjoy lower rates if stress and depression, have higher academic and work achievements, and have closer relationships with their loved ones (lopper, 2009). This infers that being involved on some religious affiliations would have a positive effect on the control of blood pressure.

Lastly, there is a negative correlation of religion towards managerial and colleague support. This result may not agree that religion (and prayer) and supervisory (managerial) support has no correlation (Adams, 2008). Moreover, social support has been found out to positively mediate the relationship between spirituality and religiousness to life's never-ending changes (Salsman et al., 2005). However, the result of this study does not agree on it also.

Table 17. Test of relationship between the respondent's profile and blood pressure category and the length of years suffering from hypertension

Profile	Blood Pressure Category Somer's d	Probability	Length of Years Suffering From Hypertension (Pearson Correlation Coefficient)	Probability
Age	.424**	.001	.534**	.001
Teaching Experience	.286*	.021	.530**	.002
Teaching Load	-.167	.328	-.158	.380
Administrative Load	.189	.339	.297	-.091
Research Advisees (Undergrad)	-.283*	.044	.169	.341
Research Advisees (Masteral)	-.027	.903	-.087	.629
Research Advisees (PhD)	.375	.311	-.215	.231

Committee Membership	.620	.081	.335	.057
Gender	.148	.390	.400*	.019
Civil Status	.034	.922	-.397	.115
Religion	.000	1.000	-.041	.733
Education	.050	.765	.265	.235

Table 17 shows the relationship of the respondents' profile to their blood pressure and the length of years the respondents are suffering from hypertension. There is a positive and significant correlation between age and the respondents' blood pressure. As age increases, blood pressure also has a tendency to increase. It also has a positive and significant correlation towards the length of years they are suffering from hypertension. As age increases, the length of years suffering from hypertension increases. There is a positive and significant correlation between the length of teaching experience to the blood pressure and length of years the respondents are suffering from hypertension. This means that the longer is the teaching experience, the greater the chances that their blood pressure and length of hypertensive years increases. There is a negative and significant correlation between having research advises on the undergraduate level and blood pressure. This implies that having more undergraduate research advisees may not significantly contribute to blood pressure increase. Lastly, gender has a positive and significant correlation towards the length of years suffering from hypertension. This implies that there is a specific gender that is more prone to suffer longer hypertensive years.

The positive relationship between age and respondents' blood pressure can be explained physiologically. As we age, there are structural and functional changers with the heart and blood vessels that would contribute to the increase of blood pressure (Smeltzer et al., 2008).

The positive significant relationship between the lengths of teaching experience to the blood pressure is clinically proven though it may also vary between preschool, school and collegiate teaching. The higher the length of one's teaching experience, the more he or she is frequently exposed to high amounts of stress (Choudhary, 2004). Although the high amounts of stress could increase the blood pressure, the result of this study strongly negates this fact. Based on the findings, the higher is the length of teaching experience, the more the respondent was able to have his or her blood pressure controlled. This could be to the adjustments being made by the respondent.

The correlation between having undergraduate research advisories and blood pressure is negatively significant. In thesis making, a student has to conduct his or her research which has to be original. However, the level of difficulty between undergraduate and graduate is different. Masteral thesis is more difficult since it

involves wider range of intellectual thinking compared to undergraduate thesis (Cutbirth, 2004). Therefore, because of the simplicity of undergraduate thesis, this may have no effects to blood pressure increase. However, the researcher was not able to find some researchers to support this.

The correlation of gender towards the length of hypertensive years is positively significant. Men are usually diagnosed earlier than women. This is basically due to the fact that female hormones play a role in blood pressure control (Smeltzer et al., 2008). Therefore, the earlier is the diagnosis, the longer is the hypertensive years.

Table 18. Test for the relationship of profile and health compliance using Somer's d

Health Practices Compliance	Age	Gender	Civil Status	Teach Exp.	Religion	Education level
Exercise						
Frequency of exercise per week	.124/.308	-.162/.224	-.032/.708	.027/.835	.102/.523	.144/.120
Length of time for the exercise	.004/.973	.059/.650	.103/.349	-.053/.684	.152/.219	.154/.180
Intensity of typical workout	.076/.584	-.074/.565	-.012/.891	-.014/.912	.074/.585	.179/.127
Lifestyle						
Cigarette smoker		1.0/.295	1.0/295	1.0/295	1.0/.295	1.0/.295
Previously a cigarette smoke	.625/.299	.785/.146	.446/.366	.875/.296	.282/.591	.954/.128
No. of years smoking/smoke before quitting	.625/.299	.785/.146	.446/.366	.875/.296	.282/.591	.954/.128
Daily stress levels						
Drinking alcohol	-.099/.531	.011/.939	.072/.561	-.019/.901	.041/.805	-.091/.361
Consumption scale of alcohol	-.262/.162	.037/.845	.084/.549	-.327/.089	.061/.749	-.051/.795
	-.136/.369	.032/.833	.068/.397	-.140/.393	-.156/.348	-.032/.773
Diet						
Seldom consume red or high fat meats	.369*/.042	-.115/.511	-.073/.502	.492/.005	.196/.327	.454**/.002
Pursue a low fat diet	.143/.470	-.321/.056	-.06/.590	.262/.160	.083/.687	-175/.192
Eat at least 5 servings of fruits/vegetables per day	.128/.508	-.079/.652	-.038/.748	.026/.892	.000/1.00	-.060/.712
Almost always eat a full, healthy breakfast	.070/.712	-.10/.563	.022/.847	.156/.420	.174/.375	.004/.980
Diet includes many high-fiber foods	.051/.789	-.276/.097	-.114/.302	.257/.169	-.004/.985	.110/.458
Rarely eat sugar or high fat desserts	.120/.522	.079/.652	.038/.748	.177/.355	-.064/.760	.026/.860

Medication Adherence	.104/.588	.198/.279	.198/.153	-.018/.939	.389*/.041	.106/.532
Forget to take medications	-.385/.063	.375/.117	.288/.132	-.345/.138	.382/.083	.086/.656
Careless at time about taking medications	-.03/.881	.182/.331	.254/.08	-.041/.837	.505/.003	.094/.602
Stop taking medications when felt better sometimes	.004/.985	.020/.917	.129/.375	-.141/.466	.201/.309	.020/.908
Stop taking medications if felt worse some times						

*Significant at .05 level ** Highly significant at .01 level

Table 18 shows the correlation between health practices compliance and the respondents' profile. For diet, the consumption of meat has a positive and significant correlation towards age and educational attainment. This means that the higher the age and the educational attainment, the more the respondent seldom consume red or high fat meats. For medication adherence, there is a positive and significant correlation between forgetting taking the medications and stop taking the medications when felt well towards religion. This means that having religious affiliations does not strongly affect adherence to medication regimen.

Age and educational attainment has a positive, significant correlation to meat consumption. As mentioned above, the positive correlation between age and nutritional intake (which includes meat consumption) is related to the physiologic effects of aging (Smeltzer et al., 2008). There is a lower dietary intake among older individuals (Shahar et al., 2003). Moreover, educational attainment has been proven to have positive effects towards health. Those with more education are more likely to have ample knowledge on different health conditions and treatment regimens (Higgins et al., 2008)

Under medication adherence, there is a positive and significant correlation between forgetting taking the medications and stop taking the medication when felt well towards religion. According to the American Society of Hypertension (2009), higher levels of religious participation were related to lower levels of medication adherence. Therefore, these individuals were more likely to be classified as hypertensive. On the contrary, those with more religious activities and participation had significantly lower blood pressures (American Society of Hypertension, 2009).

Table 19. Test for the relationship of profile and health compliance using Somer's d

Health Practices Compliance	Teaching Load	Adm Load	#Undergrad Advisee	#Masteral Advisee	#PhD Advisee	Com. Membership
Exercise						
Frequency of exercise per week	-.264/.016	-.284/.013	-.095/.511	.119/.187	.035/.32	-.149/.081 88
Length of time for the exercise	-.127/.337	-.201/.051	-.101/.141	.121/.075	.008/.137	-.511/.158
Intensity of typical workout	-.162/.260	-.210/.054	-.126/.368	.214/.012	.071/.296	-511/.158
Lifestyle						
Cigarette smoker						
Previously a cigarette smoke	-.312/.317	-.281/.315	.406/.326	1.0/.295	-.031/.469	-.094/.364
No. of years smoking/smoke before quitting	-.312/.317	-.281/.315	.406/.326	1.0/.295	-.031/.469	-.094/.364
Daily stress levels	.370/.005	.246/.095	.008/.963	-.077/.353	-.022/.383	.069/.512
Drinking alcohol	.586/.000	.255/.111	-.262/.131	-.053/.749	.084/.298	.011/.907
Consumption scale of alcohol	.487/.001	.244/.138	-.211/.219	.075/.454	.049/.319	-.026/.722
Diet						
Seldom consume red or high fat meats	-.038/.819	.177/.283	.188/.327	.265/.056	.077/.299	.231/.051
Pursue a low fat diet	.000/1.000	.107/.528	-.063/.743	-.238/.013	-.048/.308	.127/.289
Eat at least 5 servings of fruits/ vegetables per day	.105/.552 .000/1.000	.241/.095 -.104/512	-.026/.896 -.026/.894	.008/.953 -.033/.789	.053/.305 -.056/.304	.041/.651 .085/.412
Almost always eat a full, healthy breakfast	-.037/.830	-.070/.657	-.088/.649	.062/.619	-.059/.303	.188/.055
Diet includes many high-fiber foods	-.158/.346	-.109/.483	-.045/.821	-.124/.303	-.053/.305	.098/.365
Rarely eat sugar or high fat desserts						
Medication Adherence						
Forget to take medications	.304/.051	.189/.208	-.056/.776	.163/.162	.056/.304	.052/.595
Careless at time about taking medications	.255/.218	.205/.345	-.250/.240	.130/.442	-.040/.318	.050/.705
Stop taking medications when felt better sometimes	.192/.255	.199/.225	-.09/.637	.241/.069	.071/.300	-.030/.762
Stop taking medications if felt worse some times	.222/.189	.022/.890	-.178/.364	-.048/.697	.067/.301	-.041/.680

Table 19 shows the relationship of profile towards health compliance. For exercise, there is negative and significant correlation between the respondents' teaching load towards the frequency of exercise per week. This means that higher teaching loads decreases the respondents' time to have regularly weekly exercises. There is also a negative and significant correlation between the frequency of exercise per week, the length of time for exercise and the intensity loads decreases a respondents' time for having regular exercise patterns, decrease exercise time (if able) and low intensity workouts. For lifestyle, there is a positive and significant correlation between daily stress levels and alcohol drinking towards teaching load. This implies that the higher the teaching load, the higher is the stress levels, the more the respondent will drink alcohol. For diet, there is a negative significant correlation between pursuing a low fat diet to the number of masteral advisees majority of the respondents have. The number of masteral advisees will not strongly affect the pursuance of a respondent to have a low fat diet. Furthermore, there is a positive and significant correlation between seldom consuming red or high fat meats and being members on some institute committees. Lastly, there is no significant correlation between medication adherences to the respondents' profile.

There is negative and significant correlation between the respondents' teaching load towards the frequency of exercise per week. The more teaching load they have, the less time they will allot for exercise (Kincaid & Pecorino, 2004). The less time they allot for exercise, the more their blood pressure will not be controlled.

The correlation between the frequency of exercise per week, the length of time for exercise and the intensity of the typical work out has a negative correlation to administrative load. According to Fields (2005), those who were handling administrative loads has problems with time management - they have less time to engage in exercise activities and if they do, there is lesser intensity because they are already tired from work. This is also true to the results of this study.

For lifestyle, there is a positive and significant correlation between daily stress levels and alcohol drinking towards teaching load. The more the teaching load, the higher is their stress levels (King, 2002). However, although they have higher stress levels, they enjoyed the challenges they encounter (Table 19). With regards to alcohol drinking, a lot of studies indicate that many people drink as a means of coping with modern life including job stress. According to Bresset (2006), while a drink after work or with dinner can be pleasurable and safe and is commonplace, people with excessive or chronic stress often drink to excess. However, for this

study, although most of the respondents were have high stress levels, they were able to control their alcohol drinking.

For diet, there is a negative, significant correlation between pursuing a low fat diet to the number of masteral advisees majority of the respondents have. The more advisees for the masteral program, the lesser they will pursue a low-fat diet. However, there has been no noted clean-cut evidence or researches to prove this.

Lastly, there is a positive and significant correlation between seldom consuming red or high fat meats and being members on some institute committees. The more they involve themselves in various institute committees, the lesser is their consumption of red or high fat meats. However, there is no noted evidence to support this one.

Table 20. Test of the relationship of the respondent's blood pressure and length of years suffering from hypertension and the health compliance using Somer's d

Health Practices Compliance	Blood Pressure Category	Probability	Length of Years Suffering From Hypertension	Probability
Exercise				
Frequency of exercise per week	-.142	.291	-.291	.016
Length of time for the exercise	-.072	.543	-.06	.651
Intensity of typical workout	-.193	.109	-.195	.082
Lifestyle				
Cigarette smoker	.375	.311	1.0	.295
Previously a cigarette smoker	.375	.311	1.0	.295
No of years smoking/smoke before quitting	.166	.294	.107	.133 /134
Daily stress levels	-.133	.418	-.308	.484
Drinking alcohol	.308	.064	-.114	
Consumption scale of alcohol				

Diet				
Seldom consume red or high fat meats	.308	.064	.264	.195
Pursue a low fat diet	.143	.433	.067	.728
Eat a least 5 servings of fruits/vegetables per day	.090	.602	-.053	.781
Almost always eat a full, healthy breakfast	.030	.867	-.041	.827
Diet includes many high-fiber Foods	-.044	.802	-.107	.565
Rarely eat sugar or high fat desserts	.226	.184	.150	.421
Medication Adherence				
Forget to take medications	.281	.089	.104	.574
Careless at times about taking medications	-.060	.232	-.160	.489
Stop taking medications when felt better sometimes	.226	.184	-.079	.696
Stop taking medications if felt worse sometime	.248	.390	-.041	.827

*Significant at .05 level **Highly significant at .01 level

Table 20 shows the relationship between the respondents' blood pressure and the years they are suffering from hypertension towards their health compliance. As reflected, there are no significant correlations in between variables being mentioned.

CONCLUSIONS

The following conclusions were derived: 1) there are positive and negative correlations between the independent and dependent variable; and 2) there is an intervening effect between the independent and dependent variables with the intervening variables. This study increases understanding of the deleterious effects of hypertension towards health and awareness of lifestyle and behavior that enhance well-being.

RECOMMENDATIONS

1. The researcher highly recommends an open communication with subordinates. They can also develop stress management programs as well as formulate a regular schedule for exercise for exercise to improve the health conditions of their faculty. A No Smoking policy would be strictly implemented as

well. They can also subscribe to health journals so that the faculty may be updated with the newest trends in hypertension management. Other health promotion activities such as bowling, badminton, dancing and other forms of recreational activities may be develop also. In terms of the teaching load, hypertensive faculty may be given a regular teaching as much as possible to decrease frequent exposure to stressful conditions. Moreover, a regular health screening protocol may be instituted for faculty members who are aspiring to be administrators or be elected for any position. Upon hiring, the administrators are encouraged to hire young, dynamic and healthy faculty to continue the productive output of the faculty force. As to having advisories, hypertensive faculty must be given priority to be advisers on the undergraduate level. Younger male faculties are encouraged to undergo blood pressure screening since they are highly susceptible to have hypertension. During meetings, they can also reinforce organizer to prepare nutritious snacks and meals during committee meetings.

2. Faculty members are encouraged to develop good interpersonal relationships with their peers, identify stressors and develop stress management techniques. Regular aerobic exercises in low intensity are strongly recommended. They are also encouraged to maintain their non-smoking habits. To be updated with the new trends in hypertension control, they can also read and share health articles to co-faculty. They can also have regular check-ups at the school clinic at least once or twice a month and not only as the need arises. They are also encouraged to develop and maintain good eating habits to effectively control blood pressure. They are also encouraged to develop and maintain a good relationship with the Divine Power if they believe on it. They can regularly engage in health promoting activities being created by the institute. In terms of teaching units, they are to limit their load by having a regular teaching if possible. They are also discouraged to involve in administrative works. But if they are already in, then they need to develop and maintain their stress management techniques. They can also integrate faith and learning to teaching as well as with their peers. They are also advised to regularly monitor their blood pressure at home. As to research advisories, they are encouraged to accept undergrad thesis. The male faculties are encouraged to develop health promoting behaviors and lifestyle changes to decrease their incidence of hypertension. Taking medications religiously is also recommended. As to diet, they are to maintain low consumption of red or fat meats.

3. It has been noted that the health profile of the faculty were not updated. The blood pressure taken on those who frequently visit the school clinic must be reflected on their health records. Aside from blood pressure screening, and

lifestyle and diet counseling, they should also offer other health services such as lipid profile, and psychological counseling. They can also have printed pamphlets readily available. Lastly, they are encouraged to formulate and create a health promotion plan to effectively protect the health status of the faculty.

4. The faculty from the College of Nursing are strongly recommended to conduct more research studies related to the health status of those who are working at MSU-IIT. They are the ones who can conduct health-related researchers aside from the Department of Biological Sciences (College of Science and Mathematics).However, collaboration between those departments may result to more favorable research outcomes. The results of their researches will greatly contribute to the productivity of the institution.

5. There are some findings of this study that do not agree will the findings of other researches especially on correlation between religion, and managerial and colleague support. It is strongly recommended that future studies be conducted to explore these issues. Moreover, more quantitative and qualitative researches could be conducted to clearly explain other findings of this study such as the effect of religion to one's health, the effects of interpersonal relationship to blood pressure, the effects of having a history of smoking to increasing blood pressure, why being married is more inclined to take lesser responsibility towards health and nutritional intake, and the relationship between having more teaching loads to managerial support and colleague. Furthermore, comparative studies can also be conducted to explore the relationships between the variables being used in the study.

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