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QUALITY OF LIFE AMONG INDIVIDUALS LIVING WITH HYPERTENSION IN URBAN AREAS: GWERU

BY

TAWANDA MUREPA

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SUPERVISOR: DR J. MUTAMBARA

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FACULTY OF SOCIAL SCIENCES

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SUPERVIOR: ……

CHAIRPERSON: ……

EXTERNAL SUPERVISOR: ……

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NAME OF AUTHOR: TAWANDA MUREPA

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Signed…….

Phone: **0718 581 973**

Email Address: **murepatawanda@gmail.com**

Date: **November 2018**

DEDICATION

I dedicate this study to my mother, Mrs. V. K. Mabhaudhi for her unconditional support, encouragement and prayers throughout the course of my study. I most of all dedicate this work to my entire family.

And

To my future wife and unborn children this work is the foundation of our happiness together until then.

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ABSTRACT

Hypertension now largely affects low and middle income countries with a higher prevalence of 46% in African adults of 25 years and above. In Zimbabwe the prevalence of hypertension ranges from 30% and 40% regardless of the cut off and this has been consistent and high in the urban areas than rural areas mostly due to urbanization. The increase in the prevalence rates reported is mostly thought to be attributable to certain unhealthy lifestyles and behaviors such as smoking, excessive alcohol intake. This study aims to determine the quality of life among individuals living with hypertension in urban areas: Gweru. The study was a cross-sectional quality of life (QOL) survey relying on quantitative data. One hundred hypertensive patients aged 18 years and above and those attending the Gweru Provincial Hospital were recruited using simple random sampling technique. Participants were interviewed using a structured questionnaire WHOQOL-BREF (26 items) tools. Descriptive statistics were used to examine mean scores of QOL. Pearson's correlation coefficient was applied to estimate the internal consistency, and the level of agreement between different domains of WHOQOL-BREF, respectively. Independent *T*-test and ANOVA test followed by multiple linear regression analyses were used to measure the association between QOL domains and independent variables. The QOL among hypertensive patients was found moderate in all domains, except for social domain that was fairly low (mean=8.12). Backward multiple linear regressions revealed that being men, married, attainment of higher education, having physical activities at moderate level and employed were positively associated with QOL. WHOQOL-BREF is a reliable instrument to measure QOL among hypertensive patients. The results revealed lower QOL in social relationships domain compared to other domains and differences in QOL across patients' demographical characteristics. Given the results, encouraging more in physical activities and strengthening treatment adherence should be considered to improve QOL of hypertensive individuals, especially for social aspect.

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LIST OF ABBREVIATIONS

BP	Blood pressure
CDC	Centre for Disease Control
CVD	Cardiovascular disease
ESC	European Society of Cardiology
ESH	European Society of Hypertension
IOM	International Office of Migration
ISH	International Society of Hypertension
MHCC	Ministry of Health and Child Care
NCDs	Non-Communicable Diseases
QOL	Quality Of Life
WHL	World Hypertension League
WHO	World Organization
WHOQOL	World Health Organization Quality of Life
WHOQOL-BREF	World Health Organization Quality of Life – 26 Items
WHOQOL – 100	World Health Organization Quality of Life – 100 Items
WHS	World Health Survey
ZNSA	Zimbabwe National Statistics Agency

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CHAPTER 1: INTRODUCTION

1.1 Introduction

The chapter focuses on the preliminary aspects of the research. It presents the research giving background of the study, statement of the problem, purpose of the study, significance of the study, research questions, delimitations of the study, limitations of the study and definition of terms.

1.2 Background of the study

Hypertension is the most hazard factor of cardiovascular and kidney ailment, and a main hazard factor for mortality. As per World Health Organization (WHO, 2015) more than 1 out of 5 grown-ups worldwide have high blood pressure a condition that causes about half of all death from stroke and coronary illness. According to Center for Disease Control (CDC) report (2015), 1.1 billion individuals on the planet have hypertension and almost 50% of this number do not know they have the condition. Expanded pulse caused an expected 9.4 million deaths and 162 million years of life lost worldwide in 2010 (ISH, 2014). This makes hypertension a typical medical issue worldwide and a solitary most critical reason for morbidity and mortality internationally and features the earnest need of activity to address the issue (Beaglehole et al, 2008). In almost all developed nations, across the board conclusion and treatment with low cost medication have prompted a critical drop in the extent of with raised blood pressure (BP). For instance, the commonness of raised BP in the WHO district of the America in 1980 were 31%, when contrasted with 18% of 2014 (WHO, 2015).

Conversely, low-pay nations have the most elevated pervasiveness of raised BP. In the WHO African district, over 30% of adults in many nations are assessed to have hypertension and this extent is expanding (WHO, 2014). According to Ha et al (2014) regardless of such high predominance awareness as well as BP control are appropriately poor in developing nations because of poor dietary propensities, high cost of medication, deficient access to information, healthcare conveniences and poverty. The World Hypertension League and International Society of Hypertension (WHL and ISH) in their 2014 report, demonstrated that presently, the overall weight of hypertension is most prominent in low and middleincome countries center as two thirds of the adult population who suffer from hypertension are in these regions and this is

expected to increase. The situation is not so different from other low and middle income countries, particularly in West Africa, non-communicable diseases have remained on the sharp rise in over three decades (Dalal et al, 2011). According to a report by Imperial College in London (2013), the prevalence of the disease has been consistently on the rise in the last two or three decades. In six years from now (2025), projections based on current epidemiological data suggests that 150 million adults in Sub-Saharan Africa will live with hypertension, this will be a very sharp increase in that of year 2000 which had about 80 million adults with hypertension (Opie, 2005).

In the first half of twentieth century, hypertension was nearly non-existent in African social orders. The predominance has been firmly connected with changes in individual and societal way of life, for example, an increase in excessive alcohol consumption, tobacco utilize, lessened physical movement, and selection of "Western" diets that are high in salt, refined sugar and undesirable fats and oils (WHO, 2013). Not only are the effects of hypertension and its related complications dire on the morbidity and mortality on the continent of Africa but economically, the disease puts a lot of strain on the already scarce resources of the region. According to Gaziano (2009), in 2001 the direct healthcare cost attributable to high blood pressure in sub-Saharan Africa was estimated at 2 billion US dollars.

The Zimbabwe National Statistics Agency, and Ministry of Health and Child Care (ZNSA and MHCC), (2014), states that by 2014 deaths from cardiovascular malady were positioned fourth among the main ten reasons for mortality in those more than 5 years old. Hypertension is the most prevalent cardiovascular disease in Zimbabwe (Ministry of Health and Child Care., 2015). Mutowo (2015), postulated that the prevalence of hypertension in the country is 30% regardless of the cut off. There is also a 4% prevalence of severe undiagnosed hypertension in females and 3.7% in males. Thus, hypertension's role in cardiovascular disease is well established, is a growing medical problem in Zimbabwe.

Quality of life (QOL) is an essential pointer to assess hypertensive treatment results. An ongoing deliberate survey of 20 studies showed that hypertensive patients had a lower QOL contrasted with normotensive individuals (Ha et al., 2014). The QOL of hypertensive patients tend to be more regrettable among those with co-morbidity. In Zimbabwe, a great deal of studies have analyzed QOL among older people, and individuals living with HIV and AIDS. Concerning our

insight, there is no examination estimating QOL among individuals living with hypertension, from this foundation there is the need then to inspecting QOL among individuals living with hypertension in Zimbabwe. Understanding QOL of people living with hypertension will help approach producers and healthcare services supervisors plan and implement culture particular help and care.

1.3 Statement of the problem

The Zimbabwean government recognizes the growing importance of non-communicable diseases (NCDs) including Hypertension. However, in developing countries like Zimbabwe diabetes and cardiovascular diseases in comparison with non-communicable diseases (NCDs) have not been addressed under specific control programs such as those that exist for several contagious and communicable diseases (Zimbabwe NCDs Risk Factors Surveillance Report, 2005). In the Zimbabwe National Statistics Agency, and Ministry of Health and Child Care (2014), states that by 2014 deaths from cardiovascular disease were ranked fourth among the top ten cause of mortality. ("Health Reporter say," 2017), the quantity of new patients analyzed of hypertension additionally kept on expanding from 671 931 detailed cases in 2012 to 718 648 individuals in 2016. This shows that the problem of hypertension in Zimbabwe is on the drastic increase.

QOL is an important indicator, to determine an evaluation outcome of a hypertensive treatment. Demographic status, psychological factors, socio-economic status, social and physical environment health of an individual is also a good interpreter of the quality of life of the hypertensive (Ha, 2014). An ongoing systematic survey of 20 studies demonstrated that hypertensive patients had a lower QOL contrasted to normotensive individuals Trevisol el at, (2011). As per Soni el at, (2010) the QOL of hypertensive patients has a tendency to be more terrible among those with co-morbidity. In Zimbabwe studies have inspected QOL among the aged, and individuals living with HIV and AIDS (Patel el at., 2009).

In Zimbabwe and the study area under review, no study was conducted to assess QOL amongst individuals living with hypertension in urban area. As to rapid growth of prevailing hypertension in Zimbabwe, it is of paramount important to have an in-depth comprehension and discernment about the differences in the QOL amongst individuals living with hypertension. In this sense, the

study is designed to investigate QOL among individuals living with hypertension as well as how it relates to socio-demographic factors.

1.4 Purpose of the study

The purpose of the study, aimed to examine QOL among individuals living with hypertension in Zimbabwe mostly urban areas in four dimensions (physical health, psychological, social relationship and environment) using the WHO Quality of life – BREF instrument (WHOQOL-BREF) and its connotation with socio-demographic characteristics and factors related to treatment.

1.5 Research Question

1. Which demographic factors influence QOL among individuals living with hypertension?

2. How does QOL impact on psychological function in individuals living with hypertension?

3. How does QOL impact on social function in individuals living with hypertension?

1.6 Delimitations

The study will be conducted in Gweru which is located in Midlands Province, Zimbabwe. The study will target QOL among individuals living with hypertension from Gweru urban area. In the study, patients were all involved irrespective of gender, occupational, marital status and the above aged (18) years plus. The study excluded patients with a psychiatric identification of mental disorder, patients with complications associated with alcohol consumption or other drugs as well as pregnant or breastfeeding women.

1.7 Limitations of the study

The limitation of the study is that it will focus on the QOL among people living with hypertension in urban areas Midlands' province, Gweru. The study will focus mainly in Gweru collecting data from various hospital surrounding the town for example Gweru Provincial Hospital, Mkoba Clinic among other health institutions.

1.8 Definition of key terms

1.8.1 Hypertension. It is defined as a systolic blood pressure < 140mmHg and /or a diastolic pressure > 90 mmHg, is one of the most common chronic disease (Bolivar, 2013). It has being

called the “silent killer”, because it often has no warning signs or symptoms, and many people do not even know they have it.

In this study hypertension will mean individuals receiving treatment for blood pressure at Gweru Provincial Hospital and Private Clinics around Gweru town.

1.8.2 Quality of life. It is the common term that convey anoverall sense of wellbeing, as well as aspects of happiness and contentment with life, (Centers for Disease Control and Prevention., 2000).

In the current study QOL mean the measurement of hypertensive people’s satisfaction with daily life using the WHOQOL-BREF. The areas that will be measured are demographics, socio-economic, disease status, physical health, psychological factors, social relationships and environment health.

1.8.3 Urban Area. According to the International Office of Migration (IOM) and Zimbabwe National Statistics Agency (ZIMSTAT) (2012) asserts that the approved meaning of urban areas in Zimbabwe is constructed on a combination of two conditions, namely: A settlement labelled as municipal and a compact settlement of 2,500 individuals or more and the majority of whom are occupied in non-farm occupation.

According to the current study urban area refers to Gweru town.

1.9 Chapter Summary

The chapter presented the introduction of the research bring to light the background of the study, statement of the problem, purpose of the study, research questions, delimitations of the study as well as the limitations of the study and definition of key terms that were used in the research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The literature review aimed to investigate what is known from previous studies relating to the relationship between QOL among individual living with hypertension. In this chapter the researcher defined what is hypertension, what causes hypertension, classification of hypertension, behavioral risk factors associated with hypertension, demographical and socio-economic factors.

2.2 Hypertension

As per WHO (2015), hypertension is high or raised circulatory strain, this is a condition in which the veins have industriously BP, putting them under expanded strain. BP is the power of blood pushing against the dividers of the veins (arteries) as it is pumped by the heart and estimated in millimeters of mercury (mmHg) (National Heart, Lung and Blood Institute, 2015). As per the rules of the European Society of Hypertension (ESH) and the European Society of Cardiology (ESC), (2013) optimal BP value for young, middle-aged and elderly are defined as BP less than 120 mmHg when the cardiac muscle contracts (systolic) and less than 80 mmHg when the heart relaxes (diastolic). Typical estimations of the BP are systolic 120 – 129 mmHg or potentially diastolic 80-84 mmHg ordinary values respectively 130 – 139 mmHg and additionally 85 – 89 mmHg (Table 2. 1).

Category	Systolic		Diastolic
Optimal	<120	And	<80
Normal	120 – 129	and/or	80 – 84
High normal	130 – 139	and/or	85 – 89
Grade 1 hypertension	140 – 159	and/or	90 – 99
Grade 2 hypertension	160 – 179	and/or	100 – 109
Grade 3 hypertension	≥ 180	and/or	≥ 110
Isolated systolic hypertension	≥ 140	And	<90

Table 2. 1Definitions and classifications of hypertension.

2.2.1 Classification of hypertension

Hypertension can be classified into two: namely primary and secondary hypertension. 90 – 95% of hypertension cases are caused by primary reason such as lifestyle factors (smoking, overweight, alcohol abuse and excessive use of salt) and genetics. 5 – 10% of hypertension cases have secondary causes such as disorders in kidneys and in other organs (WHO, 2013).

2.2.2 Cause of hypertension

The cause of the disease still remains mysterious as there is no single attributable cause(s), however there are many genetic, behavioral risk and social/environmental factors that can possibly lead to the development of the disease. These include, behavioral (highly influenced by people's living and working conditions); unhealthy diet (too much fat and salt intake, and eating less of fruits and vegetables); excessive alcohol intake; poor stress management, tobacco use; physical inactivity and lack of exercise. Studies have also revealed that having a family history

of hypertension makes someone predisposed to developing the condition if positive lifestyle modifications are not done. Therefore, the disease can be developed genetically (Padmanabhan, &Dominiczak, 2012). Social and environmental factors such as urbanization, globalization, income, education and housing are risks factors to developing hypertension.

2.2.3 Complications of hypertension

Hypertension is related with an enhanced risk of myocardial infarction, heart failure, cognitive impairment, stroke, and renal failure (Sack el at., 2010). The complications of hypertension are linked to either persistent raises of blood pressure, with consequent variations the vasculature and heart, as well as the accompanying atherosclerosis that is accelerated by long-standing hypertension (Sawicka el at 2011). WHO, (2015) postulated that by placing added stress on the blood vessels hypertension can result in a buildup of cholesterol and fatty substances on the inside walls of the blood vessels causing atherosclerosis.

2.3 Hypertension and Quality of life

On the factors influencing the QOL of the individual living with hypertension, an examination by Youssef et al (2005) put forward that a portion of the central point that effect on the QOL of hypertensive patients are target organ complexities and unfriendly impacts of antihypertensive drugs. Marital status and physical activities were essential independent components influencing QOL. The aged were related with lower QOL in both physical and mental wellbeing. Ladies with hypertension had lower fulfillment rating in psychological wellbeing than men. Using the WHOQOL-BREF, Ha el at (2014) found the average scores of all the domains of QOL with the most elevated normal score of satisfaction found in the Social relationship, while the least normal score was found in the Psychological category. Moreover, an ongoing deliberate survey of 20 studies showed that individuals living with hypertension had a lower QOL contrasted with normotensive people (Trevisol, 2001).

As indicated by Klocek and Kawecka-Jaszcz (2003), found that QOL in individuals with critical hypertension in general was essentially lower than that in age coordinated normotensives. The examination likewise demonstrated that as far as sex, QOL in men was higher than that in women, the QOL was decreasing both in individuals living with hypertension and normotensives, however in women living with hypertension there was a pattern towards deteriorating QOL over 65 years old and this was in sharp disparity to age coordinated men in

whom the QOL improved. In relations to health seeking behaviors, the study found that the QOL in treated healthy hypertensive was far higher than that in age coordinated untreated subjects, yet until 40 years old was higher than in treated age coordinated hypertensive. The occupation status, educational level and familial history of hypertension was related to QOL lived.

Multiple regression analysis done by the Klocek study discovered that the QOL lived by the individual with hypertension are independently affected by these socio-demographic factors: gender, age, education and familial hypertension. These factors accounted for 32.7% of the observed variance of QOL. However, employment, education, gender and age accounting for 65.8% of variance of QOL were independent factors in normotensive subjects (Klocek et al., 2003).

A lot of studies have been done in the area of the QOL lived by the hypertensive patients (Ha et al 2014; Klocek 2003). However very few of these studies have been done in low center salary nations, for example, Zimbabwe as well as the continent of Africa in general.

2.4 Demographics and Hypertension

On this section the researcher will explain the relationship between demographics (such as age, marital status and education) and hypertension based on previous studies.

2.4.1 Age

The aftereffects of the examination demonstrate that expanded age is connected with a critical increment in the predominance of hypertension and especially of systolic hypertension after age 60 years (Toth et al., 2013). The increase in weight between ages 30-50 years is connected with huge increments in diastolic BP and this pattern is likewise found in African-Americans who are heavier than whites. The increase in age is related with an expansion pervasiveness of auxiliary types of hypertension including renal inadequacy, essential hypothyroidism and atherosclerotic renovascular hypertension (Toth et al., 2013).

2.4.2 Marital Status

Those who are not ever married had a greater hazard of hypertension when matched to married men, even when attuned for dissimilar demographic, life-style variables, social economic as well as not ever married men had lesser body mass index than married subjects (Lipowicz&Lopuszanska., 2005). Difference between a married woman and a man due to

sustained stress and unhealthy dietary intake (mainly potassium and sodium intake), low social support, and cost-effective features of living alone were proposed as elements, which might describe at least partially the maritaldiversity in blood pressure and the possibility of hypertension in men.

2.4.3 Education

The level of education reached by an individual significantly affects the level of blood pressure (Wang et al., 2006), and this was in disparity to earlier studies by Xu et al., (1997) that reported a relationship between individuals' level of education and his/her blood pressure. In treatment and precautionary healthcare, Tedesco et al., (2001) in deliberating education as a risk factor found that, people without or with low levels of education have known very little about the risk factors to develop hypertension.

2.5 Behavioral Risk Factors for Hypertension

Eating disorders especially in women who may turned to be overweight and obesity were found to prevail in hypertension. As proposed by Mutowo et al (2015), hypertension was discovered higher in urban populace. As per (WHO, 2013) way of life changes have been related in the improvement of hypertension in African urban populaces, especially appropriation of Western-type diet, expanded psychosocial stretch and physical latency. The Zimbabwe National Strategy (2009), reports that the pervasiveness of hypertension in Zimbabwe is expanding for the most part due to tobacco smoking, high salt eating regimen, physical inactivity, tobacco smoking, high salt eating regimen and over the top liquor utilization.

2.5.1 Alcohol Consumption

According to Ezzati et al., (2002) consumption of alcohol and alcoholic beverages is quite common in Africa. There is an uninterrupted outcome among extraordinary levels and particular patterns of alcohol intake and rising risk of hypertension. Low to moderate levels of alcohol intake also leads to an increasing trend in developing hypertension and this is no different between genders (Briasoulis., 2012). In order to minimize liquor consumption, interventions have to be presented in a multi-sectorial and adapted to the resident circumstances. Just as the

case of decreasing smoking of tobacco, such interventions could comprise prohibition of liquor advertising especially to young people and increasing taxes on alcohol (Beaglehole., 2011).

2.5.2 Tobacco Use

A study by (Abankwah., 2016) on socio-economic differences in the QOL of adult hypertensives, proposed smoking tobacco as a well-known hazard that increases the increase of cardiovascular diseases like thrombosis, hypertension, stroke and heart attack. (Sansom, Rogers, & Wood., 2004), stop smoking is recognized to lessen the general hazard of cardiovascular diseases. According to Beaglehole et al (2011), to decrease the level of smoking at the population, it is important to implement interventions that are multi-sectorial in nature such as banning of tobacco adverts, increasing taxes on tobacco products and ban smoking in public spaces (Beaglehole et al., 2011).

The incidence of tobacco use varied broadly at the 2003 World Health Survey (WHS). According to the survey, men smokes further than females in Africa, with the main differences perceived in Africa. Southern Africa had a highest widespread in countryside than in municipal areas in many nations. However, smoking levels were to be higher among the urban than rural populations in nations like Mauritania, Kenya, South Africa as well as Senegal.

2.5.3 Inadequate Physical Activity

According to (Fernandez, 2010; Rossi, 2012), sufficient physical action have been supported to partake far reaching health-promoting properties and has an independent and an uninterrupted role in decreasing hypertension. The low stages of chronic ailments bring into being in Africa was traditionally explained in to be as a result of the high level of physical activity in the region. However, this is currently not true, increasing rates of urbanization going on across the continent has resulted in deceasing amounts of physical activity (Gersh., 2010).

2.5.4 High Salt Intake

According to Cappuccio et al, (2006) in Africa a high sodium intake is very common, or the most part from salt used to protect nourishment or to make it more delectable. Salt can be added to effectively prepared sustenance by customer. Aside reducing blood pressure and related

cardiovascular disease risk, decreased salt consumption has other advantageous cardiovascular impacts that are autonomous of and added substance to its impact on BP Elliott, (2009). According to Beaglehole (2011) cutting down on salt intake has been stated to have a direct effect on reducing aortic left ventricular hypertrophy, stroke and chronic kidney disease, stiffness and proteinuria.

2.5.5 Insufficient Fruit and Vegetable Consumption

According to Dauchet et al, (2009) consumption of fruits and vegetables is some important component of healthy food and this varies considerably among nations, economic, reflecting traditional as well as agronomic production milieus. The benefits of vegetables and fruits are in the reduction on cardiovascular mainly hypertension and other associated risk factorsNotwithstanding high salt admission, many individuals in Africa habitually do not eat enough vegetables and fruits, bring about low potassium consumption and this in turn are correlated with raised BP in some patients. A potassium consumption of 90 mmol/day is mostly commended (Kwon., 2015).

2.5.6 Obesity

The (WHO) characterizes corpulence as a condition in which overabundance muscle to fat ratio has amassed to such a degree, to the point that wellbeing might be antagonistically influenced. Obesity significantly expands the hazard for hypertension and has likewise been appeared to be related with coronary vein infection and a few tumors, and to decrease future (Chan and Woo, 2010). As weight is quickly ascending in various nations on the planet, it will be critical to share best practices, for example, great eating routine and taking part in physical exercises to diminish this pattern Gersh el at, (2010).

2.6.7 Stress

Stress has turned into a dominating piece of individuals' lives and its effect on BP is of extraordinary general wellbeing hugeness. In spite of the fact that it does not specifically cause hypertension, it can prompt rehashed BP rises which at long last prompt hypertension Briones and Touyz (2010). As per Abankwah, (2016) stress can cause hypertension through rehashed pulse heights and furthermore by incitement of the sensory system to create a lot of vasoconstriction hormones that will expand BP. There is emergent evidence that the various risk

factor for hypertension do no work in isolation but tend to cooperate in clusters Harrison and Gongora (2009). So, exposure to stress will not only increase blood pressure levels but will also lead to increased fat and alcohol intake. According to Myers, (2007) a final common pathway for many of these risk factors is the sympathetic nervous system which is involved in the development of essential hypertension in its early stages and in the hypertensive effects of obesity, salt and possibly stress as well.

2.6 Socioeconomic Position and Hypertension

Williams (1990) said that the social structure and personality perception provide a theoretical and analytical framework for understanding the persisting relationship amongst socioeconomic status and health outcomes. According to Seeman (2008), developed countries exist fairly good amount of evidence suggestive of an inverse relationship between individual socioeconomic status with mortality, cardiovascular disease morbidity and risk factors including hypertension. However, studies done in sub-Saharan Africa have found unpredictable findings with some reporting inverse association (Gupta, 1994; Bovet, 2002) and others reporting positive associations (Signh, 1997; Periera, 1998). Sherman et al., (2006) found out that low youth financial position was related with a 60% more prominent probabilities of hypertension, and low adulthood financial position was related with a two-crease more noteworthy probabilities of hypertension. Contrast and men of high financial position in both youth and adulthood, the probabilities of hypertension were seven times more prominent for low/low financial position men, four times more noteworthy for low/high financial position men, and six times more noteworthy for high/low financial position men. Different indicators of socioeconomic status have been used in health research. According to Galobardes (2006), these include employment grade, housing conditions and amenities, occupation, income, employment status, employment grade, housing tenure, education, societal class and wealth. In a study done in Sub-Saharan Africa indicated that the wealth of an individual is positively related to the incidence and prevalence of hypertension (Ploubidis et al., 2013).

2.7 Conceptual Framework

The framework will be based on the QOL concept developed by the WHO (1999). From literature the factors that influence QOL among individuals living with hypertension can be grouped into demographic factors, behavioral factors, and disease status and socio-economic factors.

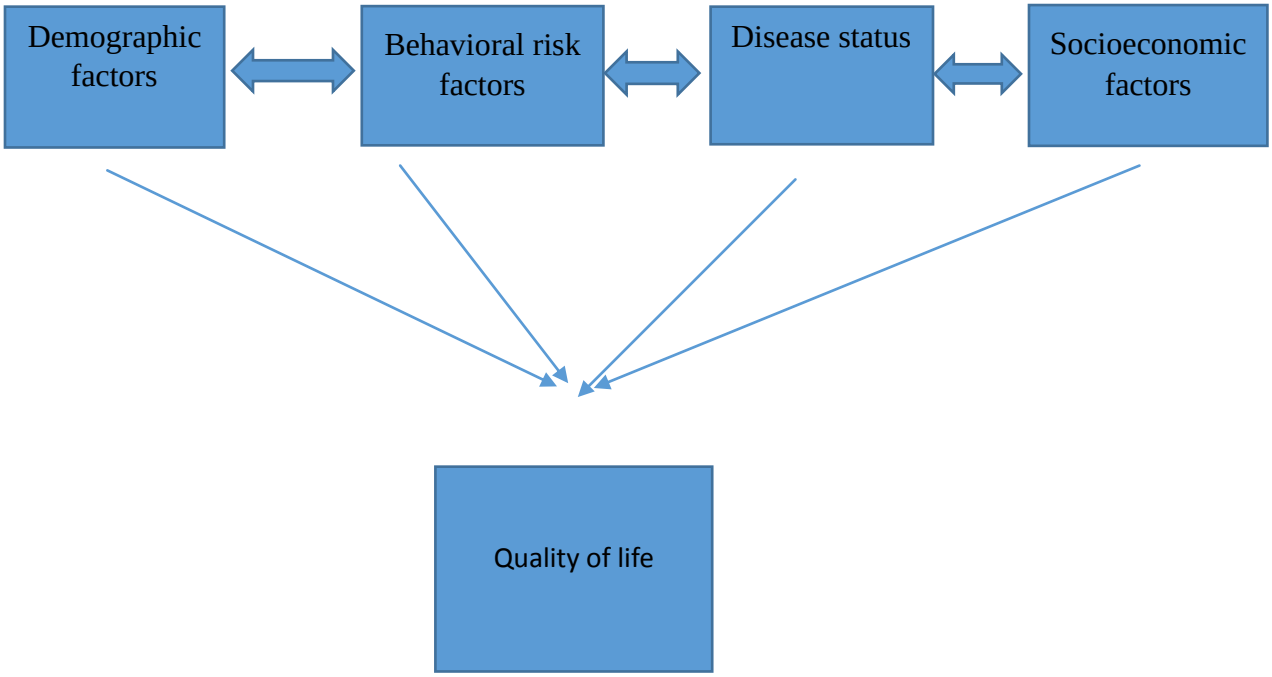

Figure 2. 1: Conceptual framework of factors related with quality of life in hypertensive patients.

Behavioral factors such as salt intake, physical inactivity, excessive alcohol intake, obesity, not eating enough vegetables and natural products, family, work as well as emotional related stress negatively affects the disease status of the individual living with hypertension. As the status worsens, the quality of life lived by the individual also worsens. Factors such as age, sex, religion, marital status interact independently to affect the individual living with hypertension's physical function which also affects the QOL of an individual. Decision to seek or not to seek timely healthcare services and adherence to treatment regimens directly affects the hypertensive patients' disease status which leads to a lower QOL.

The socio-economic circumstance of the individual can affect the QOL of individual living with hypertension both negatively or positively. A hypertensive patients' educational status, the level of income and the type of work he/she does can also impact on the disease status in terms of physical functioning. Most at times, there are side effects associated with the drugs given for the treatment of hypertension. These side effects negatively affects the physical functioning capabilities of the hypertensive hence influencing the QOL. All these factors either positively or negatively impacts on the QOL lived by individuals with hypertension.

2.8 Knowledge gap

Understanding the QOL among individuals living with hypertension is important in addressing the challenges hypertension poses to the general health of the population. Most studies on QOL has been done in the developed countries with very little in the developing countries. This study therefore becomes relevant as it will not only bridge the knowledge gap in the area but also provide useful information on the QOL among individuals living with hypertension in Zimbabwe. It may also assist health care professionals in managing hypertension through education and treatment and help policy formulators in developing relevant and context specific policies capable of improving QOL. Unlike the studies with were carried in the developed countries which were only focusing on adult (55-80 years) hypertensive, this study will also include young adults in the area under study.

2.9 Chapter Summary

From the literature review, it can be observed that positive life style modifications can impact positively on the disease status of the hypertensive. This can affect the health related QOL among individuals living with hypertension. Most studies on QOL has been done in developed

countries with very little in the developing countries. It is apparent that the dire consequences that hypertension and its accompanying complications place on people living with the disease cannot be underestimated.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter outlines the methods that was used to collect data for the study research. It covers the research approach, research design, population target, sample and sampling techniques, data analysis, ethical considerations, validity and reliability of the research instruments, pilot study, pretest and research instruments.

3.2 Research Approach

In this study, the researcher used the quantitative approach. Cengage (2010), asserts that quantitative methods emphasize objective measurements and the statistical, mathematical, or numerical analysis of data collected through polls, questionnaires, and surveys, or by manipulating pre-existing statistical data using computational techniques. Quantitative research focuses on gathering numerical data and generalizing it across groups of people or to explain a particular phenomenon Daniel (2010). This approach can be applicably applied to the study of QOLamong people living with hypertension since the research does not begin with a hypothesis but is likely to develop one after data collection.

3.3 Research Design

There are two categories of quantitative research which are descriptive and experimental research (Mclead, 2017). The researcher used a cross-sectional study which is a descriptive quantitative approach. It attempts to quantify relationships between variables (Hopkins, 2000). The purpose of the study is to explore the phenomena of QOL in relation to individuals living

with hypertension in urban areas. The study seeks to increase knowledge on issues affecting the QOL and enabling factors that can be used to improve it.

4.3 Population target

In terms of target population, this is the group of individuals with the relevant characteristics for the study. According to Lucas (1986), a target population is a universe from which subjects of research are to be drawn. In this research the targeted population was individuals living with hypertension in urban area Gweru. Data was collected in female ward, male ward and outpatients departments at Gweru Provincial Hospital.

3.5 Sample and Sampling technique

The researcher used simple random sampling for the selection of the sample and key informants for the study using the lottery method. As per the explorable.com, (2009) there are numerous techniques to continue with straightforward irregular examining, the most primitive and mechanical would be the lottery strategy. Each number was set in a bowl or a cap and blended altogether. The visually impaired collapsed participants at that point picks numbered labels from the cap. Every one of the people bearing the numbers picked by the analyst were the subjects for the examination. (Banerjee and Chaudhury, 2010), characterized irregular inspecting as arbitrary if each person in the populace has an equivalent probability of being incorporated. The example size of the examination was computed utilizing a recipe of assessing the mean.

3.6 Data Analysis

Information was dissected utilizing Microsoft excel version 2016 and SPSS version 20.0 software package and p value <0.05 was considered significant. A descriptive data analysis was initially performed in the statistical analysis (mean, maximum, minimum, median) of numeric variables, as well as frequency tables and charts. Pearson two-tailed and anova were used to measure the level of association between variables.All items on the generic QOL questionnaire, on a five-point scale, wascategorized into five domains: overall general health global (two items), physical (seven items), psychological (six items), social relationship (three items) and environment (eight items). The score scale was the Likert scale with five possible answers 1 (very dissatisfied/very poor) to 5 (very satisfied/very good). The total raw score for these five dimensions was transformed into 0 (lowest) to 100 (highest) with low score indicating poor QOL.

3.7 Research instruments

Research instruments are measurement tools (for example/ questionnaires or scales) designed to obtain data on a topic of interest from research subjects. In this study structured questionnaire was used as the research instrument.

3.7.1 Structured Questionnaire

The research instrument is the WHOQOL-BREF questionnaire developed by World Health Organization, a short form of WHOQOL-100, it is a cross cultural instrument. According to the WHOQOL Group (1998), the instrument can capture broadly and totally all aspect of QOL including physical health, psychological, social relationship and environment. Gholami (2013), state that, as WHOQOL-BREF does not impose a great burden on the respondent it is seen as the most useful instrument to assess QOL. Hence the researcher used WHOQOL-BREF in the study to measure QOL among hypertensive patients.

According to Skevington et al (2004), the WHOQOL-BREF comprises four domains containing 24 aspects, plus two national items on overall quality of life and general health. There are a total of seven items in the physical domain (pain and discomfort, energy and fatigue, sleep and rest, mobility, daily living activities, dependence on medication and working capacity), six in the psychological domain (positive feeling, thinking and concentration, self-esteem, bodily image and appearance, negative feelings and spiritual/religious/personal beliefs), three in the social domain (personal relationships, social support and sexual activity), and eight in the environmental domain (physical safety and security, home environment, financial resources, availability of health and social care, opportunities for acquiring new information and skills, participation in recreation and leisure, physical environment and transport). Each item of the WHOQOL-BREF was scored from 1 to 5 on a response scale.

3.7.2 Pre-test

The questionnaire was pretested among 10 local people to adjust wording before data collection and this give the opportunity to know how many minutes needed to response to the questionnaire. Many participants were able to administer the questionnaire within the time range of 15 to 20 minutes.

3.7.3 Pilot Study

A pilot study was led to test the questionnaire that was provided for the study. The researcher, medical practitioners, hypertensive and normotensive individuals participated in the pilot study. According to Kim, (2010) the purpose of the pilot study is to provide a framework that can be used to direct the main study. The pilot study alerts on possible problems with the study, areas for adjustment, and research feasibility (Teijlingen& Hundley, 2001; Kim, 2010).

3.7.4 Validity and reliability

Validity it is when a test is measuring what it is supposed to measure (Flagg 2010). (Baer 2014) postulates that reliability involves obtaining the same result after multiple testing that is giving consistent results over time, across raters. The WHOQOL-BREF is a 26-item version of the WHOQOL-100 assessment. (WHOQOL Group, 1994) its psychometric properties were analyzed using a cross-sectional data obtained from a survey of adults carried out in 23 countries: Zimbabwe was also among the 23 countries. According to Skevington (2004), postulated that analyses of internal consistency, item-total correlations, discriminant validity and construct validity through confirmatory factor analysis, indicate that the WHOQOL-BREF has well to excellent psychometric properties of reliability and performs well in preliminary tests of validity. These results indicate that overall, the WHOQOL-BREF is a sound, cross-culturally valid assessment of QOL, as reflected by its four domains: physical, psychological, social and environment (Skevington et al, 2004). Evidence of test-retest reliability for the WHOQOL-BREF is already known (WHOQOL Group, 1998). It was predicted that sick participants would report poorer QOL than well participants but no predictions were made for other socio-demographic and center differences (Skevington et al, 2004).

The WHOQOL-BREF has been used in sub-Saharan Africa. A search for all names of sub-Saharan African nations and the term "WHOQQOL-BREF" on MedLine, CINAHL and PsycInfo, located some papers which were relevant for use of WHOQOL-BREF in sub-Saharan Africa. These papers shown the use of WHOQOL-BREF versions in Nigeria (for example Adewuya and Makanjuola, 2009), Tanzania (for example Howitt et al, 2011), Uganda (for example Muhwezi et al, 2010), Rwanda (for example Mutimura et al, 2008), Zimbabwe (for example Mhaka-Mutepfa, 2018; Patel, 2015). In summary, there are few translations of WHOQOL-BREF into the languages of Africa (Akinpelu et al, 2006)

3.8 Ethical Considerations

The study began after the approval from institutional review board and it was guided by the following ethical principles- informed consent and confidentiality.

3.8.1 Informed consent

The investigation was disclosed to all members and composed educated assent was gotten before directing the meetings. Members were educated that they had the privilege not to share or to pull back from the examination whenever and that any failure to take an interest would not weakness them from their consideration and treatment. The duration of the study was informed to the participants. When participants generously volunteer and informed about the study, they are likely to commit to the study. Commitment enabled hypertension patients to disclose relevant and authentic information which was essential for understanding their role on their QOL.

3.8.2 Confidentiality

In all research, participants' privacy and confidentiality is of paramount importance. The researcher guaranteed the participants that information in the study was to be kept confidential. Data was kept securely and was made accessible only to the principal investigator and dissertation committee members. No references were made in oral report or written linking the participants to this study. It enabled individuals with hypertension to be comfortable with presenting issues daunting their QOL without the fear of being traced given that they disclose sensitive information about their families, husband/wife etc.

3.9 Chapter Summary

In this chapter, the researcher present the research approach and research designs that was used in the study and also outlines the cons and pros of each approach. The population target, sample and sampling technique and data analysis was explained, that is through how data were going to be evaluated in the research. The research instrument, its pre-test, pilot study and its valid and reliable was discussed. The issue to do with privacy and respect of human rights was also explained through ethical considerations.

CHAPTER 4: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

The chapter outlines and presents the results of the survey data gathered from 100 hypertensive patients attending female ward, male ward and mainly the outpatients departments at Gweru Provincial Hospital. It presents the findings on demographic characteristics of hypertensive patients, socio-economic status, quality of life lived by hypertensive patients, the differences in quality of life by the psychological functioning, social functioning, environmental functioning and physical functioning.

4.1 Demographics Characteristics

Presented in Table 4.1, are the demographics characteristics. The mean±SD age of the individuals living with hypertension under study was 4.96±2.792. The highest frequency of the study population (20) was found in (18 - 24) age group. The majority of the study respondents representing were female representing 52% with the remaining 48% representing men. Out of the respondents 72% were Christians which is the most dominant religion in Zimbabwe, 4 % were Islam and 24% had no religion dominion.

The majority of the hypertensive patients were marriage/living together (32%), 28% of them were never married and never lived together and 16% were the least respondents representing the

widowed. The population under study is dominated by Shona, which is the majority ethnic in the region representing 76%. The other ethnic group was the Ndebele (24%) which were the minority of the study. The majority of the participants reported secondary education as their level of literacy and higher tertiary and many of them were jobless.

Variables	**Male(n=48) N%**	**Female (n=52) N%**	**Total (n=180) N (%)**
Age			
18-24	8(8.00)	12(12.00)	20(20.00)
25-30	4(4.00)	0(0.00)	4(4.00)
31-36	4(4.00)	8(8.00)	12(12.00)
37-42	4(4.00)	4(4.00)	8(8.00)
43-49	8(8.00)	0(0.00)	8(8.00)
50-56	4(4.00)	8(8.00)	12(12.00)
57-66	8(8.00)	4(4.00)	12(12.00)
67-70	4(4.00)	8(8.00)	12(12.00)
71-85	4(4.00)	8(8.00)	12(12.00)
Education			
No education	5(5.00)	11(11.00)	16(16.00)
Primary	2(2.00)	2(2.00)	4(4.00)
Secondary	18(18.00)	22(22.00)	40(40.00)
Higher tertiary	29(29.00)	11(11.00)	40(40.00)

Religion			
Christianity	24(24.00)	48(48.00)	72(72.00)
No religion	20(20.00)	4(4.00)	24(24.00)
Islam	4	0(0.00	4(4.00)
Marital status			
Married	16(16.00)	16(16.00)	32(32.00)
Divorced	12(12.00)	8(8.00)	20(20.00)
Widowed	0(0.00)	16(16.00)	16(16.00)
Never married	16(16.00)	12(12.00)	28(28.00)
Ethnics			
Shona	36(36.00)	40(40.00)	76(76.00)
Ndebele	12(12.00)	12(12.00)	24(24.00)
Employment			
Unemployment	24(24.00)	32(32.00)	56(56.00)
Formal employment	16(16.00)	16(16.00)	32(32.00)
Informal employment	8(8.00)	4(4.00)	12(12.00)

Table 4. 1Demographics Characteristics of individuals living with hypertension.

4.2 Quality of life assessment of hypertensive patients

Table 4.2, presents WHOQOL-BREF normal score of self-related QOL and self-related wellbeing status (General QOL), physical health, psychological health, social connections and environment. Apart from reporting their satisfaction with their QOL to be neither satisfied nor dissatisfied was (2.96, (1.044)), participants also perceived their rate with their quality of life to be neither poor nor good was (2.84, (1.012)). The most noteworthy normal score of fulfillment was found in the environment area (22.20, (7.112)), while the least normal score was found in

the social relationships space (8.12, (2.702)). The psychological and physical domains also recorded mean scores of (18.08, (3.738); 19.32 (3.250)) respectively.

QOL Domains	Min	Max	Mean (SD)
Self-related QOL-Q1	1	4	2.84(1.012)
Self-related health status-Q2	1	4	2.96(1.044)
Physical health	15	24	19.32(3.250)
Psychological health	11	24	18.08(3.738)
Social relationships	4	13	8.12(2.702)
Environment	10	33	22.20(7.112)

Table 4. 2Quality of life Q1, Q2 and domain scores (N=100)

4.3 Demographic factors influence QOL among people living with hypertension

Presented in table 3, is the mean score of each domain across demographic characteristics. Gender, age, marital status, level of education, and employment have significant association with the quality of life bases on domains. In gender female were significantly less than the scores of male in both domain. Participants aged <66 years were significantly better than other groups on physical domain. The age of 18-24 years scored less mean (15.60±3.530) on the psychological domain than any other age group. The highest mean score were recorded for participants in environment and physical domain across all age. However, participants above 66 years had very low mean scores in social relationship domain compared to others below 60 years.

On marital status,the environment domain had higher mean scores compared to the other domains. The married participants scored a significantly higher mean in all the domains than those who were divorced, never married and widowed. The social relationship domain had the lowest mean scores with widowed, never married and divorced (4.75±0.856; 7.00±2.309 and 8.20±2.191).There was a significant difference between marital status and the social relationship domain of quality of life (p=0.01).

Similarly across employment, participants had the higher mean score in environment domain and least mean scores in the social domain. The psychological and physical domain also had above average mean sores for the study patients. Participants that were formal employment had the highest mean score in all domain. On religion social relationship domain also scored a lower

mean while the environment domain scored higher mean. All the quality of life domains score across ethnicity had above average mean scores.

The researcher also found similar results on education, participants scored higher mean in environment domain and least mean scores in social domain. As presented in table 3 below, the mean of aggregate score of ladies, separated, never wedded, widowed, no or low education (primary education) and jobless were fundamentally not as much as the scores of different groups.

Variable	**WHO-QOL-Brief Domain**				
	General	**Physical**	**Psychological**	**Social**	**Environmental**
Age					
18-24	5.00±2.052	16.80±2.285	15.60±3.530	7.20±2.191	21.80±6.204
25-30	8.00±0.000	19.00±0.000	16.00±0.000	900±0.000	26.00±0.000
31-36	6.00±1.706	18.00±3.717	17.00±2.256	7.00±2.558	23.00±8.224
37-42	7.50±0.535	22.00±1.069	19.50±3.742	10.00±1.069	23.50±2.673
43-49	7.00±0.000	20.00±2.138	18.50±3.742	9.50±2.673	20.00±6.414
50-56	6.67±0.492	23.33±0.985	23.33±0.492	10.67±0.492	29.67±2.605
57-66	7.67±0.492	23.33±0.492	21.67±2.146	11.00±1.706	28.00±5.970
67-70	3.33±0.492	17.00±0.853	16.00±2.558	4.67±0.985	12.00±1.706
71-85	4.00±0.853	17.00±0.853	16.00±0.853	633±1.303	18.33±2.605
Total	**5.80±1.907**	**19.32±3.250**	**18.08±3.738**	**8.12±27.02**	**22.20±7.112**

Gender					
Male	5.83±2.215	19.50±3.390	18.42±4.031	8.75±2.741	22.00±7.663
Female	5.77±1.592	19.15±3.140	17.77±3.456	7.54±2.555	22.38±6.634
Total	**5.80±1.907**	**19.32±3.250**	**18.08±3.738**	**8.12±2.702**	**22.20±7.112**
Marital S					
Married	7.13±0.793	23.25±0.672	22.25±1.741	10.75±1.107	28.63±4.094
divorced	6.40±1.789	18.60±2.563	16.80±2.707	8.20±2.191	19.60±6.824
Widowed	4.00±0.730	17.00±0.730	16.25±2.236	4.75±0.856	16.50±3.759
Never married	5.29±2.088	16.86±2.206	15.71±2.967	7.00±2.309	21.00±6.577
Total	**5.92±1.856**	**19.38±3.306**	**18.21±3.761**	**8.13±3.761**	**22.50±7.102**
Variable	**General**	**Physical**	**Psychological**	**Social**	**Environmental**
Employment					
Unemployed	4.93±1.925	17.93±2.815	16.93±2.709	7.00±2.288	19.86±6.853
Formal employed	7.00±1.344	21.25±3.203	19.37±4.598	9.50±2.688	26.25±6.154
Informal employed	6.67±0.492	20.67±1.969	20.00±3.717	9.67±2.146	22.33±6.169
Total	**5.80±1.907**	**19.32±3.250**	**18.08±3.738**	**8.12±2.702**	**22.20±7.112**
Religion					
Christianity	6.11±1.675	20.06±3.314	18.94±3.745	8.33±2.926	23.39±7.066
Islam	2.00±0.000	15.00±0.000	13.00±0.000	6.00±0.000	17.00±0.000
No religion	5.50±2.022	17.83±2.078	16.33±2.615	7.83±1.993	19.50±6.846
Total	**5.80±1.907**	**19.32±3.250**	**18.08±3.738**	**8.12±2.702**	**22.20±7.112**

Ethnic					
Shona	6.05±1.773	19.63±3.413	18.79±3.660	8.42±2.640	23.37±7.341
Ndebele	5.00±2.126	18.33±2.479	15.83±3.088	7.17±2.729	18.50±4.818
Total	**5.80±1.907**	**19.32±3.250**	**18.08±3.738**	**8.12±2.702**	**22.20±7.112**
Education					
No education	2.21±1.333	12.06±2.999	10.84±2.633	7.43±1.926	14.59±6.066
Primary	2.45±0.000	8.06±0.000	7.14±0.000	4.00±0.000	10.00±0.000
Secondary	7.12±2.078	16.83±1.068	18.23±1.738	8.83±2.992	21.50±9.021
Higher tertiary	8.50±2.393	20.00±3.314	19.13±4.999	9.57±2.993	22.12±7.141
Total	**5.80±1.907**	**19.32±3.250**	**18.08±3.738**	**8.12±2.702**	**22.20±7.112**

Table 4. 3Evaluation of the mean±SD of hypertension domains of QOL based on demographic variables

From table 4, indicates the correlation or the strength of association between index of WHOQOL-Brief domains with general QOL, disease factors as well as individual domains were calculated by Pearson's statistics. Each domain was significantly related with overall QOL using two-tailed 't' test ($p<.01$). All scores of domains were correlated with the total measure of the quality of life significantly ($p<0.05$). So higher scores in one variable is associated with higher scores in others variables. For instance, psychological well-being is highly correlated with social relationship which means if score high on psychological well-being is also much likely to score high on social relationship. If one scores less in the other variables is also likely to score less on the otherThe most significant positive correlation was observed for the social relationship and environmental domains (0.840) followed by physical and social relationship domains (0.838).

	Physical	Psychological	Social relationships	Environment	Disease	General QOL
Physical	1.000					

Psychological	0.823	1.000				
Social	0.838	0.819	1.000			
Environment	0.714	0.738	0.840	1.000		
Disease	0.479	0.704	0.597	0.794	1.000	
General QOL	0.669	0.620	0.758	0.766	0.529	1.000

Table 4. 4Correlation between domains of WHOQOL-Brief Hypertension

4.4 Socio-economic characteristics of patients

This section presents the results obtained from hypertensive patients, classifying them according to their employment status.

4.4.1 Employment

As shown in figure 4.5, out of the proportion of the study participants, 50% of the respondent were unemployed occupying the majority of the population under study. 32% and 12% were formal and informal employed respectively.

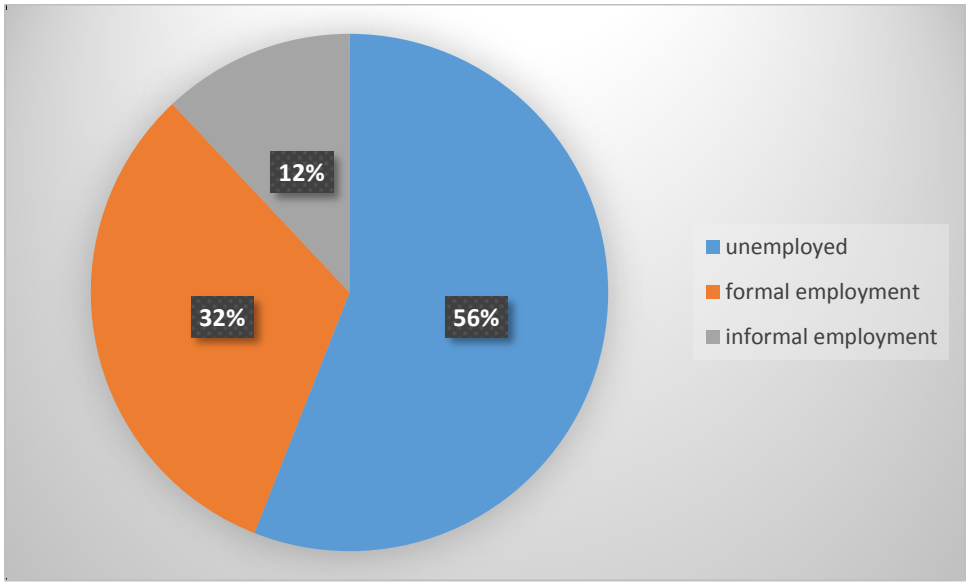

Figure 4. 1: Distribution of patients' by employment status

Out of the unemployed, students and retired hypertensive patients were 16% represented. Those who were unable to work due to their hypertension condition and housewife were also represented by 8% each respectively. As shown in Table 4.6.

Unemployed	**Frequency**	**Percentages %**
Student	16	16.0
Housewife	8	8.0
Retired	16	16.0
Unable due to my hypertension condition	8	8.0

Table 4. 5: Distribution of unemployed.

4.5 Relationship of QOL and psychological functioning

As shown in by the ANOVA below, the research findings on the impact of quality of life on psychological functioning were highlighted. The results on the impact level were very highly significant (very unlikely to have occurred by chance alone). The significant value of the model is ($p<.01$) less than alpha (.05), therefore the model is significant.

ANOVA[b]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	4.341	1	4.341	26.891	.000[a]
	Residual	15.819	98	.161		
	Total	20.160	99			

a. Predictors: (Constant), qualityof living

b. Dependent Variable: psychologicalfunctioning

As shown in the model summary, presenting the finding on how quality of life impact on psychological functioning in hypertensive patients. The results presented that 20.7% of the variance in psychological functioning can be explained by one's quality of life.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.464[a]	.215	.207	.40177

a. Predictors: (Constant), quality of living

4.6 Relationship of QOL and social functioning in individuals living with hypertension

As shown in table by the ANOVA below, the research findings on the impact of quality of life on social functioning were highlighted. The results on the impact level were very highly significant (very unlikely to have occurred by chance alone) as shown by significant .000. The significant value of the model is ($p<.01$) less than alpha (.05), therefore the model is significant.

ANOVA[b]

Model	**Sum of Squares**	**Df**	**Mean Square**	**F**	**Sig.**

1	**Regression**	**12.156**	**1**	**12.156**	**37.601**	**.000[a]**
	Residual	**31.684**	**98**	**.323**		
	Total	**43.840**	**99**			

a. Predictors: (Constant), quality of living

b. Dependent Variable: social functioning

Presenting the finding on how quality of life impact on social functioning in hypertensive patients. The results shown were 27% of the variance in social functioning can be explained by one's quality of life. As shown in the model summary below.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.527[a]	.277	.270	.56860

a. Predictors: (Constant), quality of living

4.7 Chapter Summary

The chapter presents the results findings on demographic factors which influence QOL among people living with hypertension. These demographic factors are age, gender, and marital status, ethnic among others. It present the correlation of WHOQOL-BRIEF domain. It also presents findings on how does quality of life impact on psychological and social functioning in people living with hypertension.

CHAPTER 5: DISCUSSIONS, CONCLUSSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the findings of the study according to the research questions of the study. It includes a summary and further discussions of the key findings of this study and relates to published literature on the quality of life among individuals living with hypertension.

5.2 Demographic factors influence QOL among people living with hypertension

The demographic factors which influence QOL among individuals living with hypertension yielded some interesting results. The majority of the represented age range of hypertensive patients were (18-24), this might be so because the researcher was interested to know about the QOL within the age range thus a lot of time was taken to find these participants because of the fact that the disease is known to be prevalence among the elderly (Toth et al, 2013). In the study findings, a lessening in QOL were perceived with an increase with age, butonly in relation to social relationship as well as environment health slightly than physical as well as psychological health. These study findings were similar to (Ha et al, 2014) however, the study done in Vietman, measured change in QOL by age in older individuals regardless of exact disease group.

In line with other studies conducted (Tran et al., 2012; Ha et al., 2014; Van., 2010; Gholami et al., 2013), the researcher founded a difference in QOL by sex. 52% of the participants were female and 48% were male hypertensive patients. This may indicate that the disease could be very prevalent amongst females rather than males as they constitute more than 50% of the study participants and this was in support of other findings from (Pimenta, 2012; Veenstra, 2013). Be that as it may, albeit different examinations have demonstrated proof of sexual orientation dissimilarity in QOL. In this study, the score of women in all domains of QOL was reported to be lower than men but that was not significant, these results were comparable to the study of (Ha et al., 2014) which found that, women reported poorer QOL for pain, energy, positive feeling, self-esteem negative feeling, sexual activity, transport and learning opportunities. In line with a study by (Nojomi, 2008), these issues might be starts from absence of positive impression of their job in the general public, being detached from monetary and social perspective and furthermore the effect of components, for example, sex imbalance, viciousness against ladies, absence of social and family supporting.

Findings of this study, those who attained secondary and tertiary education had fundamentally higher mean scores in the environment, psychological and physical health. This proposes the

impact of training on the feeling of wellbeing, better or good behavioral risk factors and security of individuals living the hypertension. Education has been broadly distinguished as a determinant of QOL, in relation to Gholami, (2013) and Erikson et al, (2000) studies which reported that individuals with larger amounts of education regularly report better QOL.

In this examination hypertensive patients who were formal and informal employed, in most domains especially environmental, social relationships, physical and psychological function would be advised to QOL conditions than different patients. This reflected to positive effects of employment status as a factor in advancing QOL. Like (Eriksson et al, 2000), examine in Sweden a noteworthy relationship was found between larger amount of being utilized and better QOL. Unemployed on the other hand is associated with lower mean score in all four domains of QOL. This may be due to economic, social and political issues in Zimbabwe that leaves the unemployment insecure, financial poor, less motivated to copy, engage in more risk behaviors, low self-sufficiency and stress related issues for failure to meet societal expectations.

The examination found an essentially higher QOL over each of the four domains among wedded members contrasted and the individuals who were widowed, divorced and never wedded. This is comparable to the past discovering (Ha el at., 2014), which recommended that wedded life makes a feeling of fulfillment and satisfaction. This outcome is additionally in accordance with that of past studies in Vietnam. (Le Hoi el at, 2010); Malawi (Cobourn el at, 2012) and Indonesia (Hakimi el at, 2010). The study also found that hypertension is most prevalence in never married and widowed compared to married/living together, this was in contrary to the study by (Abankwah, 2016) which state that the prevalence of hypertension was higher among the married due to conflict between husband and wife and some other marital issues. To support the research outcomes on the prevalence of hypertension in never married and widowed, this may be due to the fact that there are more emotional and psychological issues in never married and widowed, for example loneliness, stress, economic hardships, pressure from family members etc.

The study findings revealed that, there were more hypertensive patients in the Christian faith than those of no religion and Islam. This was so because in Zimbabwe Christianity is the main religion, it also recorded the highest mean in environmental health (23.39±7.066). These findings show that hypertensive patients who believe in Christianity were more optimistic about their

daily life, content with their physical environment, daily needs, information and as well as transport.

5.4 Relationship between QOL and psychological functioning

QOL was reported lower on the psychological functioning of individuals living with hypertension, this is in accordance with the study by (Ha el at., 2014) which found that the most minimal score found in psychological health demonstrated more negative however more pessimistic sentiments about existence, not being great about the capacity of reasoning, learning, memory and focus, and poor confidence. This reflected through the reactions to questions asked: what amount do they appreciate life, to what degree do they feel their life to be significant, ready to think, ready to acknowledge substantial appearance, how fulfilled they are with themselves and how frequently do they have negative sentiments, for example, terrible disposition, lose hope, uneasiness, discouragement. The investigation among hypertensive individuals in Brazil found tantamount outcomes with the most elevated mean fulfillment for social relationship ((Basopo and Mujasi, 2017). Notwithstanding, the investigation in Brazil found a higher range in score of QOL from 59.7 to 72.3.

5.5 Relationship between QOL and social functioning.

In the research findings, the lowest mean rating of QOL in all domains were found in social relationship. The social domain incorporates three features: individual relationship, practical socialsupport and sexual action. This revealed that the participants were not satisfied with personal relationships with friends, family and spouses. The other issue might be due to the fact of economic constraint we are experiencing as a country is causing for less emotional and financial support from families since they are busy doing their own things to survive. A higher dissatisfied was recorded in sexual activity were 36 participants recorded not satisfied. Similar results of the study were highlighted by (Abankwah, 2016), QOL was reported lower in social relationship on hypertensive patients. In relation to (Aranda-Naranjo, 2004), a significant number of these patients battle with various social issues, for example, shame, neediness, discouragement, substance misuse and social convictions which can influence their personal satisfaction from physical wellbeing perspective, as well as from mental and social wellbeing

perspective and cause various issues in valuable exercises and interests of the patients. This study is in contrary to (Ha el at., 2014) the most astounding mean fulfillment rating found in the social relationship space reflected nice sentiments in personal relationship, genuinely great sharing/bolster from family and companions, and great satisfaction from sexual action. As Ichikawa and Natpartan revealed in their study, having social acceptability has the most critical association with better personal satisfaction and the social supporting paying little mind to clinical phase of the infection, had wanted effect on psychosocial parts of patients' life.

5.6 Conclusions.

From the study the following conclusions were drawn

This study has shown that demographical factors like age, gender, marital status, ethnic and religion are predictors of QOL on hypertensive patients. There are more women than men individuals who are affected by hypertension. Women with hypertension had lower satisfaction rating in all domain expect in environmental health. Most patients are also in the never married, widowed and divorced category of marital status. Among the ethnic groups, Shona were more affected by the disease than Ndebele and also Christians were the majority than no religion and Islam. More of the Christians participants were very content with their QOL in environmental health and psychological well-being.

In the study area, hypertensive patients who scored lower or below average mean had low socio-economic status. Social and economic determinants of health combine with behavioral risk factors can either reduce or increase the incidence or prevalence of a disease. From the conceptual framework, social determinants of health such as marriage status, education and occupation are predictors of QOL and this has been confirmed by study findings. This was evident in their level of education and employment. There exist vast disparities between those with higher levels of education and those with lower levels of education. Employment status also is a contribution factor of QOL, those who are employed scored higher mean than those who are unemployed and their QOL is far much better than the unemployed.

On the relationship between QOL and psychological functioning, these conclusions were made, there were a positive correlation between one’s QOL and psychological functioning. That is the

better someone is in psychological functioning the better their QOL is and also the vice-visa is true. In this study as shown in the discussion above more hypertensive patients scored lower on their psychological functioning.

On the relationship between QOL and social functioning, conclusion was made, there was a higher level of association between the QOL and social functioning. QOL was reported lower in social relationship with individuals suffering from hypertension A considerable lot of these patients battle with various social issues, for example, destitution, substance misuse, stigma as well as depression. Another conclusion that was made were most of the participants were not satisfied with their sex life and also since lower social functioning is associated with poor QOL, there is need to enhance good social relationship to have better QOL.

5.7 Recommendation

After having given an account of the experiences of QOL among individuals living with hypertension. It is clear that there are certain steps that need to be taken so as to enhance QOL and to pay more attention to other factors that may affect treatment regimens of hypertensive patients. Therefore, basing on the findings of this research these recommendations have been recorded:

- Health facilities need to strengthen health education on better measures to improve and sustain the current QOL of individual living with hypertension. In detail, education must be directed at patients who are lowly educated, women, unemployed, both age ranges and those with comorbidities. This will influence positively on reduce the incidence of comorbidities.
- To reduce the incidence and possibility of hypertension, educational out-reach programs on life style adjustments and risk factors for hypertension targeted at unemployed, women, never married, youth and lowly educated person.
- Interventions designed at improving the socio-economic circumstances of the individuals living with hypertension are needed. This could be in kind form or monetary as it will guarantee access to other facilities needed for better treatment outcomes and health.
- The government must improve the social, political and economic situation of our country that will lead for job creation. This will bring back hope and employment.

- Hypertensive (individual) patients must strictly follow dietary plans and engage in modest to high levels of physical activities.
- Further research must be done to institute the extent of differences in the socio-economic status of individuals living with hypertension in relations to pursuing better quality of life and treatment.

5.8 Chapter Summary

This chapter gave a discussion of the results of the research study. These finding of the research could not be compared with the findings of the previous researches on the area of the study due to the fact that this is the first research of its nature in Zimbabwe, however comparisons were made to previously conducted research in other parts of the world. The discussion focused on the demographical factors which can influence quality of life, impact of quality of life on psychological and social functioning. Conclusions of the research study were also drawn in this chapter and revealed factors that can both contribute to good or poor quality of life. Finally, recommendations were brought forward to reduce the risk and incidence of hypertension and also to bring forth the area of further studies.

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APPENDIX A: LETTER FROM THE DEPARTMENT OF PSYCHOLOGY

Midlands State University

Established 2000

P BAG 9055
GWERU

Telephone: (263) 54 260404 ext 2156
Fax: (263) 54 260233/260311

FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY

Date: 05/09/2018

To whom it may concern

Dear Sir/Madam

RE: REQUEST FOR ASSISTANCE WITH DISSERTATION INFORMATION
FOR TAWANDA MUREPA R1524290

BACHELOR OF PSYCHOLOGY HONOURS DEGREE

This letter serves to introduce to you the above-named student, who is studying for a Psychology Honours Degree and is in his/her 4th year. All Midlands State University students are required to do research in their 4th year of study. We therefore, kindly request your organisation to assist him/her with any information that she/he requires.

Topic: QUALITY OF LIFE AMONG INDIVIDUALS LIVING WITH HYPERTENSION IN URBAN AREAS: GWERU

For more information regarding the above, feel free to contact the undersigned.

Yours faithfully

pp

N. Ncube
A/Chairperson

GWERU PROVINCIAL HOSPITAL
MEDICAL SUPERINTENDENT
18 SEP 2018
P.O. BOX 135, GWERU
ZIMBABWE

MIDLANDS STATE UNIVERSITY
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY
– 5 SEP 2018
PRIVATE BAG 9055
GWERU

APPENDIX B: APPROVED LETTER FROM GWERU PROVINCIAL HOSPITAL

4549 Mkoba 17

Gweru

10 September 2018

Approved 18/9/2018 18/9/2018

MEDICAL SUPERINTENDENT

Gweru Provincial Hospital

P. O. Box 135

Gweru

GWERU PROVINCIAL HOSPITAL
MEDICAL SUPERINTENDENT
P.O. BOX 135, GWERU
ZIMBABWE

Dear Sir/Madam

RE: Application for data collection

I am applying for permission to collection data at your organization. I am a student currently studying for a Bachelor of Science in Psychology Honours Degree at the Midlands State University. I am kindly ask for your support to my research project by allowing me to do my data collection. The title of the research is: **Quality of life among individuals living with hypertension in urban areas: Gweru.**

Attached documents are the letter from the university, research methodology and research instruments.

Looking forward to hear from you.

Sincerely

Tawanda Murepa

0718581973

APPENDIX C: RESEARCH INSTRUMENT

Dear Respondents

My name is Tawanda Murepa, currently studying for a Bachelor of Science in Psychology Honours Degree at the Midlands State University. I kindly ask for your support to my research project by responding to questions asked by this questionnaire. The title of the research is: **Quality of life among individuals living with hypertension in urban areas: Gweru**.You are assured that the answers you give will be strictly confidential and your name will not be mentioned in my response report.

Please choose the answer that appears most appropriate on the spaces provided on this questionnaire.

Question No.	Questions	Response
Section A	**Demographics**	
01	Sex: 1. Male 2. Female	
02	Age range 1. 18 – 24 2. 25 – 30 3. 31 – 36 4. 37 – 42 5. 43 – 49 6. 50 – 56 7. 57 – 63 8. 64 – 70 9. 70 - 85	
03	What is your marital status? 1. Married/living together 2. Divorced/Separated 3. Widowed 4. Never married and never lived together	
04	What is your religious denomination? 1. Christianity 2. Islam 3. Traditional/Spiritualist 4. Buddhism 5. Hinduism 6. Judaism 7. No Religion	

	8. Other (Specify)……..	
05	What ethnic group do you belong? 1. Shona 2. Ndebele 3. Venda 4. Tonga 5. Shangaan 6. Nambya 7. Kalanga 8. Other (Specify)……..	
Section B	**Socio-economic characteristics of patient**	
2.01	What is your highest educational level attained? 1. No education 2. Primary 3. Secondary 4. Higher tertiary	
2.02	What is your employment status? 1. Unemployed 2. Formal employment 3. Informal employment	
2.03	If unemployed, reason for not being employed? 1. Student 2. Housewife 3. Retired 4. Unable due to my hypertension condition 5. Other (specify)……..	
2.04	What is your overall monthly household income?	
2.05	How many people are dependent on this income?	
2.06	Do you own agricultural land: [0] No [1] Yes, How big?	
2.07	Do you own livestock's [0] No [1] Yes How many? 1. Cattle 2. Goats 3. Chickens 4. Pigs	
2.08	How would you rate your household's economic status in relation to general conditions in Zimbabwe? 1. Very wealthy 2. wealthy	

	3. Moderate 4. Poor 5. Very poor	
Section C	**Quality of life assessment**	
	General health (I ask that you think about your life in the last four weeks)	
3.01	How would you rate your quality of life? 1. Very poor 2. Poor 3. Neither poor nor good 4. Good 5. Very good	
3.02	How satisfied are you with your health? 1. Very dissatisfied 2. Dissatisfied 3. Neither satisfied nor dissatisfied 4. Satisfied 5. Very satisfied	
	Physical health	
3.04	To what extent do you feel that physical pain prevents you from doing what you need to do? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.05	How much do you need any medical treatment to function in your daily life? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.06	How much do you enjoy life? 1. Not at all 2. A little 3. A moderate 4. Very much 5. An extreme amount	
3.07	To what extent do you feel your life to be meaningful? 1. Not at all 2. A little 3. A moderate 4. Very much	

	5. An extreme amount	
3.08	How well are you able to concentrate? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. Extremely	
3.09	How safe do you feel in your daily life? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. Extremely	
3.10	How satisfied are you with your sleep? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. Extremely	
	Psychological factors	
3.11	How much do you enjoy life? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.12	To what extent do you feel your life to be meaningful? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.13	How well are you able to concentrate? 1. Not at all 2. A little 3. A moderate 4. Very much 5. An extreme amount	
3.14	Are you able to accept your bodily appearance? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.15	How satisfied are you with yourself? 1. Not at all	

	2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.16	How often do you have negative feelings such as bad mood, despair, anxiety, depression? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
	Social relationships	
3.17	How satisfied are you with your relationships with family, friends etc? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.18	How satisfied are you with your sex life? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.19	How satisfied are you with the emotional and financial support you get from your friends? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
	Environment	
3.20	How safe do you feel in your daily life? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.21	How healthy is your physical environment? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.22	Have you enough money to meet your needs?	

	1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.23	How available to you is the information that you need in your daily-to-day life? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.24	To what extent do you have the opportunity for leisure activities? 1. Not at all 2. 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.25	How satisfied are you with the condition of your living place? 1. Not at all 2. A little 3. A moderate 4. Very much 5. An extreme amount	
3.26	How satisfied are you with your access to health services? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
3.27	How satisfied are you with your transport? 1. Not at all 2. A little 3. A moderate amount 4. Very much 5. An extreme amount	
Section D	**Disease status and behavior**	
3.28	How long have you been hypertensive 1. <1 year 2. 1-3 years 3. 3-5 years 4. >5 years	
3.29	What kind of food do you eat on a normal day? 1. Protein	

	2. Fatty 3. Carbohydrate 4. Balanced diet 5. Others (Specify)……..	
3.30	How many times do you eat fruits in a week? 1. Not at all 2. 1-3 times 3. More than 3 times 4. Every day	
4.00	How is your physical health in general? 1. Very good 2. Good 3. Fair 4. Poor 5. Very poor	
4.01	How many times do you exercise in a week? 1. Not at all 2. 1-3 times 3. More than 3 times 4. Every day	
4.02	Have you had any of following health problems during the past one year? Yes No Chronic disease a) Kidney diseases 1 2 b) Diabetes mellitus 1 2 Other diseases a) Cancer 1 2 b) Cardiovascular diseases 1 2 c) Injury 1 2 d) Persistent disability 1 2 Others (Specify)……	
	Alcohol	
4.03	Do you currently consume alcoholic beverages? 1. Yes 2. No 3. No, nut I used to drink	
4.04	How many times do you drink alcoholic beverages usually? 1. Once daily	

	2. Twice daily 3. 3 times daily 4. Once a week 5. More than once in a week1	

THANK YOU FOR YOUR TIME

APPENDIX D **AUDIT SHEET**

MIDLANDS STATE UNIVERSITY

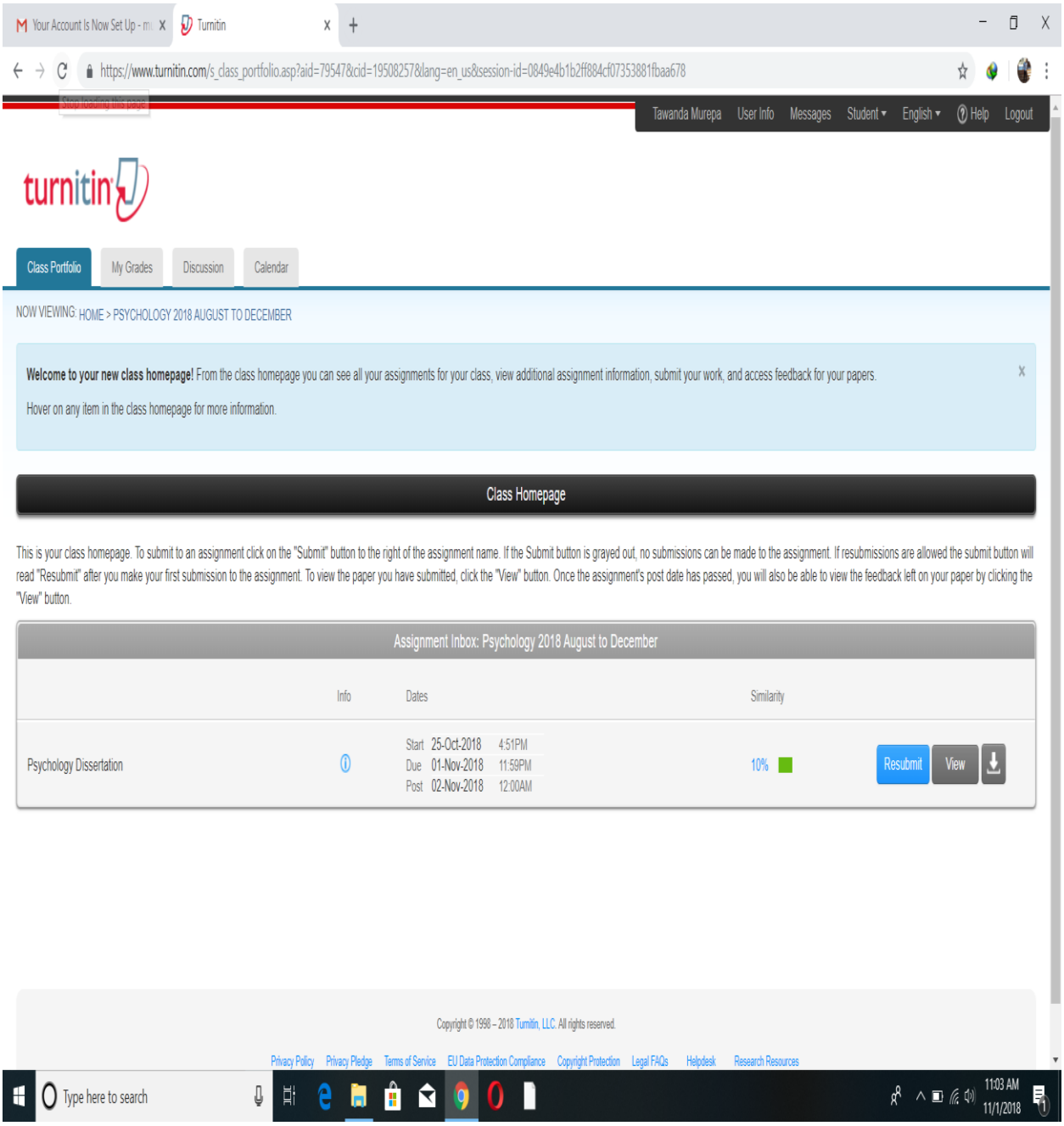
SUPERVISOR – STUDENT AUDIT SHEET

DATE	TOPIC DISCUSSED	COMMENT	STUDENT'S SIGNATURE	SUPERVISOR'S SIGNATURE
26/04/18	Proposal	Rework		
30/04/18	Proposal	Proceed		
07/05/18	Chapter 1	Rework		
11/05/18	Chapter 1	Proceed		
22/05/18	Chapter 2	Rework		
06/06/18	Chapter 2	Proceed		
16/06/18	Chapter 3	Rework		
28/06/18	Chapter 3	Proceed		
07/07/18	Chapter 4	Rework		
18/07/18	Chapter 4	Proceed		
14/09/18	Chapter 5	Rework		
20/10/18	Chapter 5	Proceed		
01/11/18	First draft	Rework		
02/11/18	First draft	Proceed		

STUDENT'S SIGNATURE: .....

SUPERVISOR'S SIGNATURE: .....

APPENDIX E: TURNIT IN REPORT



MARKING GUIDE

Name of student: Tawanda Murepa **REG No: R152429V**

	ITEM	POSSIBLE SCORE	ACTUAL SCORE	COMMENTS
A	RESEARCH TOPIC AND ABSTRACT: Clear and concise	5		
B	PRELIMINARY PAGES Title page, approval form, release form, dedication, acknowledgement, appendices, table of contents	5		
C	AUDIT SHEET Clearly shown on the audit sheet	5		
D	CHAPTER 1 Background, statement of the problem, significance of the study, research questions, hypothesis, assumptions, purpose of the study, delimitations, limitations, definition of terms	10		
E	CHAPTER 2 Address major issues and concepts of the study. Findings from previous work, relevancy of literature to the study Identify knowledge gap, subtopics	15		
F	CHAPTER 3 Appropriateness of approach, design, target population, population sample, research tools, data collection procedures, presentation and analysis	15		
G	CHAPTER 4 Findings presented in a logical manner, tabular data properly summarized and not repeated in the text	15		
H	CHAPTER 5 **Discussion (10)** Must be a presentation of generalizations shown by results: how results and interpretations agree with existing and published literature, relates theory to practical implications **Conclusions (5)** Ability to use findings to draw conclusions **Recommendations (5)**	20		
I	Overall presentation of dissertation	5		
J	References	5		
	Total	100		

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