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PREVALENCE AND SOCIODEMOGRAPHIC DETERMINANTS OF HYPERTENSION AMONG SCHOOL TEACHERS IN URBAN PRAYAGRAJ: A COMMUNITY-BASED CROSS-SECTIONAL STUDY

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ABSTRACT

Background: Hypertension is a leading non-communicable disease and a major contributor to cardiovascular morbidity and mortality globally. School teachers, as an occupational group, are uniquely exposed to high levels of psychological stress, sedentary work patterns, and inadequate health surveillance, rendering them particularly vulnerable. There is a paucity of data on the prevalence of hypertension and its associated sociodemographic determinants among school teachers in mid-sized urban centres like Prayagraj. The objective is to estimate the prevalence of hypertension and evaluate its association with sociodemographic variables among school teachers in urban Prayagraj.

Materials and Methods: A community-based cross-sectional study was conducted among 320 school teachers (TGT and PGT) from government and private schools in urban Prayagraj, selected by multistage random sampling, over a 12-month period (February 2025–January 2026). Hypertension was diagnosed as SBP ≥140 mmHg and/or DBP ≥90 mmHg per JNC-7 criteria. Sociodemographic data were collected via semi-structured interview. Chi-square test and logistic regression were performed using SPSS version 20 ($p<0.05$ considered significant).

Results: Of 320 participants (males 60.93%, mean age 40–49 years), 31.56% were hypertensive and 5.93% were prehypertensive. Hypertension was significantly associated with marital status ($\chi^2=20.38$, $p=0.0004$); divorced/widowed teachers had the highest prevalence (64.52%). On logistic regression, divorced/widowed marital status was the only independent sociodemographic predictor (AOR=1.242; 95% CI: 1.001–1.512; $p=0.027$). Age, school type, religion, socioeconomic status, and sole-earner status showed no statistically significant association.

Conclusion: Nearly one-third of school teachers in urban Prayagraj have hypertension, with divorced/widowed marital status as the sole independent sociodemographic determinant. Regular occupational screening, targeted health education, and workplace wellness programs are urgently warranted for this group.

Keywords: Hypertension, School teachers, Prevalence, Sociodemographic factors, Urban Prayagraj, Occupational health.

INTRODUCTION

Hypertension is a leading cause of global morbidity and mortality, functioning as a primary driver of cardiovascular, cerebrovascular, and renal diseases.[1] The World Health Organization (WHO) estimates that hypertension is responsible for approximately 10.8 million deaths globally each year, accounting for nearly one-third of all deaths worldwide.[2] According to the Global Burden of Disease (GBD) study 2017, high systolic blood pressure claimed over 10.4 million lives and 218 million disability-adjusted life years (DALYs).[1] An estimated 1.4 billion adults aged 30–79 years worldwide had hypertension in 2024—representing 33% of this age group, with two-thirds residing in low- and middle-income countries.[2]

Hypertension is a multifactorial disease resulting from a complex interaction between genetic predisposition and environmental and lifestyle factors. Sustained elevation of blood pressure arises through mechanisms including increased sympathetic nervous system activity, activation of the renin–angiotensin–aldosterone system, endothelial dysfunction, vascular stiffness, and impaired renal sodium handling.[4,5] The WHO STEPwise approach to non-communicable disease (NCD) surveillance recommends systematic assessment of behavioural, physical, and biochemical risk factors to understand hypertension patterns in specific populations.[6]

In India, the epidemiological transition is marked by a rising burden of NCDs, with hypertension as a leading contributor. National Family Health Survey-5 (NFHS-5) data indicate that nearly one-fourth of Indian adults have elevated blood pressure, with higher prevalence in urban areas.[9] The Great India Blood Pressure Survey corroborated this, reporting high hypertension prevalence accompanied by poor levels of awareness, treatment, and control.[10] Occupational stress has emerged as an important contributor to hypertension, particularly among professions involving high mental workload and sedentary behaviour.[7] Certain occupations are known to exacerbate or even precipitate hypertension and other cardiovascular diseases.[8]

School teachers constitute an important occupational group frequently exposed to significant psychological stress arising from academic responsibilities, administrative duties, examination pressures, and performance expectations. A study from Addis Ababa, Ethiopia, identified hypertension as a significant health problem among teachers, with a prevalence of 21.8%.[11] Findings from Bangladesh reported a hypertension prevalence of 52% among school teachers.[12] In India, studies among schoolteachers have reported prevalence rates of 45.4% in Assam, 28.6% in Karnataka, and 24% in Telangana.[13,14,15] A study from North-East Delhi reported hypertension prevalence of 13.3% among school teachers,[16] while a study from Chennai reported a prevalence of 24.8%.[17] Findings from Hyderabad indicated that nearly 60% of school teachers had either prehypertension or hypertension, with significant associations observed with lifestyle practices and workplace stress.[18] Similar findings from Puducherry, Karnataka, and Tamil Nadu have emphasised the need for early screening and lifestyle modification in this group.[14,19,20]

Despite the growing burden of hypertension in urban India, there is a paucity of data on hypertension and its sociodemographic determinants among school teachers in mid-sized urban centres such as Prayagraj. Most studies have focused on metropolitan cities or rural populations, leaving a significant evidence gap. The present study was therefore designed to estimate the prevalence of hypertension and evaluate its association with sociodemographic factors among school teachers in urban Prayagraj, with the aim of generating locally applicable evidence to guide targeted preventive interventions and occupational health policies.

MATERIALS AND METHODS

Study Design and Setting: A community-based cross-sectional study was conducted among school teachers in urban Prayagraj, Uttar Pradesh, India, from February 2025 to January 2026.

Sample Size and Sampling: Sample size was calculated using an estimated hypertension prevalence of 36% (referenced from a prior Indian study), at 95% confidence level with 15% allowable error, yielding n=304; rounded to 320 for the final sample. Multistage random sampling was employed: in stage one, 8 government and 8 private schools were randomly selected from lists compiled through the BSA and CBSE offices. In stage two, TGT and PGT teachers were selected by stratified proportional sampling from each school, enrolling 20 teachers per school (TGT=160; PGT=160).

Inclusion/Exclusion Criteria: All consenting TGT and PGT teachers from selected schools were included. Pregnant teachers and those on long leave or deputation during the data collection period were excluded.

Data Collection: Data were collected through face-to-face interview using a semi-structured questionnaire covering sociodemographic details including age, gender, marital status, educational qualification, type of school, family type, sole-earner status, and socioeconomic status (classified by the Modified BG Prasad Scale). Blood pressure was measured using a standardised mercury sphygmomanometer following JNC-7 protocol (two readings in seated position, five-minute interval, average used). Hypertension was defined as SBP ≥140 mmHg and/or DBP ≥90 mmHg; prehypertension as SBP 120–139 mmHg and/or DBP 80–89 mmHg.

Statistical Analysis

Data were analysed using SPSS version 20. Frequency and percentage were calculated for categorical variables. Chi-square test and Fisher–Freeman–Halton exact test (for cells with low expected frequency) were used to determine association between categorical variables and hypertension. Logistic regression analysis was performed to identify independent sociodemographic predictors. Statistical significance was set at $p<0.05$. Ethical clearance was obtained from the Institutional Ethics Committee prior to commencement of the study.

RESULTS

A total of 320 school teachers participated in the study. The sociodemographic profile of study participants is presented in [Table 1].

Table 1: Sociodemographic Profile of Study Participants (n=320)

Variable	Category	Frequency (n=320)	Percentage (%)
Age (years)	< 29	72	22.50
	30 – 39	75	23.44
	40 – 49	97	30.31
	> 50	76	23.75
Gender	Male	195	60.93
	Female	125	39.07
Marital Status	Married	243	75.93
	Unmarried	46	14.37
	Divorced	15	4.68
	Widowed	16	5.00
Education	Bachelor's Degree	115	35.9
	Master's Degree	181	56.6
	Doctorate	12	3.8
	Others	12	3.8
School Type	Government	160	50.00
	Private	160	50.00
Family Type	Nuclear	181	56.56
	Joint	139	43.43
Sole Earner	Yes	150	46.87
	No	170	53.13
SES (Modified BG Prasad)	Class I (Upper)	269	84.06
	Class II (Upper Middle)	48	15.00
	Class III (Middle)	3	0.94

The majority of participants were males (60.93%). The largest age group was 40–49 years (30.31%). Most participants were married (75.93%) and held a Master's degree (56.6%). An equal proportion of government (50%) and private (50%) school teachers were enrolled. Nuclear family structure was predominant (56.56%). The Modified BG Prasad Scale classified 84.06% of participants in Class I (Upper socioeconomic class).

Prevalence of Hypertension

The prevalence of hypertension among study participants is presented in [Table 2].

Table 2: Prevalence of Hypertension Among Study Participants (n=320)

Hypertension Status	Govt. School (n=160)	Private School (n=160)	Total (n=320)
Normotensive	104 (65.00%)	96 (60.00%)	200 (62.50%)
Prehypertensive	10 (6.25%)	9 (5.62%)	19 (5.93%)
Hypertensive	46 (28.75%)	55 (34.38%)	101 (31.56%)
Total	160	160	320

Out of 320 participants, 101 (31.56%) were hypertensive, 19 (5.93%) were prehypertensive, and 200 (62.50%) were normotensive. Hypertension prevalence was higher among private school teachers (34.38%) compared to government school teachers (28.75%), though this difference was not statistically significant.

Association of Sociodemographic Factors with **Hypertension:** The association between various sociodemographic variables and hypertension is presented in [Table 3].

Table 3: Association of Sociodemographic Variables with Hypertension

Variable	Category	Hypertension Present n (%)	Hypertension Absent n(%)	χ^2 Value	p-value
Age (years)	< 29	22 (30.56)	50 (69.44)		
	30 – 39	20 (26.67)	55 (73.33)	2.41	0.490
	40 – 49	30 (30.93)	67 (69.07)		
	> 50	29 (38.16)	47 (61.84)		
School Type	Government	47 (29.38)	113 (70.63)	0.476	0.490
	Private	54 (33.75)	106 (66.25)		
Marital Status	Married	63 (25.93)	180 (74.07)		

	Unmarried	18 (39.13)	28 (60.87)	20.38	0.0004*
	Divorced/ Widowed	20 (64.52)	11 (35.48)		
Religion	Hindu	89 (31.79)	191 (68.21)		
	Muslim	10 (31.25)	22 (68.75)	0.167	0.919
	Others	2 (25.00)	6 (75.00)		
Sole Earner	Yes	54 (36.49)	94 (63.51)	3.09	0.078
	No	47 (27.33)	125 (72.67)		
SES	Class I (Upper)	80 (29.74)	189 (70.26)		
	Class II (Upper Middle)	20 (41.67)	28 (58.33)	—	0.280†
	Class III (Middle)	1 (33.33)	2 (66.67)		

* Statistically significant ($p<0.05$); † Fisher–Freeman–Halton exact test applied due to low expected cell frequencies

Hypertension prevalence increased with advancing age (30.56% in <29 years to 38.16% in >50 years), although this trend was not statistically significant ($\chi^2=2.41$, $p=0.490$). No significant association was observed between school type and hypertension ($\chi^2=0.476$, $p=0.490$).

Marital status showed a statistically significant association with hypertension ($\chi^2=20.38$, $p=0.0004$). The highest prevalence was observed among divorced/widowed participants (64.52%), followed by unmarried (39.13%) and married teachers (25.93%). Religion ($p=0.919$), sole-earner status ($p=0.078$), and socioeconomic status ($p=0.280$) did not show statistically significant associations.

Logistic Regression Analysis of Sociodemographic Predictors

Logistic regression analysis to identify independent sociodemographic predictors of hypertension is presented in [Table 4].

Table 4: Logistic Regression Analysis of Sociodemographic Variables Associated with Hypertension

Variable	Category	Wald	AOR (95% CI)	p-value
Age (Ref: <29 yr)	30 – 39	1.764	0.590 (0.271–1.285)	0.184
	40 – 49	1.589	0.599 (0.270–1.329)	0.207
	> 50	0.346	0.811 (0.404–1.629)	0.556
Religion (Ref: Hindu)	Muslim	0.511	1.886 (0.331–10.447)	0.475
	Others	0.559	2.064 (0.309–13.792)	0.455
Marital Status (Ref: Unmarried)	Married	0.506	0.638 (0.185–2.201)	0.477
	Divorced/Widowed	6.549	1.242 (1.001–1.512)	0.027*
School Type (Ref: Govt.)	Private	0.289	0.864 (0.506–1.474)	0.591
Family Type (Ref: Nuclear)	Joint	31.50	1.621 (0.951–2.763)	0.076
Sole Earner (Ref: Yes)	No	0.944	1.313 (0.758–2.272)	0.331
SES (Ref: Class I)	Class II	0.003	0.954 (0.76–11.338)	0.104
	Class III	0.226	0.634 (0.144–14.011)	0.892

* Statistically significant ($p<0.05$); AOR = Adjusted Odds Ratio; CI = Confidence Interval

On multivariate logistic regression, among all sociodemographic variables, only divorced / widowed marital status emerged as a statistically significant independent predictor of hypertension (AOR=1.242; 95% CI: 1.001–1.512; $p=0.027$). Age, religion, school type, family type, sole-earner status, socioeconomic status, and educational qualification were not independently associated with hypertension after adjustment.

DISCUSSION

The present community-based cross-sectional study found a hypertension prevalence of 31.56% among school teachers in urban Prayagraj. An additional 5.93% were in the prehypertensive range, indicating that more than one-third of the study population had either established or incipient blood pressure elevation. These findings reaffirm that school teachers constitute a high-risk occupational group for hypertension and underscore an urgent need for targeted preventive strategies within this professional cohort.

Prevalence: Comparison with Indian Studies The prevalence observed in the present study (31.56%) is contextually comparable to findings reported from other regions of India. Chetia et al., in a study from Dibrugarh, Assam, reported a hypertension prevalence of 45.4% among high school teachers, a notably higher figure possibly attributable to differences in age distribution and dietary patterns in that region.[13] Girish and Majgi, in Karnataka, reported a prevalence of 28.6% among primary school teachers, a figure proximate to that of the present study.[14] Rama Devi et al. documented a prevalence of 24% in Telangana,[15] while Verma et al. reported a comparatively lower prevalence of 13.3% among school teachers of North-East Delhi, likely reflecting differences in study population demographics and lifestyle exposures.[16] Jane Monica et al., studying female school teachers in Chennai, further highlighted the burden of lifestyle-related conditions in this group.[17] Rama Devi et al. from Hyderabad found that nearly 60% of school teachers had either prehypertension or hypertension, with significant associations with workplace stress and lifestyle practices,[18] — a trend consistent with the present study's findings. Studies from Puducherry,[19] and Tamil Nadu,[20] similarly

documented a high burden of hypertension and inadequate awareness among school teachers, emphasising the nationwide nature of this occupational health problem. Mini et al. highlighted the need for school-based hypertension control programmes in Kerala, underscoring that the teaching profession demands specifically tailored health interventions.[1]

Comparison with National Data The NFHS-5 (2019-21) reported that approximately 24% of Indian adults have elevated blood pressure, with higher prevalence in urban areas.[9] The Great India Blood Pressure Survey documented a high burden of hypertension in India along with poor levels of awareness, treatment, and control across the general adult population.[10] The prevalence of 31.56% documented in the present study is higher than these national population-based estimates, indicating that the teaching profession may confer an additional burden of hypertension risk beyond that attributable to urbanisation and general demographic factors alone. This excess risk likely reflects the combined contribution of occupational stress, sedentary work behaviour, and inadequate access to routine health screening.

International Comparison Globally, hypertension among teachers has been studied in diverse settings. Tesfaye et al. reported a hypertension prevalence of 21.8% among the general adult population in Addis Ababa, Ethiopia — a figure lower than the present study, possibly owing to differences in occupational composition of the study group and lower levels of urbanisation.[11] In contrast, Barua et al. reported a substantially higher prevalence of 52% among school teachers in Dhaka, Bangladesh, attributable in part to high rates of salt intake, physical inactivity, and limited health awareness in that cohort.[12] Fikadu and Lemma, studying teachers and bankers in Addis Ababa, noted that socioeconomic status influenced hypertension risk differently across occupational groups,[8] while Kurtul et al. found a hypertension prevalence of comparable magnitude among hospital employees in Turkey, reiterating that high-stress knowledge-based professions consistently demonstrate elevated hypertension burden.[3] The present study's prevalence of 31.56% falls within the broader international range for teacher populations, confirming hypertension as a globally prevalent occupational health concern among educators.

Age and Hypertension: Although hypertension prevalence showed a numerical increase with advancing age — from 30.56% in the <29-year group to 38.16% in teachers aged >50 years — this association was not statistically significant in the present study (χ^2=2.41, p=0.490). This non-significant finding may be explained by the relatively uniform age distribution of the study population and the comparatively limited sample size across individual age strata. The logistic regression analysis further confirmed that no age group had a statistically significant independent association with hypertension (all p>0.05). The attenuation of this association in the present study suggests that within a relatively homogeneous professional group such as school teachers, occupational and lifestyle factors may play a more prominent explanatory role than age alone.

School Type and Hypertension: No statistically significant association was observed between school type (government vs. private) and hypertension (χ^2=0.476, p=0.490), with prevalences of 28.75% and 34.38% respectively. The marginally higher prevalence in private school teachers may reflect differences in workload, performance expectations, and job insecurity inherent in private sector employment. However, this difference did not attain statistical significance in the present study. Mini et al., in their study of school teachers across Kerala, similarly found that broad institutional factors were less important than individual lifestyle behaviours in determining hypertension risk,[1] consistent with the present findings.

Marital Status and Hypertension The most significant and clinically important finding of the present study was the strong, statistically significant association between marital status and hypertension (χ^2=20.38, p=0.0004). Among divorced/widowed teachers, the hypertension prevalence was 64.52% — more than twice the prevalence among married teachers (25.93%) and substantially higher than among the unmarried (39.13%). On multivariate logistic regression, divorced/widowed status emerged as the only independent sociodemographic predictor of hypertension (AOR=1.242; 95% CI: 1.001–1.512; p=0.027), retaining significance after adjustment for all other variables.

This finding is biologically and psychosocially plausible. Marital dissolution and spousal bereavement are associated with sustained psychosocial stress, loss of social support, social isolation, disrupted daily routines, and deterioration of health-promoting behaviours — all of which are established contributors to sympatho-adrenal activation, renin–angiotensin–aldosterone system dysregulation, and ultimately sustained elevation of blood pressure.[4,5] Furthermore, divorced and widowed individuals, particularly in the Indian sociocultural context, may experience heightened financial stress (especially when sole earners), social stigma, and reduced access to emotional buffering — factors collectively compounding cardiovascular risk. Married individuals, in contrast, are more likely to receive spousal encouragement for health-seeking behaviour, dietary compliance, and medication adherence, consistent with the lowest hypertension prevalence (25.93%) observed in this group.[7] This finding aligns with Momin et al.'s observation in Surat that psychosocial and household factors independently contribute to hypertension risk in occupational cohorts,[7] and with Fikadu and Lemma's finding that social and occupational context modifies hypertension risk among teachers.[8]

Religion, Sole-Earner Status, and Family Type: Religion was not significantly associated with hypertension in this study (χ^2=0.167, p=0.919). The distribution of religious groups in the study population was predominantly Hindu (87.5%), limiting the statistical power to detect inter-religious differences. Sole-earner status, while showing a higher numerical prevalence of hypertension among sole earners (36.49% vs. 27.33%), did not reach statistical significance (p=0.078), possibly due to the study being marginally underpowered for this sub-analysis. Similarly, joint family structure did not independently predict hypertension on logistic regression (p=0.076), though the trend approached significance and warrants further exploration in larger cohorts.

Socioeconomic Status: Socioeconomic status, assessed by the Modified BG Prasad Scale, was not significantly associated with hypertension in the present study (p=0.280). The overwhelming majority of participants (84.06%) were classified in Class I (Upper socioeconomic class), a feature inherent to the teaching profession as a salaried, educated occupational group. This restricted socioeconomic range substantially limited the ability to detect inter-class differences and may explain the non-significant finding. Fikadu and Lemma observed in Ethiopia that the relationship between socioeconomic status and hypertension is complex and occupation-dependent.[8]

Prehypertension and Public Health Implications: A prehypertension prevalence of 5.93% was noted in the present study. While lower than the hypertensive proportion, prehypertensive individuals carry a well-documented risk of progressing to overt hypertension, particularly in the presence of persistent occupational stress and unhealthy lifestyle behaviours. Rama Devi et al,[18] and Gomathy et al,[19] have previously highlighted the importance of identifying and counselling prehypertensive teachers for lifestyle modification before they develop frank hypertension. Annadurai documented inadequate hypertension awareness among school teachers in Tamil Nadu,[20] a barrier to timely intervention that is likely similarly prevalent in Prayagraj. Together, these findings argue strongly for institution of systematic, periodic blood pressure screening, targeted health education, and psychosocial support — particularly for teachers who are divorced, widowed, or otherwise socially isolated — as components of a comprehensive occupational health programme for schools.

Strengths and Limitations

This is among the first community-based studies to systematically assess the prevalence and sociodemographic determinants of hypertension among school teachers in urban Prayagraj, a rapidly urbanising mid-sized city of Uttar Pradesh. The use of multistage random sampling with proportional representation of TGT/PGT and government/private schools enhances the generalisability of findings within the urban Prayagraj teaching population. Blood pressure was measured using standardised JNC-7 protocol, ensuring diagnostic consistency. Limitations include the cross-sectional design, which precludes causal inference; the absence of biochemical investigations such as serum lipid profiles and renal function tests; and the exclusion of primary school teachers. Future longitudinal studies incorporating dietary, stress, and biochemical parameters would provide a more comprehensive understanding of hypertension determinants in this population.

CONCLUSION

This community-based cross-sectional study establishes a hypertension prevalence of 31.56% among school teachers in urban Prayagraj, comparable to the urban adult burden in national surveys. Divorced/widowed marital status is the only independent sociodemographic predictor of hypertension in this cohort. The findings highlight the need for institution of regular blood pressure screening, health education on hypertension risk, and psychosocial support mechanisms—particularly for teachers experiencing marital disruption. in addition to individual risk factors, occupational stress, sedentary work patterns, administrative responsibilities, examination-related workload, and multiple non-teaching assignments may contribute significantly to the development of hypertension among teachers. Annual health check-up and blood pressure screening should be conducted for all teachers. Workplace wellness programmes incorporating regular health education, physical activity, yoga, stress management, counselling services, and periodic occupational health assessments should be implemented to facilitate early identification and management of hypertension and related risk factors. Regular health education regarding hypertension, diabetes, obesity, healthy diet, and physical activity should be provided.

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