

The state of hypertension care in 44 low- and middle-income countries

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1 **The state of hypertension care in 44 low- and middle-income**
2 **countries: a cross-sectional study of individual-level nationally**
3 **representative data from 1.1 million adults**

4
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89 **Abstract**

90 **Background:** Evidence from nationally representative studies in low- and middle-income
91 countries (LMICs) on where patients are lost in the hypertension care continuum is sparse. This
92 information, however, is essential for the effective design and targeting of health services
93 interventions, and to assess progress in improving hypertension care. This study aimed to
94 determine the cascade of hypertension care in 44 LMICs – and its variation between countries
95 and population groups – by dividing the progression from need to successful treatment into
96 discrete stages and measuring the losses at each stage.

97 **Methods:** We pooled individual-level population-based data collected between 2005 and 2016
98 from 44 LMICs. Hypertension was defined as systolic blood pressure (BP) ≥ 140 mmHg or
99 diastolic BP ≥ 90 mmHg or reporting use of medication for hypertension. Among those with
100 hypertension, we calculated the proportion who had i) ever had their BP measured, ii) been
101 diagnosed, iii) been treated, and iv) achieved control. We disaggregated the hypertension care
102 cascade by age, sex, education, household wealth quintile, body mass index, smoking status,
103 country, and region. We used linear regression to predict – separately for each cascade step – a
104 country's performance based on gross domestic product (GDP) per capita, allowing us to identify
105 countries whose performance fell outside of the 95% prediction interval.

106 **Findings:** 1,100,507 participants were included of whom 192,441 (17.5%) had hypertension.
107 73.6% (95% CI, 72.9 – 74.3) of those with hypertension ever had their BP measured, 39.2%
108 (95% CI, 38.2 – 40.3) were diagnosed, 29.9% (95% CI, 28.6 - 31.3) received treatment, and
109 10.3% (95% CI, 9.6 – 11.0) achieved control. Countries in Latin America and the Caribbean
110 generally achieved the highest performance, while those in sub-Saharan Africa performed worst.
111 Bangladesh, Brazil, Costa Rica, Ecuador, Kyrgyzstan, and Peru performed significantly better on

112 all care cascade steps than predicted based on GDP per capita. Being a woman, older, more
113 educated, wealthier, and not a current smoker were all positively associated with reaching each
114 of the four steps of the care cascade.

115 **Interpretation:** This study provides critical evidence for the design and targeting of health
116 policies and service interventions for hypertension in LMICs by detailing at what step and for
117 whom there are gaps in the care process in each study country. In addition, we have identified
118 countries that perform better than expected based on their economic development in a diversity
119 of world regions, which can guide policy decisions. Given the high disease burden caused by
120 hypertension in LMICs, nationally representative hypertension care cascades as constructed in
121 this study could be used as an important tracer of effective universal health coverage.

122 **Funding:** Harvard McLennan Family Fund

123 **Research in context**

124 *Evidence before this study:* We searched MEDLINE from January 1966 until January 2019 for
125 studies with variations of the words ‘hypertension’, ‘screened’, ‘aware’, ‘treated’, and
126 ‘controlled’ in the title or abstract. To date, the largest study of individual-level data to compare
127 hypertension awareness, treatment, and control between low- and middle-income countries
128 (LMICs) – and examine how these indicators vary among population groups within countries –
129 was the Prospective Urban Rural Epidemiology (PURE) Study. However, the PURE study was
130 based on a convenience – rather than random – sample of communities, used data from 2003 to
131 2009, and included only 14 LMICs.

132 *Added value of this study:* This is the first study based on nationally representative samples of
133 adults in LMICs to determine where in the hypertension care process patients are lost, and how
134 this varies between and within countries. We make four key additions to the current evidence
135 base. First, we quantify for each of 44 LMICs the loss of individuals with hypertension at each
136 step of the hypertension care cascade, which can guide national policy makers in whether to
137 prioritise efforts to improve screening, diagnosis, initiation of treatment, or medication adherence
138 and care retention. Second, we examine how the hypertension care cascade varies within LMICs
139 between different population groups, providing important information on possible target groups
140 for relevant interventions. Third, by benchmarking countries’ performance against their Gross
141 Domestic Product (GDP) per capita, this analysis identifies countries that performed better than
142 expected based on their wealth and thus likely hold valuable policy lessons for countries at a
143 similar level of economic development. Lastly, this study provides a benchmark of health system
144 performance for managing hypertension in LMICs against which future progress can be
145 compared.

146 ***Implications of all the available evidence:*** The proportion of adults with hypertension lost at
147 each step of the hypertension care cascade varied widely between countries, with male, younger,
148 less educated, less wealthy, and currently smoking adults generally being less likely to reach
149 each cascade step. While the proportion who achieved control was low in all four regions
150 examined, countries in Latin America and the Caribbean had, on average, the best care cascade
151 indicators whereas countries in sub-Saharan Africa tended to have the lowest performance. Well-
152 designed and targeted interventions to improve hypertension care in LMICs are urgently needed.
153 More research is required to understand why some LMICs achieve substantially better
154 hypertension care cascade indicators than others and how the hypertension care cascade can be
155 improved most effectively in different settings.

156 **Introduction**

157 Hypertension is a major risk factor for several common non-communicable diseases (NCDs) in
158 low- and middle-income countries (LMICs), particularly stroke, heart disease, and chronic
159 kidney disease.¹ The prevalence of hypertension is increasing dramatically in LMICs.² In fact,
160 the world regions with the highest hypertension prevalence are now thought to be sub-Saharan
161 Africa, South Asia, and Central and Eastern Europe – all regions that are largely comprised of
162 LMICs.²

163
164 Evidence regarding where in the hypertension care continuum from screening to successful
165 treatment patients are lost to care, and how these patterns vary between and within countries, is
166 essential to designing effective health services interventions to improve hypertension control. In
167 addition, assessing the success of health systems in managing important – yet inexpensively
168 treatable – NCD risk factors, like hypertension,³ would be a useful measure of health system
169 performance that could feasibly be tracked as part of national and international targets, such as
170 the move towards universal health coverage.⁴ Specifically, as LMICs undergo the
171 epidemiological transition from acute communicable to chronic non-communicable diseases,
172 such a health system performance measure could help track countries' progress in shifting health
173 services away from mainly providing episodic care for acute conditions towards furnishing long-
174 term, person-centred care for chronic conditions.

175
176 Estimates of health system performance for hypertension from population-based studies in
177 LMICs are sparse.⁵ This dearth of evidence – along with the projected rapid rise in the number of
178 people with hypertension in these settings⁶ – was the main reason for this collaboration's focus

179 on LMICs rather than high-income countries. In an effort to inform the design of health services
180 interventions and provide a cross-country comparison of health system performance for
181 managing hypertension, this study aimed to i) determine where patients in LMICs are lost to care
182 along the hypertension management continuum, and ii) how these patterns vary among countries
183 and population groups within countries.

184

185 **Methods**

186 **Data sources:**

187 We requested access to the most recent nationally representative World Health Organisation
188 (WHO) Stepwise Approach to Surveillance (STEPS) survey conducted since 2005 for all
189 countries that were, as per the World Bank, a LMIC at the time of the survey. This search led to
190 access to the individual-level data of 22 surveys (**Figure S1**). We preferred STEPS surveys
191 because they use the same standardised questionnaire, tend to sample a wide age range of adults,
192 and are the official method developed by the WHO for monitoring NCD risk factors at the
193 population level.⁷ For LMICs for which we were unable to acquire an eligible STEPS survey, we
194 conducted a systematic search (**Text S1**), which led to the inclusion of an additional 22 survey
195 datasets (**Figure S2**). Detailed information on the sampling strategy of each survey is provided in
196 **Text S2**. Forty countries measured BP using a digital upper arm meter, two using a digital wrist
197 meter, and two using a manual mercury sphygmomanometer (**Table S1**). Thirty-five countries
198 measured BP three times, five two times, three two times with a third measurement if the first
199 two differed by a pre-defined margin, and one (the Seychelles) five times.

200

201 **Definition of hypertension:**

202 Hypertension was defined as systolic BP ≥ 140 mmHg or diastolic BP ≥ 90 mmHg or reporting use
203 of medications for hypertension. For participants with three BP measurements, we used the mean
204 of the last two measurements (last four for the Seychelles); for participants with only two
205 measurements, we computed the mean of both available measurements.

206

207 **Constructing the hypertension care cascade:**

208 We computed the percentage of all those with hypertension who had ever received a BP
209 measurement ('ever measured' [step 1]), had been diagnosed with hypertension by a healthcare
210 provider ('diagnosed' [step 2]), were currently taking anti-hypertensive medication ('treated'
211 [step 3]), and had a normal BP (systolic BP < 140 mmHg and a diastolic BP < 90 mmHg) plus
212 reported to have received relevant lifestyle advice and/or to be taking anti-hypertensive
213 medication ('controlled' [step 4]). In supplementary analyses, we show all results when defining
214 'treated' as having received relevant lifestyle advice or taking anti-hypertensive medication.
215 More detail on the computation of the care cascade is provided in **Text S3**.

216

217 **Statistical analysis:**

218 None of the analyses presented in this manuscript were pre-specified. Countries were categorised
219 according to the regional groupings of the WHO regional offices whereby the European and
220 Eastern Mediterranean Region as well as the South-East Asia and Western Pacific Region were
221 merged to avoid having only two countries with data in a region. All analyses accounted for the
222 complex survey design using sampling weights. Our primary analyses weighted each country
223 proportional to its population size in 2015.⁸ In supplementary analyses, we show all results when
224 assigning the same weight to each country.

225

226 We plotted the proportion of participants with hypertension in a country who reached each step
227 of the care cascade against countries' Gross Domestic Product (GDP) per capita (in constant
228 2011 international dollars as estimated by the World Bank⁹) in the year of data collection for the
229 survey to ascertain health system performance relative to a country's wealth. In addition, we
230 regressed – separately for each cascade step – the proportion of participants with hypertension
231 who reached the given step on sex, ten-year age group, education, household wealth quintile,
232 BMI group (BMI<18.5kg/m² [underweight], 18.5≤BMI<25.0kg/m² [normal weight],
233 25.0≤BMI<30.0kg/m² [overweight], and BMI≥30.0kg/m² [obese]), and a binary indicator for
234 current tobacco smoking. Specifically, we fitted uni- and multi-variable Poisson regressions with
235 a country-level fixed effect adjusting standard errors for clustering at the level of the primary
236 sampling unit. In 20 countries, household wealth quintile was computed based on a principal
237 component analysis of participants' answers to a suite of questions on key household dwelling
238 characteristics and household ownership of durable goods. Fourteen countries did not have these
239 data but did have data on household income, which we used instead to create household wealth
240 quintiles for these surveys. More detail is provided in **Text S4**. Household wealth, smoking, and
241 BMI data was not available for ten, six, and five countries, respectively (**Table S4**). These
242 countries were therefore removed from those regressions that included these variables as
243 independent variables. All analyses were complete case analyses.

244

245 **Ethics:**

246 This study received a determination of “not human subjects research” by the institutional review
247 board of the Harvard T.H. Chan School of Public Health on 9 May 2018.

248

249 **Role of the funding source:**

250 The funder had no role in study design, data collection, data analysis, data interpretation, or
251 writing of the report. PG and LMJ had full access to all the data in the study and had final
252 responsibility for the decision to submit for publication.

253

254 **Results**

255 **Sample characteristics:**

256 The survey-level median response rate was 90.9% (interquartile range [IQR]: 81.5 – 95.6)
257 (**Table 1**). Among those interviewed, the percentage of participants with a missing outcome (BP
258 or response to the first cascade step) ranged from 0.0% in Belize, Romania, and the Seychelles to
259 30.2% in Mexico, whereby the survey-level median was 2.3% (IQR: 0.6 – 8.6). 1,100,507
260 participants with a non-missing outcome were included in the analysis. The survey-level median
261 age among these participants was 39.5 years (IQR: 34.8 – 44.5). 192,441 (17.5%) participants
262 had hypertension. Detailed sample characteristics are shown in **Table S2-4**.

263

264 **The hypertension care cascade by country and region:**

265 The prevalence of hypertension and undiagnosed hypertension by country and ten-year age
266 group is shown in **Table S5**. Among those with hypertension, 73.6% (95% CI, 72.9 – 74.3) ever
267 had their BP measured, 39.2% (95% CI, 38.2 – 40.3) had been diagnosed prior to the survey,
268 29.9% (95% CI, 28.6 - 31.3) were treated, and 10.3% (95% CI, 9.6 – 11.0) had achieved control
269 of their hypertension (**Figure S3**). 31.7% (95% CI, 30.6 – 32.7) of those with hypertension had
270 received relevant lifestyle or took anti-hypertensive medication (**Figure S4**). The estimates for
271 each cascade step were similar when assigning an equal weight to each country (**Figure S5-6**).

272 **Figure S7-10** shows the care cascade disaggregated by ten-year age group. The hypertension
273 care cascade for each country is shown in **Figure S11-12**.

274

275 Out of the four world regions examined, Latin America and the Caribbean had the best care
276 cascade indicators, while sub-Saharan Africa had the worst (**Figure 1** and **Table S6-7**). Fewer
277 than five percent of those with hypertension had achieved control in ten of 16 countries (63%) in
278 sub-Saharan Africa, compared to three of eight (38%) in South-East Asia and the Western
279 Pacific, one of ten (10%) in Europe and the Eastern Mediterranean, and zero of 10 countries
280 (0%) in Latin America and the Caribbean (**Table S8**). Within regions, there was substantial
281 variation among countries with Costa Rica being the best-performing country for each cascade
282 step in Latin America and the Caribbean. Other high-performing countries – relative to other
283 countries in their region – were Bangladesh, Namibia, and Romania. The relative differences
284 between regions and countries were similar when defining treatment as receiving lifestyle advice
285 or taking anti-hypertensive medication (**Figure S13**), weighting countries equally (**Figure S14-**
286 **15**), and disaggregating the care cascade in each region by ten-year age group (**Figure S16-17**).

287

288 **The hypertension care cascade by Gross Domestic Product per capita:**

289 GDP per capita was positively associated with a country's performance for each cascade step
290 (**Figure 2**). Countries that performed substantially better on all cascade steps than predicted
291 based on their GDP per capita in the year of the survey were Bangladesh, Brazil (excluding the
292 first step as the 95% prediction interval at Brazil's GDP per capita included perfect performance
293 for 'ever measured'), Costa Rica, Ecuador, Kyrgyzstan, and Peru ('ever measured' was not
294 assessed in Kyrgyzstan and Peru). Countries that performed significantly worse on all cascade

295 steps than expected based on GDP per capita were Albania ('ever measured' was not assessed),
296 Indonesia ('ever measured' was not assessed), Tanzania, Uganda, and South Africa. These
297 results were similar when defining treatment as receiving lifestyle advice or taking anti-
298 hypertensive medications (**Figure S18**), and when examining hypertension care cascade
299 indicators by GDP per capita separately for each ten-year age group (**Figure S19-22**).

300

301 **Individual-level predictors of cascade progression:**

302 Being a woman, in an older age group, and in a higher household wealth quintile were all
303 associated with a higher probability of reaching each cascade step in both uni- and multi-variable
304 regressions (**Table 2**). In addition, except for the controlled step in the multi-variable regression,
305 being overweight or obese was associated with a higher probability of reaching each cascade step
306 in all regressions. Furthermore, we found that i) higher educational attainment was positively
307 associated with reaching each cascade step once adjusted for age and sex; ii) current smokers had
308 a lower probability of reaching each cascade step than those who did not currently smoke; and
309 iii) being obese was associated with a higher RR of reaching each cascade step (with the
310 exception of the controlled step in the multi-variable regression) than being overweight. The
311 positive associations with education were strongest in low-income countries and weakest in
312 upper middle-income countries (**Table S9**). By region, these positive associations with education
313 were generally strongest in sub-Saharan Africa, and did not exist – or were significant in the
314 negative direction in some regression models – in the Europe and Eastern Mediterranean region
315 (**Table S10**). All regression results were similar when assigning the same weight to each country
316 (**Table S11-13**).

317

318 Stratifying the percent of participants with hypertension who reached each cascade step by sex,
319 age group, and education (**Figure 3**) demonstrates that i) the proportion achieving control was
320 less than 20% in all age and education group combinations; ii) in each educational attainment
321 category, less than half were diagnosed in age groups below 55 years; and iii) women had a
322 higher probability of reaching each cascade step than men in virtually all age and education
323 group combinations.

324

325 **Discussion**

326 Overall, the performance of health systems in LMICs for managing hypertension was poor, with
327 less than half of those with hypertension having been diagnosed, less than a third taking anti-
328 hypertensive medications, and only one in ten achieving control. However, there was a large
329 degree of variation among regions and countries. Regionally, Latin America and the Caribbean
330 performed best and sub-Saharan Africa fared worst. Relative to GDP per capita, several
331 countries in Latin America and the Caribbean (Brazil, Costa Rica, Ecuador, and Peru) as well as
332 Bangladesh and Kyrgyzstan performed well. Together, these findings provide an important
333 benchmark of health system performance for managing hypertension in LMICs against which
334 future progress can be compared.

335

336 Within countries, we found that men were less likely to reach each step of the hypertension care
337 cascade than women, which may be due to multiple factors, such as a focus of primary
338 healthcare services on maternal and child health, gender norms concerning care-seeking, and
339 healthcare facility opening hours. As hypertension care services are strengthened in LMICs, it
340 will be crucial that health systems identify ways of engaging men in hypertension screening and

341 care to avoid further widening the existing gender gap in life expectancy.¹⁰ In addition, given our
342 finding that those who were smokers and with overweight or obesity did generally not have a
343 higher probability of completing the hypertension cascade, it will be important for hypertension
344 services in LMICs to more consistently reach and retain those at the highest CVD risk. Lastly,
345 we observed that individuals with lower education and household wealth were generally more
346 likely to be lost to care prior to completion of the cascade. This finding is especially concerning
347 given that those of a lower socioeconomic status are likely less able to access high-quality care
348 for, and more likely to experience catastrophic healthcare expenditures from, CVD events.¹¹
349 More optimistically, however, our findings also imply that well-designed investments in
350 improving hypertension care present an opportunity to reduce health inequalities between
351 socioeconomic groups in LMICs.

352

353 Relative to their GDP per capita, countries that performed particularly well in our analysis
354 included Costa Rica, Kyrgyzstan, and Bangladesh, implying that important lessons could be
355 learned from the approaches adopted by these health systems. We briefly outline three possible
356 reasons that may partially explain these countries' comparatively strong performance. First, they
357 have all established primary healthcare system structures at a highly local geographic level.
358 Costa Rica's EBAIS clinics each serve a population of 4,000 people and offer a full range of
359 primary care and health promotion services.¹² Similarly, Kyrgyzstan has established family
360 group practices that provide comprehensive primary healthcare, with each practice serving a
361 village of at least 2,000 inhabitants.¹³ Bangladesh has invested since 2009 in the establishment of
362 approximately 14,000 community clinics, which are tasked with providing hypertension and
363 diabetes screening.¹⁴ In addition, it has an extensive presence of informal providers, licensed and

364 unlicensed drug stores, and non-governmental organisations throughout the country,¹⁵ which are
365 likely also playing an important role in meeting the population's demand for NCD care at a local
366 level. Second, the health systems of Costa Rica and Kyrgyzstan have implemented structures that
367 allow for effective community outreach for NCDs. Each of Costa Rica's community clinics
368 include at least one community health worker (CHW) who measures BP during home visits and
369 follows up at home with patients lost from care.^{16,17} In addition, CHWs in Costa Rica hold health
370 promotion sessions – including on CVD prevention – in community settings, which can help in
371 the generation of demand for care. Kyrgyzstan has established village health committees, which
372 consist of volunteers who were trained by primary healthcare staff to provide basic health
373 promotion and care services, including for hypertension.¹³ While Bangladesh has several large-
374 scale CHW programmes,¹⁸ these mostly do not yet focus on NCDs.¹⁸ However, moving forward,
375 the existence of these large-scale CHW programmes presents an important opportunity for the
376 country to further improve hypertension and NCD care. Third, anti-hypertensive medications are
377 generally both available and affordable in all three countries, which is not the norm in many
378 LMICs.¹⁹ In Costa Rica, these medications are fully covered under the Costa Rican social
379 security fund and widely available at primary care facilities.¹⁷ In Kyrgyzstan, a 2015 survey
380 found that key anti-hypertensive medications were widely available and generally affordable to
381 the local population.²⁰ Similarly, in Bangladesh, the PURE study found that calcium-channel
382 blockers and β -blockers were available in 43 and 49 of 55 communities, respectively, and only
383 7% of sampled households were unable to afford at least one type of anti-hypertensive
384 medication.²¹

385

386 While the hypertension care cascade is a useful measure of health system performance in
387 LMICs, there are important contextual factors beyond the health system that likely are
388 responsible for some of the differences in the success of hypertension management that we
389 observed between and within countries. Perhaps most importantly, the probability of reaching
390 each of the care cascade steps likely is affected by individuals' socioeconomic circumstances,
391 which in turn vary widely between and within countries. For instance, even if care is provided
392 free of charge, time lost from income-generating activities and transport costs can still pose a
393 substantial obstacle to accessing care for those with little income and savings.²² Likewise,
394 individuals with a lower educational attainment may be less well-equipped to engage with
395 relevant health promotion messages and to actively negotiate an effective treatment plan with
396 healthcare providers. In addition to socioeconomic circumstances, epidemiological factors may
397 affect the hypertension care cascade. For instance, adults living in populations that are exposed
398 to a high risk of a fatal non-CVD event, such as through infectious diseases, may be less willing
399 to invest time, effort, and money into the prevention of CVD events. Similarly, even though
400 hypertension control can be achieved solely through medications, social and environmental
401 factors that affect BP – such as sodium content of the food supply,²³ air pollution,²⁴
402 conduciveness of the physical environment to physical activity,²³ and social norms to diet, excess
403 weight, and exercise – likely also have an impact on the probability that individuals achieve
404 hypertension control, especially among adults with low medication adherence.

405

406 This study has several limitations. First and foremost, while many surveys used the same WHO
407 STEPS questionnaire to enquire about hypertension care and employed a similar approach to
408 measuring BP, there were some differences in how questions were phrased and translated into

409 local languages, and in how BP was measured (e.g., the exact model of BP meter). This may
410 have affected our estimates and thus be responsible for some of the variation that we observed
411 between countries and regions. Of note, however, is that the core elements of the questions asked
412 about hypertension care were the same across surveys. Second, the age range sampled in each
413 survey varied between countries. We have minimized potential bias from this data constraint by
414 showing each figure that compares countries or regions separately for each ten-year age group
415 (see **Figure S7-10, S16-17, and S19-22**). Third, while – to our knowledge – this study includes
416 the largest set of LMICs of any study on this topic thus far, the 44 LMICs in this analysis
417 (representing 67% of the population living in LMICs worldwide⁸) are not representative of all
418 LMICs globally. Specifically, it is possible that LMICs included in this analysis had better
419 hypertension care indicators because implementing a survey that was eligible for this study may
420 be a sign of a country’s commitment to hypertension care. Fourth, the surveys were conducted at
421 different time points. Each country’s performance should thus be interpreted as the performance
422 in the given survey year rather than as the country’s current performance. To reduce bias from
423 secular trends when comparing countries against each other, we benchmarked performance
424 against each country’s GDP per capita in the survey year (rather than current GDP per capita).
425 Fifth, even though the median percentage across countries of missing values for the variables
426 needed to ascertain the hypertension care cascade was only 2.3%, some countries had a
427 substantially higher proportion of participants with a missing outcome variable, which could
428 have resulted in selection bias. Sixth, due to data constraints, we used the same threshold in each
429 survey to define a BP that requires treatment. This approach, thus, ignored that guidelines in use
430 in some countries at the time of the survey may have defined eligibility for anti-hypertensive
431 medications differently, such as based on a global CVD risk or target-organ damage. Lastly,

432 because we did not include a previous hypertension diagnosis in our definition of hypertension,
433 we may have falsely excluded some participants with hypertension from our care cascade
434 analysis. Our hypertension definition, however, is the same as was used in other studies of
435 hypertension care,²⁵⁻²⁸ and yields conservative estimates for the care cascade under the
436 assumption that some of those who reported a previous hypertension diagnosis, but had a normal
437 BP and did not report to be on treatment, did, in fact, not have hypertension.

438

439 This study identified important variation in the hypertension care cascade between and within
440 countries, which can guide governments with regards to the design – such as whether to prioritise
441 efforts to improve screening, diagnosis, treatment initiation, or medication adherence – and
442 target groups of appropriate interventions and reforms. Given that hypertension is a major risk
443 factor for several of the most common causes of death in LMICs,¹ and that the condition can be
444 effectively controlled at a low cost,³ the hypertension care cascade could be used as an important
445 tracer of health system performance in LMICs. Improving hypertension care, however, will be a
446 formidable undertaking requiring strong political will and financial commitments.

447

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452

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454 PG, JMG, JID, TB, RA, SV, and LMJ co-conceived the study. PG, JMG, MEM, CE, JID, TB,
455 RA, SV, and LMJ led the data collation. PG, JMG, and LMJ led the data analysis. PG wrote the
456 first draft of the manuscript and all authors provided critical inputs on multiple iterations. All
457 authors have approved the final version. PG is the guarantor of the work.

458

459 **Declaration of interests**

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461 All other authors declare no competing interests.

462

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468

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- 551

552 **Figure legends**

553 Figure 1. The hypertension care cascade by region^{1,2}

554 ¹ Vertical error bars are 95% confidence intervals.

555 ² Individual points depict the point estimate for each country.

556 Abbreviations: S.E. Asia=South-East Asia; W. Pacific = Western Pacific; ALB=Albania;

557 AZE=Azerbaijan; BGD=Bangladesh; BLZ=Belize; CRI=Costa Rica; IDN=Indonesia;

558 KAZ=Kazakhstan; KGZ=Kyrgyz Republic; LSO=Lesotho; MEX=Mexico; MNG=Mongolia

559 MOZ=Mozambique; NAM=Namibia; NPL=Nepal; PER=Peru; ROU=Romania;

560 SYC=Seychelles; TLS=Timor-Leste; UGA=Uganda; ZAN=Zanzibar

561

562 Figure 2. Hypertension care cascade indicators by GDP per capita^{1,2,3,4,5,6}

563 ¹ Gross Domestic Product per capita is shown in constant 2011 international dollars for the year
564 in which the survey was carried out.

565 ² The grey ribbon depicts the point-wise 95% prediction interval.

566 ³ The vertical bars depict 95% confidence intervals.

567 ⁴ The p-values for the coefficients of the linear regressions of each cascade step onto GDP per
568 capita (with each country having the same weight) were <0.001 except for ‘Controlled’
569 (p=0.0014)

570 ⁵ Country labels are not shown for the following countries in the “controlled” plot to avoid over-
571 crowding: Benin, Burkina Faso, Comoros, Ghana, Kenya, Liberia, Mozambique, Nepal,
572 Tanzania, Timor-Leste, Togo, and Uganda.

573 ⁶ The figure is shown separately for each ten-year age group in Figure S19-22.

574

575 Abbreviations: ALB=Albania; AZE=Azerbaijan; BEN=Benin; BFA=Burkina Faso;
576 BGD=Bangladesh; BLZ=Belize; BRA=Brazil; BTN=Bhutan; CHL=Chile; CHN=China;
577 COM=Comoros; CRI=Costa Rica; ECU=Ecuador; EGY=Egypt; GDP=Gross Domestic Product;
578 GEO=Georgia; GHA=Ghana; GRD=Grenada; GUY=Guyana; IDN=Indonesia; IND=India;
579 KAZ=Kazakhstan; int=international; KEN=Kenya; KGZ=Kyrgyzstan; LBN=Lebanon;
580 LBR=Liberia; LSO=Lesotho; MEX=Mexico; MNG=Mongolia; MOZ=Mozambique;
581 NAM=Namibia; NPL=Nepal; PER=Peru; ROU=Romania; RUS=Russian Federation;
582 SWZ=Swaziland; SYC=Seychelles; TGO=Togo; TLS=Timor-Leste; TZA=Tanzania;
583 UGA=Uganda; UKR=Ukraine; VCT=St. Vincent & the Grenadines; ZAF=South Africa;
584 ZAN=Zanzibar

585

586 Figure 3. The percent of participants with hypertension reaching each cascade step stratified by
587 sex, age group, and education.^{1,2,3}

588 ¹ The colour gradient and the numbers in each cell of the figure display the same point estimates.

589 ² ‘Primary school’ refers to having received some primary schooling or having completed
590 primary school.

591 ³ ‘High school or above’ refers to having received some secondary schooling, having completed
592 secondary school, or having received some type of tertiary education.

593

Table 1. Survey characteristics by region^{1,2}

| Country | Year ³ | Response rate (%) ⁴ | Missing outcome ⁵ (%) | Sample size | Hypertensive, n (%) | Median age (y) | Age range (y) | Female (%) | GDP per capita ⁶ | Population in 2015 (thousands) |
|--|-------------------|--------------------------------|----------------------------------|-------------|---------------------|----------------|---------------|------------|-----------------------------|--------------------------------|
| <i>Latin America and the Caribbean</i> | | | | | | | | | | |
| Belize | 2005/06 | 92.6 | 0.0 | 2,434 | 695 (28.6) | 44 | 20-97 | 59.0 | 7,947 | 359 |
| Brazil | 2013 | 86.0 | 10.6 | 57,466 | 17,517 (30.5) | 41 | 18-101 | 56.5 | 15,430 | 205,962 |
| Chile | 2009/10 | 85.0 | 8.4 | 4,851 | 1,497 (30.9) | 46 | 15-100 | 59.8 | 18,995 | 17,763 |
| Costa Rica | 2010 | 87.8 | 0.6 | 3,607 | 1,291 (35.8) | 47 | 18-110 | 72.0 | 13,000 | 4,808 |
| Ecuador | 2012 | 81.5 | 19.8 | 29,659 | 2,834 (9.6) | 34 | 20-59 | 58.7 | 10,322 | 16,144 |
| Grenada | 2011/12 | 67.8 | 2.8 | 1,097 | 460 (41.9) | 44 | 24-64 | 59.9 | 11,249 | 107 |
| Guyana | 2016 | 66.7 | 0.6 | 2,640 | 776 (29.4) | 40 | 18-69 | 59.9 | 7,266 | 769 |
| Mexico | 2009-12 | 90.0 | 30.2 | 20,946 | 5,066 (24.2) | 35 | 15-99 | 56.6 | 15,668 | 125,891 |
| Peru | 2012 | 94.3 ⁷ | 5.3 | 29,415 | 7,771 (26.4) | 54 | 40-96 | 52.6 | 10,944 | 31,377 |
| St. Vincent & the Grenadines | 2013 | 67.8 | 0.4 | 3,457 | 1,056 (30.5) | 42 | 18-70 | 55.9 | 10,193 | 109 |
| <i>Europe and the Eastern Mediterranean</i> | | | | | | | | | | |
| Albania | 2008 | 95.4 | 4.3 | 6,380 | 1,494 (23.4) | 33 | 15-49 | 55.2 | 9,154 | 2,923 |
| Azerbaijan | 2006 | 83.3 | 0.4 | 10,486 | 1,712 (16.3) | 32 | 15-59 | 75.9 | 10,711 | 9,617 |
| Egypt | 2015 | 95.0 | 0.5 | 14,790 | 2,476 (16.7) | 33 | 15-59 | 53.0 | 10,096 | 93,778 |
| Georgia | 2016 | 75.7 | 4.2 | 4,034 | 1,800 (44.6) | 50 | 17-70 | 70.4 | 9,277 | 3,952 |
| Kazakhstan | 2012 | 93.0 | 13.8 | 10,901 | 2,995 (27.5) | 43 | 15-90 | 57.3 | 21,987 | 17,750 |
| Kyrgyzstan | 2012 | 96.5 | 2.5 | 9,422 | 852 (9.0) | 29 | 15-49 | 75.5 | 2,870 | 5,865 |
| Lebanon | 2008/09 | 62.0 | 1.2 | 2,800 | 841 (30.0) | 37 | 18-95 | 52.9 | 15,193 | 5,851 |
| Romania | 2015/16 | 69.1 | 0.0 | 1,970 | 611 (31.0) | 47 | 18-80 | 52.5 | 21,080 | 19,877 |
| Russia | 2007/08 | 61.4 | 2.7 | 4,209 | 2,696 (64.1) | 62 | 18-100 | 64.2 | 24,006 | 143,888 |
| Ukraine | 2007 | 81.5 | 17.9 | 7,932 | 2,013 (25.4) | 33 | 15-49 | 68.4 | 8,497 | 44,658 |
| <i>South-East Asia and the Western Pacific</i> | | | | | | | | | | |
| Bangladesh | 2011 | 95.0 | 10.4 | 7,593 | 2,052 (27.0) | 48 | 35-96 | 49.5 | 2,571 | 161,201 |
| Bhutan | 2014 | 96.9 | 0.2 | 2,814 | 1,107 (39.3) | 39 | 18-69 | 61.9 | 7,366 | 787 |
| China | 2009 | 88.0 ⁸ | 9.3 | 9,752 | 2,842 (29.1) | 50 | 15-99 | 52.5 | 8,652 | 1,397,029 |
| India | 2015/16 | 96.0 | 2.0 | 742,838 | 98,451 (13.3) | 30 | 15-54 | 85.6 | 5,924 | 1,309,054 |
| Indonesia | 2014 | 83.0 | 0.7 | 32,492 | 7,882 (24.3) | 35 | 15-110 | 53.2 | 10,003 | 258,162 |
| Mongolia | 2009 | 95.0 | 0.4 | 5,420 | 1,719 (31.7) | 36 | 15-65 | 40.8 | 7,368 | 2,977 |
| Nepal | 2013 | 98.6 | 0.5 | 4,124 | 1,211 (29.4) | 40 | 15-69 | 67.8 | 2,164 | 28,656 |

| | | | | | | | | | | |
|---------------------------|---------|--|---|-------------------------|---|--|--------|--|--|-------------------------|
| Timor-Leste | 2014 | 96.3 | 1.6 | 2,568 | 713 (27.8) | 40 | 18-69 | 58.5 | 1,888 | 1,241 |
| Sub-Saharan Africa | | | | | | | | | | |
| Benin | 2008 | 99.0 | 0.3 | 3,799 | 1,218 (32.1) | 42 | 15-65 | 51.5 | 1,841 | 10,576 |
| Burkina Faso | 2013 | 97.8 | 15.1 | 3,993 | 713 (17.9) | 36 | 25-64 | 53.9 | 1,562 | 18,111 |
| Comoros | 2011 | 96.5 | 1.4 | 5,381 | 1,443 (26.8) | 39 | 25-64 | 71.2 | 1,415 | 777 |
| Ghana | 2007/08 | 79.4 | 9.6 | 5,030 | 2,677 (53.2) | 60 | 18-110 | 46.7 | 2,760 | 27,583 |
| Kenya | 2015 | 95.0 | 1.4 | 4,408 | 1,188 (27.0) | 35 | 18-69 | 60.2 | 2,836 | 47,236 |
| Lesotho | 2014 | 90.8 | 3.9 | 5,690 | 989 (17.4) | 27 | 15-59 | 52.6 | 2,677 | 2,175 |
| Liberia | 2011 | 87.1 | 1.7 | 2,482 | 719 (29.0) | 36 | 24-64 | 57.9 | 734 | 4,500 |
| Mozambique | 2005 | 98.3 | 7.0 | 3,073 | 1,102 (35.9) | 38 | 25-64 | 58.4 | 742 | 28,011 |
| Namibia | 2013 | 96.9 | 17.9 | 3,617 | 1,543 (42.7) | 46 | 35-64 | 57.6 | 9,256 | 2,426 |
| Seychelles | 2013 | 73.0 | 0.0 | 1,240 | 413 (33.3) | 47 | 25-64 | 57.2 | 24,791 | 94 |
| South Africa | 2012 | 39.8 | 3.6 | 6,317 | 2,644 (41.9) | 39 | 15-98 | 64.9 | 12,215 | 55,291 |
| Swaziland | 2014 | 81.8 | 9.9 | 3,183 | 948 (29.8) | 33 | 15-70 | 65.1 | 7,871 | 1,319 |
| Tanzania | 2012 | 94.7 | 1.2 | 5,636 | 1,737 (30.8) | 40 | 23-65 | 53.8 | 2,228 | 53,880 |
| Togo | 2010 | 91.0 | 3.7 | 4,190 | 846 (20.2) | 32 | 15-64 | 52.0 | 1,208 | 7,417 |
| Uganda | 2014 | 99.0 | 2.1 | 3,904 | 983 (25.2) | 33 | 18-69 | 59.8 | 1,637 | 40,145 |
| Zanzibar | 2011 | 91.0 | 0.7 | 2,467 | 848 (34.4) | 40 | 24-64 | 61.6 | 1,318 ⁹ | 1,441 ¹⁰ |
| Total | - | 90.9 ¹¹ (81.5 – 95.6) ¹² | 2.3 ¹¹ (0.6 – 8.6) ¹² | 1,100,507 ¹³ | 192,441 ¹³ (29.3 ¹¹) | 39.5 ¹¹ (34.8 – 44.5) ¹² | - | 58.2 ¹¹ (53.2 – 62.5) ¹² | 8,222 ¹¹ (2,651 – 11,491) ¹² | 4,177,630 ¹³ |

Abbreviations: n=number; y=years; GDP=Gross Domestic Product.

¹ Values are unweighted (i.e., do not account for the complex survey design).

² Except for the percent missing, all values were calculated among those with a non-missing outcome variable (i.e., no missing BP measurement or questionnaire answer needed to calculate the hypertension cascade).

³ Years in which the data collection for the survey was carried out.

⁴ This includes both the household and the individual response rate.

⁵ This is the percent of participants for whom the blood pressure measurement was missing or a who had a missing response for the survey question needed to ascertain whether the participant had reached the first step of the country's hypertension care cascade.

⁶ This is the GDP per capita in constant 2011 international dollars (as estimated by the World Bank⁹) for the year in which data was collected for the survey.

⁷ This is the response rate among women; the men's response rate in Peru was not available.

⁸ This is the response rate for the 2006 wave of the survey (the most recent wave for which a response rate was published).

⁹ This is the GDP per capita in constant 2007 international dollars using data from the Office of the Chief Government Statistician of Zanzibar.²⁹

¹⁰ The population estimate for Zanzibar was taken from the Tanzania Population Projection Report 2013-2035.³⁰

¹¹ This is the median value with each country having the same weight.

¹² This is the interquartile range.

¹³ This is the sum across all countries.

Table 2. Uni- and multi-variable regressions of each cascade step onto individual-level predictors¹

| | Ever BP measured | | Diagnosed | | Treated | | Controlled | |
|---|------------------|--------|------------------|--------|------------------|--------|------------------|--------|
| | RR | P | RR | P | RR | P | RR | P |
| Uni-variable regressions² | | | | | | | | |
| Sex | | | | | | | | |
| Male | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Female | 1.16 (1.14-1.18) | <0.001 | 1.39 (1.33-1.46) | <0.001 | 1.50 (1.41-1.58) | <0.001 | 1.69 (1.53-1.87) | <0.001 |
| Age group | | | | | | | | |
| 15-24 years | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| 25-34 years | 1.39 (1.33-1.46) | <0.001 | 1.51 (1.30-1.74) | <0.001 | 1.47 (1.22-1.77) | <0.001 | 1.09 (0.88-1.36) | 0.426 |
| 35-44 years | 1.52 (1.46-1.60) | <0.001 | 2.18 (1.93-2.47) | <0.001 | 2.24 (1.94-2.57) | <0.001 | 1.27 (1.09-1.48) | 0.002 |
| 45-54 years | 1.57 (1.50-1.65) | <0.001 | 3.14 (2.79-3.52) | <0.001 | 3.51 (3.08-4.00) | <0.001 | 1.67 (1.44-1.92) | <0.001 |
| 55-64 years | 1.57 (1.50-1.64) | <0.001 | 3.87 (3.43-4.36) | <0.001 | 4.78 (4.17-5.49) | <0.001 | 2.15 (1.81-2.55) | <0.001 |
| ≥65 years | 1.56 (1.48-1.64) | <0.001 | 4.21 (3.72-4.76) | <0.001 | 5.42 (4.72-6.22) | <0.001 | 2.10 (1.76-2.51) | <0.001 |
| Education | | | | | | | | |
| No schooling | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Primary school ³ | 1.08 (1.05-1.10) | <0.001 | 0.97 (0.91-1.04) | 0.454 | 0.97 (0.89-1.06) | 0.462 | 1.02 (0.86-1.22) | 0.807 |
| ≥ High school ⁴ | 1.13 (1.11-1.16) | <0.001 | 0.92 (0.86-0.98) | 0.014 | 0.88 (0.81-0.96) | 0.003 | 1.08 (0.92-1.27) | 0.322 |
| Household wealth quintile | | | | | | | | |
| 1 (poorest) | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| 2 | 1.12 (1.09-1.14) | <0.001 | 1.12 (1.02-1.23) | 0.021 | 1.14 (1.02-1.29) | 0.024 | 1.19 (0.98-1.44) | 0.075 |
| 3 | 1.18 (1.15-1.21) | <0.001 | 1.10 (1.00-1.20) | 0.053 | 1.12 (1.00-1.26) | 0.049 | 1.05 (0.87-1.27) | 0.596 |
| 4 | 1.26 (1.23-1.30) | <0.001 | 1.19 (1.10-1.29) | <0.001 | 1.25 (1.13-1.39) | <0.001 | 1.23 (1.02-1.49) | 0.026 |
| 5 (richest) | 1.36 (1.32-1.40) | <0.001 | 1.31 (1.20-1.44) | <0.001 | 1.42 (1.27-1.58) | <0.001 | 1.65 (1.38-1.98) | <0.001 |
| BMI group | | | | | | | | |
| Underweight | 0.82 (0.78-0.85) | <0.001 | 0.85 (0.75-0.96) | 0.009 | 0.86 (0.72-1.02) | 0.085 | 0.89 (0.72-1.10) | 0.265 |
| Normal weight | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Overweight | 1.16 (1.14-1.18) | <0.001 | 1.21 (1.15-1.28) | <0.001 | 1.22 (1.14-1.31) | <0.001 | 1.02 (0.89-1.17) | 0.730 |
| Obese | 1.25 (1.22-1.28) | <0.001 | 1.54 (1.43-1.66) | <0.001 | 1.66 (1.52-1.81) | <0.001 | 1.21 (1.05-1.40) | 0.007 |
| Tobacco smoking | | | | | | | | |
| Not currently smoking | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Currently smoking | 0.88 (0.86-0.90) | <0.001 | 0.76 (0.71-0.81) | <0.001 | 0.68 (0.62-0.74) | <0.001 | 0.59 (0.51-0.69) | <0.001 |

Multi-variable regression with age group, sex, and education⁵

| | | | | | | | | |
|-----------------------------|------------------|--------|------------------|--------|------------------|--------|------------------|--------|
| Sex | | | | | | | | |
| Male | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Female | 1.20 (1.18-1.23) | <0.001 | 1.40 (1.33-1.47) | <0.001 | 1.50 (1.42-1.59) | <0.001 | 1.78 (1.61-1.98) | <0.001 |
| Age group | | | | | | | | |
| 15-24 years | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| 25-34 years | 1.42 (1.36-1.49) | <0.001 | 1.50 (1.30-1.73) | <0.001 | 1.46 (1.22-1.76) | <0.001 | 1.08 (0.87-1.35) | 0.468 |
| 35-44 years | 1.57 (1.50-1.65) | <0.001 | 2.12 (1.87-2.41) | <0.001 | 2.15 (1.87-2.48) | <0.001 | 1.23 (1.05-1.43) | 0.010 |
| 45-54 years | 1.66 (1.58-1.74) | <0.001 | 3.14 (2.79-3.54) | <0.001 | 3.49 (3.06-3.99) | <0.001 | 1.68 (1.45-1.95) | <0.001 |
| 55-64 years | 1.66 (1.58-1.74) | <0.001 | 3.95 (3.48-4.48) | <0.001 | 4.86 (4.22-5.60) | <0.001 | 2.22 (1.85-2.66) | <0.001 |
| ≥65 years | 1.68 (1.59-1.77) | <0.001 | 4.45 (3.90-5.08) | <0.001 | 5.74 (4.96-6.64) | <0.001 | 2.31 (1.90-2.82) | <0.001 |
| Education | | | | | | | | |
| No schooling | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Primary school ³ | 1.14 (1.11-1.17) | <0.001 | 1.14 (1.06-1.23) | <0.001 | 1.18 (1.08-1.29) | <0.001 | 1.22 (1.03-1.46) | 0.024 |
| ≥ High school ⁴ | 1.26 (1.23-1.30) | <0.001 | 1.33 (1.24-1.42) | <0.001 | 1.39 (1.27-1.51) | <0.001 | 1.59 (1.34-1.88) | <0.001 |

Multi-variable regressions with all predictor variables⁶

| | | | | | | | | |
|-----------------------------|------------------|--------|------------------|--------|------------------|--------|------------------|--------|
| Sex | | | | | | | | |
| Male | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Female | 1.16 (1.14-1.18) | <0.001 | 1.26 (1.19-1.34) | <0.001 | 1.31 (1.22-1.42) | <0.001 | 1.54 (1.35-1.76) | <0.001 |
| Age group | | | | | | | | |
| 15-24 years | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| 25-34 years | 1.33 (1.27-1.39) | <0.001 | 1.29 (1.09-1.53) | 0.003 | 1.16 (0.93-1.44) | 0.187 | 0.95 (0.73-1.23) | 0.698 |
| 35-44 years | 1.42 (1.36-1.49) | <0.001 | 1.73 (1.49-2.01) | <0.001 | 1.61 (1.37-1.89) | <0.001 | 1.03 (0.85-1.23) | 0.790 |
| 45-54 years | 1.50 (1.44-1.57) | <0.001 | 2.61 (2.27-3.01) | <0.001 | 2.67 (2.30-3.10) | <0.001 | 1.40 (1.18-1.67) | <0.001 |
| 55-64 years | 1.47 (1.40-1.54) | <0.001 | 3.46 (2.96-4.06) | <0.001 | 3.92 (3.31-4.64) | <0.001 | 2.01 (1.60-2.53) | <0.001 |
| ≥65 years | 1.47 (1.40-1.54) | <0.001 | 4.02 (3.42-4.73) | <0.001 | 4.76 (4.01-5.63) | <0.001 | 2.11 (1.65-2.69) | <0.001 |
| Education | | | | | | | | |
| No schooling | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Primary school ³ | 1.08 (1.05-1.11) | <0.001 | 1.06 (0.97-1.16) | 0.179 | 1.09 (0.98-1.21) | 0.128 | 1.13 (0.90-1.43) | 0.279 |
| ≥ High school ⁴ | 1.11 (1.09-1.14) | <0.001 | 1.16 (1.06-1.27) | 0.001 | 1.17 (1.05-1.31) | 0.005 | 1.33 (1.06-1.66) | 0.013 |
| Household wealth quintile | | | | | | | | |
| 1 (poorest) | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| 2 | 1.09 (1.06-1.12) | <0.001 | 1.11 (1.00-1.23) | 0.051 | 1.13 (1.00-1.27) | 0.054 | 1.15 (0.91-1.44) | 0.242 |
| 3 | 1.14 (1.11-1.18) | <0.001 | 1.08 (0.98-1.19) | 0.119 | 1.12 (0.99-1.26) | 0.071 | 1.00 (0.80-1.26) | 0.993 |
| 4 | 1.20 (1.16-1.24) | <0.001 | 1.18 (1.07-1.30) | 0.001 | 1.25 (1.11-1.41) | <0.001 | 1.17 (0.93-1.48) | 0.186 |
| 5 (richest) | 1.27 (1.23-1.31) | <0.001 | 1.28 (1.16-1.41) | <0.001 | 1.36 (1.21-1.53) | <0.001 | 1.56 (1.23-1.96) | <0.001 |
| BMI | | | | | | | | |
| Underweight | 0.88 (0.84-0.91) | <0.001 | 0.84 (0.72-0.98) | 0.030 | 0.83 (0.68-1.01) | 0.057 | 0.87 (0.69-1.11) | 0.263 |

| | | | | | | | | |
|-----------------------|------------------|--------|------------------|--------|------------------|--------|------------------|-------|
| Normal weight | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Overweight | 1.08 (1.06-1.10) | <0.001 | 1.19 (1.12-1.27) | <0.001 | 1.20 (1.11-1.30) | <0.001 | 0.97 (0.83-1.13) | 0.655 |
| Obese | 1.11 (1.09-1.13) | <0.001 | 1.47 (1.37-1.59) | <0.001 | 1.58 (1.45-1.72) | <0.001 | 1.01 (0.86-1.20) | 0.873 |
| Tobacco smoking | | | | | | | | |
| Not currently smoking | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | | 1.00 (Ref.) | |
| Currently smoking | 0.94 (0.92-0.97) | <0.001 | 0.93 (0.86-1.00) | 0.048 | 0.87 (0.79-0.96) | 0.006 | 0.74 (0.62-0.89) | 0.001 |

Abbreviations: BP=blood pressure; RR=Risk Ratio; P=P-value; Ref.=reference category;

¹ Standard errors were adjusted for clustering at the level of the primary sampling unit.

² These regressions included only one of the variables shown in the table and a binary indicator for each country (country-level 'fixed effects').

³ This refers to having received some primary schooling or having completed primary school.

⁴ This refers to having received some secondary schooling, having completed secondary school, or having received some type of tertiary education.

⁵ These regressions included sex, age group, education, and a binary indicator for each country (country-level 'fixed effects').

⁶ These regressions included sex, age group, education, household wealth quintile, BMI, tobacco smoking, and a binary indicator for each country (country-level 'fixed effects').