

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

Geldsetzer, Pascal; Manne-Goehler, Jennifer; Marcus , Maja-Emilia ; Ebert, Cara; Zhumadilov, Zhaxybay ; Wesseh, Chea Stanford; Tsabedze, Lindiwe; Supiyev , Adil ; Sturua, Lela; Bahendeka, Silver K; Sibai , Abla M. ; Quesnel-Crooks, Sarah; Norov, Bolormaa; Mwangi, Joseph Kibachio; Mwalim, Omar; McClure, Roy Wong; Mayige, Mary T; Martins, Joao S; Lunet, Nuno ; Labadarios, Demetre

DOI:

[10.1016/S0140-6736\(19\)30955-9](https://doi.org/10.1016/S0140-6736(19)30955-9)

License:

Creative Commons: Attribution-NonCommercial-NoDerivs (CC BY-NC-ND)

*Document Version*

Peer reviewed version

*Citation for published version (Harvard):*

Geldsetzer, P, Manne-Goehler, J, Marcus , M-E, Ebert, C, Zhumadilov, Z, Wesseh, CS, Tsabedze, L, Supiyev , A, Sturua, L, Bahendeka, SK, Sibai , AM, Quesnel-Crooks, S, Norov, B, Mwangi, JK, Mwalim, O, McClure, RW, Mayige, MT, Martins, JS, Lunet, N, Labadarios, D, Karki, KB, Kagaruki, GB, Jorgensen , JMA, Hwalla , NC, Houinato, D, Houehanou, C, Msaidie, M, Guwatudde, D, Singh Gurung, M, Gathecha, G, Dorobantu, M, Damasceno , A, Bovet, P, Bicaba, BW, Aryal, KK, Andall-Brereton, G, Agoudavi, K, Stokes, A, Davies, J, Bärnighausen, T, Atun, R, Vollmer, S & Jaacks, LM 2019, 'The state of hypertension care in 44 low-income and middle-income countries: a cross-sectional study of nationally representative individual-level data from 1.1 million adults', *The Lancet*, vol. 394, no. 10199, pp. 652-662. [https://doi.org/10.1016/S0140-6736\(19\)30955-9](https://doi.org/10.1016/S0140-6736(19)30955-9)

[Link to publication on Research at Birmingham portal](#)

### General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

### Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact [UBIRA@lists.bham.ac.uk](mailto:UBIRA@lists.bham.ac.uk) providing details and we will remove access to the work immediately and investigate.

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  
5 Pascal Geldsetzer ScD<sup>1</sup>, Jennifer Manne-Goehler MD<sup>1,2</sup>, Maja-Emilia Marcus MA<sup>3</sup>, Cara Ebert  
6 MSc<sup>3</sup>, Zhaxybay Zhumadilov PhD<sup>4</sup>, Chea S. Wesseh MA<sup>5</sup>, Lindiwe Tsabedze MPH<sup>6</sup>, Adil  
7 Supiyev PhD<sup>7</sup>, Lela Sturua PhD<sup>8</sup>, Bahendeka K. Silver PhD<sup>9</sup>, Abla M. Sibai PhD<sup>10</sup>, Sarah  
8 Quesnel-Crooks MSc<sup>11</sup>, Bolormaa Norov MSc<sup>12</sup>, Joseph K. Mwangi MD<sup>13</sup>, Omar Mwalim  
9 MPH<sup>14</sup>, Roy Wong-McClure MD<sup>15</sup>, Mary T. Mayige MBChB<sup>16</sup>, Joao S. Martins PhD<sup>17</sup>, Nuno  
10 Lunet PhD<sup>18</sup>, Demetre Labadarios MBChB<sup>19</sup>, Khem B. Karki MD<sup>20</sup>, Gibson B. Kagaruki MSc<sup>16</sup>,  
11 Jutta M.A. Jorgensen MD<sup>21</sup>, Nahla C. Hwalla PhD<sup>22</sup>, Dismand Houinato PhD<sup>23</sup>, Corine  
12 Houehanou PhD<sup>23</sup>, Mohamed Msaidié MD<sup>24</sup>, David Guwatudde PhD<sup>25</sup>, Mongal S. Gurung  
13 PhD<sup>26</sup>, Gladwell Gathecha MSc<sup>13</sup>, Maria Dorobantu FESC<sup>27</sup>, Albertino Damasceno PhD<sup>18,28,29</sup>,  
14 Pascal Bovet MD<sup>30,31</sup>, Brice W. Bicaba MD<sup>32</sup>, Krishna K. Aryal PhD<sup>33</sup>, Glennis Andall-Brereton  
15 PhD<sup>11</sup>, Kokou Agoudavi MD<sup>34</sup>, Andrew Stokes PhD<sup>35</sup>, Justine I. Davies MD (res)<sup>36,37</sup>, Till  
16 Bärnighausen MD<sup>1,38,39,†,\*</sup>, Rifat Atun FRCP<sup>1,40,†</sup>, Sebastian Vollmer PhD<sup>1,3,†</sup>, Lindsay M. Jaacks  
17 PhD<sup>1,41,†</sup>

18  
19 <sup>1</sup> Department of Global Health and Population, Harvard T.H. Chan School of Public Health,  
20 Boston, MA, USA;

21 <sup>2</sup> Division of Infectious Diseases, Massachusetts General Hospital, Harvard Medical School,  
22 Boston, MA, USA;

23 <sup>3</sup> Department of Economics and Centre for Modern Indian Studies, University of Goettingen,  
24 Göttingen, Germany;

25 <sup>4</sup> National Laboratory Astana, University Medical Center, Nazarbayev University, Astana,  
26 Kazakhstan

27 <sup>5</sup> Liberia Ministry of Health, Monrovia, Liberia;

28 <sup>6</sup> Swaziland Ministry of Health, Mbabane, Swaziland;

29 <sup>7</sup> Laboratory of Epidemiology and Public Health, Center for Life Sciences, National Laboratory  
30 Astana, Nazarbayev University, Astana, Kazakhstan;

31 <sup>8</sup> Non-Communicable Disease Department, National Center for Disease Control and Public  
32 Health, Tbilisi, Georgia;

33 <sup>9</sup> Saint Francis Hospital, Nsambya, Kampala, Uganda;

34 <sup>10</sup> Department of Epidemiology & Population Health, Faculty of Health Sciences, American  
35 University of Beirut, Beirut, Lebanon

36 <sup>11</sup> Non-Communicable Diseases, Caribbean Public Health Agency, Port of Spain, Trinidad and  
37 Tobago;

38 <sup>12</sup> National Center for Public Health, Ulaanbaatar, Mongolia;

39 <sup>13</sup> Division of Non-Communicable Diseases, Kenya Ministry of Health, Nairobi, Kenya;

40 <sup>14</sup> Zanzibar Ministry of Health, Zanzibar;

41 <sup>15</sup> Epidemiology Office and Surveillance, Caja Costarricense de Seguro Social, San Jose, Costa  
42 Rica;

43 <sup>16</sup> National Institute for Medical Research, Dar es Salaam, Tanzania;

44 <sup>17</sup> Faculty of Medicine and Health Sciences, National University of East Timor, Rua Jacinto  
45 Candido, Dili, Timor-Leste;

46 <sup>18</sup> Departamento de Ciências da Saúde Pública e Forenses e Educação Médica, Faculdade de  
47 Medicina da Universidade do Porto, Porto, Portugal

48 <sup>19</sup> Faculty of Medicine and Health Sciences, Stellenbosch University, Stellenbosch, South Africa;  
49 <sup>20</sup> Nepal Health Research Council (NHRC), Ramshah Path, Kathmandu, Nepal;

50 <sup>21</sup> D-Tree International, Boston, MA, USA

51 <sup>22</sup> Faculty of Agricultural and Food Sciences, American University of Beirut, Beirut, Lebanon

52 <sup>23</sup> Laboratory of Epidemiology of Chronic and Neurological Diseases, Faculty of Health  
53 Sciences, University of Abomey-Calavi, Cotonou, Benin;

54 <sup>24</sup> Ministry of Health, Solidarity, Social Cohesion and Gender, Government of the Union of  
55 Comoros, Moroni, Union of Comoros;

56 <sup>25</sup> Department of Epidemiology and Biostatistics, School of Public Health, Makerere University,  
57 Kampala, Uganda;

58 <sup>26</sup> Health Research and Epidemiology Unit, Ministry of Health, Thimphu, Bhutan;

59 <sup>27</sup> Cardiology Department, Emergency Hospital of Bucharest, Bucharest, Romania;

60 <sup>28</sup> Faculdade de Medicina, Universidade Eduardo Mondlane, Maputo, Mozambique

61 <sup>29</sup> EPIUnit—Instituto de Saúde Pública, Universidade do Porto, Porto, Portugal

62 <sup>30</sup> Institute of Social and Preventive Medicine, Lausanne, Switzerland;

63 <sup>31</sup> Ministry of Health, Victoria, Republic of Seychelles;

64 <sup>32</sup> Institut Africain de Santé publique (IASP), Ouagadougou, Burkina Faso;

65 <sup>33</sup> DFID/NHSP3/MEOR, Abt Associates, Kathmandu, Nepal

66 <sup>34</sup> Togo Ministry of Health, Lome, Togo;

67 <sup>35</sup> Boston University Center for Global Health and Development, Boston, MA, USA;

68 <sup>36</sup> MRC/Wits Rural Public Health and Health Transitions Research Unit, School of Public  
69 Health, University of Witwatersrand, Johannesburg, South Africa;

70 <sup>37</sup> Institute of Applied Health Research, University of Birmingham, Birmingham, UK;

71 <sup>38</sup> Africa Health Research Institute, Somkhele, South Africa;

72 <sup>39</sup> Institute of Global Health, Heidelberg University, Heidelberg, Germany;

73 <sup>40</sup> Department of Global Health and Social Medicine, Harvard Medical School, Harvard  
74 University, Boston, Massachusetts, United States of America

75 <sup>41</sup> Public Health Foundation of India, New Delhi, Delhi NCR, India

76

77 † Joint senior authors.

78 Word count: 3,497 words (Abstract: 427 words)

79

80 \* **Corresponding author:**

81 Professor Till Bärnighausen

82 Institute of Global Health, Heidelberg University, 69120 Heidelberg, Germany

83 E-mail: [till.baernighausen@uni-heidelberg.de](mailto:till.baernighausen@uni-heidelberg.de)

84 Phone: +49 6221 565344

85

86 Full professors: Zhaxybay Zhumadilov, Abla M. Sibai, Demetre Labadarios, Nahla C. Hwalla,

87 Dismand Houinato, David Guwatudde, Maria Dorobantu, Justine I. Davies, Till Bärnighausen,

88 Rifat Atun, Sebastian Vollmer

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)  $\geq 140$  mmHg or  
99 diastolic BP  $\geq 90$  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.<sup>1</sup> The prevalence of hypertension is increasing dramatically in LMICs.<sup>2</sup> 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.<sup>2</sup>

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,<sup>3</sup> 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.<sup>4</sup> 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.<sup>5</sup> This dearth of evidence – along with the projected rapid rise in the number of  
178 people with hypertension in these settings<sup>6</sup> – 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.<sup>7</sup> 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  $\geq 140$ mmHg or diastolic BP  $\geq 90$ 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.<sup>8</sup> 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 Bank<sup>9</sup>) 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/m<sup>2</sup> [underweight], 18.5≤BMI<25.0kg/m<sup>2</sup> [normal weight],  
233 25.0≤BMI<30.0kg/m<sup>2</sup> [overweight], and BMI≥30.0kg/m<sup>2</sup> [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.<sup>10</sup> 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.<sup>11</sup>  
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.<sup>12</sup> 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.<sup>13</sup> 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.<sup>14</sup> In addition, it has an extensive presence of informal providers, licensed and

364 unlicensed drug stores, and non-governmental organisations throughout the country,<sup>15</sup> 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.<sup>16,17</sup> 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.<sup>13</sup> While Bangladesh has several large-  
374 scale CHW programmes,<sup>18</sup> these mostly do not yet focus on NCDs.<sup>18</sup> 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.<sup>19</sup> In Costa Rica, these medications are fully covered under the Costa Rican social  
379 security fund and widely available at primary care facilities.<sup>17</sup> In Kyrgyzstan, a 2015 survey  
380 found that key anti-hypertensive medications were widely available and generally affordable to  
381 the local population.<sup>20</sup> Similarly, in Bangladesh, the PURE study found that calcium-channel  
382 blockers and  $\beta$ -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.<sup>21</sup>

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.<sup>22</sup> 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,<sup>23</sup> air pollution,<sup>24</sup>  
402 conduciveness of the physical environment to physical activity,<sup>23</sup> 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 worldwide<sup>8</sup>) 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,<sup>25-28</sup> 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,<sup>1</sup> and that the condition can be  
444 effectively controlled at a low cost,<sup>3</sup> 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

#### 448 **Funding**

449 LMJ, PG, JMG, and RA received funding from the Harvard McLennan Family Fund. The  
450 corresponding author had full access to the data and had final responsibility for the decision to  
451 submit for publication.

452

#### 453 **Contributors**

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**

460 AS has received a research grant from Johnson & Johnson for work unrelated to this manuscript.

461 All other authors declare no competing interests.

462

#### 463 **Acknowledgements**

464 We would like to thank Clare Flanagan, Sarah Frank, Michaela Theilmann, Esther Lim, Yuanwei  
465 Xu, and Jacqueline Seiglie for help with data harmonization and translation of study  
466 documentation. We would also like to thank each of the country-level survey teams and study  
467 participants who made this analysis possible.

468

469 **References**

- 470 1. GBD 2017 Risk Factors Collaborators. Global, regional, and national comparative risk  
471 assessment of 84 behavioural, environmental and occupational, and metabolic risks or clusters of  
472 risks for 195 countries and territories, 1990-2017: a systematic analysis for the Global Burden of  
473 Disease Study 2017. *Lancet* 2018; 392(10159):1923-1994.
- 474 2. NCD Risk Factor Collaboration (NCD-RisC). Worldwide trends in blood pressure from  
475 1975 to 2015: a pooled analysis of 1479 population-based measurement studies with 19.1 million  
476 participants. *Lancet* 2017; 389(10064): 37-55.
- 477 3. Prabhakaran D, Anand S, Watkins D, et al. Cardiovascular, respiratory, and related  
478 disorders: key messages from Disease Control Priorities, 3rd edition. *Lancet* 2018; 391(10126):  
479 1224-36.
- 480 4. Hogan DR, Stevens GA, Hosseinpoor AR, Boerma T. Monitoring universal health  
481 coverage within the Sustainable Development Goals: development and baseline data for an index  
482 of essential health services. *Lancet Global Health* 2018; 6(2): e152-e68.
- 483 5. Ikeda N, Sapienza D, Guerrero R, et al. Control of hypertension with medication: a  
484 comparative analysis of national surveys in 20 countries. *Bulletin of the World Health  
485 Organization* 2014; 92(1): 10-9c.
- 486 6. Sudharsanan N, Geldsetzer P. Impact of Coming Demographic Changes on the Number  
487 of Adults in Need of Care for Hypertension in Brazil, China, India, Indonesia, Mexico, and  
488 South Africa. *Hypertension* 2019; 73(4):770-776.
- 489 7. Riley L, Guthold R, Cowan M, et al. The World Health Organization STEPwise  
490 Approach to Noncommunicable Disease Risk-Factor Surveillance: Methods, Challenges, and  
491 Opportunities. *American Journal of Public Health* 2016; 106(1): 74-8.



- 492 8. United Nations Population Division. World Population Prospects: The 2017 Revision,  
493 Key Findings and Advance Tables. New York, NY: United Nations, 2017.
- 494 9. The World Bank. GDP per capita, PPP (constant 2011 international \$). 2018.  
495 <https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.KD> (accessed May 22 2018).
- 496 10. World Health Organisation. World Health Statistics 2018: Monitoring health for the  
497 SDGs. Geneva, Switzerland: World Health Organisation, 2018.
- 498 11. Jan S, Laba TL, Essue BM, et al. Action to address the household economic burden of  
499 non-communicable diseases. *Lancet* 2018; 391(10134): 2047-58.
- 500 12. Organisation for Economic Co-operation and Development. Costa Rica - Evaluación y  
501 recomendaciones. San José, Costa Rica: Ministry of Health of the Republic of Costa Rica and  
502 Organisation for Economic Co-operation and Development, 2019.
- 503 13. Ibraimova A, Akkazieva B, Ibraimov A, Manzhieva E, Rechel B. Kyrgyzstan Health  
504 System Review. Copenhagen, Denmark: World Health Organization, 2011.
- 505 14. Ministry of Health and Family Welfare of the People's Republic of Bangladesh.  
506 Community-based health care 2019. <http://www.communityclinic.gov.bd/index.php?id=14>  
507 (accessed March 4th 2019).
- 508 15. Ahmed SM, Evans TG, Standing H, Mahmud S. Harnessing pluralism for better health in  
509 Bangladesh. *Lancet* 2013; 382(9906): 1746-55.
- 510 16. Peseć M, Ratcliffe HL, Karlage A, Hirschhorn LR, Gawande A, Bitton A. Primary  
511 Health Care That Works: The Costa Rican Experience. *Health Affairs (Millwood)* 2017; 36(3):  
512 531-8.
- 513 17. Peseć M, Ratcliffe HL, Bitton A. Building a thriving primary health care system: The  
514 story of Costa Rica. Boston, MA: Ariadne Labs, 2017.

- 515 18. El Arifeen S, Christou A, Reichenbach L, et al. Community-based approaches and  
516 partnerships: innovations in health-service delivery in Bangladesh. *Lancet* 2013; 382(9909):  
517 2012-26.
- 518 19. Wirtz VJ, Kaplan WA, Kwan GF, Laing RO. Access to Medications for Cardiovascular  
519 Diseases in Low- and Middle-Income Countries. *Circulation* 2016; 133(21): 2076-85.
- 520 20. Medicines Transparency Alliance. *Medicine Prices, Availability, Affordability in Kyrgyz*  
521 *Republic*. Bishkek, Kyrgyz Republic: Medicines Transparency Alliance, 2015.
- 522 21. Attaei MW, Khatib R, McKee M, et al. Availability and affordability of blood pressure-  
523 lowering medicines and the effect on blood pressure control in high-income, middle-income, and  
524 low-income countries: an analysis of the PURE study data. *Lancet Public Health* 2017; 2(9):  
525 e411-e9.
- 526 22. Chimbindi N, Bor J, Newell ML, et al. Time and money: the true costs of health care  
527 utilization for patients receiving 'free' HIV/TB care and treatment in rural KwaZulu-Natal.  
528 *Journal of Acquired Immune Deficiency Syndromes* 2015; 70(2): e52-60.
- 529 23. Olsen MH, Angell SY, Asma S, et al. A call to action and a lifecourse strategy to address  
530 the global burden of raised blood pressure on current and future generations: the Lancet  
531 Commission on hypertension. *Lancet* 2016; 388(10060): 2665-712.
- 532 24. Brook RD, Weder AB, Rajagopalan S. "Environmental hypertensionology" – the effects  
533 of environmental factors on blood pressure in clinical practice and research. *The Journal of*  
534 *Clinical Hypertension* 2011; 13(11): 836-42.
- 535 25. Chow CK, Teo KK, Rangarajan S, et al. Prevalence, awareness, treatment, and control of  
536 hypertension in rural and urban communities in high-, middle-, and low-income countries.  
537 *JAMA* 2013; 310(9): 959-68.

- 538 26. Lu J, Lu Y, Wang X, et al. Prevalence, awareness, treatment, and control of hypertension  
539 in China: data from 1.7 million adults in a population-based screening study (China PEACE  
540 Million Persons Project). *Lancet* 2017; 390(10112): 2549-58.
- 541 27. Falaschetti E, Mindell J, Knott C, Poulter N. Hypertension management in England: a  
542 serial cross-sectional study from 1994 to 2011. *Lancet* 2014; 383(9932): 1912-9.
- 543 28. Wozniak G, Khan T, Gillespie C, et al. Hypertension Control Cascade: A Framework to  
544 Improve Hypertension Awareness, Treatment, and Control. *Journal of Clinical Hypertension*  
545 (Greenwich) 2016; 18(3): 232-9.
- 546 29. Office of Chief Government Statistician Zanzibar. Gross Domestic Product (GDP). 2018.  
547 <http://www.ocgs.go.tz/profile.php> (accessed July 11 2018).
- 548 30. National Bureau of Statistics, Ministry of Finance and Planning. National Population  
549 Projections. Dar es Salaam, Tanzania: Office of the Chief Government Statistician, 2018.
- 550
- 551

552 **Figure legends**

553 Figure 1. The hypertension care cascade by region<sup>1,2</sup>

554 <sup>1</sup> Vertical error bars are 95% confidence intervals.

555 <sup>2</sup> 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<sup>1,2,3,4,5,6</sup>

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

565 <sup>2</sup> The grey ribbon depicts the point-wise 95% prediction interval.

566 <sup>3</sup> The vertical bars depict 95% confidence intervals.

567 <sup>4</sup> 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 <sup>5</sup> 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 <sup>6</sup> 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.<sup>1,2,3</sup>

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

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

591 <sup>3</sup> ‘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<sup>1,2</sup>

Country	Year <sup>3</sup>	Response rate (%) <sup>4</sup>	Missing outcome <sup>5</sup> (%)	Sample size	Hypertensive, n (%)	Median age (y)	Age range (y)	Female (%)	GDP per capita <sup>6</sup>	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 <sup>7</sup>	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 <sup>8</sup>	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
<b>Sub-Saharan Africa</b>										
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 <sup>9</sup>	1,441 <sup>10</sup>
<b>Total</b>	-	90.9 <sup>11</sup> (81.5 – 95.6) <sup>12</sup>	2.3 <sup>11</sup> (0.6 – 8.6) <sup>12</sup>	1,100,507 <sup>13</sup>	192,441 <sup>13</sup> (29.3 <sup>11</sup> )	39.5 <sup>11</sup> (34.8 – 44.5) <sup>12</sup>	-	58.2 <sup>11</sup> (53.2 – 62.5) <sup>12</sup>	8,222 <sup>11</sup> (2,651 – 11,491) <sup>12</sup>	4,177,630 <sup>13</sup>

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

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

<sup>2</sup> 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).

<sup>3</sup> Years in which the data collection for the survey was carried out.

<sup>4</sup> This includes both the household and the individual response rate.

<sup>5</sup> 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.

<sup>6</sup> This is the GDP per capita in constant 2011 international dollars (as estimated by the World Bank<sup>9</sup>) for the year in which data was collected for the survey.

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

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

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

<sup>10</sup> The population estimate for Zanzibar was taken from the Tanzania Population Projection Report 2013-2035.<sup>30</sup>

<sup>11</sup> This is the median value with each country having the same weight.

<sup>12</sup> This is the interquartile range.

<sup>13</sup> This is the sum across all countries.





Table 2. Uni- and multi-variable regressions of each cascade step onto individual-level predictors<sup>1</sup>

	Ever BP measured		Diagnosed		Treated		Controlled	
	RR	P	RR	P	RR	P	RR	P
<b>Uni-variable regressions<sup>2</sup></b>								
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 <sup>3</sup>	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 <sup>4</sup>	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 education<sup>5</sup>***

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 <sup>3</sup>	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 <sup>4</sup>	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 variables<sup>6</sup>***

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 <sup>3</sup>	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 <sup>4</sup>	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;

<sup>1</sup> Standard errors were adjusted for clustering at the level of the primary sampling unit.

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

<sup>3</sup> This refers to having received some primary schooling or having completed primary school.

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

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

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