



Global report on hypertension 2025

High stakes – turning evidence into action



World Health
Organization

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Foreword

Every year, millions of people die from heart attacks, strokes, and kidney failure as the result of uncontrolled high blood pressure, or hypertension. Hypertension is a silent killer, often displaying no symptoms until it is too late. But while hypertension is one of the world's leading causes of premature death, it is also preventable.

In 2023, WHO released the first *Global report on hypertension*, focusing on the individual, community, and public health burden of high blood pressure, and what can be done to address it. While many countries are implementing policies to prevent and control hypertension, the world is still lagging behind the target set in the Sustainable Development Goal to reduce premature mortality from noncommunicable diseases by one-third by 2030.

This second global report provides examples of action being taken around the world in countries at all income levels, and the lessons that can be drawn from their experience. The report reviews many of the systemic barriers to providing people with the full range of services to control hypertension, along with ways of overcoming them, with a special focus on access to treatment and financial protection.

As countries work towards achieving universal health coverage, prevention and treatment of hypertension provides some of the most cost-effective and affordable public health interventions available today. Now is the time to turn evidence into action.



Dr Tedros Adhanom Ghebreyesus

Director-General

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Executive summary

Hypertension: the need for urgent action

Every second of every day, more than 1 billion people face avoidable risk of heart attack, stroke, and death from uncontrolled high blood pressure. In 2024, an estimated 1.4 billion people aged 30–79 years were affected worldwide, yet fewer than 1 in 5 (320 million) had the condition adequately controlled. Uncontrolled hypertension is a leading risk factor for heart attack, stroke, chronic kidney disease and dementia. This high global prevalence underscores the urgent need for countries to implement measures for its prevention and control; and the large number of people with uncontrolled hypertension exposes persistent gaps in effective management.

Hypertension imposes a significant financial burden on individuals, families, health systems, and economies. The challenge is even more severe in low- and middle-income countries, where cardiovascular diseases, including hypertension, led to economic losses estimated at US\$ 3.7 trillion from 2011 to 2025 – around 2% of GDP in these countries. Despite the potential for billions of dollars of savings in global health care, public health commitment and investment in hypertension prevention and control remains insufficient. Action will become even more important in the coming decades, with the global burden of hypertension set to rise due to people living longer and the population structure shifting towards older age groups.

A number of countries are leading the way

Despite the sobering global picture presented in this report in the analysis of data from 195 countries and territories – where 99 countries have national hypertension control rates below 20% – other countries are charting a path to success in hypertension control programmes. WHO tools such as the HEARTS technical package, and the guidance on care for people living with, or at risk of, hypertension, are essential packages of care integrated into universal health coverage. These packages are enabling countries to increase the proportion of people who receive effective treatment for hypertension, to control the condition and protect their health. The report spotlights three countries that have demonstrated steady progress in this endeavour:

- *The Republic of Korea* has integrated health reforms – including low costs for antihypertensive medications and capping co-payments – resulting in high rates of blood pressure control nationally: 59% in 2022.

- The *Philippines* has successfully incorporated the WHO HEARTS technical package into primary care services, achieving 65% blood pressure control in the regional demonstration project.
- *Bangladesh* has embedded hypertension services into essential health service packages. Sustained improvements in treatment and control at the subnational level have achieved an increase in blood pressure control from 18% in 2020 to 58% in 2025.

These countries have demonstrated strong political leadership; policies that integrate hypertension control into universal health coverage; commitment to funding; and strong community engagement.

Overcoming barriers: key enabling factors for hypertension control

Despite progress being made in some countries, gaps persist in all countries in their response to hypertension at individual, programme, and policy levels, from prevention to treatment and lifelong management. The result is that hypertension is not being successfully controlled globally. Countries frequently lack:

- effective prevention policies, such as the promotion of potassium enriched, low-sodium salt;
- access to validated blood pressure devices;
- standardized treatment protocols, and adequately trained primary care teams;
- reliable budgetary allocation, procurement and supply chains for essential medicines;
- financial protection for patients, particularly in low- and middle-income countries; and
- robust information systems to monitor quality of care and equity – i.e. how well services are being provided to every person.

Key elements of a successful hypertension control public health programme include:

- **Health promotion and prevention:** Increasing health literacy and awareness on hypertension, and implementing the WHO HEARTS technical package, are essential to address important risk factors, such as excess in salt intake; physical inactivity; alcohol use; tobacco use; and consumption of industrially-produced trans fats.
- **Accurate and timely diagnosis:** Universal measurement of blood pressure among adult patients attending all health care facilities, can be facilitated by adopting national policies and guidelines to include routine blood pressure measurement into primary care.

- **Treatment:** Key enablers for better treatment outcomes include reliable access to affordable medications; simplified treatment protocols (including single-pill combinations); team-based care models; task-sharing among health care workers; and policies to include antihypertensive medicines in national essential medicines lists, subsidized programmes, and health benefit packages.
- **Continuity of care and adherence:** Engaging patients in self-management; implementing team-based care; simplifying treatment regimens; improving patient tracking and recall systems; and leveraging mobile health, digital tools, and telemedicine, can strengthen follow-up and long-term blood pressure control.

Access to medicines: a cornerstone of hypertension control

Because access to essential antihypertensive medicines remains a persistent challenge in many low- and middle-income countries, the report devotes an entire section to this issue.

Across the 194 countries profiled in the report, unacceptable disparities are evident: while 93% of high-income countries report that all 5 essential hypertensive medicines (thiazide diuretics, ACE inhibitors, angiotensin II receptor blockers, calcium channel blockers, and beta blockers) are generally available, this figure falls to just 28% in low-income countries. Barriers span the pharmaceutical value chain, from regulatory systems and medicine selection, to pricing, procurement, prescribing, and dispensing. These gaps limit availability, affordability, and appropriate use, undermining blood pressure control and contributing to the global burden of cardiovascular disease.

Addressing these barriers requires government leadership, sustained investment, and system-wide reforms. Strategies include strengthening regulatory capacity; aligning national essential medicines lists with WHO recommendations; prioritizing cost-effective single-pill combinations; and adopting transparent purchasing, pricing and reimbursement mechanisms. Efficient procurement mechanisms, and strong supply chain management are valuable ways to enhance access to treatment for hypertension. Improving prescribing and dispensing practices is also essential.

These interventions, combined with policies that reduce financial barriers for patients, offer a clear pathway for countries to expand access to quality-assured medicines, improve population health, and reduce the economic burden of uncontrolled hypertension. Because hypertension is nearly always asymptomatic – hence its designation the “silent killer” – programmes that provide medications affordable to patients achieve significantly higher adherence and control rates, ultimately reducing the associated health care and societal costs.

Prevention, treatment and control of hypertension are central to universal health coverage

While access to affordable hypertension medicines for those in need is necessary, it is not sufficient to achieve hypertension control. Countries that have made rapid progress in hypertension control show that, for progress to be sustainable, prevention, screening, treatment, and long-term management must be embedded within universal health coverage reforms. One of the sections of this report focuses specifically on this issue.

Clear entry points exist across every phase of developing or revising health benefit packages for universal health coverage, from governance and prioritization to costing, implementation, and monitoring.

Health financing reforms complement these efforts by embedding hypertension in pooled funding arrangements, reducing out-of-pocket costs, and using strategic purchasing to incentivize quality care. Prioritizing disadvantaged populations and engaging people with lived experience of hypertension, further strengthens equity and accountability, helping countries to both close coverage gaps and maximize the impact of investments in hypertension medicines and care.

Recommendations

The report outlines five recommended actions to help countries achieve fast and sustainable results in their fight against hypertension:

- Integrate hypertension interventions into the universal health coverage reforms of countries.
- Improve access to affordable antihypertensive medicines and validated devices to measure and monitor blood pressure.
- Invest in health workforce and expand team-based care.
- Monitor population trends, and evaluate progress in hypertension control by strengthening health information systems with a focus on the number and estimated proportion of all people with hypertension who are receiving treatment and have their blood pressure controlled.
- Raise public awareness of the silent nature and dangers of hypertension, and make hypertension prevention and control every person's business.

Implementing these recommendations is central to achieving the targets of universal health coverage. Countries that implement these recommendations will prevent millions of people experiencing stroke, heart attack, kidney disease, and dementia, while reducing the huge socioeconomic burden these conditions impose.



Anna, 74, has her blood pressure checked at her homestead in the village of Maziva in Masvingo, Zimbabwe. © WHO / Tafadzwa Ufumeli

Introduction

The urgent threat of hypertension

Hypertension, often called the “silent killer,” is a major global public health threat. In 2024, it affects approximately 1.4 billion people aged 30–79 years worldwide, yet only 320 million people had their blood pressure controlled. Uncontrolled hypertension leads to heart attacks, heart failure, strokes, chronic kidney disease, dementia, and other serious complications, resulting in substantial socioeconomic costs. The high prevalence demonstrates the need for stronger prevention efforts, while the high number of people with uncontrolled hypertension highlights systemic weaknesses in detection, diagnosis, and long-term management. As hypertension also often occurs with other comorbid physical and mental health conditions, with shared risk factors, integrated care, especially in primary care, is crucial.

Why this report now?

This report is published at a critical juncture for health and development. In September 2025, global heads of state, health ministers, and leaders will convene for the Fourth United Nations (UN) High-level Meeting on the prevention and control of noncommunicable diseases (NCDs) and the promotion of mental health and well-being (HLM4) (1). This meeting marks a unique opportunity to renew and accelerate commitments to tackling NCDs, including hypertension – a leading cause of NCD mortality and morbidity.

With five years remaining to achieve the Sustainable Development Goal (SDG) targets (2) – including SDG target 3.4.1, which aims to reduce premature mortality from NCDs by one third – the need to scale up action to meet NCD universal health coverage (UHC) and other health and development targets has never been more urgent.

Prevention and treatment save lives and money

There are lifesaving and cost-effective interventions for prevention and control of hypertension. By implementing prevention and control measures, countries can:

- **fast-track progress toward SDG 3.4.1** (Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease). Hypertension is a leading risk factor for cardiovascular disease, the leading cause of death globally. Effective strategies to prevent hypertension can substantially reduce premature mortality from NCD conditions.
- **contribute to SDG target 3.1**, to reduce global maternal mortality to fewer than 70 live births per 100 000 by 2030. Hypertensive disorders of pregnancy, such as pre-eclampsia and eclampsia, are major contributors to maternal deaths. Early detection and management of hypertension before and during pregnancy can prevent these complications, reduce maternal mortality, and improve infant outcomes (3–5).
- **present a strategic investment for scaling up population health services and achieving SDG 3.8 target on UHC**. Hypertension treatment is affordable, feasible, and scalable in primary care, reducing the risk of costly complications and enhancing economic productivity. In addition, **addressing hypertension builds broader system capacity for integrated NCD care**.

Hypertension control requires and strengthens core health system capacities, such as standardized clinical protocols, reliable supply chains for medicines and diagnostics, and a well-trained workforce. These same elements are foundational to managing a wide range of NCDs, including diabetes, cancer, chronic respiratory diseases, and mental health conditions; and to the provision of maternal health services and others.

Several countries are demonstrating that progress is possible. With strong political commitment and leadership, the application of evidence-based strategies recommended by WHO, and integrated into UHC, can result in higher rates of hypertension control, lives saved, and reductions in costly complications.

Scaling proven strategies, tailoring them to local contexts, and integrating them into UHC must now be a priority for all countries. This report provides a practical roadmap to support countries in their endeavours.

Purpose and objectives of the report

This *Global hypertension report* demonstrates that hypertension control is possible through strong political commitment, integration into health systems, improved access to essential medicines, and strategic use of enabling factors (see Box 1).

- Section 1 describes the burden of hypertension, its trends, determinants, and impact on individuals, communities, and health systems;

- Section 2 highlights progress in selected countries at national and subnational levels; the enabling factors helping these countries advance action; and some of the remaining barriers.
- Section 3 outlines strategies for improving access to antihypertensive medicines.
- Section 4 describes the strategic entry points for hypertension interventions in UHC health benefit packages.
- Section 5 presents actionable, evidence-based recommendations to accelerate progress in hypertension prevention and control.

The report is directed at policy-makers and public health and clinical practitioners in government; nongovernmental organizations; academia; the private sector; and other developmental partners.

Box 1. What is new in this second global hypertension report?

The first WHO *Global report on hypertension*^{*}, published in 2023, highlighted the importance of hypertension prevention and control. The report:

- provided comprehensive and comparable estimates of mortality, prevalence, treatment, and control at the country, regional, and global levels;
- examined the economic burden of hypertension;
- modelled the impact of scaling up treatment on lives saved; and
- introduced the WHO HEARTS technical package as a framework for effective hypertension prevention and control.

This new WHO report builds on the 2023 report, by describing:

- key levers for progress towards hypertension control;
- the progress made in a number of countries;
- barriers that have impeded progress – spotlighting key enabling factors behind success;
- key factors for improving access to antihypertensive medicines; and
- strategic entry points for integrating hypertension prevention and control into universal health coverage.

^{*} See: <https://iris.who.int/handle/10665/372896>.



Patient during his rehabilitation exercises in the balance manager at the Federal Center for Cerebrovascular Pathology and Stroke in Moscow. © WHO / NOOR / Sebastian Liste



1 Hypertension is a public health threat

Key messages

- ✓ Hypertension is a critical public health issue due to its impact on premature mortality, morbidity and economic burden. With global population growth and ageing, the number of people with hypertension is projected to rise.
- ✓ In 2024, it is estimated that hypertension affected around 1.4 billion adults aged 30–79 years worldwide. This number has doubled since 1990.
- ✓ Prevalence across WHO regions ranges from 29% in the Western Pacific Region to 38% in the Eastern Mediterranean Region.
- ✓ Globally, only 320 million people (23%) of those living with hypertension have their blood pressure effectively controlled.
- ✓ Only 4 countries – Canada, Costa Rica, Iceland, and the Republic of Korea – have achieved hypertension control rates >50%; 99 countries have control rates <20% at the national level.
- ✓ In 2011, high blood pressure caused the death of 11 million people (16% of all deaths worldwide), more than any other risk factor for NCDs.
- ✓ Hypertension imposes a heavy financial burden on individuals, families, health systems, and national economies.
- ✓ The number of people with hypertension is projected to rise globally over the coming decades, with the number of affected individuals potentially surpassing 1.5 billion by 2030 if no action is taken.

Hypertension is a chronic condition that significantly increases the risk of cardiovascular and kidney diseases. It is defined as a sustained elevation of blood pressure in the arteries, which carry blood from the heart to all tissues and organs (6, 7). Most individuals with elevated blood pressure have no symptoms and are unaware of their condition until serious health issues arise, earning it the designation, “silent killer”. The WHO definitions of hypertension and high systolic blood pressure used in this report are described in Box 2. Key terms and definitions used for surveillance of blood pressure and hypertension are presented in Table 1.

During the past 15 years, hypertension has increasingly been included in high-level health agendas and international targets. The political declaration of the first High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in 2011, explicitly mentioned high-blood pressure, noting [with] *“concern that maternal and child health is inextricably linked with non-communicable diseases and their risk factors, specifically as prenatal malnutrition and low birth weight create a predisposition to obesity, high blood pressure, heart disease and diabetes later in life; and that pregnancy conditions, such as maternal obesity and gestational diabetes, are associated with similar risks in both the mother and her offspring”*. The declaration not only contributed to bringing hypertension to the forefront of the global health agenda, it also called for urgent action to address its risk factors (8). Following this, a voluntary global target of a 25% reduction in raised blood pressure,¹ by 2025, against a 2010 baseline, was adopted by the Sixty-sixth World Health Assembly in 2013, driving countries to strengthen their hypertension control strategies (9, 10).

This section provides compelling evidence on the public health significance of hypertension.

Hypertension usually has no noticeable symptoms; that’s the challenge! Early diagnosis and routine screening are essential because the first sign of hypertension may be a stroke or heart attack.

—Takwe Boniface Njecko, Cameroon

¹ The term “raised blood pressure” was used in the World Health Assembly 2013 resolution. More recently the more commonly-used term is “uncontrolled hypertension”.

Box 2. Hypertension and high systolic blood pressure

Clinical definition of hypertension: WHO defines clinical hypertension in adults as systolic blood pressure readings of ≥ 140 mmHg and/or diastolic blood pressure readings of ≥ 90 mmHg on both days when measured on two different days (11).

Surveillance definition of hypertension: To identify the proportion of the population with hypertension using surveillance data, hypertension is frequently defined as systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg, or if a person is taking medication for hypertension (12). This is the definition used in this report for all hypertension and for hypertension diagnosis, treatment and control estimates. The data are from, or are projected from, the estimates produced by the NCD Risk Factor Collaboration (NCD-RisC) (13), which are also available from the WHO Global Health Observatory.

Definition of high systolic blood pressure: High blood pressure raises the risk of death from heart and kidney diseases – even at systolic blood pressures < 130 mmHg, which is below most treatment thresholds. Estimating the excess mortality caused by high blood pressure – by comparing it to a “theoretical minimum risk level” where mortality risk is lowest – helps quantify the impact of higher-than-optimal blood pressure on population health (14). Although this minimum risk level, estimated to be between 110–115 mmHg, may not be achievable with current interventions, using it as a benchmark allows for meaningful comparisons between different risk factors and their effects on population mortality. This report presents estimates of deaths attributed to high systolic blood pressure (i.e. ≥ 110 –115 mmHg), rather than deaths from clinical hypertension (i.e. systolic blood pressure ≥ 140 mmHg). These attributable mortality estimates are higher than estimates of potential lives saved by improving hypertension treatment and control.

Table 1. Key terms and definitions used for surveillance of blood pressure and hypertension in populations

Hypertension prevalence

Numerator: systolic blood pressure (SBP) ≥ 140 mmHg or diastolic blood pressure (DBP) ≥ 90 mmHg or taking medication for hypertension *Denominator:* adults aged 30–79 years

Uncontrolled hypertension prevalence

Numerator: SBP ≥ 140 mmHg or DBP ≥ 90 mmHg *Denominator:* adults aged 30–79 years

Diagnosis coverage

Numerator: has hypertension and has received previous hypertension diagnosis *Denominator:* adults aged 30–79 years with hypertension, as defined above

Treatment coverage

Numerator: has hypertension and is taking medication for hypertension *Denominator:* adults aged 30–79 years with hypertension, as defined above

Effective treatment coverage

Numerator: has controlled hypertension: taking medication for hypertension and SBP < 140 mmHg and DBP < 90 mmHg *Denominator:* adults aged 30–79 years with hypertension, as defined above

High systolic blood pressure

The concept of high SBP is used for comparative risk assessment (3). It refers to any SBP above the theoretical minimum risk level, estimated to be at 110–115 mmHg.

1.1 Hypertension is very common and usually uncontrolled

In 2024, hypertension affected approximately 1.4 billion adults aged 30–79 years worldwide. This represents 33% of the population in this age range,² and has changed little since 1990 when prevalence was 32%. However, due to population growth and ageing, the number of individuals affected has more than doubled from the 650 million reported in 1990. Across WHO regions, prevalence ranges from 29% in the Western Pacific

² All prevalence values in this section are age-standardized using the WHO standard population to ensure that comparisons across geographies and over time are not affected by differing proportions of younger and older adults. All hypertension and hypertension diagnosis, treatment and control estimates are from, or are projected from the estimates produced by the NCD Risk Factor Collaboration (NCD-RisC), which are also available from the WHO Global Health Observatory (GHO) (13).

Region to 38% in the Eastern Mediterranean Region. Likewise, across countries, prevalence varies, with 25 countries across all WHO regions having prevalence of <30%; and 37 countries >45% (Fig. 1). Globally, the percentage is slightly higher among males (34%) than females (31%).

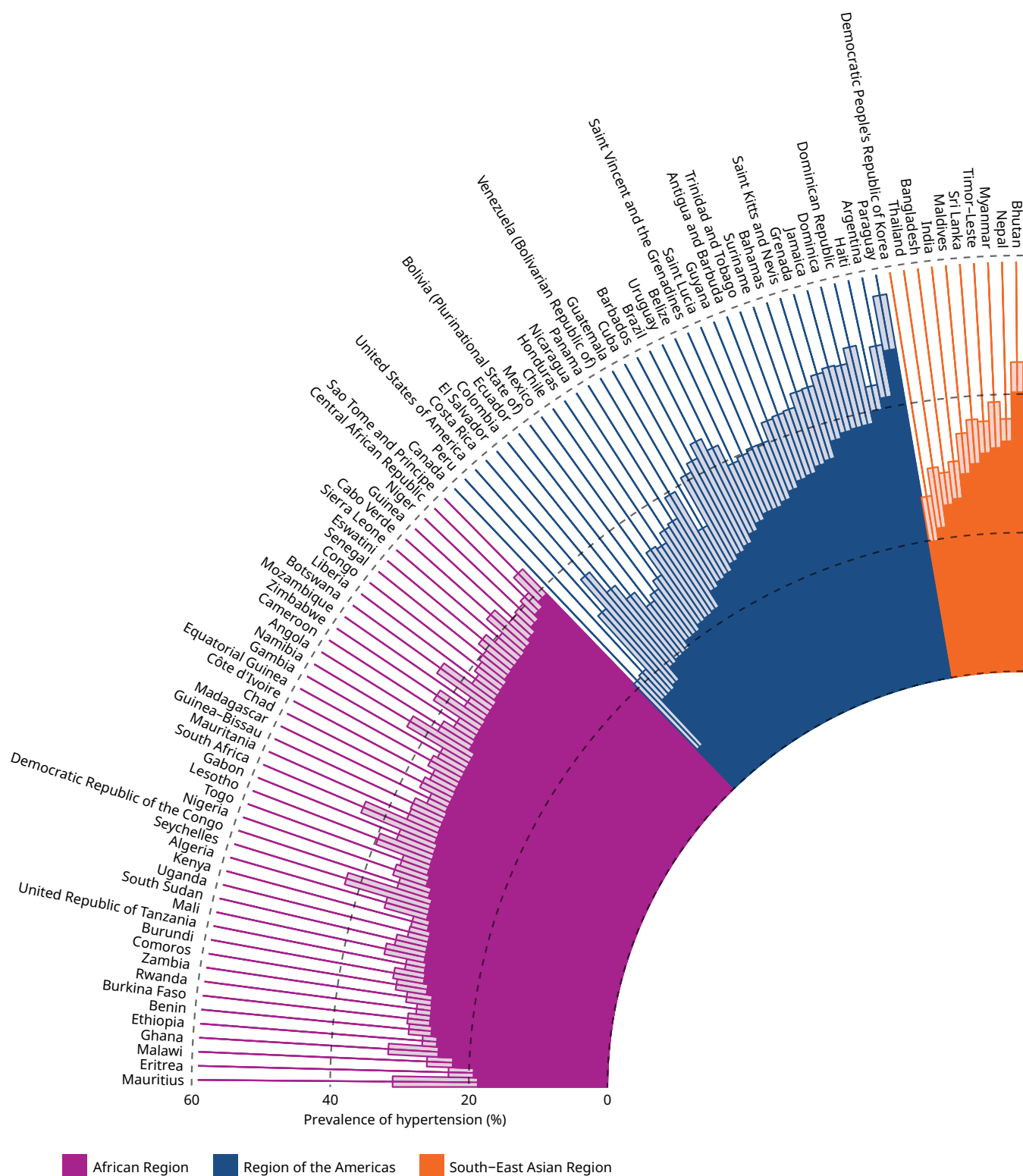
Globally, less than half of adults aged 30–79 years with hypertension are receiving treatment (Fig. 2). Treatment coverage increased from 22% in 1990 to 44% in 2024; however, of those affected, only 320 million people (23%) – that is just over 1 in 5 people worldwide – have their blood pressure controlled effectively. More women (180 million) achieved control compared to men (150 million), despite a larger number of men than women having hypertension (710 million vs. 680 million).

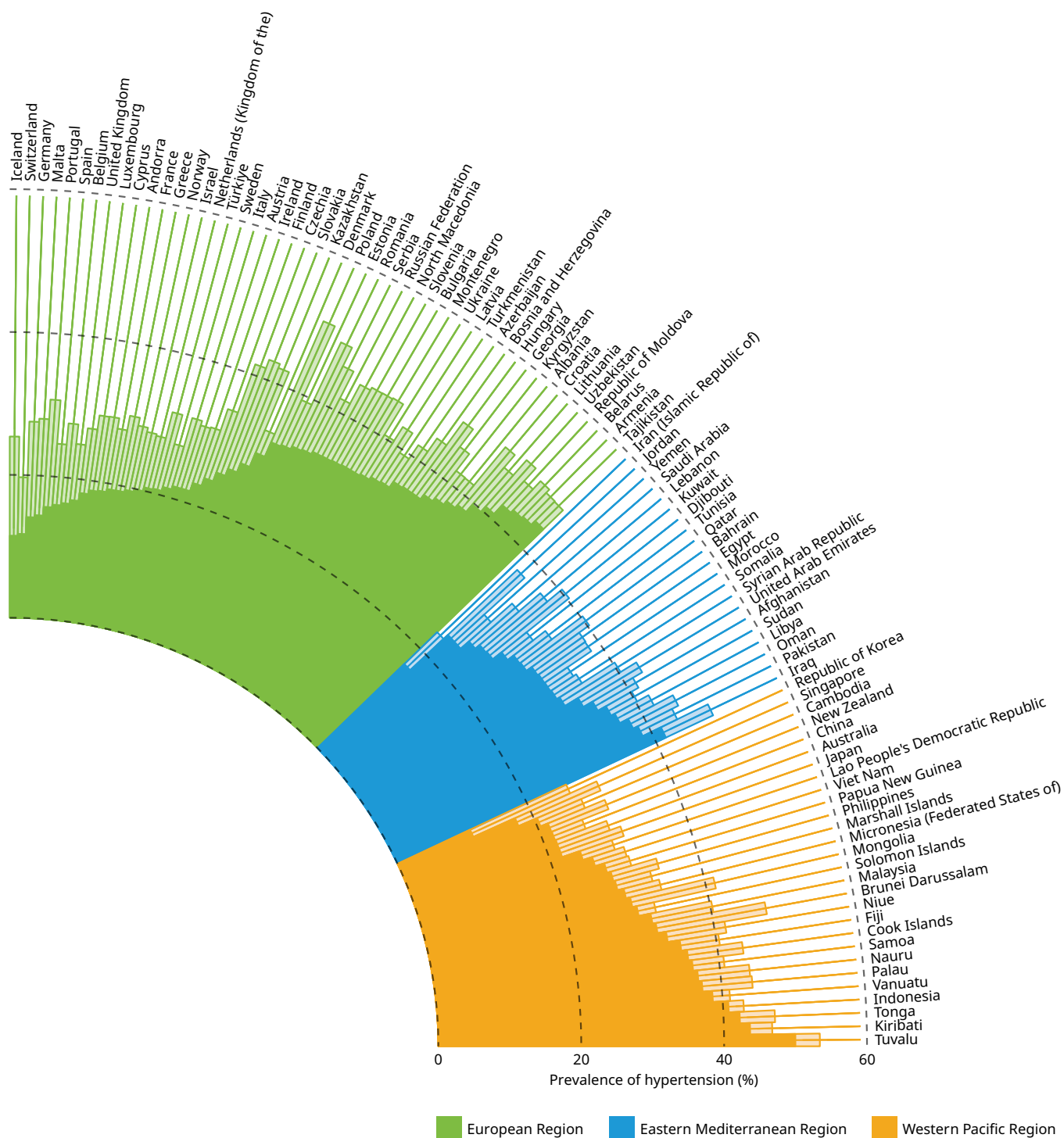
Trends from 1990 show that control of hypertension has increased globally and across all WHO regions, with the European Region and the Region of the Americas having the largest populations with controlled blood pressure (Fig. 3). The European Region is the only WHO region where the number of undiagnosed individuals has decreased over the last decades (from 110 million in 1990 to 66 million in 2024).



Health workers taking the blood pressure of a patient in Tupapa Community Clinic in Rarotonga. © WHO / Yoshi Shimizu

Fig. 1. Prevalence of hypertension, by control status, among adults aged 30–79 years, by country, in 2024*

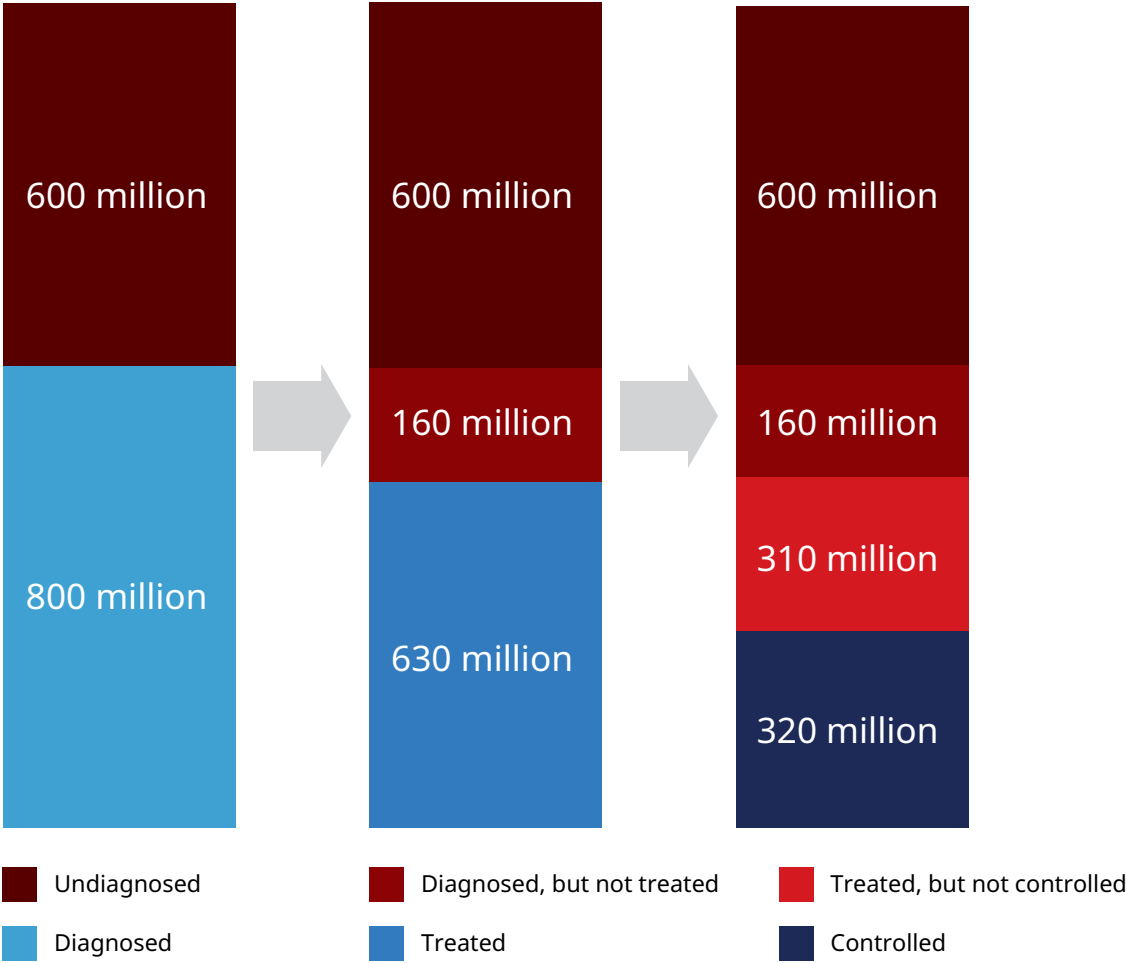




* For all 6 WHO regions, the lighter coloured bars indicate age-standardized estimates for the prevalence of controlled hypertension (systolic blood pressure [SBP] <140 mmHg and diastolic blood pressure [DBP] <90 mmHg and people taking medication for hypertension); the darker coloured bars indicate uncontrolled hypertension (SBP ≥140 mmHg or DBP ≥90 mmHg).

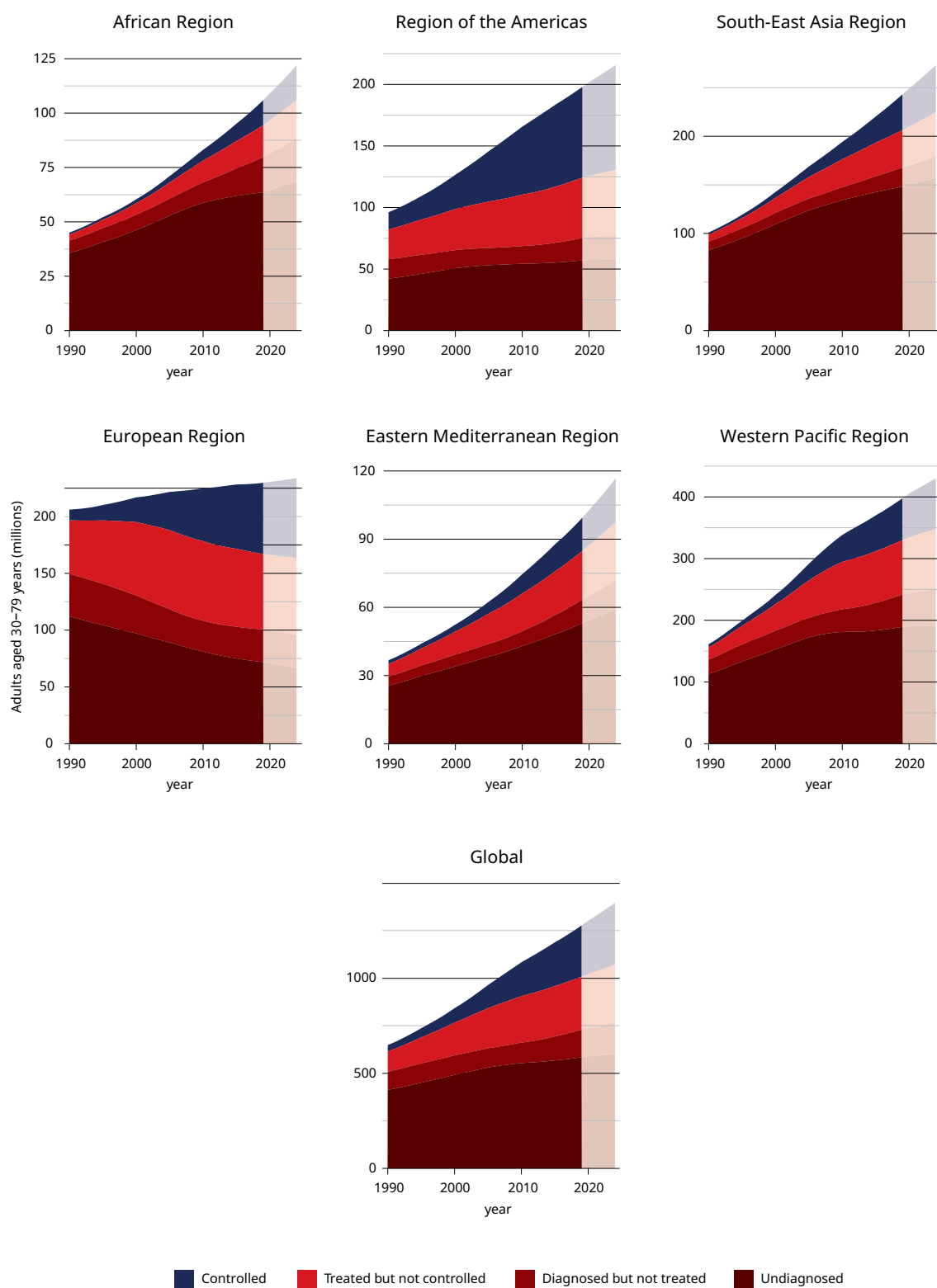
Source: Projected from NCD Risk Factor Collaboration (NCD-RisC) data (13)

Fig. 2. Number of adults aged 30–79 years with hypertension in 2024, by diagnosis, treatment and control status globally



Source: Projected from NCD Risk Factor Collaboration (NCD-RisC) data (13)

Fig. 3. Global and regional trends in number of adults aged 30–79 years, with hypertension, 1990–2024, disaggregated by control, treatment, and diagnosis status



Source: Projected from NCD Risk Factor Collaboration (NCD-RisC) data (13)

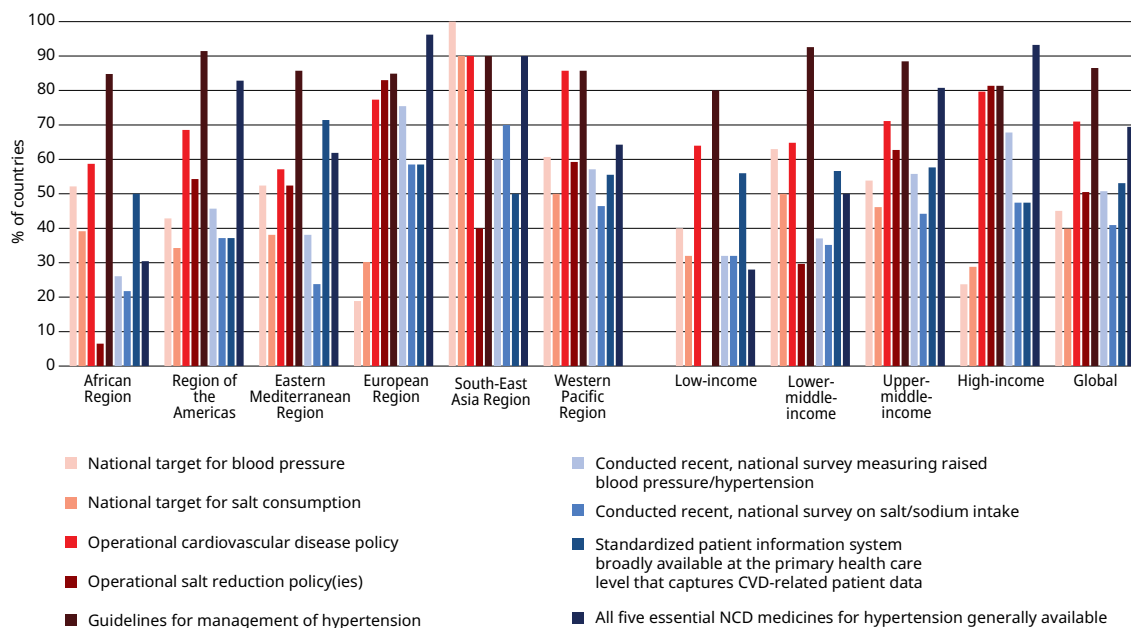
As of 2024, only 4 countries have achieved hypertension control rates >50%: Canada, Costa Rica, Iceland and the Republic of Korea. At the same time, 99 countries have control rates <20% (fewer than 1 in 5) at the national level. Country profiles included in Annex 1 provide data for each of the WHO Member States and the explanatory notes give information on the methodology applied for the projected estimates.

Data from the 2023 WHO NCD country capacity survey provided a comprehensive snapshot of the capabilities of countries to address hypertension (Fig. 4) (15):

- Globally, 45% of countries reported having a national target for blood pressure control. Significant differences were observed across WHO regions, with 100% of countries in the South-East Asia Region having such a target, but only 19% of countries in the European Region.
- With national targets for reductions in salt consumption, the global figure was 40%, ranging from 90% in the South-East Asian Region, to 50% or lower in other WHO regions.
- Globally, 71% of countries reported having an operational cardiovascular disease policy, and 51% reported having an operational salt reduction policy. Notably, no low-income country reported having an operational salt reduction policy.
- Guidelines for the management of hypertension were widely reported by 87% of countries, with >80% of countries across all WHO regions and country income groups reporting having these.
- Surveillance efforts varied: 51% of countries globally had conducted a recent national survey measuring blood pressure and hypertension, with a high of 68% in high-income countries and a low of 32% in low-income countries. For recent national surveys on salt/sodium intake, the global figure was 44% of countries. Regionally, a high of 70% of countries in the South-East Asia Region reported a recent salt/sodium intake survey.
- The availability of a standardized patient information system, broadly available at the primary health care level that captures data from patients with cardiovascular-related disease, was reported by 53% of countries globally.

Country profiles included in Annex 1 provide data for each of the WHO Member States.

Fig. 4. National response to high blood pressure, by WHO region and country income level



Source: 2023 WHO NCD country capacity survey (15)

1.2 High blood pressure is deadly

Higher-than-optimal blood pressure, even when below the threshold for hypertension or clinical treatment, increases the risk of mortality from cardiovascular and other diseases (Box 2). Global estimates for 2021 reveal that 53% of all cardiovascular mortality, including 58% of all deaths from stroke, and 31% of all deaths from chronic kidney disease were attributable to high systolic blood pressure (16). Altogether, high blood pressure caused the deaths of 11 million people, or 16% of all deaths in the world – more than any other risk factor.

The mortality rates vary significantly across regions: while 8% of all deaths in the African Region are attributable to high blood pressure, the percentage for the Western Pacific Region (22%) is far higher.³ There are also slight differences reported between sexes, with high blood pressure being the cause of death in 15% of males and 18% of females. In terms of age differences, 11% of all deaths attributable to high blood pressure occur among individuals aged <70 years; and 21% among those aged ≥70 years.

³ In accordance with resolution WHA78.25 (2025), Indonesia was reassigned to the WHO Western Pacific Region as of 27 May 2025.

1.3 Hypertension is costly

Hypertension imposes a significant financial burden on individuals, families, health systems, and national economies. In low- and middle-income countries, the economic toll is even more severe; cardiovascular diseases, including hypertension, has been estimated to result in economic losses of US\$ 3.7 trillion between 2011 and 2025, equivalent to approximately 2% of the projected gross domestic product in these countries (17). This figure represents approximately 2% of the gross domestic product in these countries (17). Despite the potential savings to global health care from effective blood pressure management, investment in hypertension programmes remains low, particularly in low- and middle-income countries (17).

In addition, the economic consequences extend beyond direct medical costs; uncontrolled hypertension leads to substantial productivity losses due to disability, absenteeism, reduced work capacity and premature mortality. These indirect costs often exceed the direct costs of care, placing a heavy burden on families, employers, and national economies. Productivity losses due to hypertension are particularly significant in low- and middle-income countries, where most people with hypertension live and where only about a third receive pharmacological treatment, and just 1 in 10 have their blood pressure under control. WHO estimates that investments in hypertension control can yield economic benefits that outweigh costs by about 18 to 1, largely by preventing millions of deaths, strokes, and heart attacks, and by reducing years lost to disability and early retirement (12).

1.4 The burden of hypertension is projected to rise

Over the coming decades, the global burden of hypertension is projected to rise, with the number of affected individuals potentially surpassing 1.5 billion by 2030. This increase is driven by demographic changes, such as population growth and ageing, particularly in low- and middle-income countries where the largest increases are anticipated. The health impact will be especially pronounced in countries with poor-quality diet, high in sodium and low in potassium; tobacco-use, overweight and obesity; consumption of alcohol; physical inactivity, and high levels of household and/or ambient air pollution. In addition, settings with ageing populations and limited access to health care or unaffordable services are expected to see increased societal and economic costs, including health care expenditures, lost productivity, and premature mortality. These factors will add further pressure on existing health systems and communities.



2 Addressing hypertension is possible

Key messages

- ✓ Improving hypertension prevention and control is possible and scalable.
- ✓ Several countries are demonstrating progress by prioritizing hypertension in their health agendas.
- ✓ A number of countries, for example Bangladesh, the Philippines and the Republic of Korea, offer practical, context-specific roadmaps towards addressing hypertension.
- ✓ Strong political commitment and leadership, backed by effective governance, policies and sufficient resources, emerge as key enabling factors to controlling hypertension.
- ✓ Despite progress made in some countries, all countries, including those performing best, remain far from achieving at least 50% control of hypertension among individuals affected.
- ✓ Although barriers are encountered across the prevention–care continuum, scalable, evidence-based enabling factors exist to address them.

The global picture of hypertension control remains sobering. Progress has been slow and, in many settings, stagnant. Despite decades of effort, only four countries have reached the target of controlling blood pressure in 50% of affected individuals. However, as demonstrated in this report, **success is possible; it is already happening; and it can be scaled.**

Significant national-level strides have been made in a number of countries, with awareness, treatment coverage and hypertension control rates greatly improving. Certain countries have demonstrated notable progress by incorporating hypertension as a priority area in their health strategic plans; and others, at subnational levels, by strengthening services in primary health care facilities. Other countries, with the support of WHO, are implementing WHO tools such as the HEARTS package (18–20), or the WHO package of essential noncommunicable (PEN) disease interventions for primary health care (Box 3 and Box 4).

From rural districts in the Philippines, to division and districts in Bangladesh, and national levels in the Republic of Korea, the pathways taken by these three countries, highlighted in the following sections, offer practical, context-specific roadmaps that other nations can adapt to accelerate progress and improve the lives of millions living with hypertension.

Box 3. The HEARTS Technical Package for Primary Health Care (18–20)

The HEARTS technical package is a standardized, modular approach, specifically designed to deliver high-quality hypertension and cardiovascular care through primary health care. The package consists of six integrated modules:

- Healthy-lifestyle counselling
- Evidence-based treatment protocols
- Access to essential medicines and technologies
- Risk-based cardiovascular management
- Team-based care and task-sharing
- Systems for monitoring and evaluation.



Healthy-lifestyle counselling

Information on the four behavioural risk factors for CVD is provided. Brief interventions are described as an approach to providing counselling on risk factors and encouraging people to have healthy lifestyles.



Evidence-based treatment protocols

A collection of protocols to standardize a clinical approach to the management of hypertension and diabetes.



Access to essential medicines and technology

Information on CVD medicine and technology procurement, quantification, distribution, management and handling of supplies at facility level.



Risk-based CVD management

Information on a total risk approach to the assessment and management of CVD, including country-specific risk charts.



Team-based care

Guidance and examples on team-based care and task shifting related to the care of CVD. Some training materials are also provided.



Systems for monitoring

Information on how to monitor and report on the prevention and management of CVD. Contains standardized indicators and CVD data-collection tools.

The WHO HEARTS technical package is designed to be adaptable to local contexts and serves as a stepwise approach for countries to build integrated, sustainable NCD programmes, ultimately aiming to reduce the global burden of heart disease and stroke, especially in low- and middle-income countries.

To support countries in successfully implementing the WHO HEARTS technical package, WHO and partners have developed two key implementation tools:

1. An **Implementation Guide**, offering practical steps for integrating HEARTS into national health systems (18); and
2. A **Consensus Protocol Tool**, which helps countries develop standardized, evidence-based treatment protocols for hypertension aligned with local contexts (19).

Box 4. WHO package of essential noncommunicable (PEN) disease interventions*

For a broader and more comprehensive approach to tackling NCDs, including hypertension, WHO developed the WHO package of essential noncommunicable (PEN) disease interventions for primary care health facilities. PEN is a set of prioritized, cost-effective, and evidence-based interventions designed to strengthen the prevention, early detection, and management of major NCDs including cardiovascular diseases (with hypertension), diabetes, chronic respiratory diseases, and early cancer detection. PEN provides a standardized set of clinical protocols and algorithms for the early detection, diagnosis, and management of these conditions. It also includes guidance on lifestyle counselling, such as promoting physical activity, healthy diets, smoking cessation, and reducing harmful alcohol use. The approach supports risk stratification, timely referral, and follow-up care to improve patient outcomes. Countries are also supported with practical tools such as essential medicines lists, diagnostic equipment specifications, and training materials tailored for use by primary care teams, including non-physician health workers.

Several countries have implemented the WHO PEN package with a focus on hypertension, demonstrating that the package has been successfully used to integrate hypertension screening, diagnosis, and management into primary health care. Evaluation of implementation shows clearly improved detection, treatment, and control rates of hypertension in a variety of low- and middle-income countries.

* See: <https://iris.who.int/bitstream/handle/10665/334186/9789240009226-eng.pdf?sequence=1>

2.1. Country success stories

2.1.1. The Republic of Korea

The Republic of Korea has emerged as one of the world's leading examples of national-level success in hypertension control.

What was the challenge?

In 1990, the national blood pressure control rate in the Republic of Korea was only 5%.⁴ Many people continued to die each year from preventable strokes and heart attacks caused by uncontrolled hypertension. Public awareness of the dangers of high blood pressure was low. Diagnosis and treatment services for hypertension at health facilities were minimal with no integrated care, leaving patients falling between diagnosis, treatment, and follow-up. No standardized treatment protocol was in place to guide clinicians, and the cost of medications discouraged many patients from continuing treatment.

What actions were taken?

With coordinated efforts from the Ministry of Health and Welfare, local public health centres, the Korea Disease Control and Prevention Agency, the National Health Insurance Service, and academic societies such as the Korean Society of Hypertension, the Republic of Korea took the following steps:

- *Integration of hypertension in national UHC efforts.* Starting in 1989, the health insurance system was consolidated into the National Health Insurance Service in 2000, creating a unified national insurer with access to population-level health data.
- *Strengthened governance mechanisms and policies.* The Republic of Korea invested efforts across several areas of their health system that improved hypertension control. These included regulations to reduce sodium intake in the population; routine blood pressure screening, ensuring early detection and continuity of care; the adoption of national guidelines and protocol-driven care, including combination therapies based on patient risk profiles; the strengthening of data and surveillance systems⁵ to monitor trends and track individual follow-up and blood pressure control; and creating incentives for achieving blood pressure control.
- *Sustainable financing.* Low costs for antihypertensive medications, and co-payments capped for seniors and waived for low-income populations, were critical to treatment adherence.

⁴ In some instances, data for the Republic of Korea, Bangladesh and the Philippines are sourced from national authorities and may not represent WHO's official statistics.

⁵ Annual publications such as the Korean Hypertension Fact Sheet enables transparent performance benchmarking.

- *Multisectoral action.* From large-scale public awareness campaigns, and the screening of workers by private sector companies, to the 2012 National Plan to Reduce Sodium Intake, the Republic of Korea adopted a multisectoral approach to tackle the risk factors for hypertension.

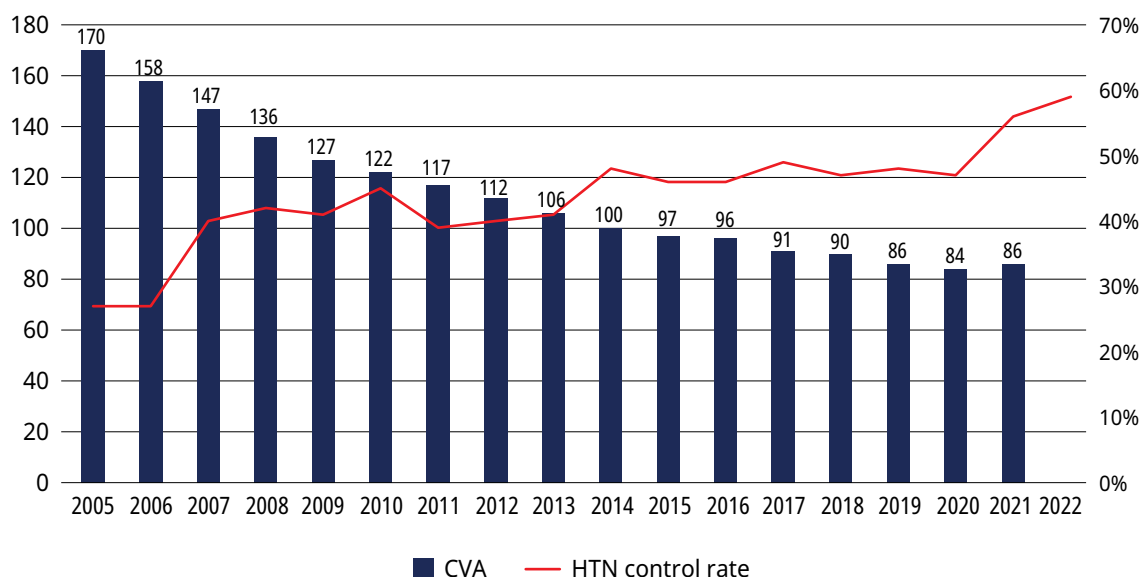
What was the impact?

Over three decades, the Republic of Korea has achieved:

- a **five-fold increase** in hypertension treatment rates (from 16% in 1990 to 74% in 2022);
- an **eleven-fold increase** in blood pressure control rates (from 5% in 1990 to 56% in 2022);
- a **44% reduction** in sodium consumption (2005–2022); and
- a **74% decline in age-adjusted cardiovascular mortality** (albeit not solely attributable to hypertension control).

More than 12 million individuals living with hypertension have benefited from these reforms. The Republic of Korea now ranks among the world's top performers in hypertension control (21, 22).

Fig. 5. Trends of hypertension control and rates of cardiovascular disease deaths in the Republic of Korea



CVA = cerebrovascular accidents; HTN = hypertension.

Source: Korea Hypertension Fact Sheet 2023 (21)

2.1.2. Philippines

The Philippines is a lower-middle-income country that presents a promising example of how hypertension control can be advanced at provincial level through implementation of the WHO HEARTS package, paving the way to scaling up services at national level.

What was the challenge?

Despite the high prevalence (33%) of hypertension in the country, only 19% of hypertensive individuals have their condition under control. In the past decades, the Philippines has had a fragmented response to NCDs, including hypertension, due to variability in health service provision approaches across different local government units. Although decentralization allows for local responsiveness, it has also led to disparities in resources invested, service quality, and different levels of prioritization to NCD programming. Decentralized health systems are often reactive rather than proactive, and access to essential services for hypertension remains inconsistent across regions.

What actions were taken?

The Philippines took the following steps to address their challenges in hypertension control:

- *Integration of hypertension in national UHC efforts.* In 2018, the Department of Health, in collaboration with WHO Philippines, launched the Healthy Hearts Philippines (HHP) Programme, which sought integration of hypertension at primary health care level to advance the country's UHC efforts. The programme was co-developed with different local government units to ensure local ownership, aligning interventions with municipal health investment plans and promoting long-term sustainability.
- *Strengthened governance mechanisms and policies.* The Philippines adopted elements of the WHO HEARTS package through different policy and programme areas, such as medicine- and dose-specific hypertension treatment protocols; the provision of validated digital blood pressure measuring devices; a strengthened digital information system; capacity-building with more than 1411 health care workers (physicians, nurses, midwives, programme staff) trained; and team-based care involving community health workers for home blood pressure checks and medicine delivery.
- *Sustainable financing.* The rollout of PhilHealth's Konsulta (the national health insurance scheme) capitation-based benefit package, which covered the costs of hypertension medicines in the treatment protocol, enabled primary care facilities to sustainably finance hypertension care. Capitation funds were used for medicine procurement, diagnostics, health worker incentives, and reducing out-of-pocket costs.

- *Multistakeholder action.* The Government of the Philippines framed hypertension as a shared community challenge, deploying culturally-appropriate health promotion strategies in underserved areas to boost screening and retention, relying on community health workers to deliver health promotion and awareness-raising activities.

What was the impact?

The provincial rollout in the Philippines of the WHO HEARTS-based hypertension control programme in Western Visayas has delivered strong and scalable results. The initial pilot in Iloilo Province in 2021, covering seven local government units, demonstrated high effectiveness, with 75.1% of the 27 165 enrolled patients achieving blood pressure control. Building on this success, the programme was expanded to the remaining 32 local government units in the province, bringing the total coverage to 39. Additionally, the programme was further expanded to 2 more provinces in the Western Visayas region, Antique and Aklan, covering 18 and 17 local government units respectively. In total, Healthy Hearts Philippines covers 74 local government units, has reached a catchment area with a total population of nearly 1.93 million adults over 5 years, and has enrolled 139 371 hypertensive patients. Among these, 91 102 (65.4%) individuals have achieved blood pressure control – more than three times the national and global average control rate. The expansion of the programme is a strategic move toward institutionalizing NCD care within the broader UHC agenda of the Philippines. These results demonstrate that a phased, locally-owned, and systems-integrated approach, grounded in the WHO HEARTS technical package, can deliver measurable improvements in hypertension care and control. The Philippines is now well-positioned to scale and institutionalize these gains within its broader UHC agenda.

2.1.3. Bangladesh

Bangladesh presents another example of a lower-middle-income country that has advanced hypertension control at the provincial level through the WHO HEARTS package, ahead of national rollout.

What was the challenge?

In 2018, almost 20 million adults in Bangladesh were living with hypertension, yet only 38% were receiving treatment and just 15% had their blood pressure under control. In the past decades, Bangladesh has faced several structural and systemic barriers, including limited access to essential medicines in rural areas; long waiting times at primary care facilities; high transportation costs; and weak patient retention systems. In addition, environmental factors such as the widespread use of solid fuels has been linked to a significant increase in cases of hypertension, especially among women (23).

What actions were taken?

Bangladesh took the following steps to address their challenges in hypertension control:

- *Integration of hypertension in national UHC efforts.* In 2018, the Ministry of Health and Family Welfare launched the Bangladesh Hypertension Control Initiative, making a high-level commitment to integrate hypertension prevention and treatment into primary care and to institutionalize best practices nationwide.
- *Strengthened governance mechanisms and policies.* Bangladesh adopted the WHO HEARTS package, focusing particularly on the team-based care model. This included task-sharing for non-physician health workers; developing a simple, stepwise, medicine- and dose-specific national treatment protocol for hypertension management; and adopting the Simple app to collect data, monitor patient progress, and improve the quality of care. In addition, in 2023, the Government launched the Community Clinics Refill Project to address the high loss to follow-up and poor retention by bringing services closer to communities.
- *Sustainable financing.* Hypertension services are now embedded in essential service packages delivered through Upazila Health Complexes and community clinics. Continued investment in digital tools, free medication provision, workforce training, and community engagement has laid the foundation for long-term sustainability.

What was the impact?

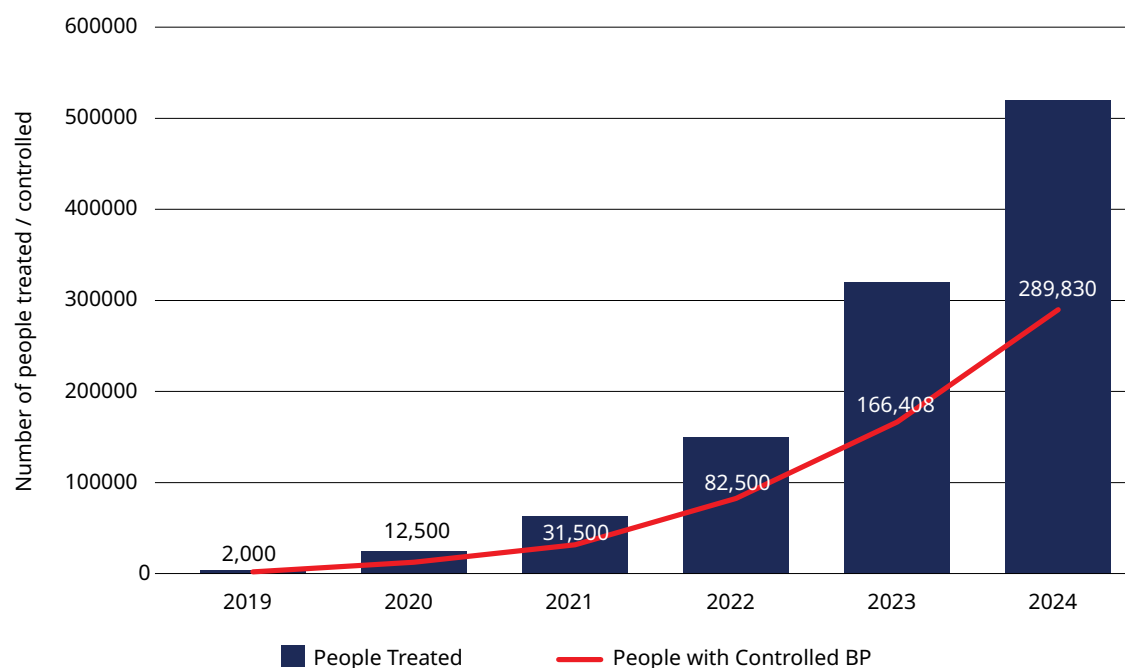
Although Bangladesh is not yet implementing the programme across the entire country, it has made significant strides at the local facility level in the implementing regions. Between 2019 and 2025, the Bangladesh Hypertension Control Initiative has demonstrated a strong and scalable impact in improving hypertension management and control. The programme began with a pilot in the Sylhet health district in 2018 and, building on the early results, expanded rapidly, reaching 63% of all Upazila Health Complexes nationwide (310 of 492 primary care facilities). Between October 2018 and June 2024, the initiative recorded a significant improvement in hypertension control, with 56% of 517 555 patients who received treatment, achieving blood pressure control in the implementing facilities. This progress marks a major step forward in Bangladesh's efforts to integrate hypertension management into primary health care and reduce cardiovascular risk at the population level (Fig. 6 and Fig. 7).

Fig. 6. Expansion of the Bangladesh Hypertension Control Initiative, 2019–2025*



* Expansion from 4 primary care facilities (Upazila Health Complexes) to 63% coverage of all primary health care facilities nationwide.

Fig. 7. Number of people treated for hypertension and blood pressure control rate, 2019–2025*



* In primary health care facilities (Upazila Health Complexes) implementing the Bangladesh Hypertension Control Initiative.

Source: HEARTS360 dashboard of the Bangladesh Hypertension Control Initiative (BHCI)

2.1.4. Reasons for success

Bangladesh, the Philippines, and the Republic of Korea achieved effective hypertension control through the following common strategies:

- Strong **political commitment and leadership** that placed hypertension prevention and control at the centre of efforts to achieve UHC.
- Coherent **governance and policies** that fostered systemic changes in service delivery, health financing and health information systems.
- **Strategical funding**, which is progressively scaled up over time to expand equitable access to care by integrating services and treatment into national benefit packages and local health programmes, thereby reducing financial hardship and encouraging adherence to treatment.

The strategies did not stand alone; they were interconnected and mutually reinforcing, allowing for change to be more resilient, scalable, and impactful. Broad stakeholder involvement was essential in bringing care closer to communities.

2.2. Remaining barriers and existing enabling factors

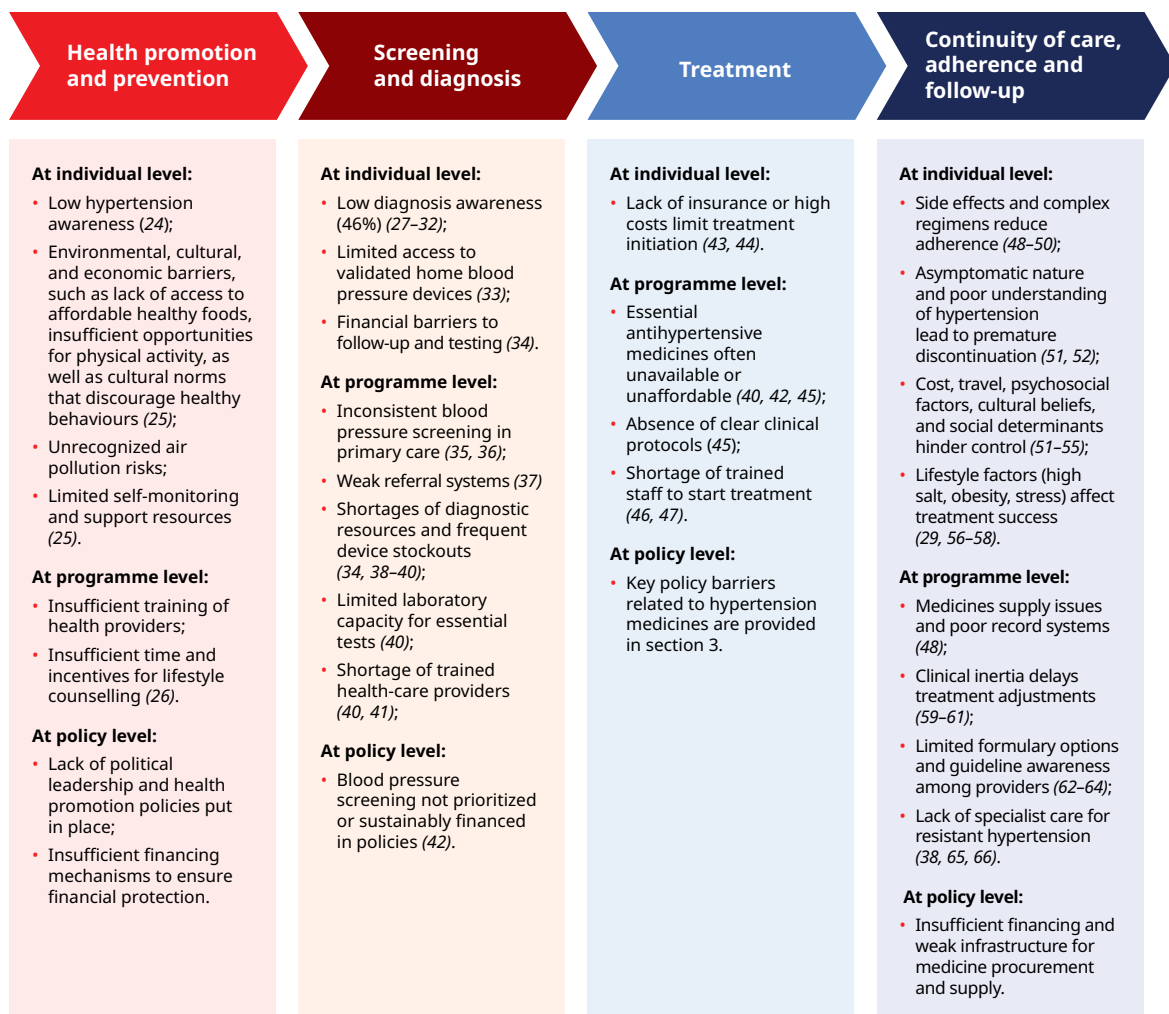
Despite the notable progress achieved in certain countries at national and subnational level, the global landscape of hypertension control remains extremely concerning. All countries, including those performing best, remain far from realizing the aspiration of universal blood pressure control. This is due to a range of barriers at individual, programme and policy levels, which occur across the entire spectrum of care, from initial prevention and health promotion, through to lifelong management and follow-up. Along this continuum, most individuals are lost to care, remain undiagnosed, or fail to achieve sustained control. This section summarizes the most common barriers that impede further progress being made with hypertension prevention and control in countries, and discusses the enabling factors that support progress, drawing on evidence from both literature reviews and expert inputs (Fig. 8) (see Annex 2 for details on scoping reviews methodology). These enabling factors operate at multiple levels, helping to create supportive environments for individuals, improve programme implementation, and shape effective health policies.



When I had my first stroke, no one explained what caused it. I spent over three months in the hospital and still didn't understand what hypertension really was. It wasn't until I had another stroke that I realized how serious it is. I wish someone had told me earlier. We need more awareness and education – people shouldn't have to learn about hypertension the hard way.”

—Michael Uchunor, Nigeria

Fig. 8. Key barriers along the continuum of hypertension care



Enabling factors – Health promotion and prevention

Individual level	<ul style="list-style-type: none">• Enhancing health literacy – especially regarding lifestyle changes such as healthy diet, regular physical activity, and tobacco cessation – empowers people to make informed choices and adopt healthier behaviours (25, 67). Education tailored to address cultural and personal contexts further supports individuals in understanding and managing their risk.• Increasing an awareness of hypertension and its associated dangers is also crucial; many people remain unaware of their condition or underestimate its seriousness (68, 69). Continuous, culturally-appropriate education delivered by health care workers, including community health workers, helps individuals understand hypertension, its risks, and the importance of adherence to treatment and healthy lifestyle choices (70).
Policy level	<ul style="list-style-type: none">• Implementing WHO's Global HEARTS Initiative packages target the harmful risk factors for hypertension and include: SAFER (71) for addressing alcohol use; MPOWER (72) for decreasing tobacco use; SHAKE (73) for reducing salt intake; REPLACE (74) for abolishing the use of industrially-produced trans fats; and ACTIVE (75) for decreasing physical inactivity. These evidence-based packages are essential for improving hypertension outcomes; they guide governments in their efforts to lower the hypertension burden and tackle root causes by integrating interventions into national strategies, creating environments that promote healthy choices and reduce the risk factors.• Reducing sodium intake for the prevention and control of hypertension and cardiovascular diseases. The WHO Sodium Country Score Card helps countries assess progress in implementing sodium reduction policies across five areas: surveillance; food reformulation; front-of-pack labelling; education; and food procurement standards (76). To further support Member States in their efforts to reduce sodium intake and lower the risk of hypertension, WHO has published a guideline on the use of lower-sodium salt substitutes (77).• Reducing air pollution, both indoors and outdoors, which is a key risk factor for hypertension. WHO recommends including the reduction of air pollution in national guidelines and screening services, with training for health professionals and personal interventions. In addition, governments should adopt cross-sectoral policies for electrification in energy, transport, housing, urban development, and health care to reduce pollution and achieve health and climate benefits (78).

Enabling factors – Screening and diagnosis

Individual level	<ul style="list-style-type: none">• Improving access to accurate home blood pressure monitoring devices, combined with appropriate training, empowers individuals to regularly check and track their blood pressure (79, 80).• Increasing an awareness of the importance of regular blood pressure checks, driven by targeted health education campaigns and community outreach, can boost demand for screening, especially among those who may not routinely visit health care facilities.• Promoting support from family, peer networks, and community leaders motivates individuals to prioritize their cardiovascular health (24).
Programme level	<ul style="list-style-type: none">• Promoting “opportunistic screening” – measuring the blood pressure of all adults during any health encounter – has been widely adopted as a simple, effective practice in many countries (7, 81). In addition, integrating hypertension screening into other health programmes, such as diabetes clinics, antenatal care, or HIV treatment visits, has also proven effective in capturing high-risk groups and improving detection rates (82, 83). Scaling accurate BP screening is important to reduce health system strain (Box 5).• Ensuring training for health providers and the dissemination of up-to-date clinical guidelines, are critical (40, 84). Enhancing task-sharing strategies, which empower trained nurses and community health workers to confirm blood pressure readings, conduct point-of-care risk assessments, and refer complex cases, help to address shortages of health care providers and expand service capacity (85, 86).• Promoting the use of technology, for example with validated automated blood pressure devices and digital tools, such as smartphone apps, SMS reminders, and telehealth platforms, to support detection efforts and to facilitate measurement-taking outside traditional clinical settings and to encourage individuals to seek screening and follow-up care (87).
Policy level	<ul style="list-style-type: none">• Adopting national policies and guidelines that strengthen routine blood pressure screening and diagnosis. For example, introducing simplified management protocols, such as those provided in the WHO HEARTS technical package, offers clear, evidence-based algorithms for primary care teams to diagnose and manage hypertension (20).

Box 5. Access to validated automated blood pressure measurement devices (BPMDs)

Why measuring blood pressure matters

Accurate blood pressure measurement is foundational to the diagnosis, treatment, and long-term control of hypertension. However, in many health systems – particularly at the primary care level – blood pressure continues to be measured using outdated or non-validated devices, which may lead to systematic misdiagnosis, undertreatment, or overtreatment.

Validated automated blood pressure measurement devices (BPMDs), defined as those which have undergone clinical accuracy testing under internationally-accepted protocols, address this critical gap. They reduce observer variability, eliminate terminal digit bias, and are easy to use, thus enabling wider task-sharing among non-physician health staff. Ensuring that only validated devices are used across the health system is essential for delivering reliable and equitable hypertension care.

Blood pressure measurements should be conducted by a trained staff member in a standardized way, with an appropriate cuff, and the patient comfortably seated with their back supported, an empty bladder and legs uncrossed. It is efficient and acceptable to conduct two blood pressure readings at first and use results of the second reading to guide decisions about the need to schedule a follow-up visit to complete the diagnostic work.

Advantages of validated automated BPMDs

Accuracy: Validated BPMDs are rigorously tested through standardized clinical protocols to ensure accurate readings across diverse populations.

Ease of use: The devices simplify the measurement process; they require minimal training and enable task-sharing among nurses, accredited social health activists, and other non-physician providers.

Scalability: The devices are suitable for use at all levels of care, including primary health centres and community clinics.

Reduced human error: The devices eliminate observer bias, hearing-related inaccuracies, and inconsistent inflation–deflation techniques.

How to advance the use of BPMDs

- *Develop clear policy mandates:* The exclusive use of validated BPMDs should be a requirement in national NCD programmes and standard treatment guidelines.
- *Define technical specifications:* Issue national-level guidance to standardize specifications for device selection, prioritizing durable, battery-operated models suitable for low-resource settings.
- *Integrate validation status in procurement processes:* Establish rate contracts or framework agreements that screen for ISO 81060–2:2018 compliance.
- *Budget for quality:* Allocate dedicated funds to procure validated BPMDs and phase out non-validated models across all levels of care.
- *Build awareness and capacity:* Conduct orientation for procurement officers, programme managers, and clinicians on the importance of using validated devices.

Enabling factors – Treatment

Individual level	<ul style="list-style-type: none"> • Reducing financial barriers to ensure sustained access to essential treatment through free or subsidized antihypertensive medication in public programmes (88). • Improving medication adherence and follow-up by providing ongoing motivation and practical assistance for patients through digital reminders and peer support systems. • Fostering medication adherence and empowering individuals to manage their condition effectively through comprehensive patient education and counselling on the importance of lifelong treatment (24, 89). • Involving patients in shared decision-making to enhance their engagement and satisfaction with care; and to achieve better health outcomes and more personalized management strategies (24).
Programme level	<ul style="list-style-type: none"> • Ensuring a reliable supply of affordable medications by implementing programme level strategies as presented in section 3 (84, 90). • Implementing simplified treatment algorithms to encourage prompt initiation. For example, standardized protocols direct providers to start a first-line treatment as soon as hypertension is confirmed at specified levels (20). • Training and mentoring primary care providers on treatment protocols to build confidence to initiate therapy and titrate medications (91) (<i>see country example in Box 6</i>). • Including single-pill combinations as part of treatment protocols to improve treatment initiation and long-term adherence (7). • Introducing team-based approaches and task-sharing to non-physician providers to increase treatment initiation. Initiation of treatment or adjustment of medications based on protocols by nurses is an effective model of care when there are shortages of physicians and, more broadly, to scale up services (13). • Integrating statin therapy with antihypertensive treatment for adults with hypertension who have additional risk factors, such as diabetes, older age, tobacco use, or a history of cardiovascular events, as recommended by international clinical guidelines (92, 93).

Policy level • **Establishing policies that promote the inclusion of hypertension medications in national essential medicines lists, subsidized programmes, and health benefit packages – as part of UHC expansion** – to ensure that hypertension treatment is accessible and affordable to those in need. In addition, pricing policies to ensure affordability, including promoting the use of quality assured generic medicines is important. (A full analysis of enabling factors across the pharmaceutical chain for hypertension medicines is provided in section 3.)

Box 6. Improving treatment of hypertension in rural China

In 2023, the cardiovascular health team at the First Hospital of China Medical University, with endorsement from the Liaoning Provincial Health Commission, implemented the Hypertension Control Promotion in Rural Communities in Northern China Project. The project, conducted in two townships in Changtu county of Liaoning Province, put village doctors at the centre of care. To develop the pilot, the team adapted WHO's HEARTS technical package to the local context, built upon Changtu's existing family doctor team structure, and incorporated lessons learned from the China Rural Hypertension Control Project trial led by the First Hospital of China Medical University which successfully built capacity at the community level (94, 95).

Simplified and standardized care protocols for high blood pressure were adopted, based on WHO HEARTS, and village clinics were supplied with validated, digital blood pressure monitors capable of automatically uploading measurements into a digital information system.

Following training, village doctors took on expanded roles in hypertension care which included distributing subsidized medications; providing health coaching on lifestyle modifications and adherence; instructing patients on home blood pressure monitoring; facilitating social support groups; contacting patients who missed follow-up visits; conducting home visits or accepting home blood pressure readings sent via photographs for record-keeping. Patients who did not achieve blood pressure control, or who had a high risk for cardiovascular disease were referred to higher-level facilities. Once their blood pressure stabilized, they were transferred back to village doctors for continued management.

By the end of 2024, more than 5000 patients were actively receiving hypertension care at 39 village clinics in Changtu county; 95% of them were retained in care in the 3 months prior, and 70% with their blood pressure controlled. Encouraged by the success of the initial trial, the Noncommunicable Disease division of the Chinese Center for Disease Control and Prevention has committed to scaling up this project. This expansion will extend hypertension management to primary care facilities within 5 demonstration zones previously designated by the National Health Commission of China for comprehensive NCD prevention and control. With village doctors leading the initiative, the expansion has the potential to safeguard a population of 4 million from the adverse effects of high blood pressure.

Enabling factors – Continuity of care, adherence and follow up

Individual level	<ul style="list-style-type: none"> • Introducing patient education and counselling approaches at treatment initiation sessions and regular follow-up visits since reinforcement has proven fundamental for adherence (96). • Engaging patients in self-management for better control of their blood pressure, by self-monitoring at home, understanding their blood pressure goals, and making behavioural changes (97–99). • Coupling self-monitoring with telehealth – for example, patients send their blood pressure readings to clinics which allows for timely medication adjustments (100, 101).
Programme level	<ul style="list-style-type: none"> • Introducing team-based care models (40, 102), with the involvement of pharmacists or community health workers, for example in counselling on adherence to medication, home visits, assistance with medication refills, or telephone follow-ups. These can significantly improve medication-taking behaviour and effectively link the community with clinics for sustained follow-up (96, 103–106). • Simplifying treatment regimens which can involve using once-daily dosing and single-pill combinations, to reduce pill burden and to increase medication adherence (107, 108). • Improving patient tracking and recall by, for example, maintaining registers and using community health workers to follow up with patients who miss appointments (109, 110). • Reducing the patient-incurred costs of treatment by extending insurance coverage or lowering medicine prices with strategies included in sections 3 and 4 of this report (111, 112). • Introducing innovations related to mobile health, digital health tools, and telemedicine to improve medication adherence and appointment attendance (113–119). • Monitoring performance through clinical audits and feedback to motivate providers to prioritize hypertension control. For example health facilities can track the percentage of patients who have controlled hypertension and use the figure as a quality metric.
Policy level	<ul style="list-style-type: none"> • Prioritizing hypertension medicines within the expansion of UHC, integrating treatment into national benefit packages provided universally through public funds including health insurance schemes, with adequate, sustainable, predictable financial resources to reduce out-of-pocket costs for individuals (further information is provided in section 3 of this report) (<i>see country example in Box 7</i>).

Box 7. Dominican Republic: a national model for equitable hypertension control in the WHO Region of the Americas

Cardiovascular disease accounts for 35% of all deaths in the Dominican Republic, with nearly 1 in 3 adults affected by hypertension. Of these, more than 40% remain undiagnosed. Historically, fragmented insurance coverage, inconsistent treatment protocols, limited access to essential medicines, and variable quality of care across primary health centres, have hindered effective hypertension control.

The Dominican Republic implemented the following measures to overcome these systemic barriers:

- *Integration into national UHC efforts.* In 2024, the government formally adopted WHO's HEARTS initiative as part of its national health strategy through the presidential programme "Más Salud y Esperanza de Vida." The HEARTS plan, endorsed at the highest political level, reoriented national priorities towards the prevention and primary care of hypertension.
- *Standardized clinical pathways and improved governance.* The Ministry of Public Health, the National Health Service, and the Pan American Health Organization coordinated the implementation of the HEARTS clinical pathway in more than 1000 primary health care centres. This pathway, aligned with regional quality standards, includes risk-based protocols, single-pill combination therapies, statins, and structured patient follow-up.
- *Expanded access to medications.* Through the national Essential Medicines Program (PROMESE/CAL), 382 People's Pharmacies now provide free antihypertensive medicines. The inclusion of 90-day dispensing models has supported treatment adherence, especially in areas with limited follow-up capacity.
- *Health workforce development.* More than 4800 health professionals have received in-person training in the HEARTS protocols. In addition, nearly 9000 individuals have been trained in accurate blood pressure measurement and chronic disease management. These efforts are part of a broader regional strategy that has strengthened the skills of more than 40 000 health workers.

As a result, by 2024, 58% of the national primary health care network was implementing HEARTS. Among patients receiving treatment in these facilities, 66% achieved control of their blood pressure. The Dominican Republic demonstrates how political commitment, regional collaboration, and structured implementation can deliver measurable results in hypertension control through primary health care.

2.2.1. The importance of data

Comprehensive, high-quality data allow health ministries to assess the true burden of hypertension, understand its underlying determinants, and devise targeted strategies for prevention and treatment. Without such data, it is difficult to accurately gauge the scale of the problem at national, regional or global levels or to monitor progress in controlling hypertension (12, 120). Data also ensure accountability.

Facility-based data are fundamental to monitor better the hypertension care cascade, identifying individuals that are diagnosed, treated and controlled. Electronic health records and facility-based patient monitoring, as promoted by WHO's HEARTS technical package, provide frameworks and indicators for ongoing evaluation and improvement of hypertension care (19). Such data are needed to help countries track progress in hypertension control, and set targets to achieve – at facility, regional or national level. Box 8 describes WHO's SEAHEARTS initiative which contributes to the prevention and control of hypertension in the South-East Asia Region.

However, individual facility-based data alone, while essential, are insufficient for determining population-level coverage and control of hypertension. Instead, systematic population surveys, such as the WHO STEPwise approach (STEPS) (121), are needed to further capture prevalence, diagnosis, treatment, and control rates in the community.

Data on hypertension, however, are often lacking in countries. Most countries have a limited number of nationally-representative data sources (122). Others continue with fragmented and incompatible systems which often use multiple, non-interoperable data management platforms within the same health facility, leading to inconsistent data collection, lack of standardization, and difficulty in integrating hypertension data across systems (47, 123). Furthermore, limited digital infrastructure is a major issue. The absence of electronic health records, unreliable Internet access, and continued reliance on poorly organized paper records hinder the systematic tracking and management of hypertension cases. WHO has developed tools to support this area of data collection, such as the NCD DHIS2 tool and the NCD e-registry tools (124, 125).

Box 8. SEAHEARTS initiative contributing to hypertension prevention and control in the WHO South-East Asia Region

The Seventy-sixth session of WHO South-East Asia Regional Committee in 2023 adopted the Resolution: *SEAHEARTS: Accelerating prevention and control of cardiovascular diseases in the South-East Asia Region (SEA/RC76/R5)*.^a The commitment on SEAHEARTS brought together measures to reduce risk factors (tobacco control, salt reduction, and trans-fatty acids) with measures to scale-up coverage and control for hypertension and diabetes in primary health care. The four milestones agreed by WHO Member States^b to be achieved by 2025 are:

- 1) 100 million people with hypertension and/or diabetes are placed on protocol-based management;
- 2) 1 billion people are covered by at least three WHO MPOWER measures for tobacco control;
- 3) 1 billion people are covered with at least one of the WHO SHAKE package measures for reducing salt intake; and
- 4) 2 billion people are protected from the harmful effects of trans-fatty acids through best practices or complementary policy measures of WHO REPLACE.

SEAHEARTS Resolution, triggered several prioritized policy and clinical intervention measures by countries. These include accelerated implementation of WHO technical packages: HEARTS (technical package for cardiovascular disease management in primary health care); MPOWER (measures to reduce tobacco demand under the WHO Framework Convention on Tobacco Control); SHAKE (technical package for salt reduction); and REPLACE (technical package for eliminating industrially produced trans-fatty acids). The progress as of December 2024 based on SEAHEARTS Monitoring Framework^c is as follows:

Progress made against SEHEARTS milestones in WHO South-East Asia Region (Dec 2024)



100 million people with hypertension and/or diabetes are placed on protocol-based management

77.5 million



Two billion people are protected from the harmful effects of trans-fatty acids through best practices or complementary policy measures of WHO replace

2.03 billion



One billion people are covered with at least one of the WHO shake package measures for reducing salt intake

2.08 billion



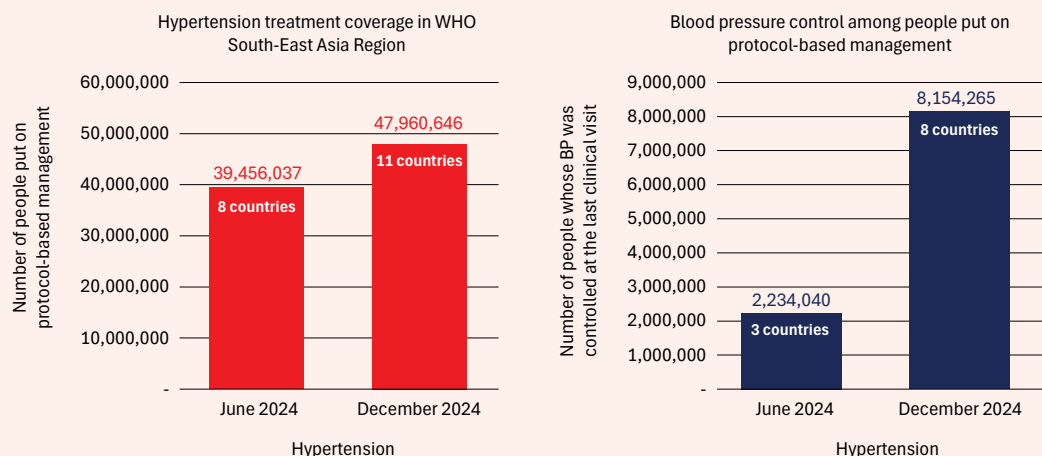
One billion people are covered by at least three WHO MPOWER measures for tobacco control

380.2 million

With the support of WHO, 8 Member States designed the country level commitments towards the collective target of 100 million people with hypertension and/or diabetes are placed on protocol-based management for hypertension and diabetes.

Remarkable progress has been made in the region in hypertension treatment coverage and control. For hypertension, the number of people placed on protocol-based management increased from 39.4 million in June 2024 to 48 million by December 2024.^d These numbers are based on unique identification, with provision to longitudinally track the people on treatment. More than 175 000 public primary health-care facilities in the region reported implementing protocol-based management and tracking treatment coverage for hypertension, representing approximately 70% of the total 246 000 primary health care facilities.

The number of people with controlled status for hypertension was initially reported from 3 countries in June 2024 (2.2 million people), increasing to 8 countries by December 2024 (8.1 million people) – a reflection of improvements made in health information systems.



^a Resolutions and Decisions of Seventy-sixth Session of the World Health Organization Regional Committee for South-East Asia (SEA/RC76/R5) (see: <https://www.who.int/southeastasia/publications/i/item/SEA-RC76-R5>).


^b In accordance with resolution WHA78.25 (2025), Indonesia was reassigned to the WHO Western Pacific Region as of 27 May 2025.

^c SEAHEARTS Monitoring Framework. New Delhi: World Health Organization Regional Office for South-East Asia; 2024 (see: <https://www.who.int/southeastasia/publications/i/item/9789290229797>).

^d SEAHEARTS Monitoring Platform. New Delhi: World Health Organization Regional Office for South East Asia; 2023 (see: <https://apps.searo.who.int/seahearts/>).



The pharmacist at Bukyan Health Center in Same'a district, Taiz governorate, manages and organizes the medicines, sorting them by type and recording their expiration dates. © WHO



3 Improving access to essential hypertension medicines

Key messages

- ✓ Treatment with affordable, evidence-based antihypertensive medicines is cost-effective and delivers substantial returns on investment.
- ✓ Access to essential hypertension medicines remains a persistent challenge in many low- and middle-income countries.
- ✓ Each step of the pharmaceutical chain presents both challenges and opportunities to improve access to essential hypertension medicines as part of their efforts to achieve UHC.
- ✓ From strengthening national regulatory systems – through setting policies to control pricing and collective negotiation and tendering, to the adoption of standardized treatment protocols – governments and their partners need to implement a series of actions to improve access to hypertension medicines and treatment outcomes.
- ✓ Many strategies presented in this section are not exclusive to hypertension, reflecting the fact that effective improvements in the pharmaceutical value chain typically require system-wide enhancements in the management and provision of all essential medicines.
- ✓ Good and replicable examples from countries exist.

“My biggest concern is that many people in my community cannot afford antihypertensive medicines. Even when diagnosed, they often go without treatment, not because they don’t care, but because the cost is too high. This is how hypertension quietly continues to harm families who are already struggling”

—Joseph Rukelibuga, Rwanda

Daily treatment with affordable, evidence-based antihypertensive medicines is cost-effective and delivers substantial returns on investment.^{6,7,8} Every dollar invested in ensuring equitable access to these essential medicines not only improves individual health outcomes but also yields significant savings by averting the high costs associated with emergency care, hospitalizations, and long-term disability resulting from cardiovascular events. Prioritizing expenditure on antihypertensive medicines as part of the UHC agenda in countries is, therefore, a smart investment; it transforms resources that would otherwise be spent on treating the devastating consequences of uncontrolled hypertension into gains in population health, economic productivity, and health system sustainability.

Access to and availability of essential hypertension medicines, however, remains a persistent challenge in many low- and middle-income countries, despite the existence of effective treatments (13, 25). Results from the 2023 WHO NCD country capacity survey (15) revealed stark disparities in the availability of the 5 essential NCD medicines that are used to treat hypertension: thiazide diuretics; ACE inhibitors; angiotensin II receptor blockers; and calcium channel antagonists. While 93% of high-income countries reported having all 5 essential medicines as generally available, the figure was just 28% for low-income countries, with over half (56%) of low-income countries reporting having 3 or fewer essential medicines as being generally available. Regionally, in the African Region, only 30% of countries reported having all medicines available, compared to >90% of countries in the European and South-East Asia regions.

This limited access to medicines is not due to a single issue, but rather the result of complex and interrelated factors present across the entire

⁶ Park C, Wang G, Durthaler JM, Fang J. Cost-effectiveness analyses of antihypertensive medicines: a systematic review. *American journal of preventive medicine*. 2017 Dec 1;53(6):S131-42.

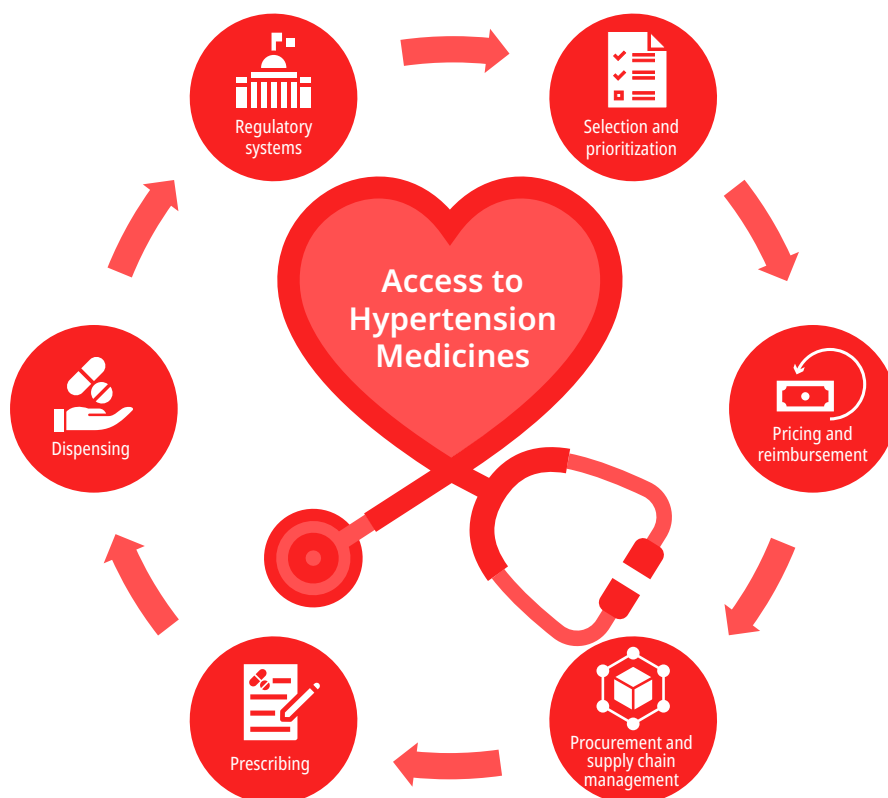
⁷ Updated Appendix 3 of the WHO Global NCD Action Plan 2013-2030. World Health Organization. 2022.

⁸ Nugent R, Brower E, Cravioto A, Koehlmoos T. A cost-benefit analysis of a National Hypertension Treatment Program in Bangladesh. *Preventive medicine*. 2017 Dec 1;105:S56-61.

pharmaceutical value chain (126). Each stage of the chain presents its own set of barriers that cumulatively restrict the availability and affordability, appropriate use of, and adherence to, hypertension medicines. Examining each segment of the chain helps to identify where bottlenecks occur and how they impact access to these essential medicines.

This section addresses the persistent barriers and potential strategies that need to be implemented to improve access to essential hypertension medicines (see Annex 2 for details on scoping review used to inform this section). The section looks more specifically at those phases of the pharmaceutical value chain that depend largely on governmental decisions: i) regulatory systems, ii) selection and prioritization, iii) pricing and reimbursement, iv) procurement and supply chain management, v) prescribing, and vi) dispensing (Fig. 9). The many strategies presented are not exclusive to hypertension, reflecting the fact that effective improvements in the pharmaceutical value chain typically require system-wide enhancements in the management and provision of all essential medicines. A more detailed analysis of the existing barriers as well as step-by-step guidance for service and programme planners at country level is provided in Annex 3. Other key elements of the chain, such as research and development or manufacturing and production are mostly the responsibility of the pharmaceutical industry and are outlined briefly in Box 9.

Fig. 9. Steps of pharmaceutical value chain for hypertension medicines in the context of national public health systems



* Adapted from the WHO roadmap for access to safe, effective and quality assured health products and technologies 2025–2030 (see: <https://www.who.int/publications/b/74762>).



3.1 Regulatory systems

The role of *regulatory systems* in access to hypertension medicines

National regulatory authorities (NRAs) are the gatekeepers of the supply chain of medical products, and they have a mandate to ensure the quality, safety and efficacy of medicines, vaccines, blood and blood products, medical devices, etc. They work within a legal framework and set of regulatory functions spanning the medical product lifecycle, from clinical trial oversight, product marketing authorization and registration, licensing establishments, regulatory inspections, testing products, post-marketing surveillance, and vigilance activities.

When a national regulatory system is independent, efficient, science based transparent, and well-managed, it supports robust and effective medical products regulation, and medicines and other health technologies entering the market are safe, efficacious, and of assured quality. This in turn protects the population from harm due to unregulated supplies, including substandard and falsified medicines, and thus fosters confidence in the health care delivery system. A well-functioning NRA creates an environment in which medicines are appropriately manufactured, stored, distributed, and dispensed. It ensures that health professionals and patients are in a position to use medicines and other medical products rationally because they have the information they need to do so, and ensures promotion and advertising is fair and balanced. It supports local production of medicines, which is key to affordability, helps create a transparent, and well-organized market for medicines and other medical products, and enables post-marketing surveillance and integrity of the supply chain. All these facets of regulation help ensure timely access to essential medicines and enable NRAs to be prepared for better response to emergencies. Moreover, at its best, a strong NRA will perform all of these functions without creating an unnecessary regulatory burden on itself and any of the stakeholders (127–129).

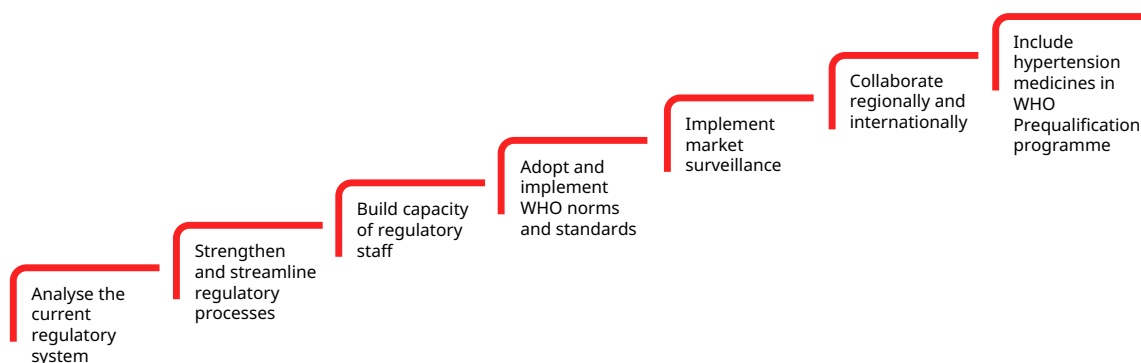
Challenges and potential strategies to improve the *regulatory landscape* for hypertension medicines

Several challenges in the regulatory landscape can hinder the availability of safe and quality essential hypertension medicines. These include:

- weak regulatory oversight that does not ensure the safety, efficacy and quality of hypertension medicines;
- slow and fragmented approval processes that delay access to hypertension medicines;

- excessive bureaucracy in regulatory inspections that slows the process of quality control and oversight; and
- poor enforcement and weak quality assurance systems for regulatory standards that enable the illegal importation and/or sale of counterfeit or substandard hypertension medicines.

The recommended steps that policy-makers can take to address these challenges are presented below.



1. **Analyse the current regulatory system:** A comprehensive analysis of the existing regulatory system can help identify gaps in regulatory capacity, processes, and outputs, and benchmarks the system against WHO standards (129, 130). Countries that do not have regulatory systems can start by establishing a legal and institutional framework to create a national medicines regulatory authority or equivalent body.
2. **Strengthen and streamline regulatory processes:** Strengthen regulatory processes through compliance with good regulatory practices in the regulation of hypertension medicines (131), ensuring transparency and streamlining in all regulatory functions.
3. **Build capacity of regulatory staff:** Invest in training and technical support for regulatory staff to improve expertise in hypertension medicine evaluation, inspection, and post-marketing surveillance.
4. **Adopt and implement WHO norms and standards:** Use WHO's internationally-recognized guidelines for medicine quality, safety, and efficacy as the foundation for national regulations. Develop clear rules for good manufacturing, distribution, and storage practices, and require compliance from all stakeholders.
5. **Implement market surveillance:** Implement regular market surveillance to monitor hypertension medicine quality and prices.
6. **Collaborate regionally and internationally:** Collaborate with regional regulatory harmonization initiatives and leverage pooled procurement mechanisms to improve access to quality-assured hypertension medicines and share regulatory resources.

7. **Expand the scope of the WHO Prequalification Programme to include hypertension medicines:** As demonstrated in other therapeutic areas – such as HIV/AIDS, tuberculosis, malaria, and reproductive health – WHO prequalification plays a vital role in improving access to quality-assured medicines. It supports regional and international procurement and facilitates national registration across multiple countries through the WHO Collaborative Registration Procedure. While a donor-funded market for antihypertensive medicines may currently be limited or absent, expanding prequalification to include these products could help catalyze the development of pooled procurement mechanisms at regional and international levels. It would also facilitate national registration efforts, thereby enhancing access to essential treatments for non-communicable diseases. These considerations have informed recent expansions of the prequalification programme to include medicines for other non-communicable diseases, such as diabetes and cancer.

Example of successful improvements of a *regulatory system* for essential hypertension medicines

The African Medicines Agency

While not yet fully operational, the African Medicines Agency (AMA) is a specialized agency of the African Union established to improve access to safe, effective, and high-quality medicines across the continent by harmonizing regulatory standards and processes (132). AMA builds on the foundation laid by the African Medicines Regulatory Harmonization (AMRH) Programme, which began in 2009 to address fragmented, inefficient, and often weak national regulatory systems that led to delayed medicine approvals and limited patient access to essential medicines (133). By fostering collaboration among African countries and regional economic communities, AMA aims to streamline medicine registration, promote mutual recognition of regulatory decisions, and create a unified approach to the oversight of pharmaceuticals, traditional medicines, and medical devices.

Regulatory harmonization is at the core of AMA's mandate, enabling the adoption of common standards, joint assessments, and shared technical guidelines across Member States (134). This approach not only reduces duplication and accelerates access to quality-assured medicines but also helps combat the proliferation of counterfeit and substandard products. AMA serves as a catalyst for pooling technical expertise and resources, providing regulatory guidance, and strengthening the capacity of national regulatory authorities, ultimately supporting the development of Africa's pharmaceutical industry and improving public health outcomes.

Ghana strengthens its regulatory system

The Ghana Food and Drugs Authority (FDA Ghana) has achieved WHO Global Benchmarking Tool “Maturity Level 3” status, which recognizes a stable, well-functioning, and integrated regulatory system (135). This status reflects Ghana’s adoption of internationally-recognized good regulatory practices, including transparent and streamlined medicine registration, risk-based inspections, and robust post-marketing surveillance. The authority participates in regional harmonization initiatives, conducts joint reviews with other regulators, and has formal measures in place to ensure consistent quality during the review process. FDA Ghana assigns high priority to openness and transparency, informing the public about regulatory activities, providing information on approved products, and giving applicants detailed reasons for decisions. The authority also has guidelines, standard operating procedures, and review templates in place, and regularly monitors regulatory performance to meet target timelines (136).

These reforms have improved public confidence, reduced circulation of substandard medicines, and facilitated the adoption of WHO-recommended hypertension treatment protocols in the public health system. FDA Ghana’s continuous improvement efforts include training assessors according to WHO recommendations, planning for electronic tracking systems, and publishing guidelines for licensing and registration that are publicly accessible. Regular post-license inspections and corrective actions further support quality and safety, ensuring that regulatory processes remain effective and transparent for all medicines, including those for hypertension (137).

3.2. Selection and prioritization

The role of selection and prioritization in access to hypertension medicines

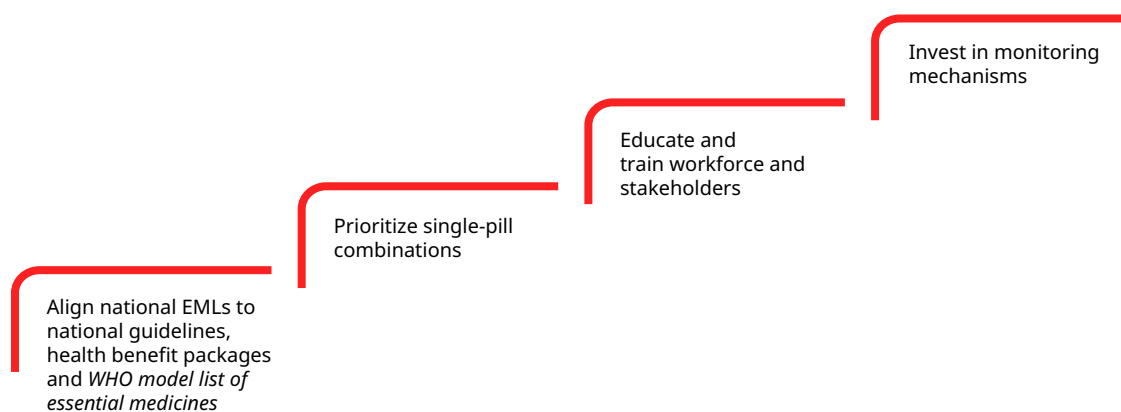
The processes of selection and prioritization refer to the systematic approach used to determine which medicines should be reimbursed under benefit packages and schemes, and therefore included in national formularies or essential medicines lists, treatment protocols, and procurement lists. See also Box 10. These processes involve evaluating medicines based on their local population needs; clinical efficacy; safety; alignment with current treatment guidelines; cost-effectiveness; availability and affordability; supply reliability; and simplicity of regimens (7); patient preferences are also considered. By prioritizing medicines that are long-acting, affordable, and proven effective, health systems can streamline procurement, facilitate large-volume purchasing, and improve adherence, ultimately supporting better outcomes at the population level.

Challenges and potential strategies to improve the *selection and prioritization* processes for essential hypertensive medicines

Several challenges in the selection and prioritization processes can hinder the availability of safe and quality essential hypertension medicines. These include:

- outdated or misaligned national EMLs that can exclude key hypertension medicines or contain medications that contradict current treatment guidelines;
- scarce monitoring of the availability of hypertension medicines at the healthcare facility level, assessing the alignment between what is recommended in the national EML and what is offered;
- national EMLs that are not aligned with the content of health benefit packages (HBPs) (see section 4 of the report) and/or benefit packages that do not include hypertension medicines and therefore limit procurement and provider reimbursement;
- lack of prioritization of combination pills that can affect adherence and treatment outcomes.

The recommended steps that policy-makers can take to address these challenges are presented below.



1. **Align national EMLs to national guidelines and health benefit packages, and to the WHO model list of essential medicines (138):**

Align national EMLs both to national hypertension guidelines, which are based on standardized protocol treatment, and to the update cycle of *WHO's model list*. Compare the antihypertensive section, ensuring inclusion of all recommended medicines listed by WHO. All medicines must be specified by their international nonproprietary name (INN)/ generic name.

2. **Prioritize single-pill combinations:** Revise national hypertension treatment guidelines and EMLs to include and prioritize single-pill combinations.
3. **Educate and train workforce and stakeholders:** Provide training and clear communication to health care providers on the EMLs, specifically on single-pill combinations and the use of INN and generic names for hypertension medicines in all official documents, procurement, and prescribing, as well as to procurement officers to comply with the prescription lists.
4. **Invest in monitoring mechanisms:** Track the availability, uptake, and clinical outcomes of updated antihypertensive medicines, as well as prescription or dispensing data for patients on treatment.

“ *If you have to take one pill a day, you are much more likely to do that than if you have to take three. Currently, the health system doesn't provide a wide enough variety of combination drugs in the public sector. But we know combination drugs improve medication compliance, and that's what helps prevent complications.”*

—Alafia Samuels, Jamaica

Example of successful *selection and prioritization* of essential hypertension medicines

Kenya adopts single-pill combinations

Kenya has taken decisive steps to improve hypertension management by adopting single-pill combination antihypertensive medicines in its 2023 Kenya Essential Medicines List (KEML), following WHO recommendations. The updated KEML now includes combinations for hypertension, such as amlodipine + hydrochlorothiazide; perindopril + amlodipine; and telmisartan + amlodipine + hydrochlorothiazide – reflecting a shift toward simplified, evidence-based treatment protocols that can reduce pill burden and improve adherence for patients (139). This move was informed by WHO's 2019 inclusion of single-pill combinations in the WHO model list of essential medicines (138) and the 2021 WHO Guideline for the pharmacological treatment of hypertension in adults recommending single-pill combinations as a preferred approach for hypertension treatment.

Early evidence and qualitative studies from Kenya suggest that the inclusion of single-pill combinations is widely accepted by patients and health care workers, who recognize the potential for improved adherence and more efficient care (140). However, successful implementation depends on consistent availability and affordability, as well as enhanced training for health care providers to support appropriate prescribing and patient education. While comprehensive national data on blood pressure control rates before and after the adoption of single-pill combinations are not yet available, Kenya's alignment with WHO guidance and the prioritization of single-pill combinations in its essential medicines policy represent a critical step toward bridging the hypertension treatment gap and reducing cardiovascular disease burden in the country.



3.3. Pricing and reimbursement

The role of *pricing and reimbursement* in access to hypertension medicines

The pricing policies and reimbursement processes refer to the systematic procedures and regulatory mechanisms through which the prices and out-of-pocket costs of antihypertensive medicines are managed, and decisions made as to whether, and to what extent, these medicines will be covered by available pooled financial resources – including public provision as well as private health insurance. The ultimate goal is to ensure access and affordability for patients and the sustainability of health system financing.

Challenges and potential strategies to improve the pricing and reimbursement processes for hypertensive medicines

Several challenges in the pricing and reimbursement processes can hinder the availability of safe and quality essential hypertension medicines. These include:

- inadequate, insufficient and/or poorly managed/inaccessible financing, which challenges the timely procurement and distribution of hypertension medicines;
- hypertension medicines that may not be included in the agreed entitlements (benefits) provided under publicly funded services and health insurance schemes;
- lack of pricing policy or policy implementation, such as on use of generic medicines;
- opaque pricing practices that undermine efforts to ensure fair pricing and equitable access to hypertension medicines; and
- Lack of disclosure of mark-up costs at early stages, resulting in higher than expected prices to account for manufacturing, distribution, and retail.

The recommended steps that policy-makers can take to address these challenges are presented below.



1. **Ensure collective negotiation and tendering:** Collective negotiation and tendering policies at national level are essential for managing pharmaceutical prices through encouraging competitive mechanisms. The price negotiation should be evidence-informed (e.g., through health technology assessment).
2. **Establish pooled procurement mechanisms, where appropriate:** Pooled procurement mechanisms should be used in conjunction with other pricing policies, such as tendering and negotiation. Both centralized or decentralized procurement of hypertension medicines can be effective depending on a country's context and capacity. Centralized

procurement, often coordinated at the national or regional level, is a common strategy for achieving economies of scale, reducing transaction costs, and securing lower prices through bulk purchasing. Decentralized models of procurement that benefit from central negotiation, can also improve medicine availability if adequate capacity and oversight are in place. The choice between centralized and decentralized procurement should be guided by local needs, technical capacity, and the ability to maintain quality, efficiency, and affordability in the supply chain.

3. **Develop and enforce transparent pricing transparency:** Following WHO guidance, adopt national policies requiring the disclosure of medicine prices at all points in the supply chain, including net transaction prices, mark-ups, and procurement costs.
4. **Promote the use of quality-assured generic hypertension medicines:** Policies that encourage the increased use of quality-assured generic medicines would influence the price of these medicines not only because they are priced lower than the originator product prior to loss of market exclusivity but also through enhanced price competition.
5. **Include hypertension medicines in health benefit packages and health insurance schemes:** Review and revise the health benefits package provided through public funding and/or social security schemes, to explicitly consider WHO-recommended antihypertensive medicines and their combinations.
6. **Implement government-managed reimbursement systems:** These systems, often embedded within national health insurance or universal health coverage schemes, directly reimburse suppliers and health care providers for the cost of health services and medicines, reducing out-of-pocket expenses for patients and supporting regular supply of medicines, including antihypertensive medicines.

Example of successful *pricing* approaches for essential hypertension medicines

India focuses on generic medicines and imposes price ceilings on essential antihypertensive medicines

India's comprehensive approach to improving hypertension care, including its National Free Drugs Service Initiative (141), the promotion of the use of generic medicines, and the imposition of price ceilings on essential antihypertensive medicines, has yielded substantial public health gains and improved blood pressure control rates. Under the India Hypertension Control Initiative (IHCI), launched in 2018–2019, the Government ensured a reliable supply of free, quality-assured generic antihypertensive medicines in public sector clinics, supported by simple, protocol-driven treatment regimens and robust medicines procurement systems (142–144).

India's efforts to improve access to hypertension medicines have been reinforced by the National Pharmaceutical Pricing Authority (NPPA) setting price ceilings for essential medicines, including antihypertensives, under the Drug Price Control Order and National List of Essential Medicines. The NPPA calculates these ceiling prices based on average market prices, ensuring medicines remain affordable while allowing fair profit margins for manufacturers. For example, the Government capped the prices of more than 500 essential medicines, resulting in significant price reductions for many medicines (145). This approach has kept out-of-pocket costs low for patients and has enabled the public health system to provide a reliable supply of affordable, quality-assured generic medicines. Studies indicate that when hypertension medicines are procured and dispensed through public sector channels or Jan-Aushadhi generic medicines stores, annual costs per patient can be up to 80% lower than in the private sector, further enhancing affordability and access (146). These pricing policies, alongside the Free Drug Initiative and promotion of generics, have been pivotal in scaling up medication coverage and improving blood pressure control rates in India.

Before these reforms, hypertension control rates in India were low, with only about 14% of hypertensive adults achieving blood pressure control (111). Following the implementation of IHCI strategies, including free medicines distribution, use of generics, and price regulation, recent programme data from Punjab and Maharashtra show that among patients retained in care and treated according to protocol, blood pressure control rates rose to 70–81% at follow-up, with mean systolic blood pressure reductions of 15–16 mmHg (144). These improvements demonstrate that public investment in affordable, accessible antihypertensive medicines not only enhances clinical outcomes but also reduces the economic burden of cardiovascular disease, offering a high value return by preventing costly heart attacks, strokes, and related complications.



3.4. Procurement and supply chain management

The role of *procurement and supply chain management* in access to hypertension medicines

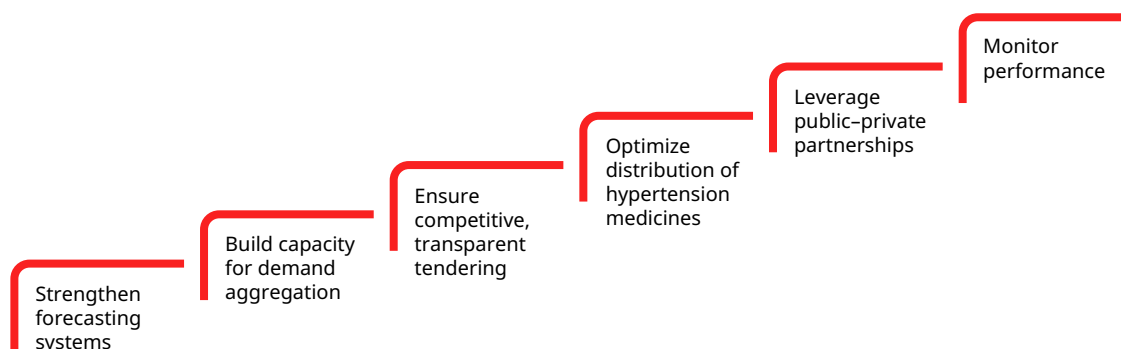
Procurement and supply chain management encompass the coordinated processes of forecasting needs, selecting suppliers, purchasing medicines, and ensuring their consistent delivery, storage, and distribution to delivery points and patients. This involves quantifying demand, negotiating prices, and leveraging procurement mechanism to maximize coverage and cost-effectiveness, as seen in reforms that reduce the number of medication classes and promote single-pill combinations. Effective supply chain management also requires compliance with regulatory and procurement legislation, transparent tendering processes, and robust systems to monitor stock levels and prevent shortages and stockouts. The ultimate goal is to ensure the continuous availability of essential hypertension medicines, guaranteeing access and continuity of care.

Challenges and potential strategies to improve *procurement and supply chain management* for hypertension medicines

Several challenges in the procurement and supply management process that can hinder the availability of safe and quality essential hypertension medicines. These include:

- poor forecasting of the demand for hypertension medicines;
- decentralized bidding mechanisms;
- delayed government payments to suppliers;
- pharmaceutical stockouts due to unreliable medicines supply including limited storage of medicines at pharmacies;
- inaccessible packaging of hypertension medicines; and
- weak distribution system and infrastructure.

The recommended steps that policy-makers can take to address these challenges are presented below.



1. **Strengthen forecasting systems:** This involves including information on hypertension within integrated health information systems that collect accurate, up-to-date data, applying standardized protocols, and applying a forecasting tool to estimate medicine needs and quantify budget requirements. Forecasting needs to adequately reflect hypertension control programmes that are scaling up rapidly with coverage increases. Morbidity-based medicines forecasting aligned with programme targets is recommended to ensure adequate sourcing.
2. **Build capacity for demand aggregation of hypertension medicines:** Strengthen policies and capacity including skilled staff, robust systems, and transparent procedures.
3. **Ensure competitive, centralized transparent tendering:** Use open, competitive bidding processes to select suppliers of hypertension medicines, ensuring transparency and value for money.
4. **Optimize distribution of hypertension medicines:** This involves improving distribution channels, infrastructure, storage capacity, inventory systems, and packaging to avoid stockouts of medicines.
5. **Leverage public-private partnerships:** Public-private partnerships can expand access to medicines and strengthen provision and supply chains.
6. **Monitor performance:** Monitor forecasts, stock levels, procurement outcomes (prices, delivery times, quality), delays, losses, or inefficiencies, and use findings to improve the system for hypertension medicines.

Example of successful *procurement and supply chain management* for essential hypertension medicines

The PAHO Strategic Fund

The Pan American Health Organization (PAHO) Strategic Fund is a regional pooled procurement mechanism designed to improve access to essential medicines for cardiovascular diseases, including antihypertensive medicines, across the Region of the Americas. By consolidating demand from participating countries, the Strategic Fund negotiates long-term agreements with multiple suppliers, ensuring the procurement of quality-assured WHO recommendations for treatment at competitive prices (147–149). This approach enables countries to obtain essential cardiovascular disease medicines, such as amlodipine, losartan, and single-pill combinations, at prices up to 99% lower than those available through national procurement channels, while also reducing transactional and quality assurance costs (150). The Strategic Fund further supports WHO Member States by providing technical cooperation for demand-planning, rational medicine use, and prevention of stock-outs, and by offering flexible credit lines to bridge financing gaps during procurement cycles (151).

The pooled procurement model has contributed to the rationalizing of product lines, the expanded access to antihypertensive medicines, and improved health system resilience, particularly in support of the HEARTS Initiative, which now covers approximately 6 million people across 12 countries in the region. While disaggregated, region-wide blood pressure control data before and after Strategic Fund implementation are not yet systematically available, country-level reports and programme evaluations have documented significant improvements in medicine availability and affordability, which are critical enabling factors for better hypertension control. For example, in countries where the Strategic Fund facilitated access to high-quality, affordable antihypertensive medicines and blood pressure monitoring devices, there have been documented increases in the proportion of patients with controlled blood pressure, as seen in HEARTS pilot sites (150). The Strategic Fund's pooled procurement mechanism thus plays a pivotal role in advancing UHC and reducing the burden of cardiovascular diseases in Latin America and the Caribbean.



3.5. Prescribing

The role of *prescribing* in access to hypertension medicines

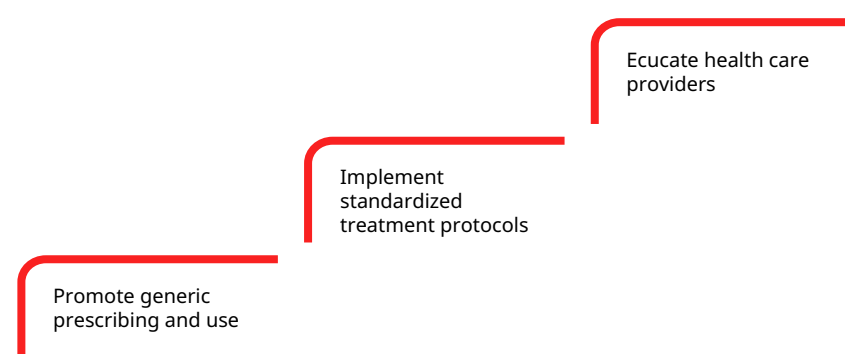
Prescribing refers to the process by which health care providers select and recommend specific antihypertensive medications based on evidence-based guidelines or standardized treatment protocols. Rational prescribing ensures that patients receive medications appropriate to their clinical needs, in the correct doses, for an adequate duration, and at the lowest possible cost to them and their communities. Ultimately, rational and protocol-driven prescribing is essential to ensure that patients fully benefit from the availability of essential hypertension medicines.

Challenges and potential strategies to improve *prescribing* for hypertension medicines

Several challenges in the prescribing process can hinder the availability of safe and quality essential hypertension medicines; these include:

- limited access to a broad formulary of antihypertensive medicines in public health settings;
- unaffordability of medicines that limit prescribing;
- lack of training on updated hypertension guidelines that impedes rational prescribing; and
- clinical inertia that challenges initiating or intensifying medication treatment.

The recommended steps that policy-makers can take to address these challenges are presented below.



1. **Promote generic prescribing and use:** Update national policies and clinical guidelines to require or strongly encourage the prescription of quality-assured generic antihypertensive medicines instead of branded medicines.

2. **Implement standardized treatment protocols:** Develop and disseminate clear, evidence-based hypertension treatment protocols that specify when to initiate and intensify therapy, including use of single-pill combinations.
3. **Educate health care providers:** Strengthen supportive supervision and provide ongoing training on hypertension guidelines, the importance of timely treatment intensification, and interpretation of blood pressure measurements (including ambulatory blood pressure monitoring).

Examples of successful approaches to improve prescribing of essential hypertension medicines

Sri Lanka adopts standardized treatment protocols

Sri Lanka has made significant strides in improving hypertension management by adopting and implementing national treatment protocols aligned with the WHO HEARTS technical package. Recognizing the rising burden of hypertension, the Ministry of Health developed and disseminated evidence-based guidelines tailored to the local context, focusing on early diagnosis, standardized treatment regimens, and regular follow-up to improve blood pressure control (152, 153). In 2021, Sri Lanka partnered with Resolve to Save Lives to pilot a quality improvement programme that leveraged real-time data dashboards, targeted clinician training, and reinforced use of a simplified national treatment protocol in select facilities (154). This initiative specifically addressed treatment inertia, a key barrier identified through data analysis, by promoting timely medication titration and standardizing care using a limited formulary of essential antihypertensive medicines.

The intervention was successfully implemented across several districts, including 34 primary care institutions in the Kalutara district; 43 in the Colombo district; 78 in the Kandy district; 34 in the Matale district; 47 in the Nuwara Eliya district; and 44 in the Galle district. Each facility was equipped with validated digital blood pressure devices and smartphones for data entry. Training on accurate blood pressure measurement and app usage ensured consistent implementation.

The impact of these interventions has been substantial. Prior to these reforms, only about 16–20% of Sri Lankan adults with hypertension had their blood pressure under control, with significant losses occurring at the steps of diagnosis and treatment intensification (155). Following the implementation of the quality improvement programme and protocol-driven care in 3 pilot facilities, medication titration rates increased by over 50%, and blood pressure control among patients in these facilities rose from 30% to 60% – with some institutions achieving control rates nearing 80%. Building on this success, the Ministry of Health expanded the quality improvement interventions to additional hospitals, with a commitment to nationwide scale-up. Sri Lanka's experience demonstrates how the adoption of standardized treatment protocols, combined with data-driven quality improvement and targeted provider training, can rapidly improve hypertension control rates and set the foundation for long-term cardiovascular health gains.



3.6. Dispensing

The role of *dispensing* in access to hypertension medicines

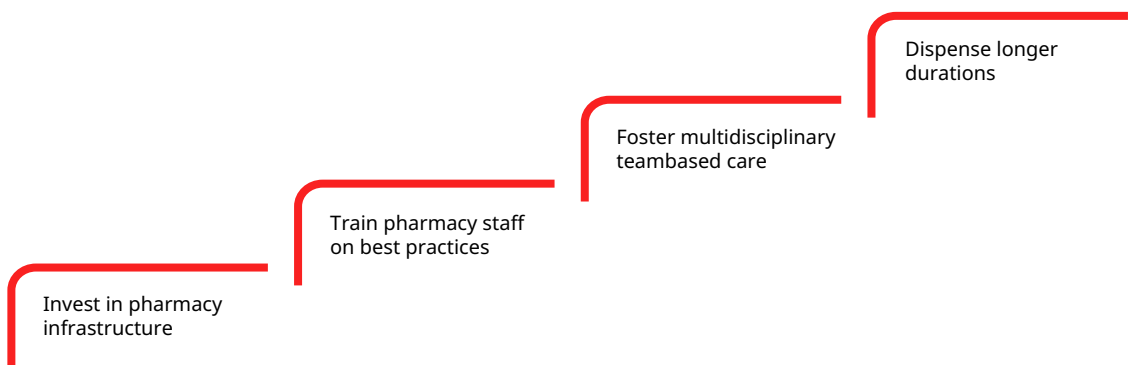
Dispensing refers to the process by which prescribed medicines are accurately prepared, labelled, and provided to the patient by pharmacy personnel or authorized health workers. This process involves validating the prescription; ensuring that the correct medicine, dose, and quantity are supplied; and giving clear instructions and counselling to the patient on how to use the medication safely and effectively. Dispensing durations – commonly 30, 60, or 90 days – can influence adherence, with longer dispensing periods (e.g. 90 days) potentially improving convenience and treatment continuity. Effective dispensing also includes checking for potential medicines interactions, proper storage advice, and educating patients about side effects and precautions, all of which are critical to optimizing hypertension control and patient outcomes. Standard operating procedures and adequate dispensing time are essential to maintain quality and safety throughout this step.

Challenges and potential strategies to improve *dispensing* for hypertensive medicines

Several challenges in the dispensing process can hinder the availability of safe and quality essential hypertension medicines; these include:

- limited access to pharmacies, which can restrict the ability of patients in rural or underserved areas to access hypertension medicines;
- inadequate pharmacy infrastructure, which affects the ability of pharmacists or health care workers to properly dispense hypertension medicines; and
- lack of training of pharmacists in stock management, patient counselling, or hypertension care; and miscoordination between pharmacists, prescribers and patients.

The recommended steps that policy-makers can take to address these challenges are presented below.



1. **Invest in pharmacy infrastructure:** Support the establishment of new pharmacies in underserved areas and expand the role of community pharmacies at primary care, ensuring that they are recognized as essential access points for hypertension medicines, and, as appropriate to the national context, involve private sector entities to improve patient access to medications. Where this is not possible, invest in dispensing nurses or other health care officials.
2. **Train pharmacy staff on best practices:** Provide training on proper storage, inventory management, and patient counselling, emphasizing the importance of privacy and medicine safety.
3. **Foster multidisciplinary team-based care:** Encourage regular meetings and shared care plans between pharmacists, prescribers, and other health care providers to align on treatment goals and medication management.
4. **Dispense longer durations:** Dispensing longer durations for hypertension medicines (30–90 days) can promote convenience, adherence for the patient and reduce routine patient load at the health facility.



Examples of successful approaches to *dispensing* essential hypertension medicines

Pharmacist-led hypertension management in Canada

Canada has demonstrated the effectiveness of pharmacist-led hypertension management through structured certification and intervention programmes. The Hypertension Canada Professional Certification Program (HC-PCP), launched in line with national guidelines, trained pharmacists to deliver protocol-driven hypertension care, including medication management, patient education, and regular follow-up. In a large-stepped wedge cluster randomized trial (the RxPATH Study), pharmacists who completed the HC-PCP achieved a significant reduction in systolic blood pressure among patients with poorly controlled hypertension. After 3 months, patients managed by these pharmacists saw an average reduction in systolic blood pressure of 4.76 mmHg compared to those receiving usual care, as well as higher rates of blood pressure control; some studies showed up to 80% of patients reaching blood pressure targets (156–158). Patient satisfaction with pharmacist-led care was also high, indicating strong acceptance of this model.

Beyond clinical improvements, pharmacist-led hypertension care in Canada has been shown to yield substantial economic benefits. Modelling studies indicate that if pharmacist care were fully implemented for all Canadians with hypertension, the health system could save over US\$15.7 billion, primarily by preventing strokes, heart attacks, and related complications (159). The success of these programmes is attributed to pharmacists' expanded scope of practice, including the prescribing authority in some provinces, structured training, and strong collaboration with patients and other health care providers. These results highlight Canada's leadership in leveraging pharmacists to improve hypertension control at the population level, with demonstrable benefits for both health outcomes and health care costs.

Box 9. The role of manufacturers in the value chain of hypertension medicines

Manufacturers play an essential role in ensuring better access to hypertension medicines. Some of the phases of the value chain system are entirely dependent on the actions of pharmaceutical companies.

For example, intellectual property policies and laws, in particular patents, play an important role in shaping access to hypertension medicines. While patents can incentivize innovation, they may also create barriers that hinder further innovation and the affordability and availability of antihypertensive medicines, particularly in low- and middle-income countries. The high cost of patented hypertension medicines can significantly limit access, especially in resource-constrained settings. Generics are typically priced significantly lower than originator medicines and play a crucial role in improving access and expanding treatment coverage.

Patents can delay the introduction of cost-effective generic medicines (160–167). For example, a 2024 analysis by experts in PAHO found that patents covering certain WHO-recommended single-pill combination antihypertensives appear to have limited competition in Mexico (168). Patents may also affect the availability of medical devices, such as certain blood pressure monitors; however, little information is available on how patents affect current markets for medical devices relevant to hypertension. Governments, regional organizations, civil society, and academia can monitor the patent landscape for antihypertensives to identify where patent barriers may exist (169).

Where patents pose a barrier to ensuring affordable access to medicines, countries have several options to overcome these barriers. The World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) establishes minimum standards for protection of intellectual property but also includes important flexibilities that allow countries to safeguard public health. These flexibilities permit governments to implement at the national level and use measures such as compulsory licensing (authorizing the production or importation of generic versions of patented medicines without the consent of the patent holder); parallel importation; bolar exception and other exceptions to patent rights. Thailand's issuance of compulsory licenses for cardiovascular and HIV medicines in the mid 2000s is a notable example, resulting in significant cost reductions and improved access for patients (170, 171).

Another example is with developing local pharmaceutical manufacturing capacity, adhering to WHO standards of good manufacturing practice, enables countries to reduce reliance on imports, enhance supply chain security, and tailor production to local health needs. Local production can also stimulate technology transfer, workforce development, and economic growth. Governments can support local manufacturing through incentives, public-private partnerships, and regulatory reforms.



4 Hypertension prevention and control are integral to achieving universal health coverage

Key messages

- ✓ To address persistent challenges, hypertension services should be considered within integrated efforts of countries to achieve UHC.
- ✓ Hypertension prevention, screening, and treatment should be considered as part of comprehensive processes to determine national health benefit packages. Strategic entry points exist at every phase of the health benefit package revision process – from preparation to implementation.
- ✓ Governments must ensure financial protection. Hypertension needs to be embedded in the core functions of health financing – revenue-raising, pooling, purchasing, and governance.
- ✓ Equity must be made an essential criterion when expanding coverage of essential hypertension services, to facilitate choices and ensure that those most in need receive services first.

As described in section 2, several countries are demonstrating that rapid progress towards hypertension prevention and control is possible. In each case, progress has been part of a broader effort to accelerate advancement towards UHC, with hypertension an integral component.

Section 4 of this report provides high-level guidance to integrate interventions for hypertension prevention and control into health benefit packages for UHC and ensure financial protection; the challenges outlined in sections 2 and 3 are thus addressed effectively. The integration of hypertension into UHC strategies takes different forms across countries, reflecting differences in health system maturity, available resources, and local priorities.

4.1. Strategic entry points for including hypertension interventions into health benefit packages

UHC requires countries to define and scale up essential health services that meet population needs while ensuring financial protection. Because no country can afford to provide every effective service to every person, prioritizing the interventions to be included in publicly financed health benefit packages is essential. This reflects “progressive universalism” – that is, steadily increasing coverage, by starting with the highest-impact services for those most in need and expanding to cover more people and more conditions as human and financial resources allow.

A health benefit package defines the health services and interventions to which individuals are entitled, including who is eligible, where the services are delivered, and how they are financed. Health benefit packages should, whenever possible, be comprehensive, covering promotive, preventive, curative, rehabilitative, and palliative services for all major health conditions including communicable and noncommunicable diseases, reproductive and maternal health, and injuries.

While countries share similar core health needs, the health benefit packages and the processes for developing or revising them, will differ due to local disease burdens, societal values, fiscal space, and institutional capacity. Health benefit packages must be evidence-based and grounded in local values, with criteria such as disease burden, cost-effectiveness, equity, and financial risk protection guiding their design.

The inclusion of hypertension into health benefit packages should not involve developing a separate package or parallel process for NCDs. Rather, it should be integrated into the overall design and revision of the national health benefit package, and use the same processes and criteria applied to other health conditions.

Developing or revising a health benefit package is an evidence-based undertaking that includes several interconnected steps. WHO uses the PRIORITY framework (Fig. 10) to illustrate these steps.

Figure 10. PRIORITY framework for evidence-informed priority setting in health



Box 10 explains what each step entails and identifies the strategic entry point for hypertension, why it matters, and how to act.

Box 10. Strategic entry points by phase

P – Prepare the groundwork

This step involves identifying the guiding committee and secretariat, technical support where required and overarching policy framework and criteria for setting priorities. This typically requires high-level policy support and reflects core health policy context and goals, considers existing institutionalization of priority-setting processes and the health financing landscape and may require a situation analysis of core capacity.

Entry point for hypertension: Ensure that NCD experts, cardiovascular clinicians, public health specialists, and people living with or at high risk of hypertension are represented in the technical working groups, advisory committees, and other governance bodies overseeing revision of the health benefit package.

Why it matters: The participation of these groups of people ensures that hypertension services are considered appropriately and based on disease burden and lived experience. Domestic political ownership of priority setting processes is essential to secure resources for health and may contribute for hypertension to be included in the final health benefit package.

How to act: Formally nominate NCD stakeholders and ensure their roles are specified in the terms of reference for governance structures. Challenge priority setting processes which are implicit, engage finance authorities, and explore fiscal space options such as health taxes or efficiency gains.

R – Refine the scope

This step focuses on determining the scope in terms of services and interventions to be considered and identifying the relevant technical expert communities to assess and appraise the scope of services.

Entry point for hypertension: Identify and describe a list of hypertension interventions, including medicines, to be considered in the priority-setting process. Conduct or update a national situation analysis on hypertension (e.g. using the country profiles in Annex 1 of this report) and identify key interventions across the continuum of care using the WHO HEARTS package.

Why it matters: Defining the candidate list of interventions is essential to ensuring relevant interventions and fairly considered for inclusion in HBP. Furthermore, given that analytical capacity is limited in most settings, this step will determine which interventions need to undergo evaluation. It ensures that high-priority hypertension services are not overlooked.

How to act: Map current services and review gaps in service provision. Define candidate interventions that are aligned with national guidelines. Use the data in the country profiles provided in Annex 1 of this report; Global Burden of Disease data; and national sources to identify hypertension-related service gaps and intervention needs.

I – Implement the assessment

This step entails collecting and analysing evidence on services and interventions using agreed criteria and methods (such as the burden of disease, cost-effectiveness, budget impact and equity). The extent to which each service or intervention achieves the criteria is assessed.

Entry point for hypertension: Ensure the availability of data assessing hypertension interventions along the generic criteria used for the health benefit package prioritization, especially cost-effectiveness, equity, budget impact, feasibility, and financial risk protection. Ensure that information on the cost of the essential hypertension services to be considered in the draft package is available; support the fiscal feasibility assessment of the draft package.

Why it matters: A transparent, criteria-driven process will support the inclusion of essential hypertension services in a fair and accountable way. Aligning clinical priorities with fiscal realities is essential for designing a realistic HBP which can be sustainably implemented.

How to act: Use global evidence (e.g. WHO hypertension guidelines (7), [WHO UHC Compendium](#), [DCP3](#)) and national data to assess hypertension interventions against agreed criteria. Present local burden and cost data; and highlight the societal cost due to the under-delivery of cost-effective interventions, such as those in WHO's PEN and HEARTS packages (18–20). If applicable, produce estimates of gains which would be generated by ensuring integration of hypertension services within the benefit package.

O – Organize the appraisal

This step includes facilitating the deliberation of options through a transparent and inclusive appraisal process, and arriving at a list of services with priorities set to present to decision-makers and payers.

Entry point for hypertension: Ensure that people living with or at high risk of hypertension, civil society organizations, and frontline providers, participate meaningfully in the appraisal processes.

Why it matters: Formal consultation and stakeholder dialogue increase legitimacy and responsiveness of the final package to community need. It also secures their ownership of the decision and their commitment to contributing, including through monitoring, to the delivery of the services.

How to act: Organize public hearings, solicit feedback from affected groups, and document transparently how their input influenced decisions.

R – Recommend actions

This step involves formulating evidence-informed decisions on priority-setting that are legitimate, aligned with values and policy relevant.

Entry point for hypertension: Ensure that decisions pertaining to hypertension interventions reflect the results of the appraisal.

Why it matters: Ensuring that the final decisions directly reflect the outcomes of the assessment and appraisal is essential for maintaining the integrity of the decision-making process.

How to act: Participate in final consultations to validate the final decisions. Flag areas of misalignment between decisions and assessment or appraisal results.

I – Implement decisions

This step involves operationalizing decisions through revised guidance, essential medicines and product lists where relevant, implementation plans for service delivery and integration into financing instruments, public financial management and procurement. As reflected in the previous steps, it is not recommended to consider implementation and financing only at the end of the process, but rather throughout it: experience has shown that benefit package developments or revisions which are aspirational (or developed for fund raising purposes) fail to be delivered because of under-financing. The many bottlenecks which can lead to an under-delivery should be a constant matter of attention (172).

Entry point for hypertension: Secure empirical studies of bottlenecks affecting delivery of hypertension interventions.

Why it matters: Final decisions about coverage of interventions need to be linked to corresponding actions for health systems, including defining the necessary investments needed to deliver them.

How to act: Invest in the domestic health system from the perspectives of NCDs and hypertension. Aligning HBP decisions with the inclusion of hypertension medicines in national lists of medicines and with price negotiation and procurement plans (173).

T – Translate and uphold entitlements

This step involves clearly communicating guidance, plans and conditions of access to users and providers and establishing mechanisms for accountability.

Entry point for hypertension: Communicate decisions to providers to ensure they understand, accept and effectively implement changes in hypertension service delivery.

Why it matters: Health-care providers need clear, practical guidance on how to implement the decisions, including updates to hypertension services, referral pathways, and patient eligibility criteria. In addition, digital information systems that assess entitlements can support providers in understanding patient coverage and eligibility.

How to act: Offering training sessions, revised protocols, and Q&A resources can minimize confusion and promote consistent service delivery.

I – Impact: evaluate and sustain progress

This step involves monitoring delivery and spending against plans, generating insight to inform revision and ensuring long-term financial and programmatic sustainability and improvement.

Entry point for hypertension: Embed hypertension coverage and control indicators into monitoring systems of health benefit packages using the WHO NCD facility-based monitoring guidance (174) or the Simple app (109).

Why it matters: Monitoring enables the tracking of progress, accountability, and iterative improvement of hypertension services.

How to act: Align with national health information systems, define performance indicators for hypertension care, and ensure that the health benefit package is updated regularly.

Integrating hypertension prevention, screening, and treatment into national health benefit packages is not only feasible but essential for achieving UHC. Strategic entry points exist at every phase of the revision process of health benefit packages – from preparation to implementation. Countries should make use of these opportunities, supported by WHO tools and guidance, to ensure hypertension is included as part of the prioritization process and sustainably financed as part of broader efforts to strengthen health systems and improve population health.

Additional information on the development of health benefit packages can be found in the literature (175–177) and in the forthcoming WHO guidance PRIORITI: interim guidance on evidence informed priority setting for health service packages, programmes and plans.

4.2. Leveraging health financing to ensure financial protection for all

Achieving UHC requires health systems to provide access to needed health services for all people without their having to face financial hardship. Health financing – using financial means to ensure that health systems meet the health needs of the population – is key to achieving UHC and ensuring access to quality care and financial protection for every individual.

Health financing can be leveraged to pursue the UHC goals of expanding access to services; improving quality of care; and reducing out-of-pocket payments that cause financial hardship. Even though health financing arrangements are not designed exclusively for hypertension, it is essential to identify entry points where hypertension prevention, screening, and treatment can be promoted, integrated, and sustained as part of broader UHC reforms.

Four core functions of health financing – **revenue-raising, pooling, purchasing, and governance** – offer distinct but interconnected pathways to embed hypertension into health system reforms. These functions are not specific to hypertension, but awareness of how they operate empowers policy-makers, programme managers, and civil society to influence decisions that affect the availability, affordability, and quality of hypertension services. The four core functions of health financing are described in Box 11.

Additional information on health financing can be found in the literature (181–184).

Box 11. Entry points for hypertension across the core functions of health financing

1. Revenue-raising

Entry point: Advocate for adequate and predictable domestic funding for essential health services including hypertension care, through general taxation, social health insurance contributions, or health taxes (e.g. on tobacco or alcohol and sugar-sweetened beverages).

Why it matters: Revenue-raising ensures sustainable financing for health services, including hypertension prevention and treatment.

2. Pooling

Entry point: Ensure that hypertension services are included in pooled funding arrangements, such as the health budget or national health insurance schemes.

Why it matters: Pooled funding spreads health risks and financial costs, helping to guarantee equity and access, regardless of income or health status.

3. Purchasing

Entry point: Include hypertension interventions in publicly-funded health benefit packages (see Box 10) and ensure that provider payment mechanisms support their due delivery.

Why it matters: Purchasing arrangements enable providers to deliver cost-effective hypertension services and incentivizes quality of care, including effectiveness, continuity of care and person-centeredness.

4. Governance

Entry point: Strengthen transparency, accountability, and inclusive decision-making in how health financing is governed, including the selection and revision of service entitlements.

Why it matters: Governance engages hypertension stakeholders in financing reforms and ensures that financing supports equitable access to quality care.

Strategic approaches for hypertension

Building on lessons presented in sections 2 and 3 of this report, several strategic approaches can support the integration of hypertension into health financing reforms:

- **Map and analyse current financing**

Use national health accounts to start with a clear picture of who pays for what and how much public money versus out-of-pocket spending is involved. Check empirical literature on health financing and hypertension paying attention to which population groups are left behind in terms of coverage or financial protection. Assess how the existing “financing landscape” serves the delivery of cost-effective hypertension interventions (see also phase 7 in box 10) and identify desirable changes or reforms.

- **Anchor hypertension funding in public revenues**
Prioritize domestic public sources – general taxation, social health insurance contributions and health taxes – so that prevention, screening and treatment are not dependent on private premiums, ad-hoc user fees, or unstable donor flows.
- **Make hypertension a visible priority in essential service packages and financing strategies**
Explicit listing in national benefit packages (Box 10), budget frameworks and medium-term expenditure plans supports sustained attention and funding.
- **Use strategic purchasing to drive quality and efficiency – capitation first**
Pay primary care providers a risk-adjusted capitation rate that covers a defined hypertension service bundle (counselling, medications, follow-up, referral). Consider linking part of the payment to measurable outputs, such as blood-pressure control rates, medication adherence and patient-satisfaction scores (178, 179).
- **Reduce out-of-pocket spending, especially for vulnerable groups, such as persons with disabilities, older adults, migrants, refugees and displaced persons, and persons affected by conflict, disasters and emergencies**
Remove point-of-service fees for antihypertensive medicines and routine monitoring; subsidize transport or mobile-clinic outreach in remote areas; and apply exemption policies for low-income households.
- **Embed hypertension indicators in health-information systems and research studies**
Track screening and treatment coverage, control, service and medicines availability, and financial-protection metrics (180), and use the data for budget negotiations and performance feedback to providers.
- **Strengthen national capacity to estimate costs for hypertension interventions and assess budget impact**
Routine costing feeds into medium-term fiscal projections and helps ministries of finance gauge the affordability of expanded coverage.
- **Foster continuous collaboration between health and finance sectors**
Joint working groups, annual budget dialogues and shared policy targets keep hypertension on the fiscal agenda and align incentives across ministries.
- **Ensure external funding is catalytic, transparent and on-budget**
Where partners support hypertension (e.g. medicines donations, technical assistance), channel funds through sector-wide mechanisms; align with national benefit packages; and disclose flows in public accounts to enhance accountability and sustainability.

By documenting the current financing landscape, anchoring funding in public revenues and applying smart purchasing and governance practices, countries can make hypertension prevention, screening and treatment an integral – and sustainably financed – part of their UHC journey.

4.3. Equity at the core of expanding hypertension services

Besides deciding which interventions to include in publicly financed health benefit packages, governments also need to decide who to include first. When expanding coverage of essential hypertension services, equity must be a relevant criterion to facilitate choices.

Prioritizing the most disadvantaged – whether defined by poverty, rural residence, minority status, disability or gender – is important for equitable progressive realization of UHC. These population groups consistently encounter greater obstacles in accessing hypertension services. For instance, individuals living in poor, rural communities often have lower awareness of hypertension due to limited access to screening and health education. Even when diagnosed, these populations may face significant challenges in accessing affordable medications and consistent follow-up care, resulting in lower rates of blood pressure control compared to more advantaged groups (24, 38, 185–188). Importantly, inequities are not confined to low- and middle-income countries or rural settings. Even in high-income countries with advanced health care infrastructure, certain populations – such as Black Americans or Indigenous peoples – continue to experience poorer hypertension control (29, 189–192). In addition, migrants, refugees and displaced persons often face significant barriers – such as language, financial constraints, lack of insurance, legal status, and cultural differences – that limit their access to hypertension care services and disrupt continuity of care, resulting in poorer disease control compared to the local population (193, 194). Box 12 looks at the barriers persons with disabilities experience in accessing hypertension care.

By intentionally targeting these groups in the early phases of coverage expansion, governments can address longstanding disparities and help to ensure that the benefits of public investment in hypertension services reach those who need them most. This approach not only aligns with the ethical imperative of leaving no one behind, as outlined in the Sustainable Development Goals, but also maximizes the impact of health system investments by focusing on populations at greatest risk of poor health outcomes. For example, outreach programmes can be designed to serve remote or underserved areas, while financial protection measures – such as fee-waivers or transportation subsidies – can help reduce out-of-pocket costs for low-income households.



We're still missing treatment for elderly people, people with disabilities, and rural communities. How can someone with low vision or poor literacy tell their medication apart, when mostly all pills look similar?"

—Anita Sabidi, Indonesia

Box 12. Barriers in hypertension care for people with disabilities

People with disabilities face distinct and significant inequities in the prevention and care of hypertension. Research consistently shows that adults with disabilities have a higher prevalence of hypertension compared to those without disabilities. In China, 43% of adults with disabilities have hypertension, a rate notably higher than in the general population (195). This increased risk is especially pronounced among those with physical impairments and mobility limitations, who also tend to have more comorbidities such as diabetes and cardiovascular disease.

Barriers to hypertension treatment for people with disabilities are multifaceted, including physical inaccessibility – such as lack of ramps, wide doors, accessible toilets, or suitable examination tables in health care facilities; and information inaccessibility – with health materials and prescriptions often not adapted for those with hearing or vision impairments (196). Discrimination and negative attitudes among health care providers further compound these challenges, leading to denial of care or poor treatment (197). Disparities in treatment and control rates are evident, with individuals with intellectual or psychosocial disabilities less likely to receive antihypertensive therapy and achieve blood pressure control compared to those with physical disabilities, partly due to communication challenges, lack of tailored education, and under-recognition of hypertension (195, 198). Additionally, studies show that older adults with severe disabilities in long-term care experience higher mortality associated with high systolic blood pressure, suggesting that disability status modifies risk and that these individuals may not receive optimal blood pressure management due to barriers in access, monitoring, and individualized care (199).

4.3.1 Embedding meaningful engagement into hypertension prevention and control

Beyond individual self-management, meaningful engagement calls for the formal and sustained inclusion of people living with hypertension in the design, implementation, and evaluation of hypertension promotion, prevention, and care. According to the *WHO framework for meaningful engagement* (200), this shift involves transitioning from informal consultation to more sustained and institutionalized participatory approaches to leadership, where people with lived experience can contribute strategic input across health governance, policy, service delivery, and research processes.

Embedding lived experience within primary health care systems can take the form of patient advisory councils, co-produced awareness and outreach campaigns, or structured peer-led education and support roles. Such approaches go beyond tokenistic involvement and have the potential to build accountability, trust, and cultural buy-in to the health system. For example, peer-led interventions have been shown to improve adherence to medication and long-term continuity of care, and increase a person's confidence in managing their condition (201, 202). As emphasized in the *WHO framework for meaningful engagement*, engaging individuals most affected – particularly those from marginalized or underrepresented communities – is essential to designing and implementing equitable and responsive health services.

“People don't always connect with generic health messages, but they listen when someone from their own community shares their experience. As a health educator, someone once told me, 'You can't understand my struggle with hypertension.' I said, 'I do... I've been living with it for quite a long time.' The whole dynamic shifted from there. It became a peer-to-peer conversation, not a lecture. That's the power of lived experience, it builds trust and makes people listen.”

—Elena Shelestova, Georgia



5 Recommendations

The recommendations outlined below are based on the evidence, enabling factors and strategic entry points reviewed in sections 2, 3 and 4 of this report.

I. Integrate hypertension interventions into the UHC reforms of countries

This involves the following actions:

- a) Include interventions for the prevention, treatment and control of hypertension into health benefit packages.
- b) Put in place mechanisms for financial protection for individuals in need of hypertension services.
- c) Embed equity as a core principle when expanding hypertension services, prioritizing people who face the greatest barriers to access.
- d) Prioritize provision of hypertension services at primary care level, including:
 - promoting universal facility-based blood pressure measurement among adults visiting primary health care facilities;
 - adopting and supporting use of simple medicine- and dose-specific treatment protocols in all primary care settings;
 - working towards making medications available without interruption and cost-free to patients; and
 - implementing an effective digital information system for hypertension management in primary care settings.

II. Improve access to affordable antihypertensive medicines

This involves the following actions:

- a) Strengthen national medicine regulatory authorities to set and enforce quality standards; regulate hypertension medicines; and monitor for substandard or falsified products.
- b) Update national essential medicines lists and treatment protocols, including single-pill combinations, in alignment with WHO guidance.
- c) Promote the use of quality-assured generic hypertension medicines
- d) Regulate price mark-ups to ensure the affordability of hypertension medicines.
- e) Establish government-managed and efficient reimbursement systems.
- f) Ensure purchasing of medicines is aligned with benefit package policies.

- g) Adopt efficient public procurement systems – for example, pooled procurement, forecasting of medicines; competitive bidding; and prioritization of quality-assured generic medicines.
- h) Improve access to validated automated blood pressure measurement devices.

III. Invest in workforce and expand team-based care

This involves the following actions:

- a) Train primary care health and care workers, including physicians, nurses, pharmacists, community health workers, and allied health professionals, on standardized, evidence-based protocols for hypertension and cardiovascular disease management.
- b) Adopt and implement task-sharing initiatives and policies, allowing appropriately-trained non-physician health workers to diagnose hypertension, initiate treatment, and provide follow-up monitoring, with clear referral criteria and clinical pathways with appropriate physician supervision.

IV. Monitor trends and evaluate progress in hypertension control by strengthening health information systems

This involves the following actions:

- a) Set time-bound, national hypertension control targets, aiming at achieving at least 50% population blood pressure control; monitor progress transparently.
- b) Invest in surveillance systems that capture hypertension, including strengthening routine facility-based data collection and integrating hypertension measurement and questions into existing population-based surveys.
- c) Track and integrate hypertension control data into existing data review mechanisms at facility, subnational, and national levels.
- d) Include hypertension metrics, with a clear focus on the number and estimated proportion of people with hypertension who are on effective treatment with documented control of blood pressure, in UHC dashboards and national monitoring frameworks.

V. Raise awareness and make hypertension prevention and control every person's business

This involves the following actions:

- a) Raise awareness about the silent nature of hypertension and the availability of effective interventions.
- b) Engage and empower the public, particularly marginalized populations, to understand their own hypertension risks; to demand services; and to seek care.
- c) Leverage the expertise of people with lived experience to co-design and deliver contextually relevant awareness efforts that address stigma, build trust, and reflect cultural and community realities.
- d) Collaborate with other sectors to promote awareness of hypertension risk factors and prevention strategies.

Not only will these recommendations and their implementation prevent millions of avoidable strokes, heart attacks, kidney disease and dementia, they can be an entry point for strengthening the response to other amenable NCDs.

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Annex 1. Hypertension profiles and explanatory notes – Country profiles

Afghanistan

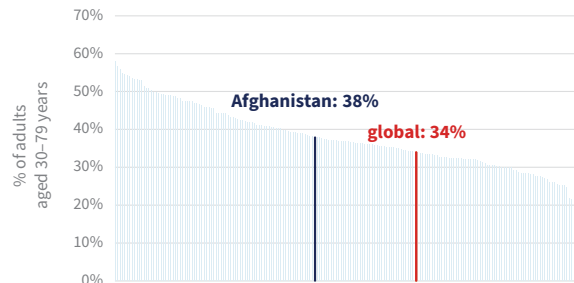
Hypertension profile

Total population (2024): 42 650 000

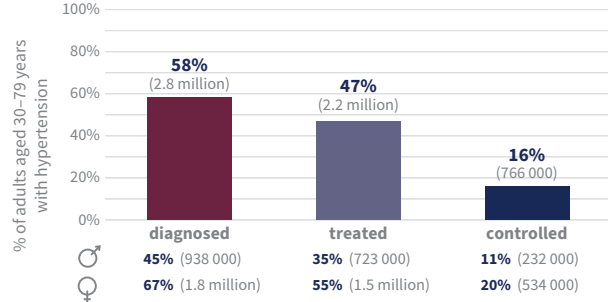
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 38% ♂ 32% ♀ 44%

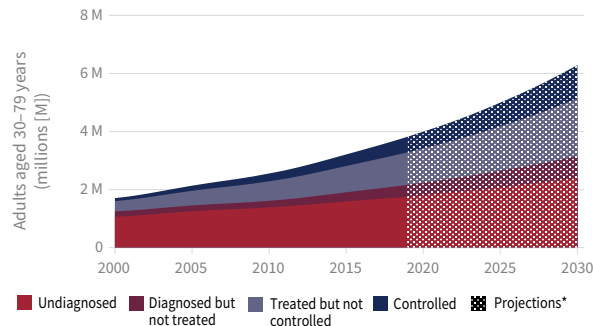
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 4.8 million adults aged 30–79 years with hypertension, approximately 4 million do not have the condition controlled^b

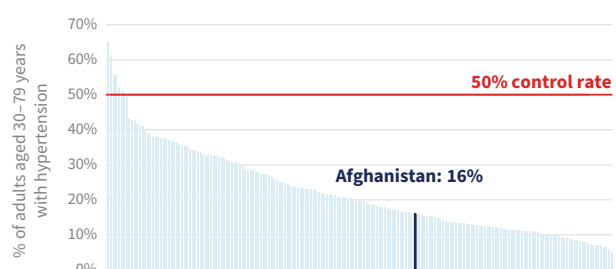


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	340 500	181 300	159 200	2021
Cardiovascular disease deaths	62 970	30 070	32 900	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	51	48	54	2021
Risk of premature death from NCDs (%) ^c	33	32	34	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	23	39	7	2022
Obesity, adults aged 18+ years (%)	18	13	22	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	33	20	46	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Don't know

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Albania

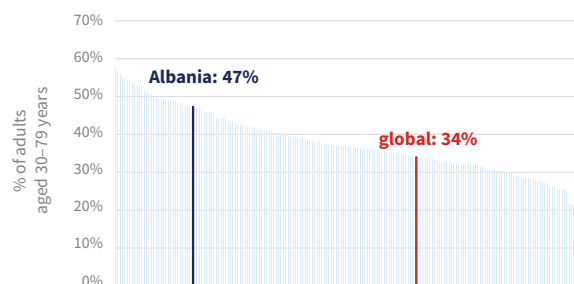
Hypertension profile

Total population (2024): 2 792 000

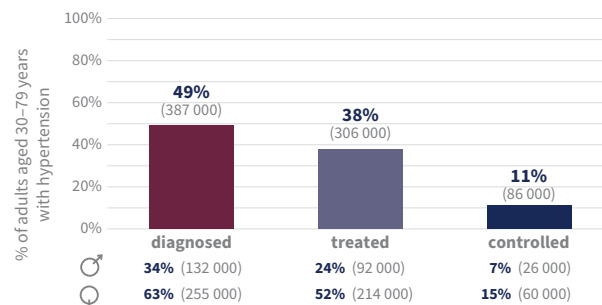
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 47% ♀ 46% 49%

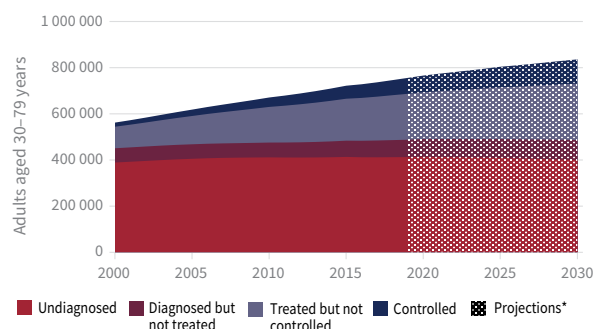
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 797 000 adults aged 30–79 years with hypertension, approximately 711 000 do not have the condition controlled^b

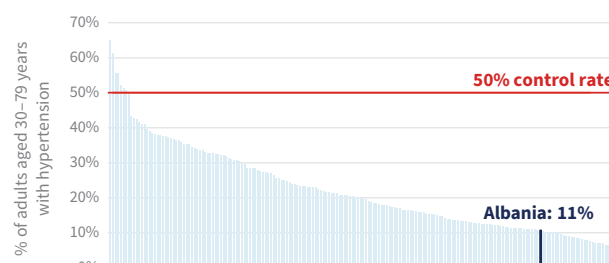


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	33 690	17 250	16 440	2021
Cardiovascular disease deaths	14 720	5960	8770	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	58	60	2021
Risk of premature death from NCDs (%) ^c	10	13	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	13	15	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	22	38	6	2022
Obesity, adults aged 18+ years (%)	27	23	30	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	24	21	27	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Algeria

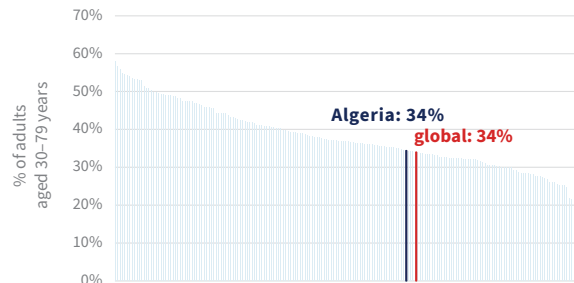
Hypertension profile

Total population (2024): 46 810 000

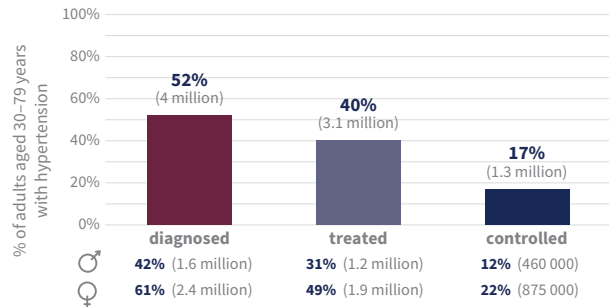
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 34% ♀ 35%

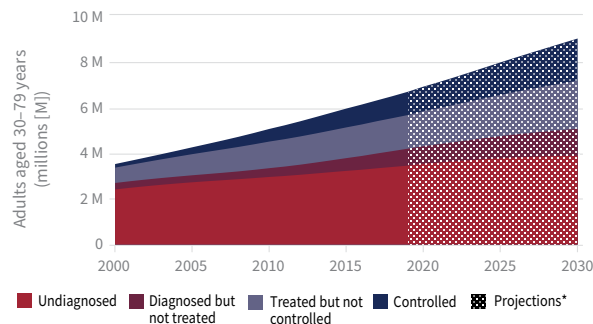
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 7.7 million adults aged 30–79 years with hypertension, approximately 6.4 million do not have the condition controlled^b

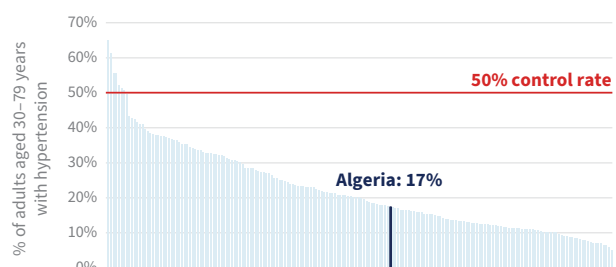


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	219 900	103 300	116 600	2021
Cardiovascular disease deaths	90 860	35 460	55 400	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	55	59	2021
Risk of premature death from NCDs (%) ^c	13	14	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	21	42	1	2022
Obesity, adults aged 18+ years (%)	24	16	33	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	29	20	38	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Andorra

Hypertension profile

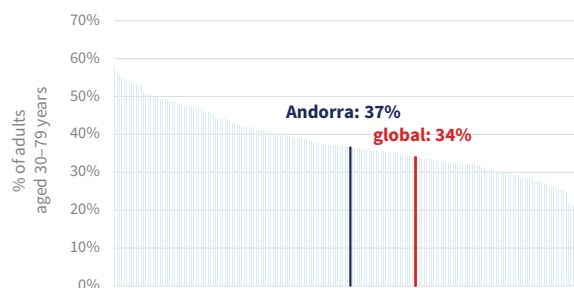
Total population (2024):

81 940

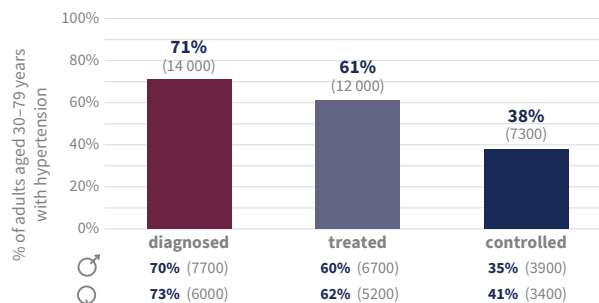
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♂ 41% ♀ 32%

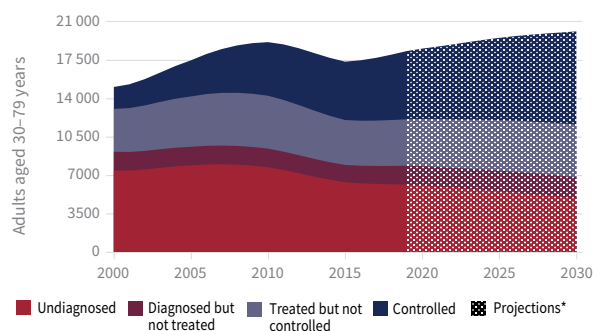
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 19 000 adults aged 30–79 years with hypertension, approximately 12 000 do not have the condition controlled^b

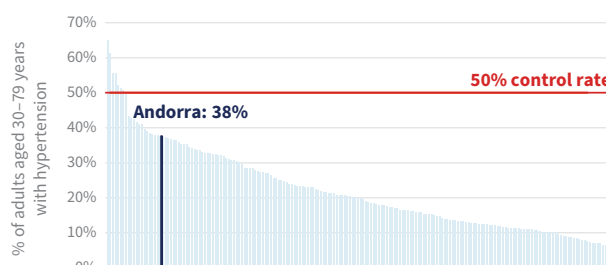


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	47	52	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	9	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	36	35	38	2022
Obesity, adults aged 18+ years (%)	20	23	18	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	27	26	28	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Angola

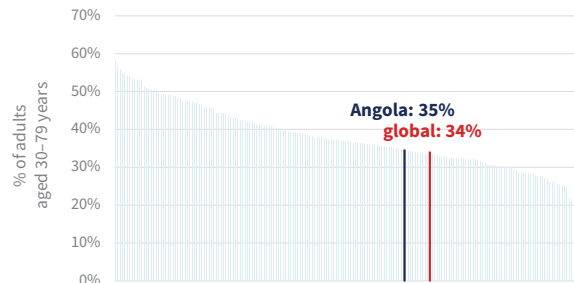
Hypertension profile

Total population (2024): 37 890 000

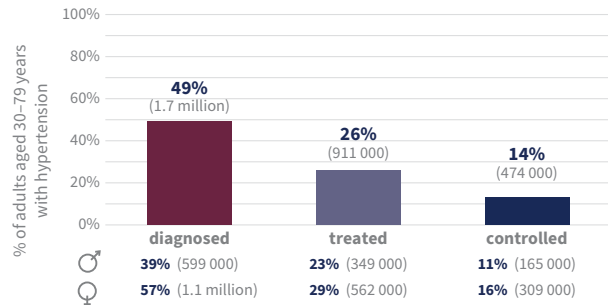
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 35% ♂ 31% ♀ 37%

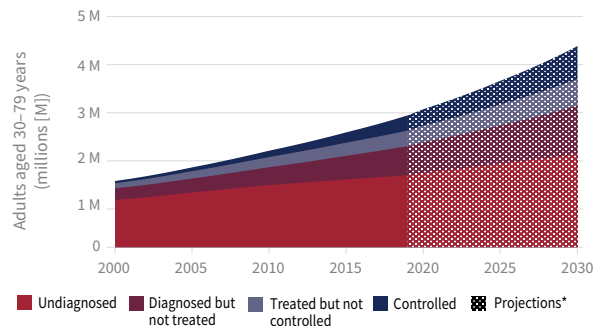
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.5 million adults aged 30–79 years with hypertension, approximately 3 million do not have the condition controlled^b

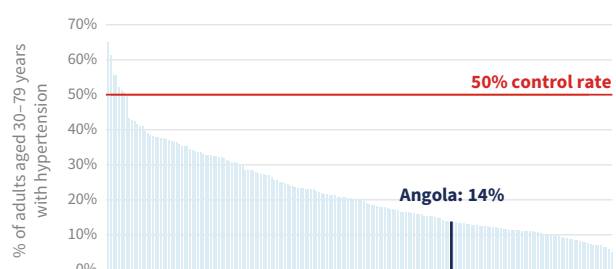


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	273 700	146 100	127 500	2021
Cardiovascular disease deaths	41 290	19 430	21 860	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	53	61	2021
Risk of premature death from NCDs (%) ^c	25	27	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	11	5	15	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	17	14	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Don't know

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Antigua and Barbuda

Hypertension profile

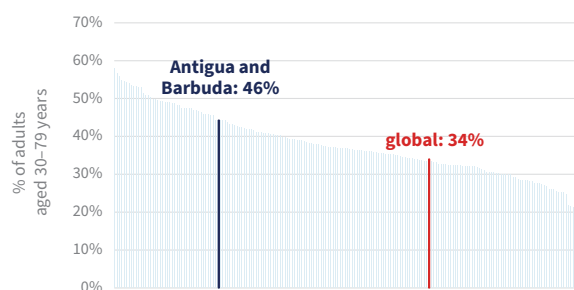
Total population (2024):

93 770

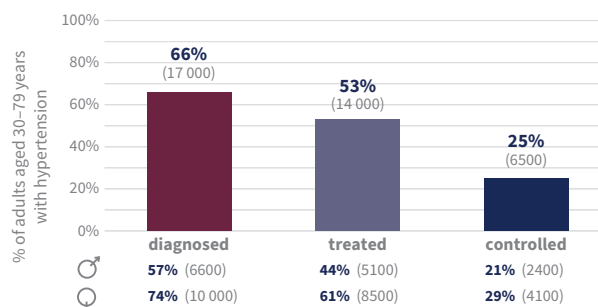
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 46% ♂ 44% ♀ 47%

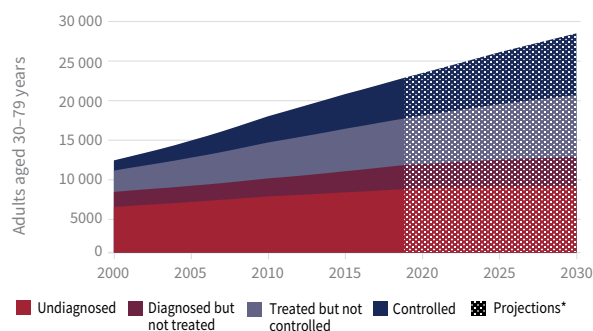
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 26 000 adults aged 30–79 years with hypertension, approximately 19 000 do not have the condition controlled^b

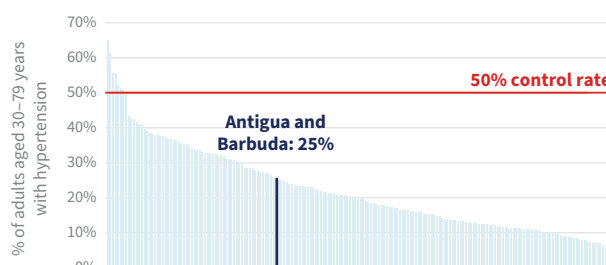


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	660	300	360	2021
Cardiovascular disease deaths	150	60	90	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	55	58	2021
Risk of premature death from NCDs (%) ^c	12	13	12	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	34	24	43	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	9	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	38	31	45	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Argentina

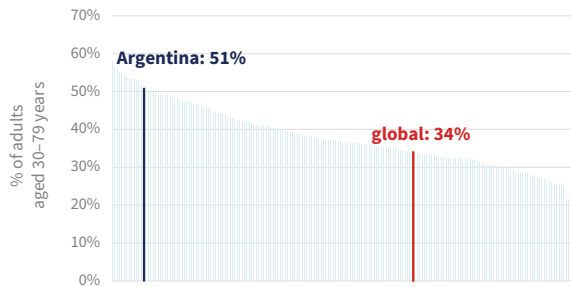
Hypertension profile

Total population (2024): 45 700 000

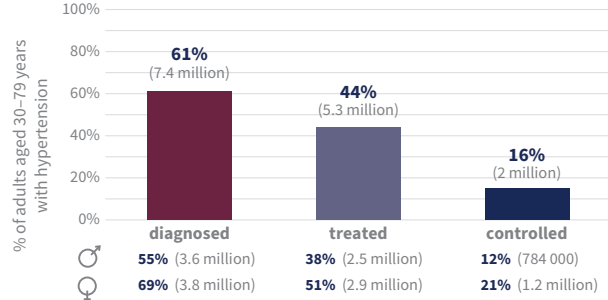
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 51% ♂ 57% ♀ 45%

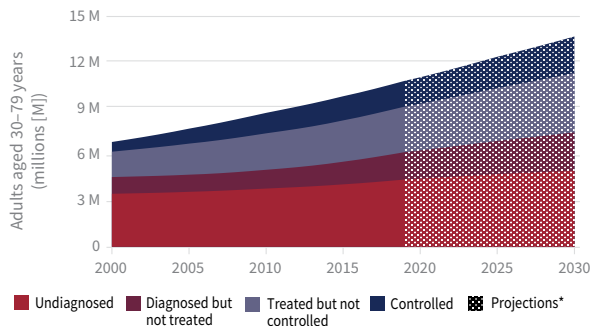
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 12.1 million adults aged 30–79 years with hypertension, approximately 10.1 million do not have the condition controlled^b

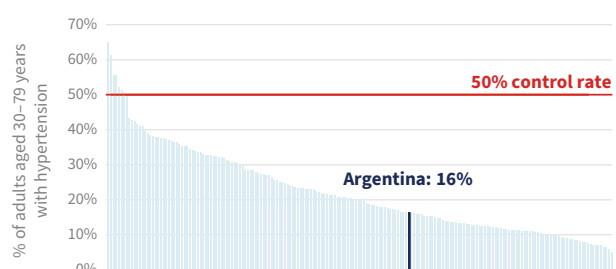


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	433 500	230 600	202 900	2021
Cardiovascular disease deaths	111 100	55 260	55 850	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	48	46	49	2021
Risk of premature death from NCDs (%) ^c	13	16	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	8	2021
Current tobacco use, adults aged 15+ years (%)	24	29	19	2022
Obesity, adults aged 18+ years (%)	36	35	37	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	9	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	39	37	40	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Armenia

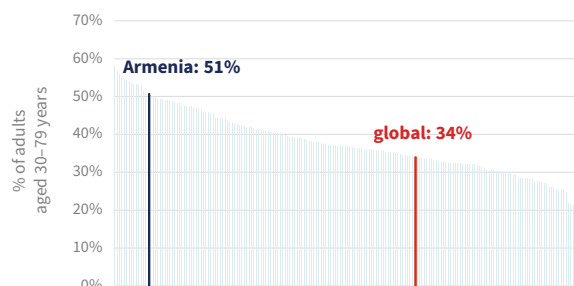
Hypertension profile

Total population (2024): 2 974 000

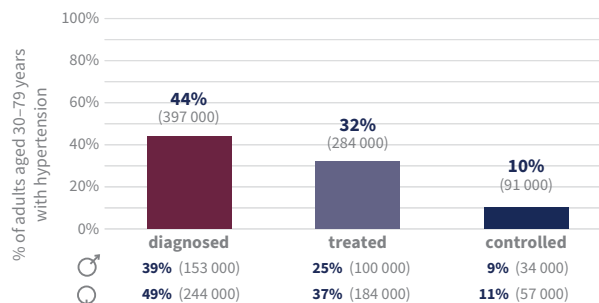
Prevalence of hypertension among adults aged 30–79 years (2024)^a

51% 51% 50%

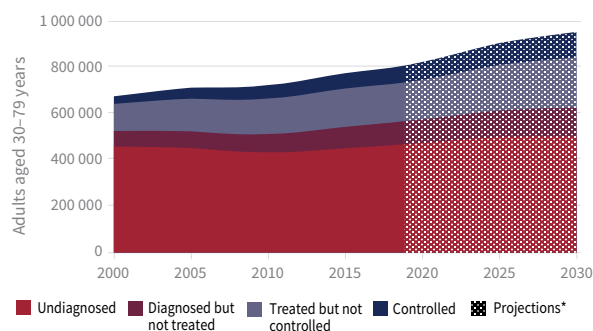
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 894 000 adults aged 30–79 years with hypertension, approximately 803 000 do not have the condition controlled^b

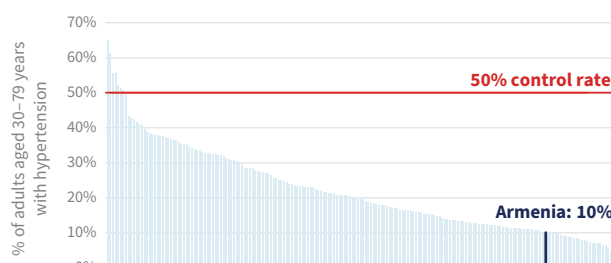


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	35 800	19 820	15 980	2021
Cardiovascular disease deaths	16 780	9000	7780	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	55	57	2021
Risk of premature death from NCDs (%) ^c	21	30	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	25	48	2	2022
Obesity, adults aged 18+ years (%)	28	20	34	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	27	28	25	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Australia

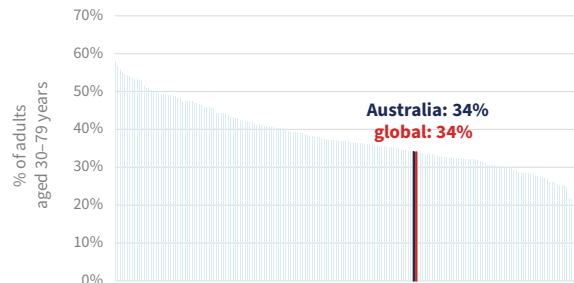
Hypertension profile

Total population (2024): 26 710 000

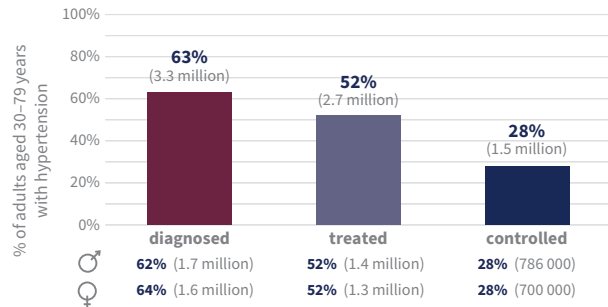
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 34% ♀ 32%

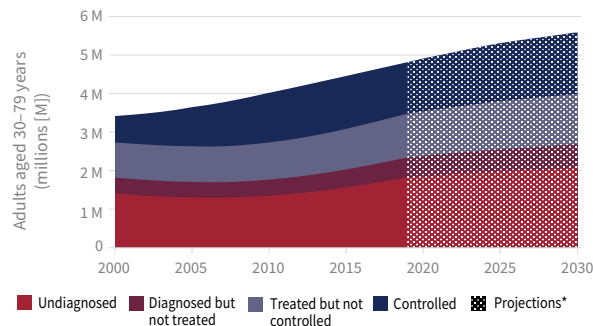
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 5.2 million adults aged 30–79 years with hypertension, approximately 3.8 million do not have the condition controlled^b

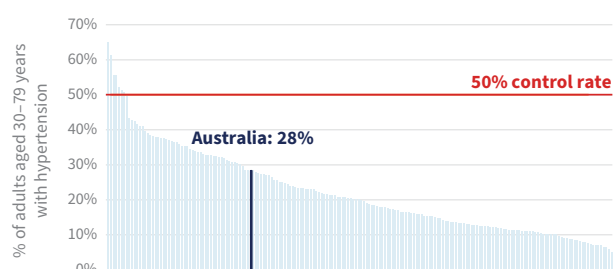


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	173 600	90 360	83 280	2021
Cardiovascular disease deaths	43 760	22 220	21 530	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	41	40	43	2021
Risk of premature death from NCDs (%) ^c	8	10	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	9	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	13	15	11	2022
Obesity, adults aged 18+ years (%)	32	33	31	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	25	24	27	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Austria

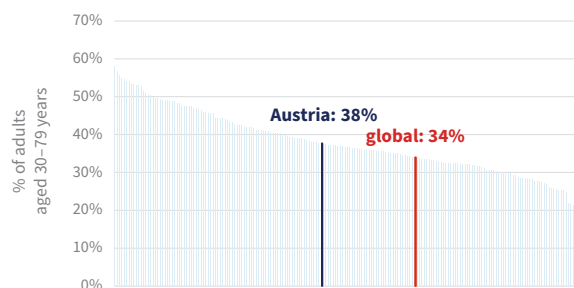
Hypertension profile

Total population (2024): 9 121 000

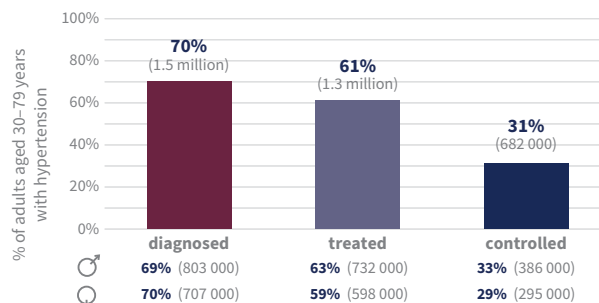
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 38% ♂ 41% ♀ 35%

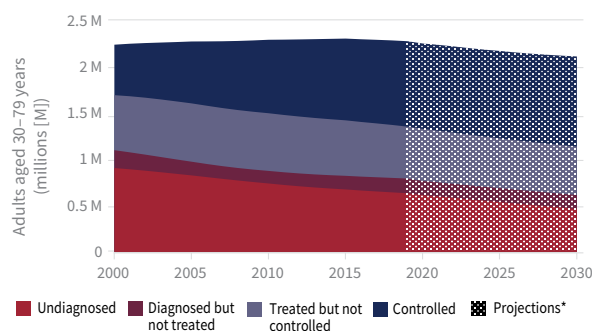
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.2 million adults aged 30–79 years with hypertension, approximately 1.5 million do not have the condition controlled^b

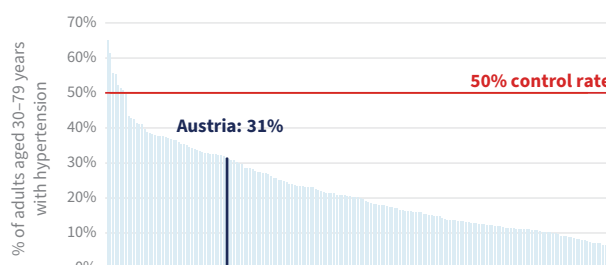


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	93 910	46 750	47 160	2021
Cardiovascular disease deaths	32 770	14 770	18 000	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	49	50	2021
Risk of premature death from NCDs (%) ^c	10	13	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	9	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	25	26	24	2022
Obesity, adults aged 18+ years (%)	17	20	14	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	12	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	20	20	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Azerbaijan

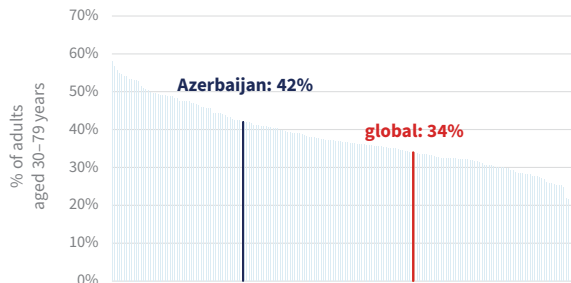
Hypertension profile

Total population (2024): 10 340 000

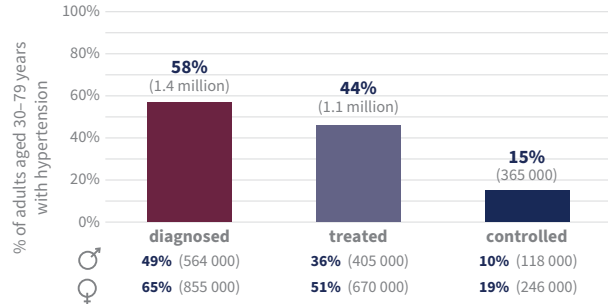
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 42% ♂ 41% ♀ 43%

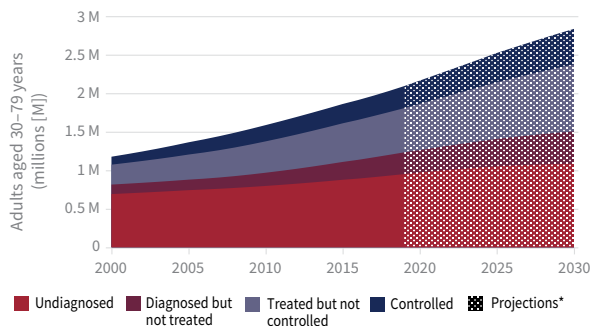
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.5 million adults aged 30–79 years with hypertension, approximately 2.1 million do not have the condition controlled^b

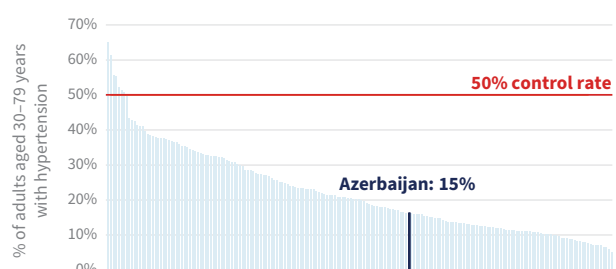


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	72 330	36 780	35 550	2021
Cardiovascular disease deaths	23 910	9410	14 510	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	55	60	2021
Risk of premature death from NCDs (%) ^c	17	20	15	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	20	39	0	2022
Obesity, adults aged 18+ years (%)	28	19	35	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	24	25	23	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Bahamas

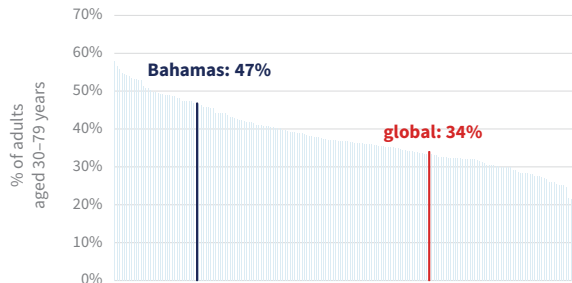
Hypertension profile

Total population (2024): 401 300

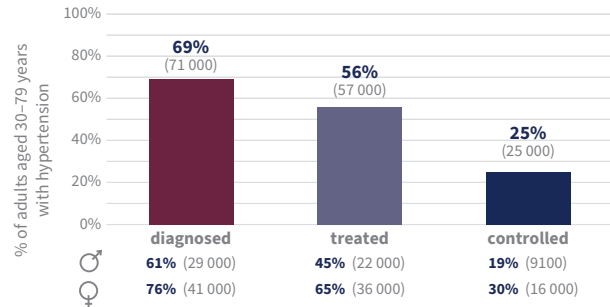
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 47% ♀ 47%

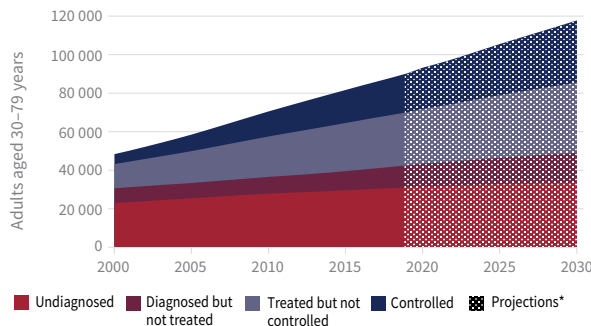
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 103 000 adults aged 30–79 years with hypertension, approximately 78 000 do not have the condition controlled^b

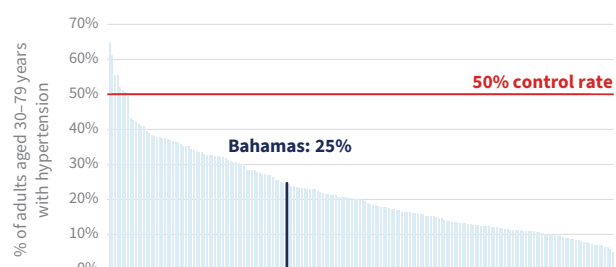


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	4550	2410	2140	2021
Cardiovascular disease deaths	1110	570	550	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	58	59	2021
Risk of premature death from NCDs (%) ^c	20	23	18	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	11	21	2	2022
Obesity, adults aged 18+ years (%)	48	39	55	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	37	27	47	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Bahrain

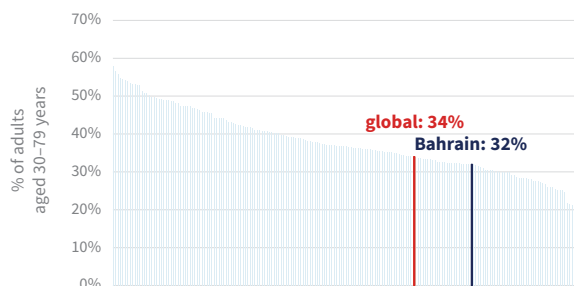
Hypertension profile

Total population (2024): 1 607 000

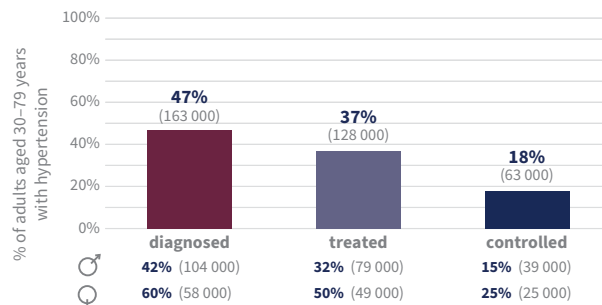
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♀ 29%

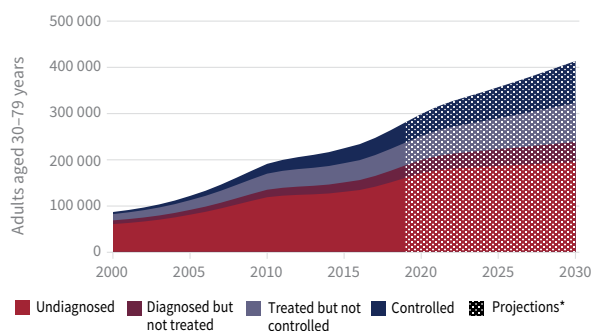
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 347 000 adults aged 30–79 years with hypertension, approximately 283 000 do not have the condition controlled^b

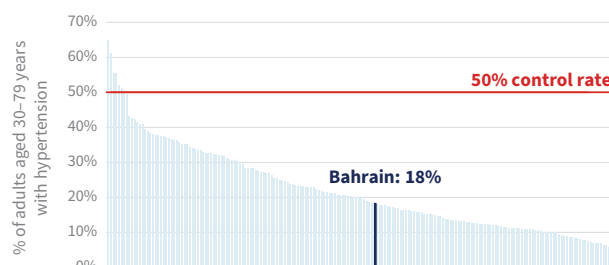


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	6120	3560	2560	2021
Cardiovascular disease deaths	1760	1020	740	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	51	56	2021
Risk of premature death from NCDs (%) ^c	15	14	16	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%) ^d	15	25	5	2022
Obesity, adults aged 18+ years (%)	37	34	44	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	39	36	43	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Bangladesh

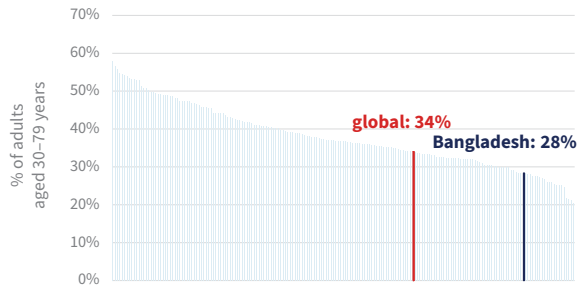
Hypertension profile

Total population (2024): 173 600 000

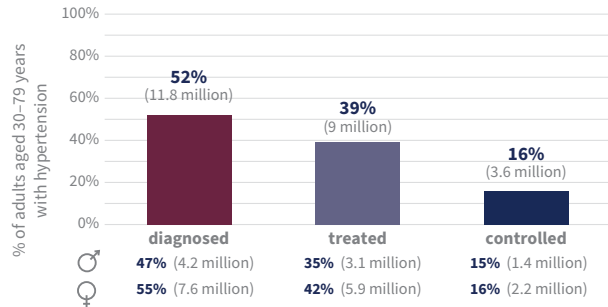
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 28% ♀ 34%

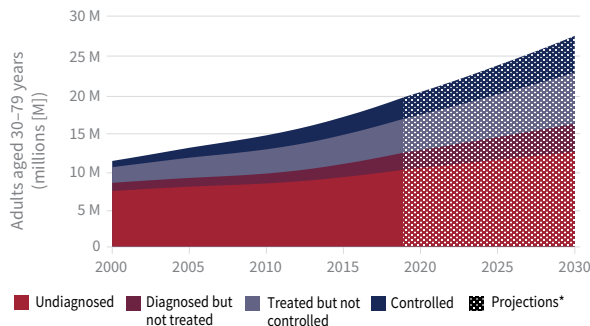
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 22.8 million adults aged 30–79 years with hypertension, approximately 19.2 million do not have the condition controlled^b

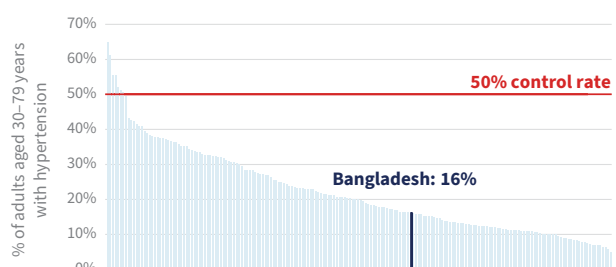


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	917 300	488 800	428 500	2021
Cardiovascular disease deaths	283 800	135 700	148 100	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	52	48	56	2021
Risk of premature death from NCDs (%) ^c	18	20	16	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	9	8	2021
Current tobacco use, adults aged 15+ years (%)	33	51	15	2022
Obesity, adults aged 18+ years (%)	5	3	8	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	0	20	21	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Barbados

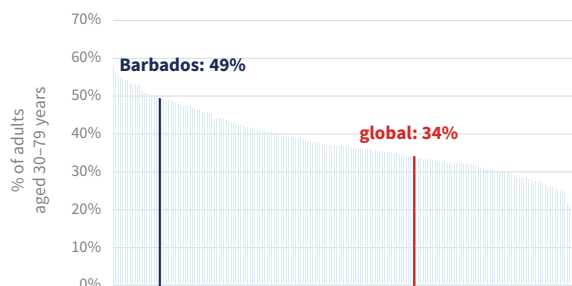
Hypertension profile

Total population (2024): 282 500

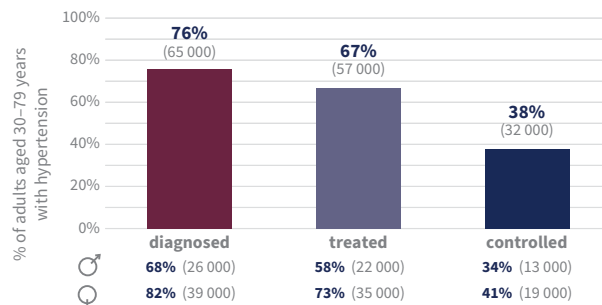
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 49% ♀ 46% 52%

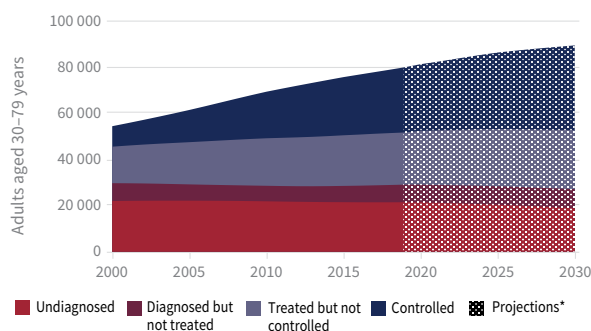
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 86 000 adults aged 30–79 years with hypertension, approximately 53 000 do not have the condition controlled^b

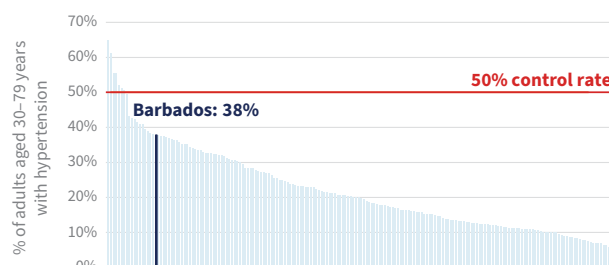


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	2610	1250	1370	2021
Cardiovascular disease deaths	690	310	380	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	54	54	2021
Risk of premature death from NCDs (%) ^c	14	16	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	6	2021
Current tobacco use, adults aged 15+ years (%)	7	12	2	2022
Obesity, adults aged 18+ years (%)	38	27	48	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	9	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	44	36	51	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Belarus

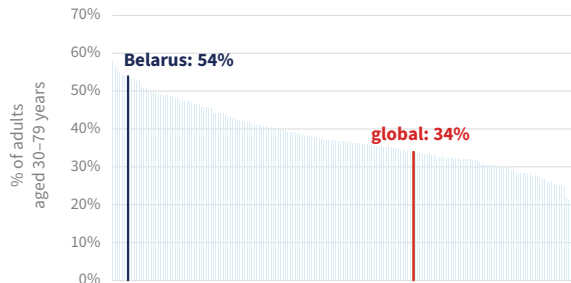
Hypertension profile

Total population (2024): 9 057 000

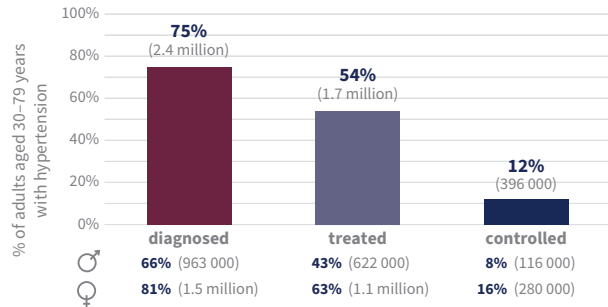
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 54% ♀ 53% ♀ 55%

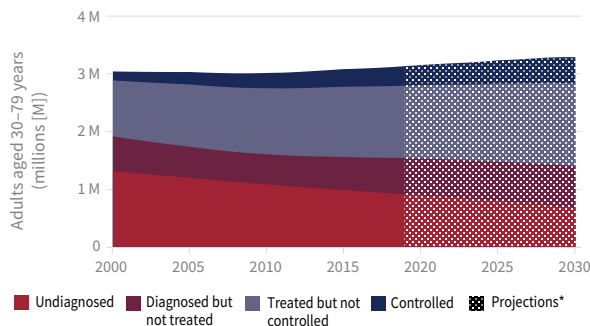
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.2 million adults aged 30–79 years with hypertension, approximately 2.8 million do not have the condition controlled^b

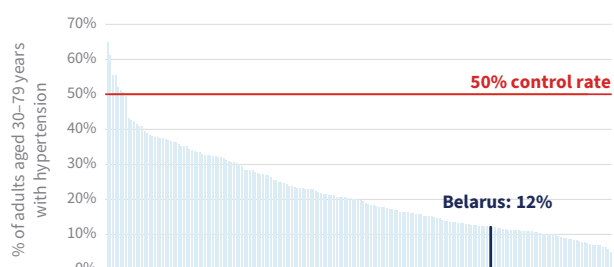


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	134 100	69 010	65 070	2021
Cardiovascular disease deaths	66 520	31 440	35 080	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	58	59	2021
Risk of premature death from NCDs (%) ^c	24	36	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	30	46	14	2022
Obesity, adults aged 18+ years (%)	27	22	30	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	14	15	14	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Belgium

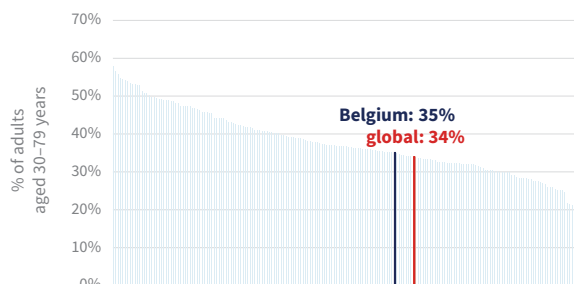
Hypertension profile

Total population (2024): 11 740 000

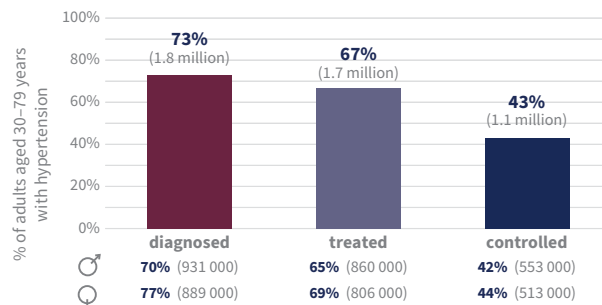
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 35% ♂ 38% ♀ 33%

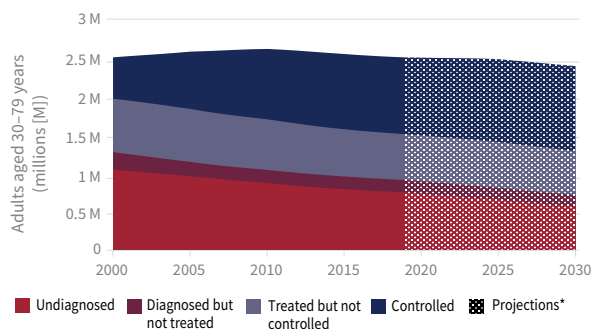
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.5 million adults aged 30–79 years with hypertension, approximately 1.4 million do not have the condition controlled^b

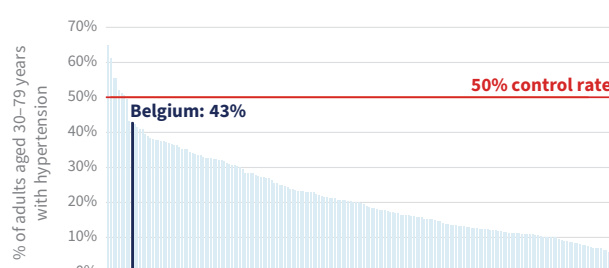


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	112 000	56 480	55 560	2021
Cardiovascular disease deaths	25 450	12 140	13 310	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	45	45	45	2021
Risk of premature death from NCDs (%) ^c	9	11	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	9	7	2021
Current tobacco use, adults aged 15+ years (%)	27	29	25	2022
Obesity, adults aged 18+ years (%)	22	21	23	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	9	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	25	22	28	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Don't know
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Belize

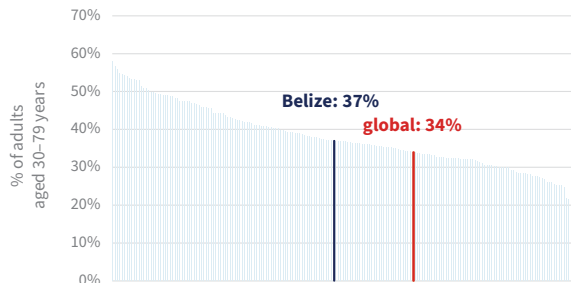
Hypertension profile

Total population (2024): 417 100

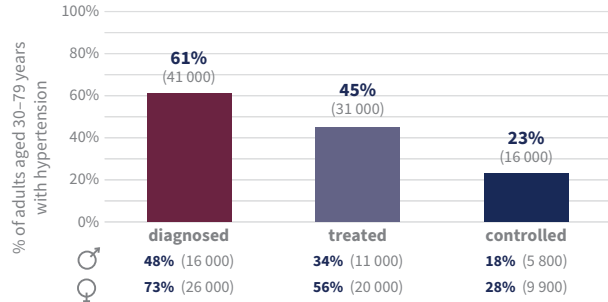
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♀ 37%

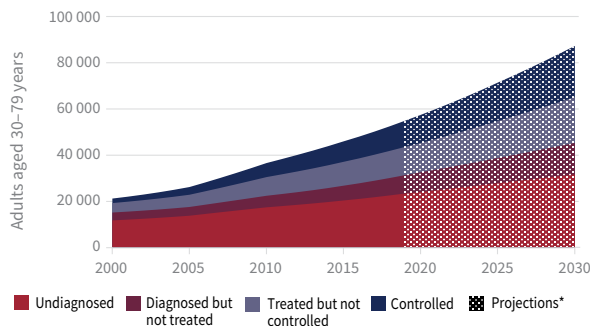
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 68 000 adults aged 30–79 years with hypertension, approximately 53 000 do not have the condition controlled^b

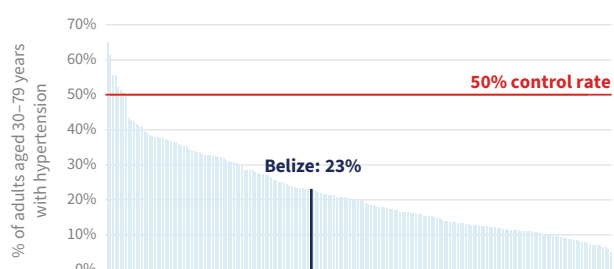


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	1930	1100	830	2021
Cardiovascular disease deaths	350	160	190	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	53	52	2021
Risk of premature death from NCDs (%) ^c	15	14	17	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%) ^d	9	16	2	2022
Obesity, adults aged 18+ years (%)	42	32	52	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	42	35	48	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Benin

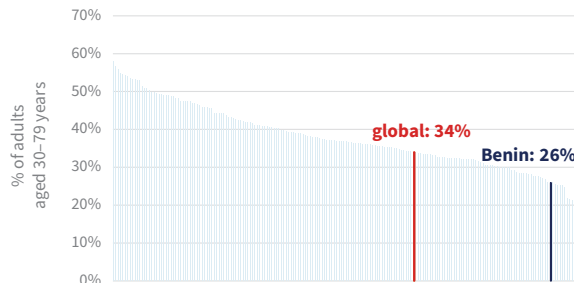
Hypertension profile

Total population (2024): 14 460 000

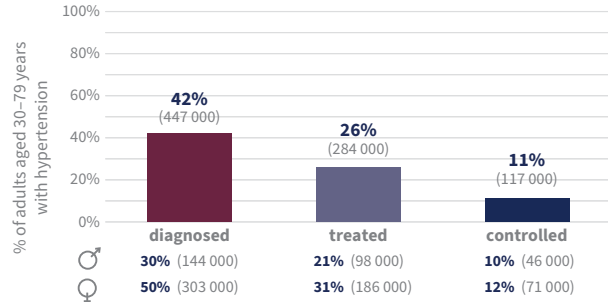
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 26% ♂ 23% ♀ 28%

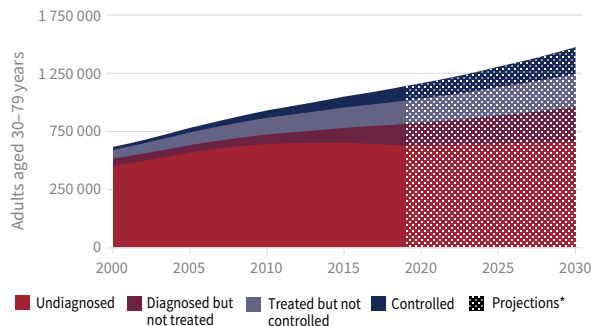
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.1 million adults aged 30–79 years with hypertension, approximately 957 000 do not have the condition controlled^b

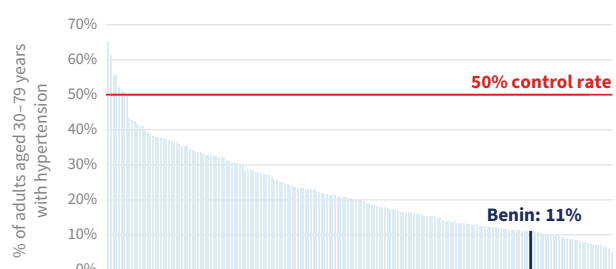


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	99 640	54 150	45 490	2021
Cardiovascular disease deaths	14 330	7040	7300	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	53	60	2021
Risk of premature death from NCDs (%) ^c	21	23	19	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	6	11	2	2022
Obesity, adults aged 18+ years (%)	10	6	13	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	18	16	20	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Bhutan

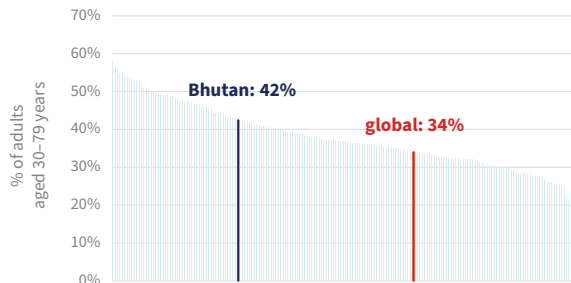
Hypertension profile

Total population (2024): 791 500

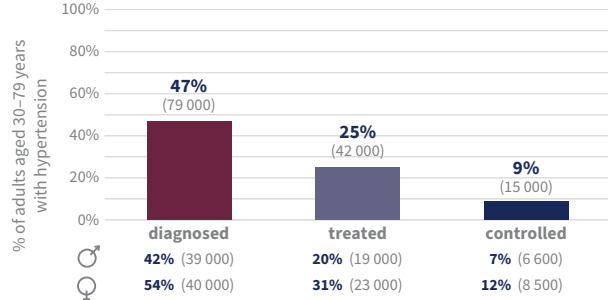
Prevalence of hypertension among adults aged 30–79 years (2024)^a

42% 44% 41%

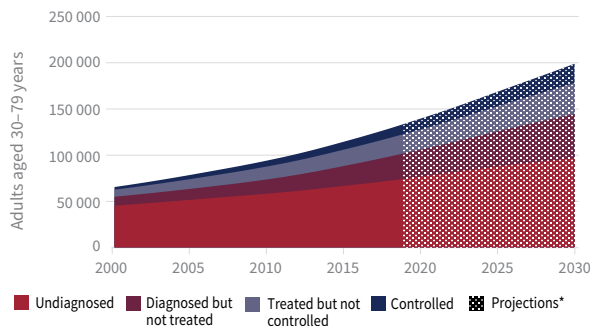
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 166 000 adults aged 30–79 years with hypertension, approximately 151 000 do not have the condition controlled^b

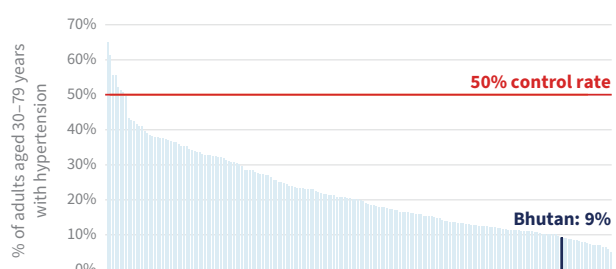


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	3780	2060	1730	2021
Cardiovascular disease deaths	1050	590	470	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	48	47	49	2021
Risk of premature death from NCDs (%) ^c	16	17	15	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	9	8	2021
Current tobacco use, adults aged 15+ years (%)	19	26	11	2022
Obesity, adults aged 18+ years (%)	12	9	15	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	10	9	11	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Bolivia (Plurinational State of)

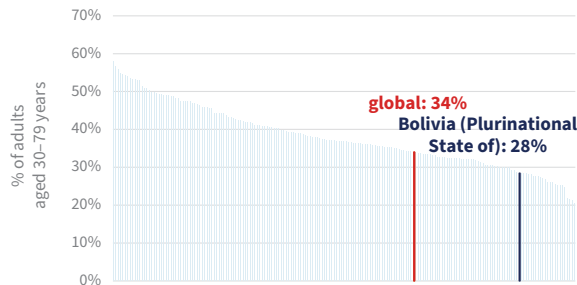
Hypertension profile

Total population (2024): 12 410 000

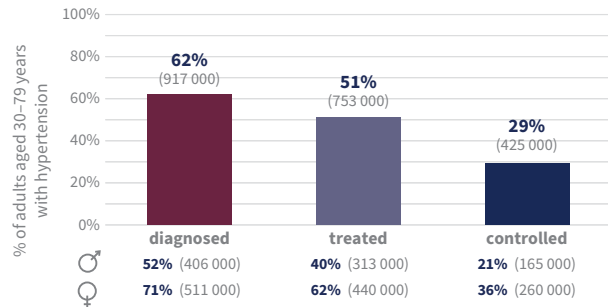
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 28% ♂ 30% ♀ 27%

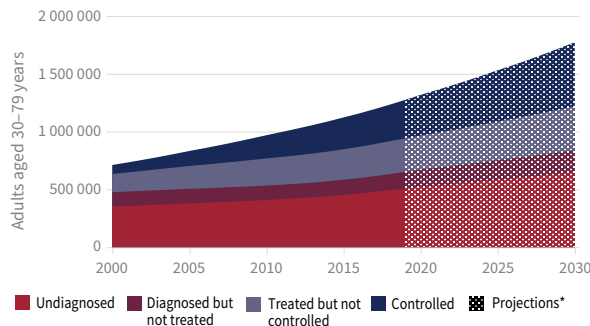
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.5 million adults aged 30–79 years with hypertension, approximately 1.1 million do not have the condition controlled^b

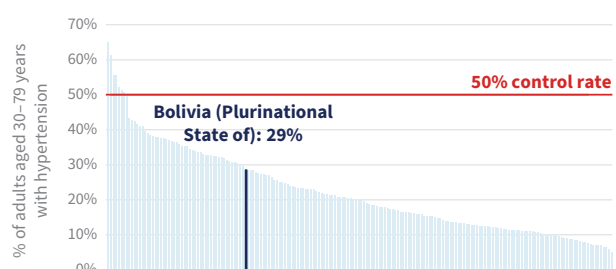


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	115 400	66 770	48 660	2021
Cardiovascular disease deaths	14 130	7950	6180	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	45	43	46	2021
Risk of premature death from NCDs (%) ^c	20	21	19	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	8	2021
Current tobacco use, adults aged 15+ years (%)	12	21	4	2022
Obesity, adults aged 18+ years (%)	28	22	33	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	23	18	27	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Bosnia and Herzegovina

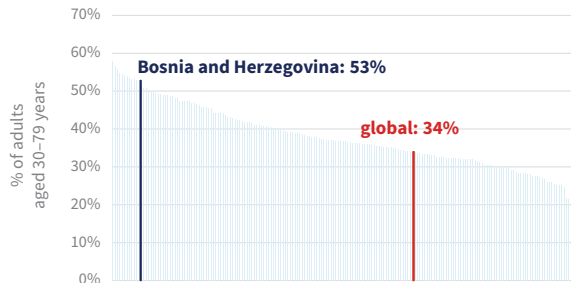
Hypertension profile

Total population (2024): 3 164 000

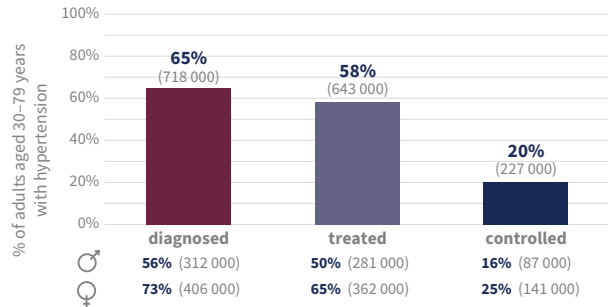
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 53% ♀ 54% ♀ 51%

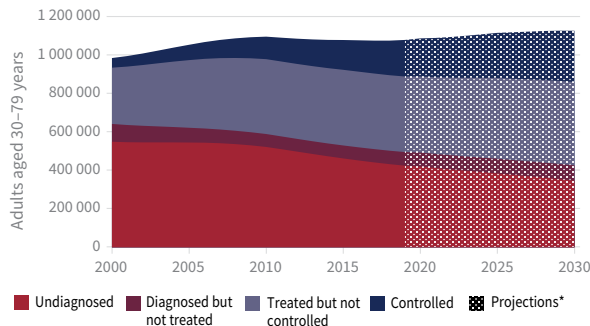
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.1 million adults aged 30–79 years with hypertension, approximately 883 000 do not have the condition controlled^b

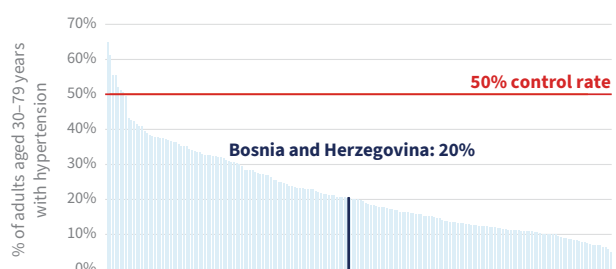


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	56 490	23 660	32 830	2021
Cardiovascular disease deaths	23 900	7870	16 030	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	55	58	2021
Risk of premature death from NCDs (%) ^c	17	22	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	12	15	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	36	42	31	2022
Obesity, adults aged 18+ years (%)	25	25	26	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	21	18	24	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Botswana

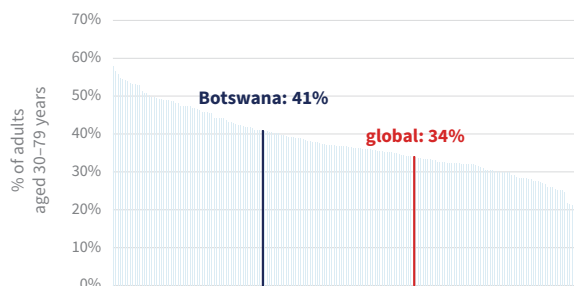
Hypertension profile

Total population (2024): 2 521 000

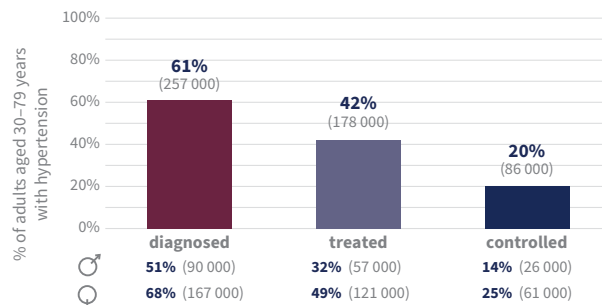
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 41% ♂ 37% ♀ 44%

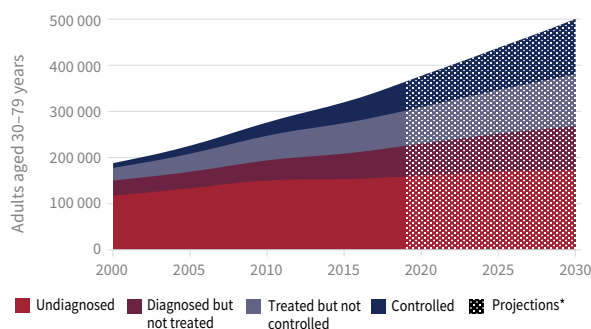
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 425 000 adults aged 30–79 years with hypertension, approximately 338 000 do not have the condition controlled^b

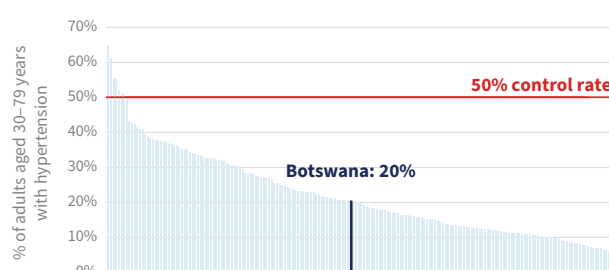


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	22 700	12 000	10 700	2021
Cardiovascular disease deaths	2540	1000	1540	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	61	60	62	2021
Risk of premature death from NCDs (%) ^c	19	18	20	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	19	30	7	2022
Obesity, adults aged 18+ years (%)	17	8	26	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	22	17	27	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Brazil

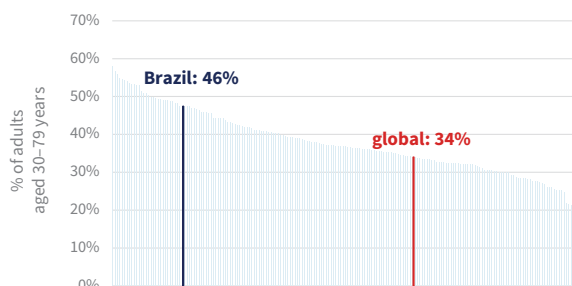
Hypertension profile

Total population (2024): 212 000 000

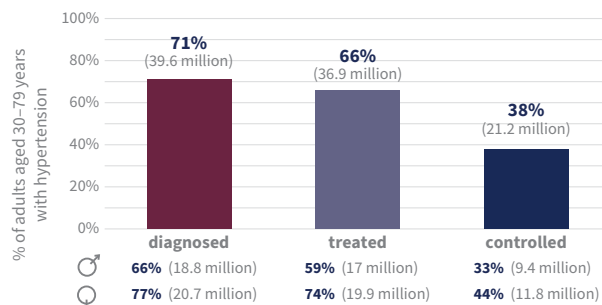
Prevalence of hypertension among adults aged 30–79 years (2024)^a

46% 49% 43%

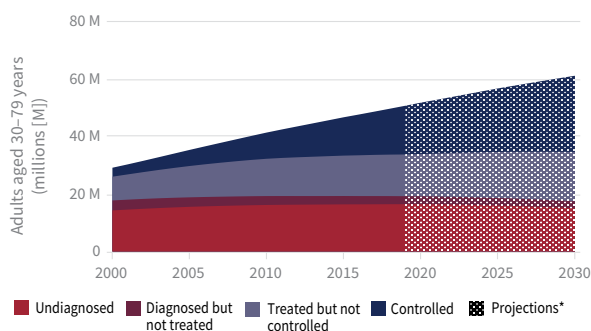
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 55.7 million adults aged 30–79 years with hypertension, approximately 34.5 million do not have the condition controlled^b

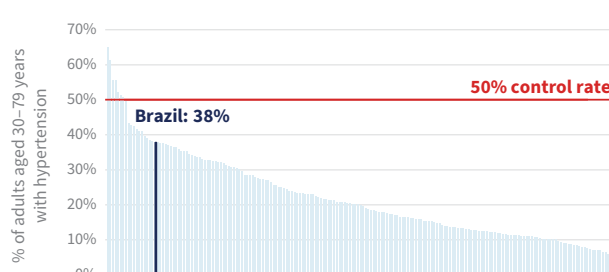


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	1 907 000	1 076 000	830 800	2021
Cardiovascular disease deaths	411 600	219 400	192 200	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	50	50	2021
Risk of premature death from NCDs (%) ^c	15	17	12	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	8	2021
Current tobacco use, adults aged 15+ years (%)	12	15	9	2022
Obesity, adults aged 18+ years (%)	29	25	33	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	9	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	40	36	45	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Brunei Darussalam

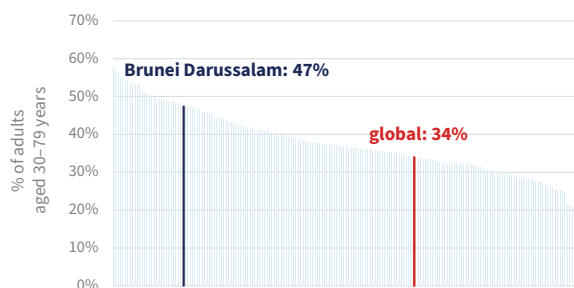
Hypertension profile

Total population (2024): 462 700

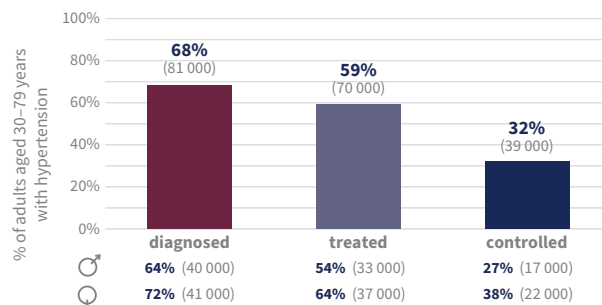
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 47% ♀ 48% 47%

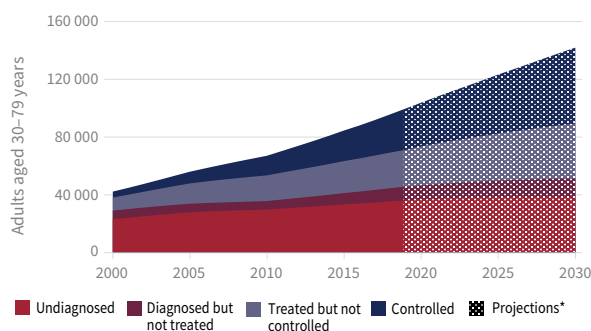
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 119 000 aged 30–79 years with hypertension, approximately 81 000 do not have the condition controlled^b

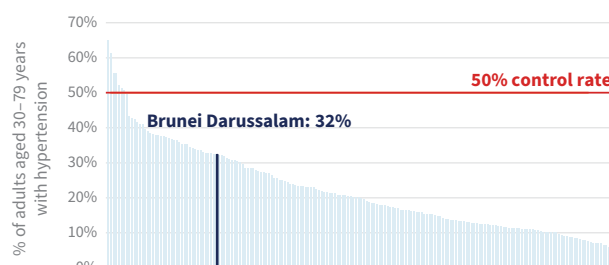


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	1970	1100	860	2021
Cardiovascular disease deaths	570	350	220	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	48	49	47	2021
Risk of premature death from NCDs (%) ^c	15	17	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	11	12	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	16	31	2	2022
Obesity, adults aged 18+ years (%)	32	31	34	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	33	28	37	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Bulgaria

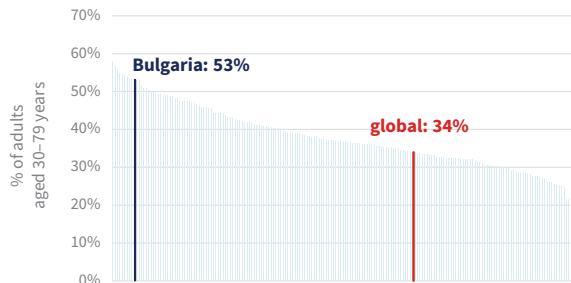
Hypertension profile

Total population (2024): 6 758 000

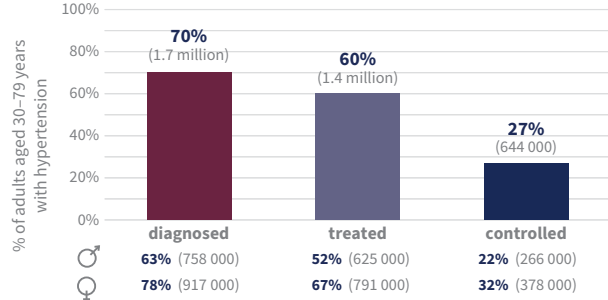
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 53% ♀ 55% 51%

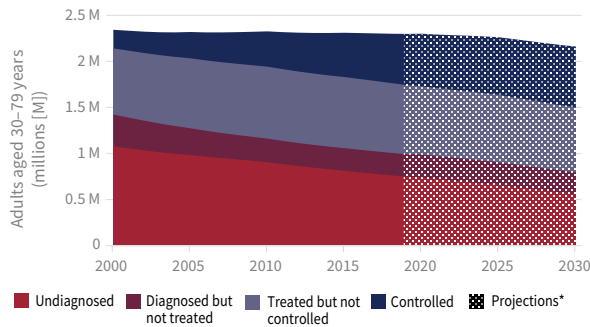
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.4 million adults aged 30–79 years with hypertension, approximately 1.7 million do not have the condition controlled^b

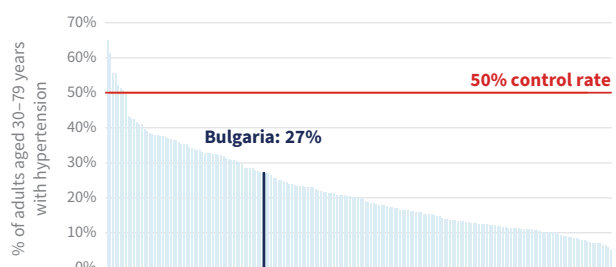


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	148 900	77 240	71 650	2021
Cardiovascular disease deaths	81 710	39 290	42 420	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	65	64	66	2021
Risk of premature death from NCDs (%) ^c	26	34	17	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	13	15	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	40	40	39	2022
Obesity, adults aged 18+ years (%)	24	26	22	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	12	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	32	32	32	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Burkina Faso

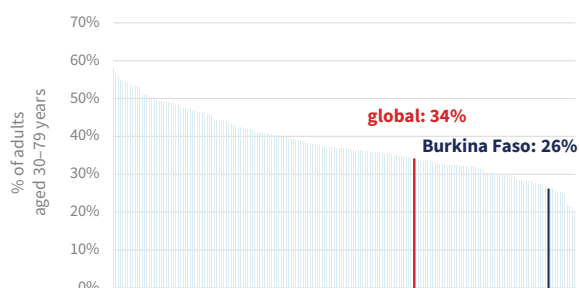
Hypertension profile

Total population (2024): 23 550 000

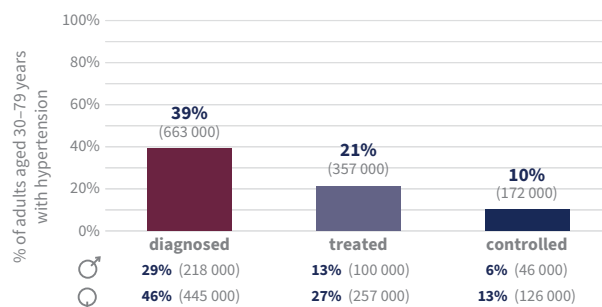
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 26% ♂ 23% ♀ 28%

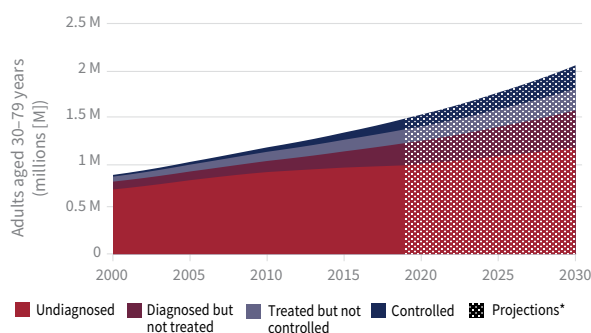
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.7 million adults aged 30–79 years with hypertension, approximately 1.5 million do not have the condition controlled^b

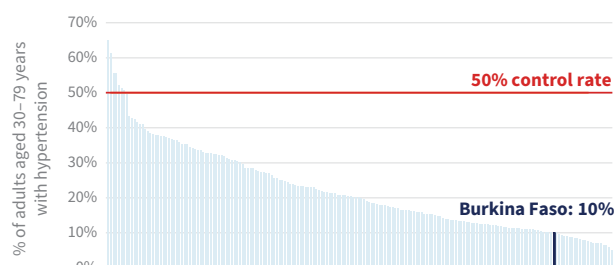


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	162 600	86 860	75 710	2021
Cardiovascular disease deaths	21 980	11 270	10 710	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	49	57	2021
Risk of premature death from NCDs (%) ^c	23	26	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	14	23	6	2022
Obesity, adults aged 18+ years (%)	6	4	9	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	17	14	19	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Burundi

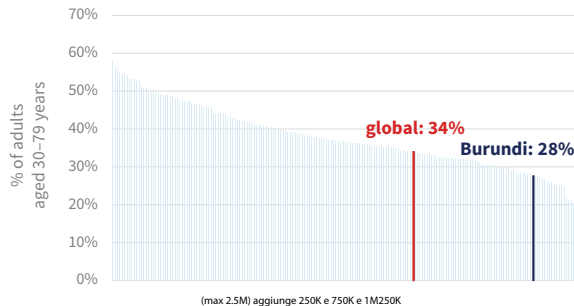
Hypertension profile

Total population (2024): 14 050 000

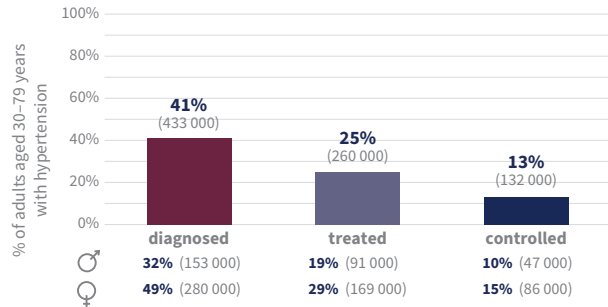
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 28% ♀ 29%

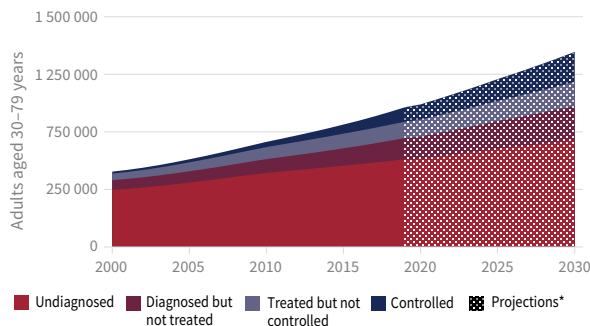
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.1 million adults aged 30–79 years with hypertension, approximately 923 000 do not have the condition controlled^b

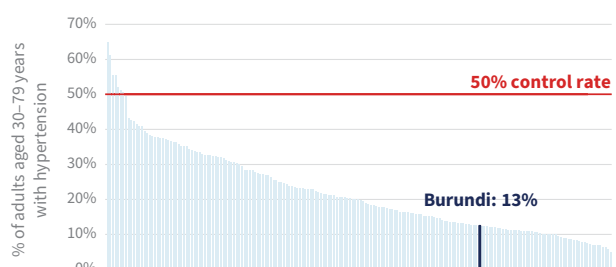


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	83 300	44 240	39 060	2021
Cardiovascular disease deaths	11 790	5560	6240	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	50	62	2021
Risk of premature death from NCDs (%) ^c	25	26	24	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	11	17	5	2022
Obesity, adults aged 18+ years (%)	5	5	4	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	14	14	15	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Cabo Verde

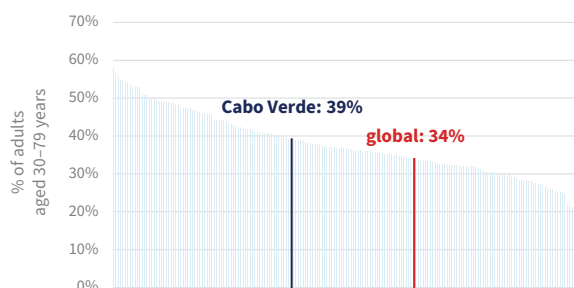
Hypertension profile

Total population (2024): 524 900

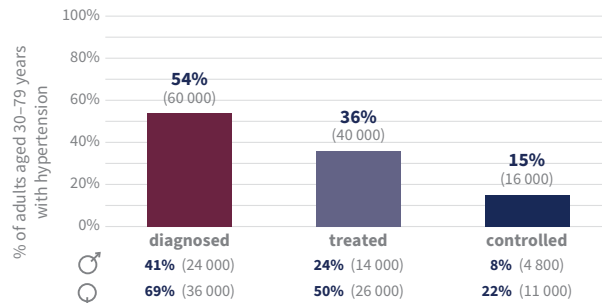
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 39% ♂ 41% ♀ 38%

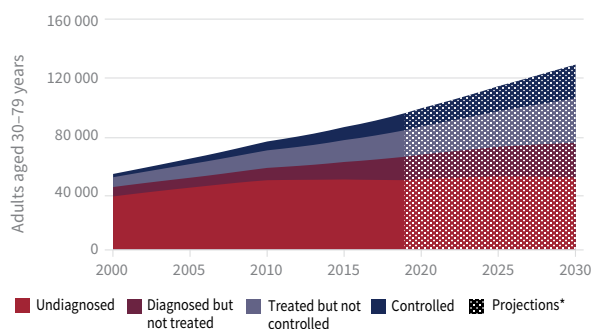
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 110 000 adults aged 30–79 years with hypertension, approximately 94 000 do not have the condition controlled^b

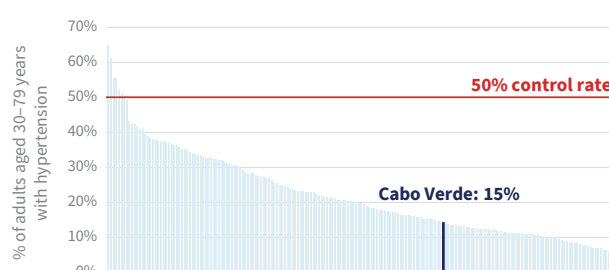


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	3230	1850	1380	2021
Cardiovascular disease deaths	1020	530	500	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	58	61	2021
Risk of premature death from NCDs (%) ^c	17	23	12	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	11	17	5	2022
Obesity, adults aged 18+ years (%)	15	8	22	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	31	22	39	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Cambodia

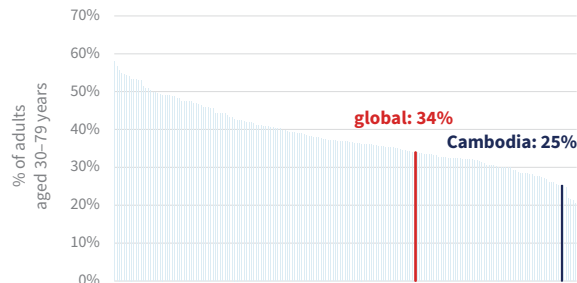
Hypertension profile

Total population (2024): 17 640 000

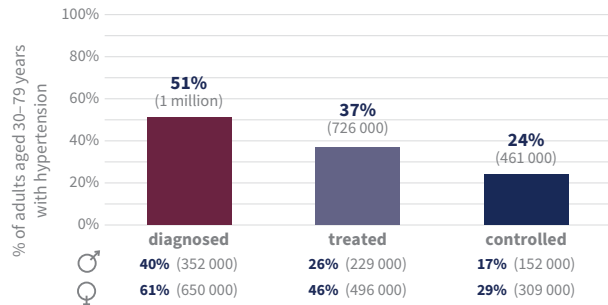
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 25% ♂ 24% ♀ 26%

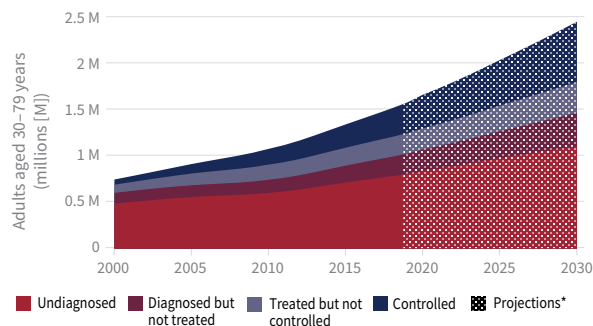
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.9 million adults aged 30–79 years with hypertension, approximately 1.5 million do not have the condition controlled^b

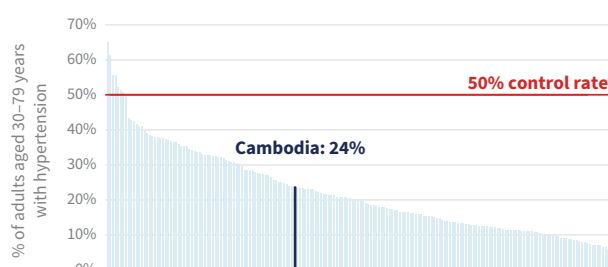


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	123 300	63 850	59 490	2021
Cardiovascular disease deaths	33 800	15 480	18 320	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	48	51	2021
Risk of premature death from NCDs (%) ^c	23	26	20	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%)	17	29	6	2022
Obesity, adults aged 18+ years (%)	4	3	6	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	13	13	14	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Cameroon

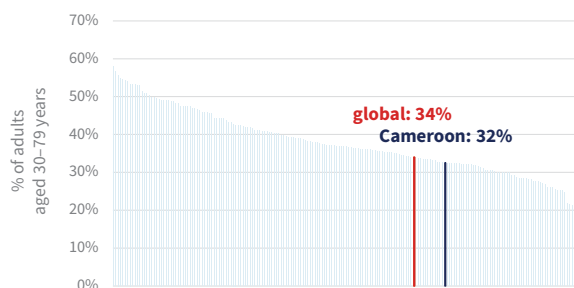
Hypertension profile

Total population (2024): 29 120 000

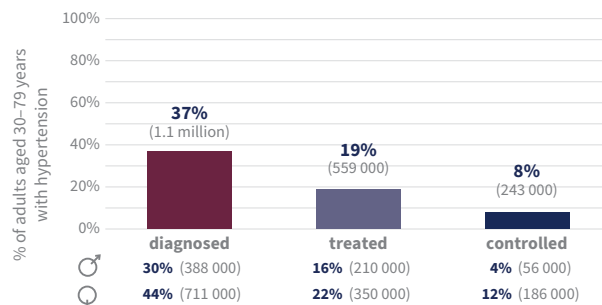
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♂ 29% ♀ 35%

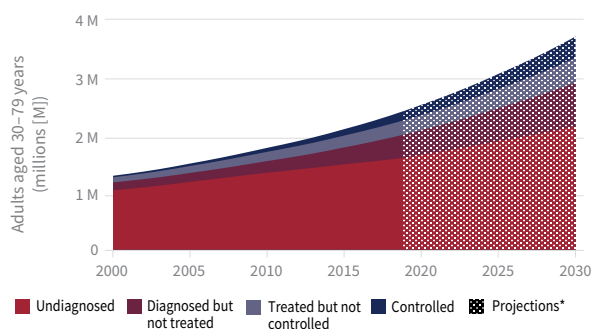
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.9 million adults aged 30–79 years with hypertension, approximately 2.7 million do not have the condition controlled^b

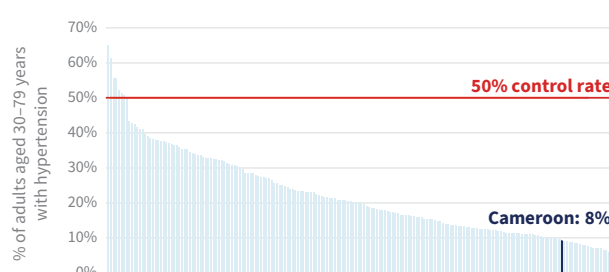


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	213 400	114 200	99 270	2021
Cardiovascular disease deaths	29 980	14 740	15 240	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	57	61	2021
Risk of premature death from NCDs (%) ^c	24	25	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	7	12	1	2022
Obesity, adults aged 18+ years (%)	13	8	19	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	19	16	21	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Canada

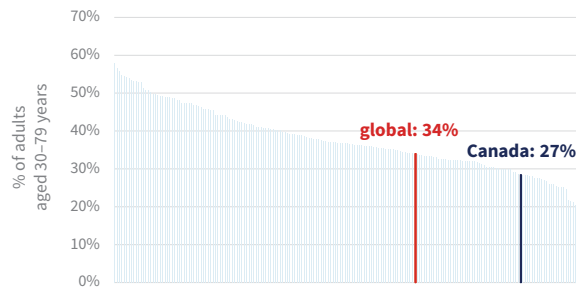
Hypertension profile

Total population (2024): 39 740 000

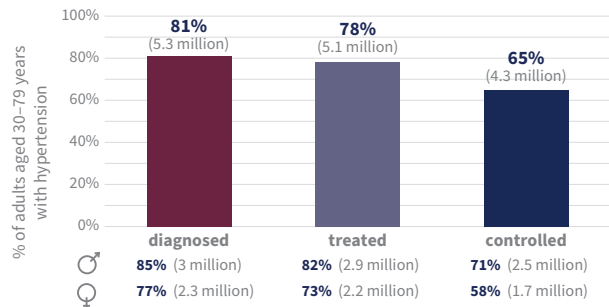
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 27% ♀ 30% ♀ 25%

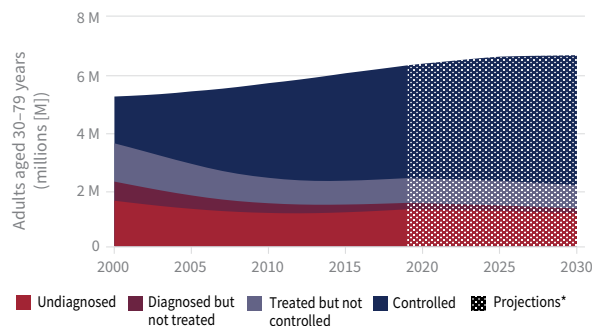
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 6.5 million adults aged 30–79 years with hypertension, approximately 2.3 million do not have the condition controlled^b

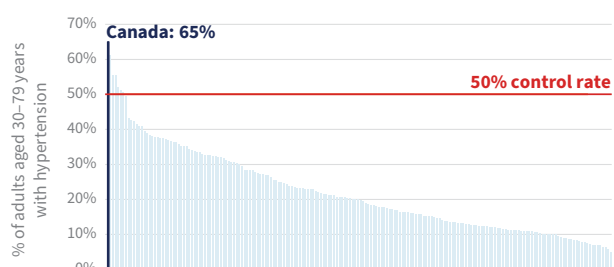


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	310 800	164 400	146 400	2021
Cardiovascular disease deaths	75 790	40 560	35 220	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	43	42	44	2021
Risk of premature death from NCDs (%) ^c	10	12	8	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	11	8	2021
Current tobacco use, adults aged 15+ years (%)	12	14	10	2022
Obesity, adults aged 18+ years (%)	27	29	26	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	10	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	37	36	39	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Central African Republic

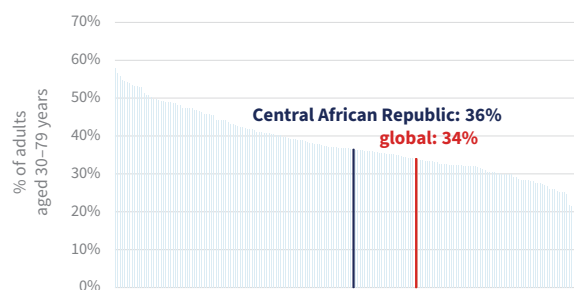
Hypertension profile

Total population (2024): 5 331 000

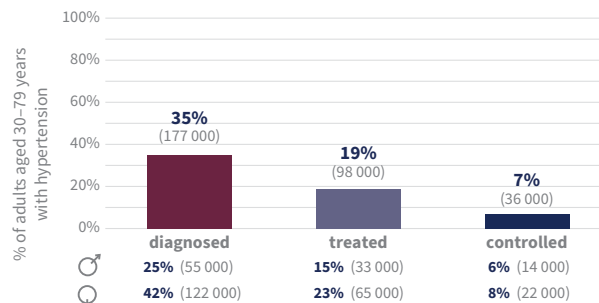
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♂ 33% ♀ 40%

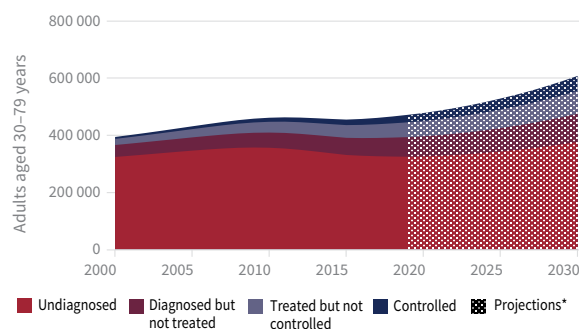
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 511 000 aged 30–79 years with hypertension, approximately 475 000 do not have the condition controlled^b

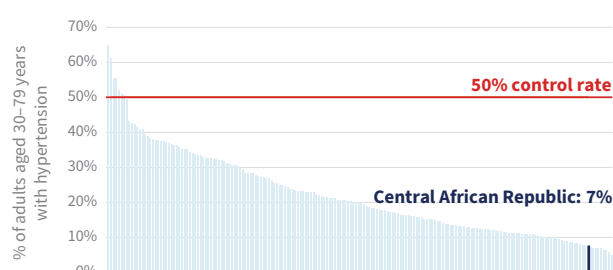


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	61 110	33 090	28 020	2021
Cardiovascular disease deaths	5830	2990	2840	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	55	51	59	2021
Risk of premature death from NCDs (%) ^c	31	36	27	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	8	5	10	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	17	14	19	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Chad

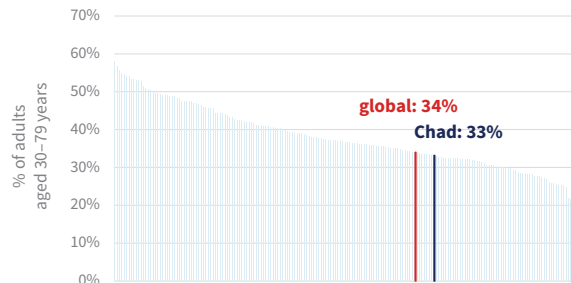
Hypertension profile

Total population (2024): 20 300 000

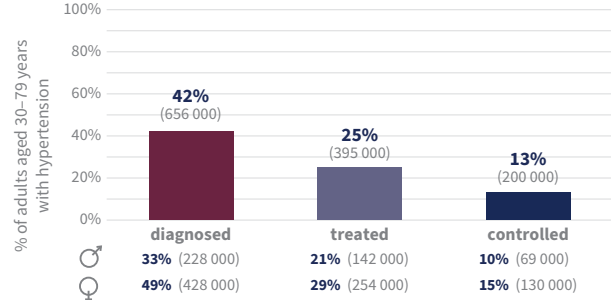
Prevalence of hypertension among adults aged 30–79 years (2024)^a

33% 29% 37%

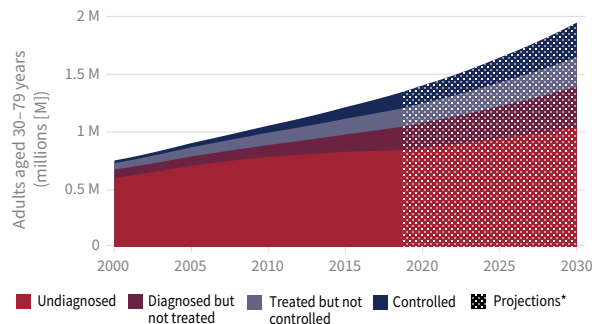
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.6 million adults aged 30–79 years with hypertension, approximately 1.4 million do not have the condition controlled^b

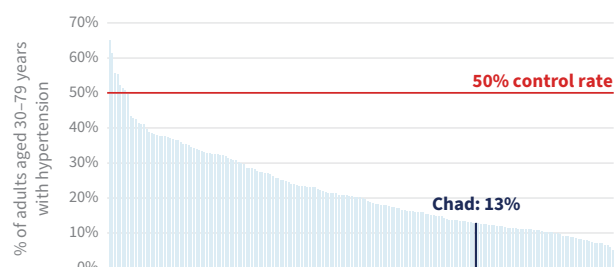


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	164 700	87 420	77 260	2021
Cardiovascular disease deaths	15 200	7300	7900	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	51	48	54	2021
Risk of premature death from NCDs (%) ^c	23	24	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	7	13	2	2022
Obesity, adults aged 18+ years (%)	6	6	5	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	18	17	19	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Don't know

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Chile

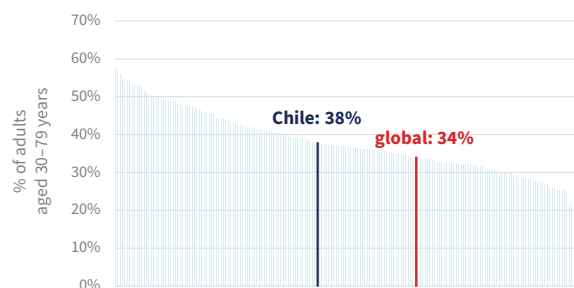
Hypertension profile

Total population (2024): 19 760 000

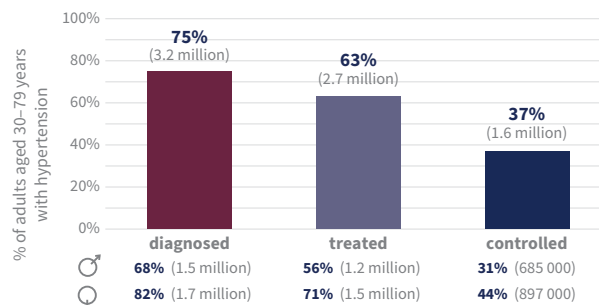
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 38% ♀ 40% ♀ 36%

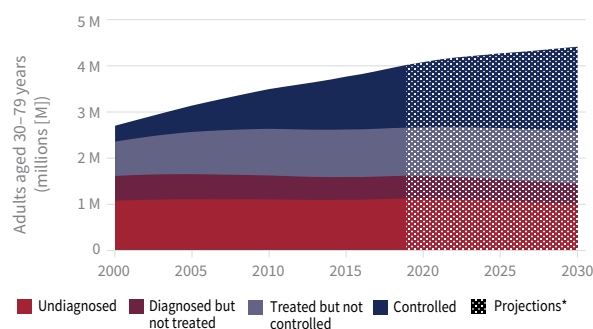
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 4.2 million adults aged 30–79 years with hypertension, approximately 2.6 million do not have the condition controlled^b

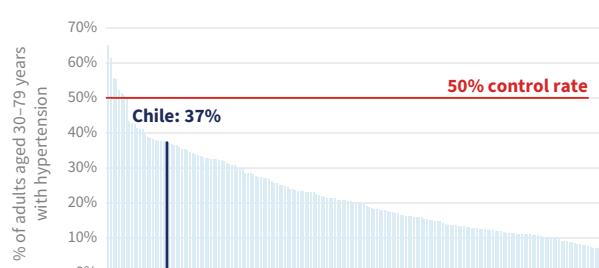


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	146 100	76 220	69 900	2021
Cardiovascular disease deaths	35 160	17 030	18 130	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	58	61	2021
Risk of premature death from NCDs (%) ^c	9	11	8	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	8	2021
Current tobacco use, adults aged 15+ years (%) ^d	29	31	27	2022
Obesity, adults aged 18+ years (%)	40	34	45	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	38	30	46	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

China

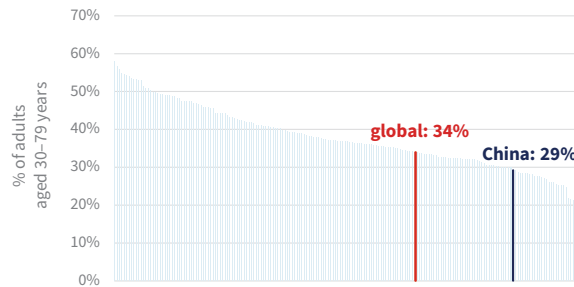
Hypertension profile

Total population (2024): 1 419 000 000

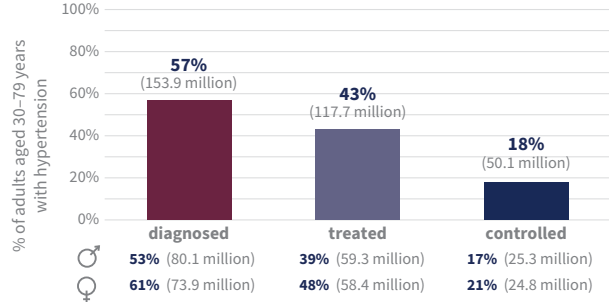
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 29% ♀ 32% ♀ 26%

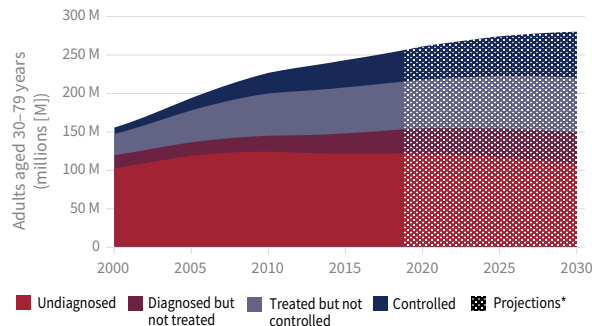
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 271.5 million adults aged 30–79 years with hypertension, approximately 221.4 million do not have the condition controlled^b

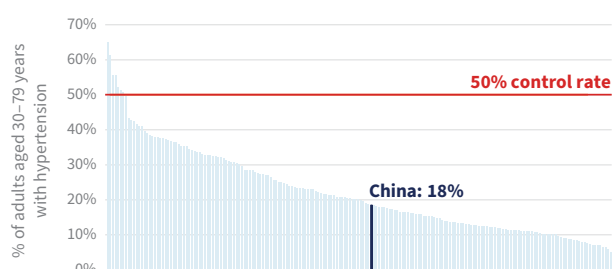


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	11 530 000	6 565 000	4 961 000	2021
Cardiovascular disease deaths	5 036 000	2 755 000	2 280 000	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	55	57	2021
Risk of premature death from NCDs (%) ^c	16	20	12	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	17	19	16	2021
Current tobacco use, adults aged 15+ years (%) ^d	23	45	2	2022
Obesity, adults aged 18+ years (%)	8	9	8	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	24	28	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Colombia

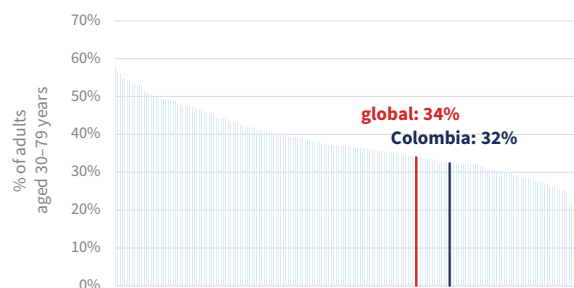
Hypertension profile

Total population (2024): 52 890 000

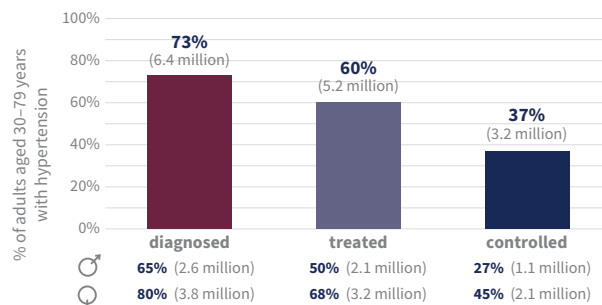
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♂ 31% ♀ 33%

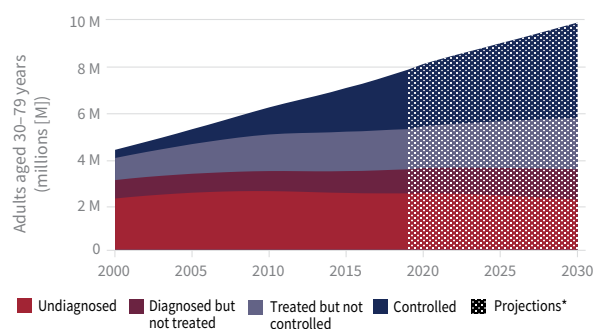
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 8.8 million adults aged 30–79 years with hypertension, approximately 5.5 million do not have the condition controlled^b

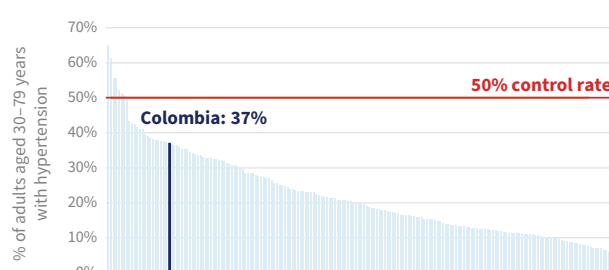


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	362 200	200 900	161 300	2021
Cardiovascular disease deaths	94 550	46 790	47 770	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	56	55	2021
Risk of premature death from NCDs (%) ^c	10	12	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	12	14	10	2021
Current tobacco use, adults aged 15+ years (%)	8	12	4	2022
Obesity, adults aged 18+ years (%)	24	18	29	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	34	28	41	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Comoros

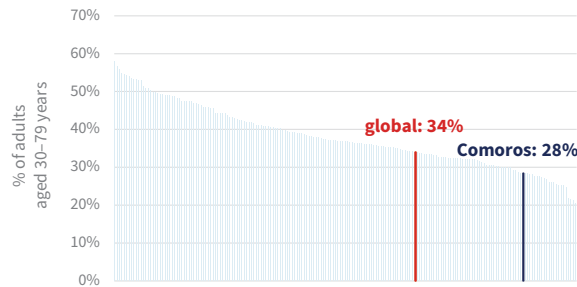
Hypertension profile

Total population (2024): 866 600

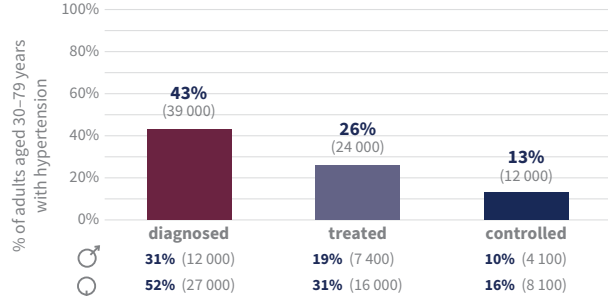
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 28% ♀ 25% ♀ 32%

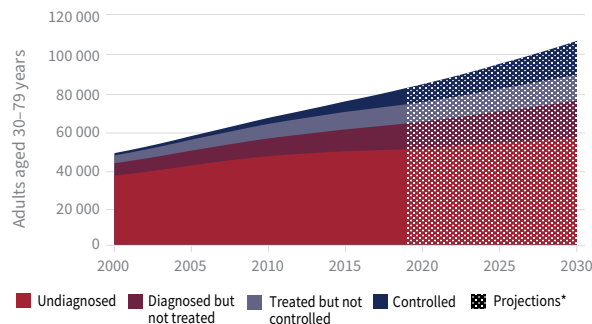
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 92 000 adults aged 30–79 years with hypertension, approximately 80 000 do not have the condition controlled^b

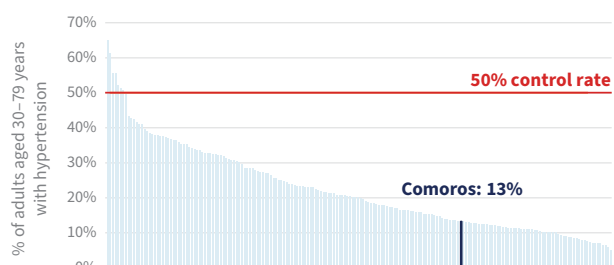


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	5510	2880	2630	2021
Cardiovascular disease deaths	1060	480	580	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	54	64	2021
Risk of premature death from NCDs (%) ^c	20	20	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	17	28	7	2022
Obesity, adults aged 18+ years (%)	16	8	24	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	17	11	24	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Congo

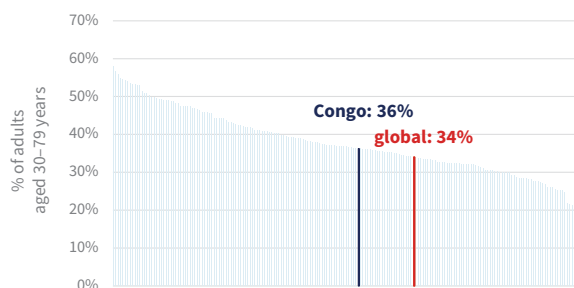
Hypertension profile

Total population (2024): 6 333 000

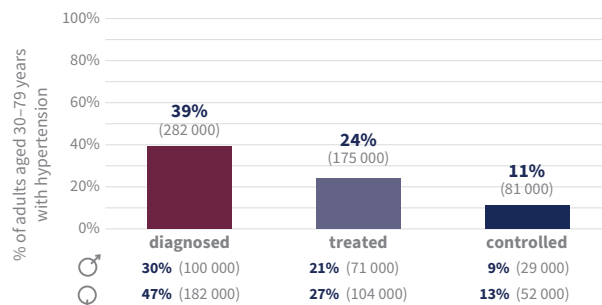
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♂ 34% ♀ 39%

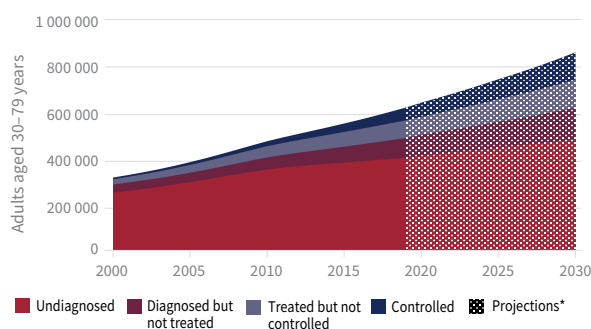
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 717 000 adults aged 30–79 years with hypertension, approximately 636 000 do not have the condition controlled^b

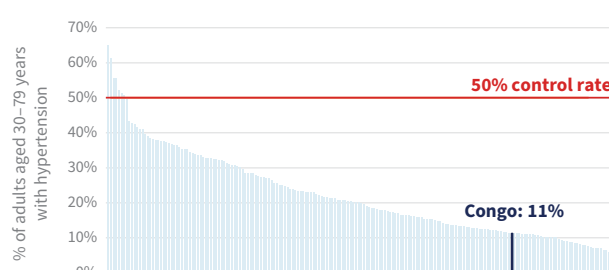


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	43 210	21 720	21 490	2021
Cardiovascular disease deaths	6810	2980	3830	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	56	63	2021
Risk of premature death from NCDs (%) ^c	21	21	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	15	29	2	2022
Obesity, adults aged 18+ years (%)	8	4	12	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	16	12	19	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Cook Islands

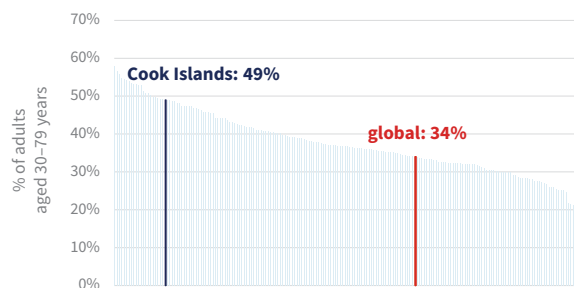
Hypertension profile

Total population (2024): 13 730

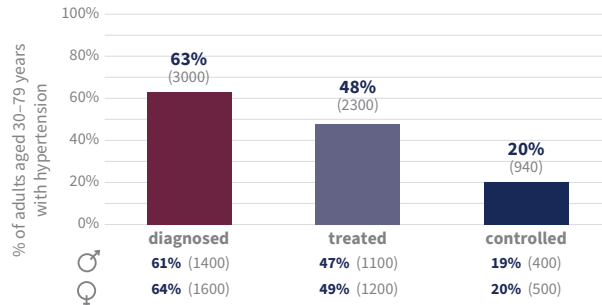
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 49% ♀ 50% ♀ 48%

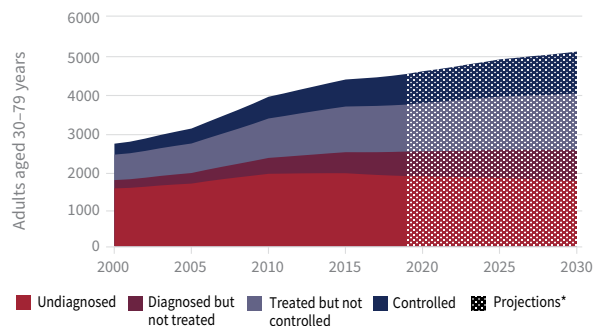
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 4800 adults aged 30–79 years with hypertension, approximately 3900 do not have the condition controlled^b

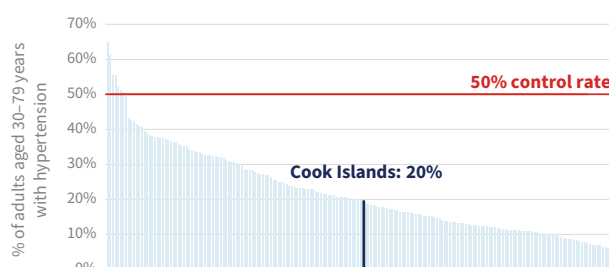


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	63	62	64	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	27	32	22	2022
Obesity, adults aged 18+ years (%)	68	65	72	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	no data	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	25	16	33	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Costa Rica

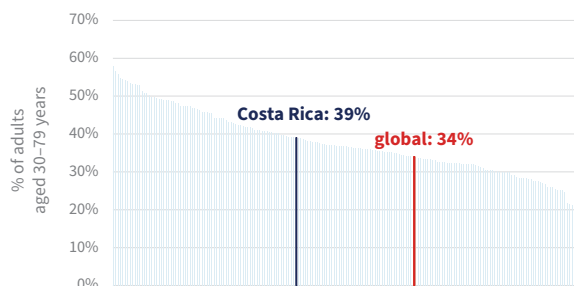
Hypertension profile

Total population (2024): 5 130 000

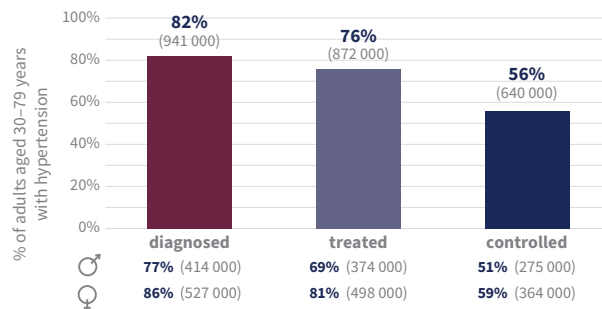
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 39% ♂ 37% ♀ 41%

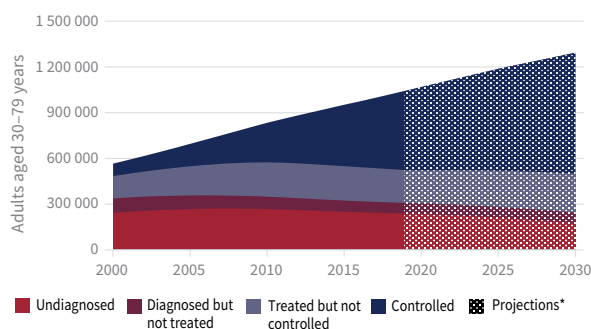
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.2 million adults aged 30–79 years with hypertension, approximately 512 000 do not have the condition controlled^b

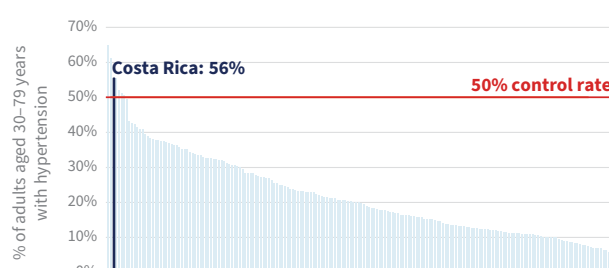


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	31 250	17 130	14 120	2021
Cardiovascular disease deaths	6650	3320	3330	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	53	57	2021
Risk of premature death from NCDs (%) ^c	10	11	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%)	9	13	5	2022
Obesity, adults aged 18+ years (%)	32	25	39	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	50	42	58	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Côte d'Ivoire

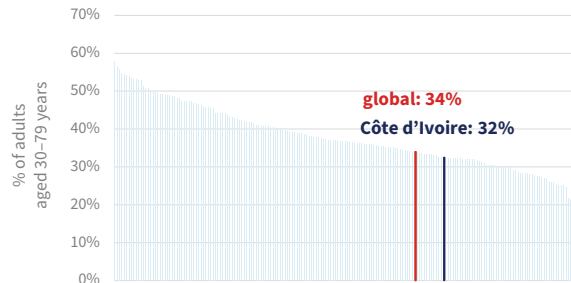
Hypertension profile

Total population (2024): 31 930 000

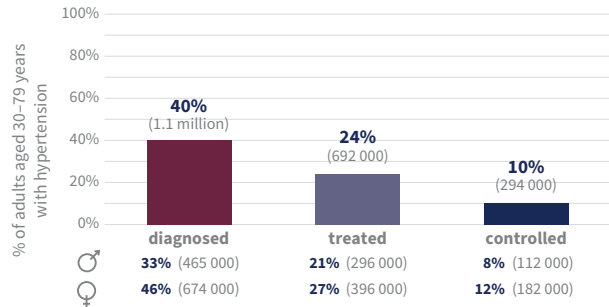
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♀ 31% ♀ 34%

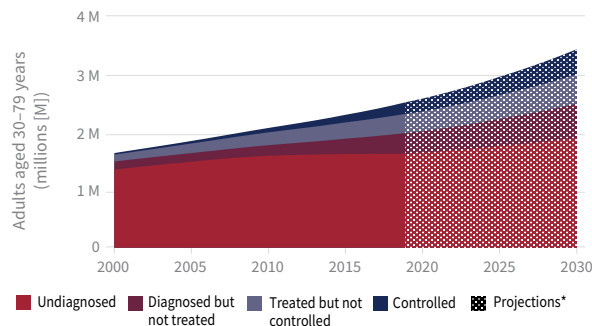
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.9 million adults aged 30–79 years with hypertension, approximately 2.6 million do not have the condition controlled^b

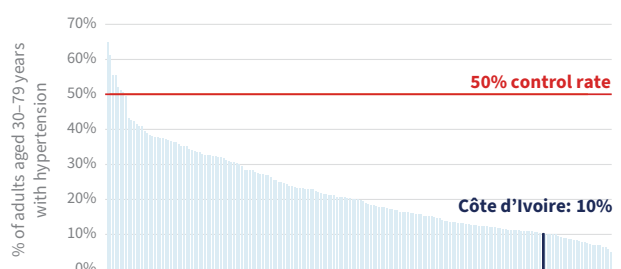


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	209 700	119 300	90 430	2021
Cardiovascular disease deaths	30 720	17 280	13 450	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	57	59	2021
Risk of premature death from NCDs (%) ^c	23	24	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	9	17	1	2022
Obesity, adults aged 18+ years (%)	11	7	14	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	20	16	24	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Croatia

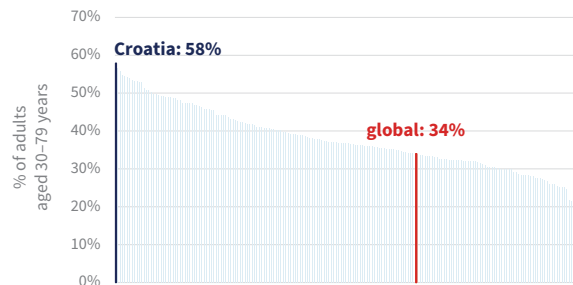
Hypertension profile

Total population (2024): 3 875 000

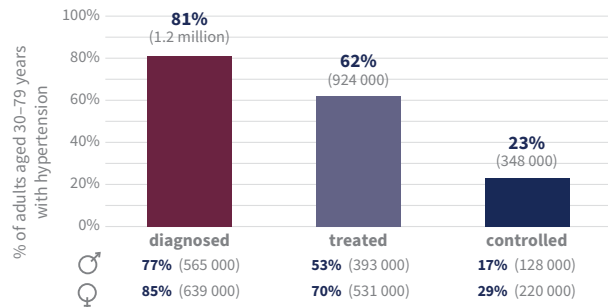
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 58% ♀ 59% ♀ 57%

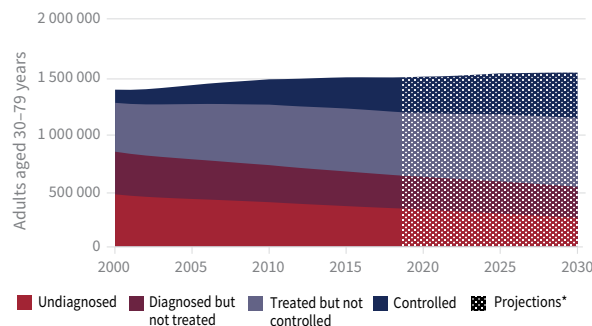
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.5 million adults aged 30–79 years with hypertension, approximately 1.1 million do not have the condition controlled^b

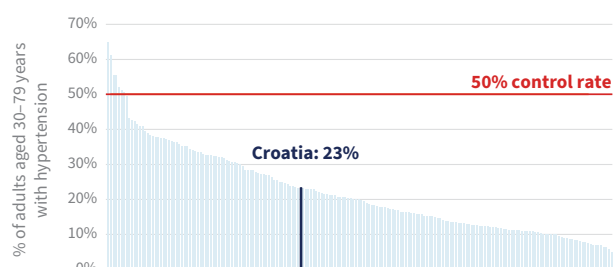


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	60 300	29 250	31 050	2021
Cardiovascular disease deaths	22 150	9190	12 950	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	56	58	2021
Risk of premature death from NCDs (%) ^c	16	21	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	12	15	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	37	37	37	2022
Obesity, adults aged 18+ years (%)	36	37	35	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	28	28	29	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Cuba

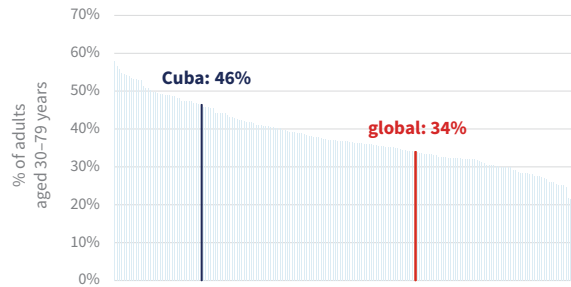
Hypertension profile

Total population (2024): 10 980 000

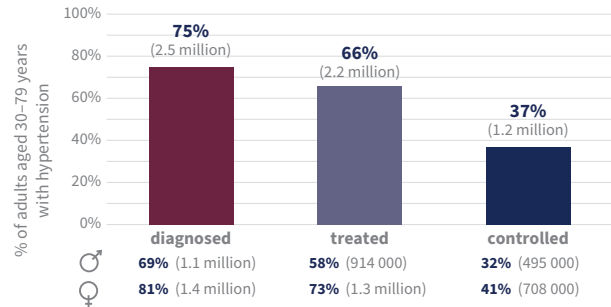
Prevalence of hypertension among adults aged 30–79 years (2024)^a

46% 45% 48%

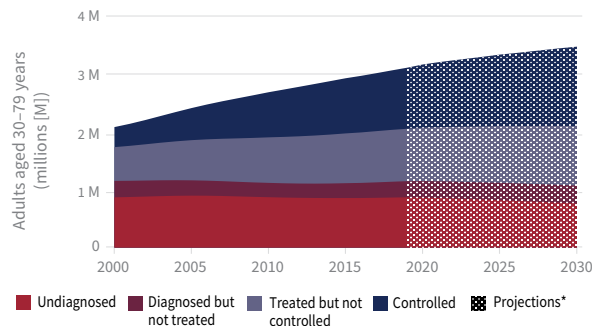
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.3 million adults aged 30–79 years with hypertension, approximately 2.1 million do not have the condition controlled^b

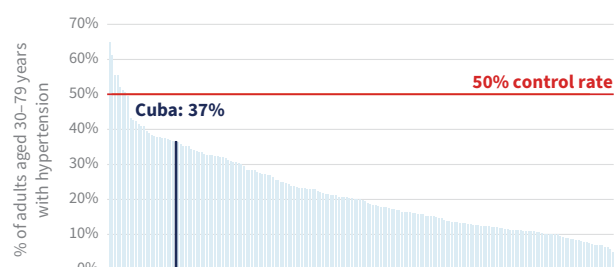


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	168 100	93 460	74 650	2021
Cardiovascular disease deaths	49 350	26 490	22 850	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	47	46	47	2021
Risk of premature death from NCDs (%) ^c	18	22	14	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	17	25	10	2022
Obesity, adults aged 18+ years (%)	24	20	27	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	61	50	72	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Cyprus

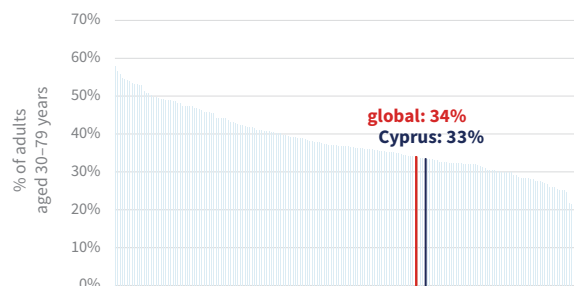
Hypertension profile

Total population (2024): 1 358 000

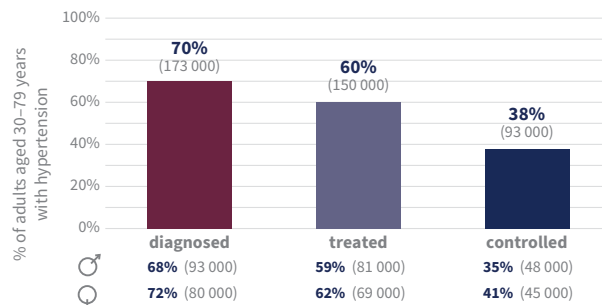
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 33% ♀ 29%

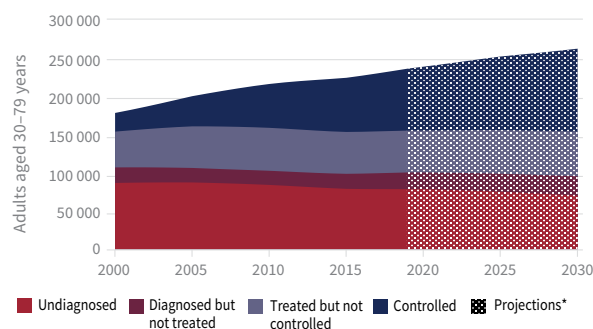
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 248 000 adults aged 30–79 years with hypertension, approximately 155 000 do not have the condition controlled^b

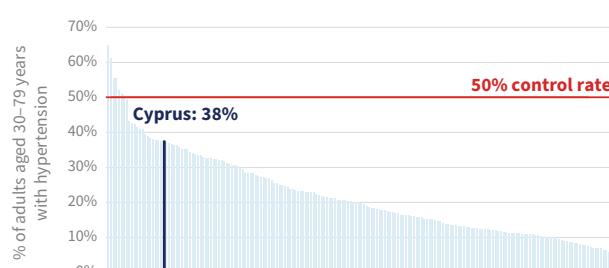


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	8440	4410	4030	2021
Cardiovascular disease deaths	2190	1150	1040	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	50	50	2021
Risk of premature death from NCDs (%) ^c	9	11	6	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	36	47	24	2022
Obesity, adults aged 18+ years (%)	25	27	23	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	41	35	47	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Don't know
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Don't know
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Czechia

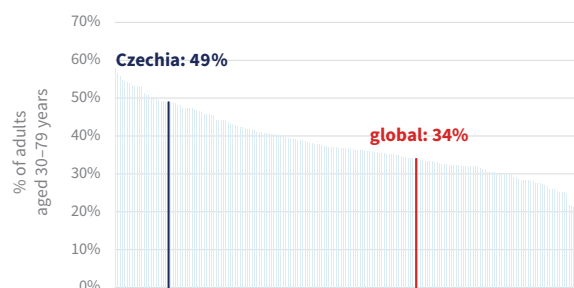
Hypertension profile

Total population (2024): 10 740 000

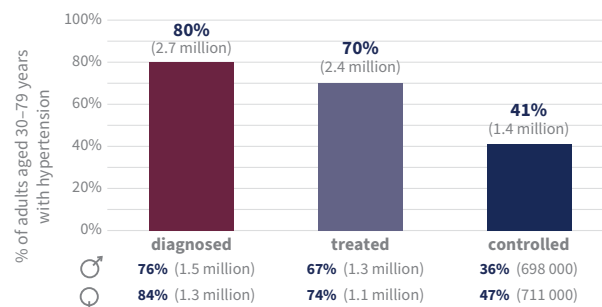
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 49% ♀ 56% 42%

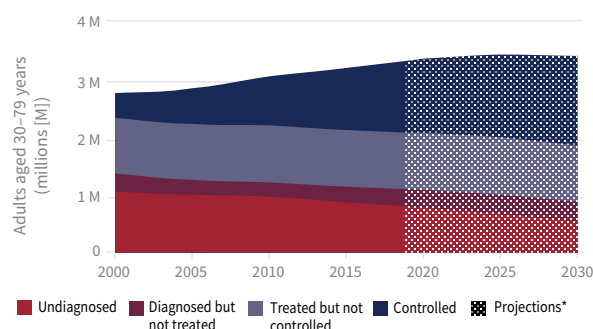
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.4 million adults aged 30–79 years with hypertension, approximately 2 million do not have the condition controlled^b

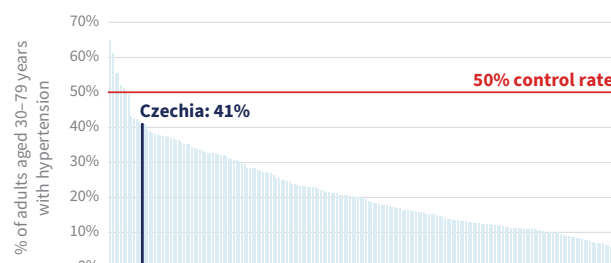


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	140 200	73 710	66 460	2021
Cardiovascular disease deaths	48 130	23 050	25 080	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	53	55	2021
Risk of premature death from NCDs (%) ^c	14	19	10	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	13	15	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	30	33	27	2022
Obesity, adults aged 18+ years (%)	31	34	28	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	14	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	23	23	24	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Democratic People's Republic of Korea

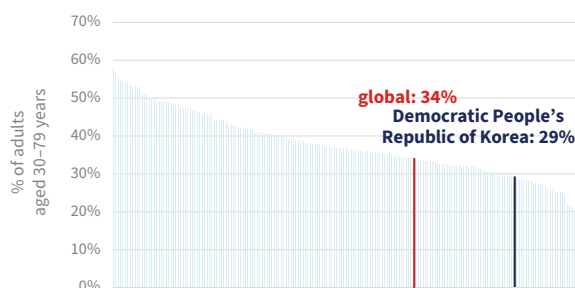
Hypertension profile

Total population (2024): 26 500 000

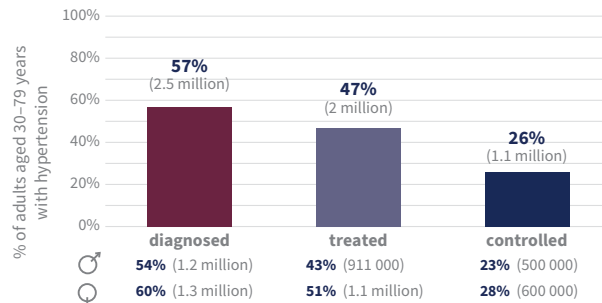
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 29% ♀ 28%

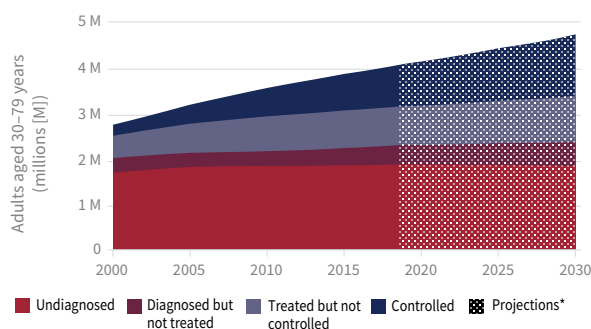
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 4.3 million adults aged 30–79 years with hypertension, approximately 3.2 million do not have the condition controlled^b

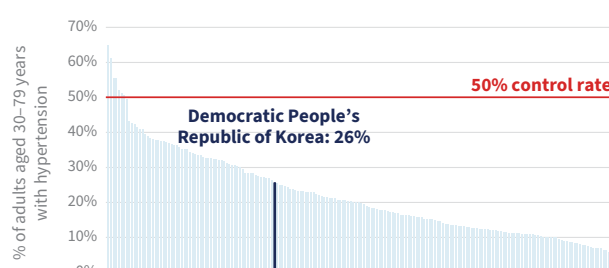


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	265 300	136 300	129 000	2021
Cardiovascular disease deaths	103 900	49 090	54 820	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	53	54	2021
Risk of premature death from NCDs (%) ^c	24	29	19	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	12	13	12	2021
Current tobacco use, adults aged 15+ years (%) ^d	17	33	0	2022
Obesity, adults aged 18+ years (%)	11	9	13	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	27	24	29	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Democratic Republic of the Congo

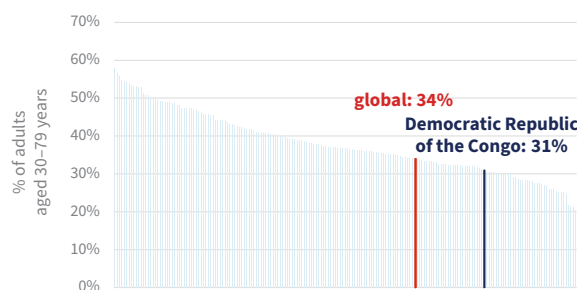
Hypertension profile

Total population (2024): 109 300 000

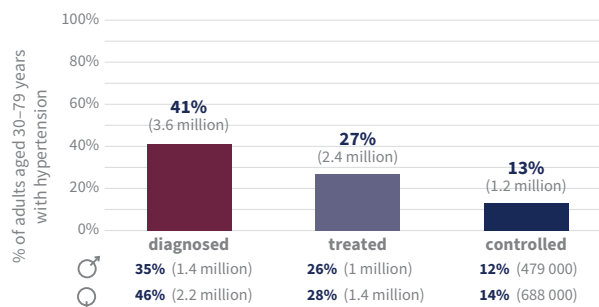
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 31% ♂ 29% ♀ 34%

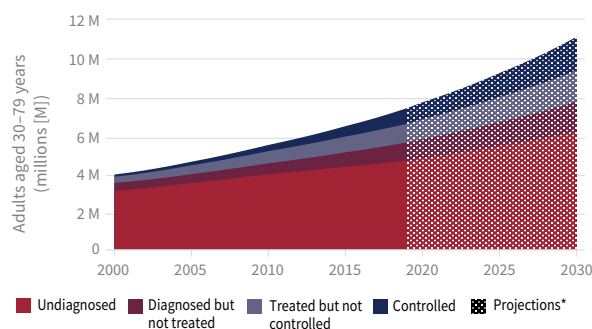
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 8.8 million adults aged 30–79 years with hypertension, approximately 7.7 million do not have the condition controlled^b

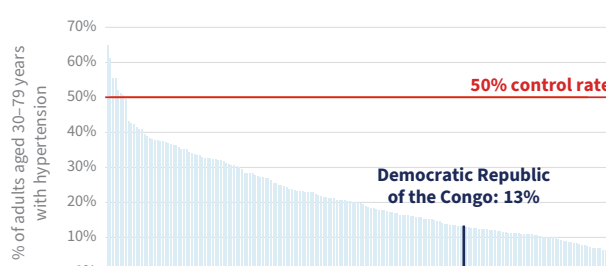


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	857 800	463 900	393 900	2021
Cardiovascular disease deaths	123 800	59 210	64 610	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	50	61	2021
Risk of premature death from NCDs (%) ^c	25	26	24	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	6	5	2021
Current tobacco use, adults aged 15+ years (%)	12	22	3	2022
Obesity, adults aged 18+ years (%)	6	3	8	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	15	12	17	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Denmark

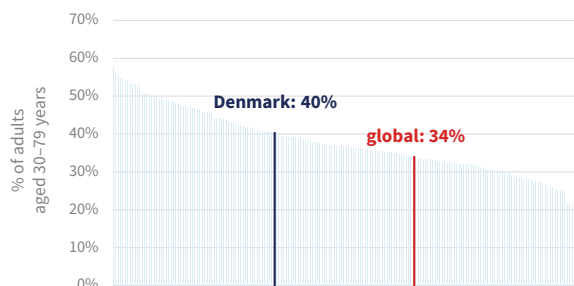
Hypertension profile

Total population (2024): 5 977 000

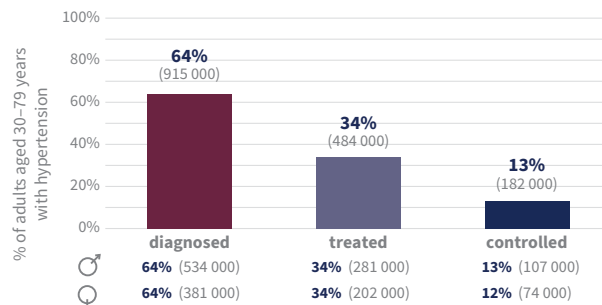
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 40% ♂ 47% ♀ 34%

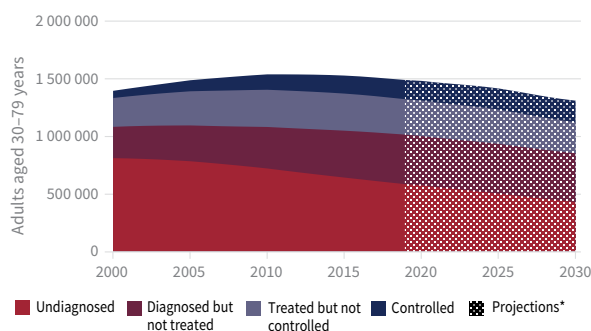
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.4 million adults aged 30–79 years with hypertension, approximately 1.2 million do not have the condition controlled^b

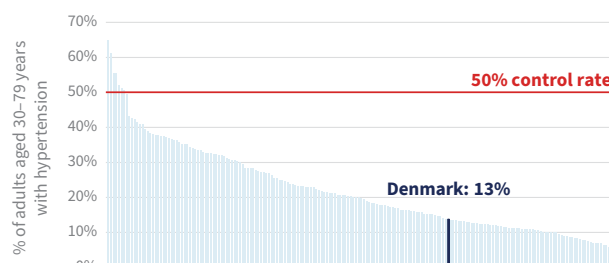


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	57 020	29 090	27 930	2021
Cardiovascular disease deaths	12 700	6580	6130	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	49	48	49	2021
Risk of premature death from NCDs (%) ^c	11	12	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	16	16	16	2022
Obesity, adults aged 18+ years (%)	14	17	12	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	10	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	12	13	11	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Djibouti

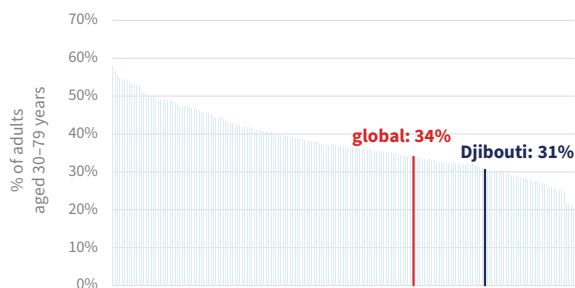
Hypertension profile

Total population (2024): 1 169 000

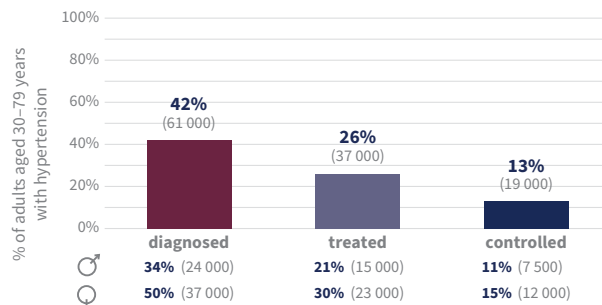
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 31% ♂ 29% ♀ 33%

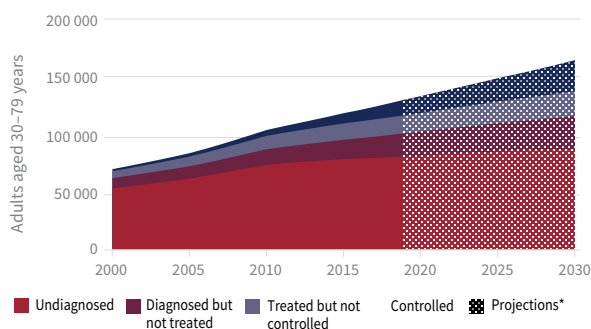
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 145 000 adults aged 30–79 years with hypertension, approximately 126 000 do not have the condition controlled^b

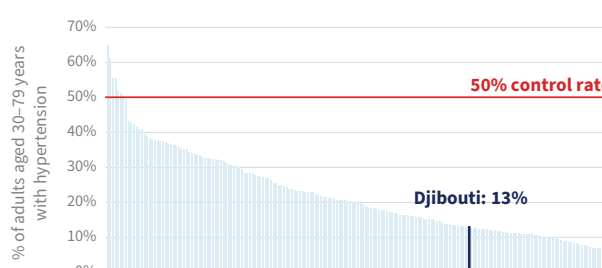


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	8870	4700	4170	2021
Cardiovascular disease deaths	1740	870	870	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	54	65	2021
Risk of premature death from NCDs (%) ^c	21	22	19	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	11	6	16	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	17	14	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Dominica

Hypertension profile

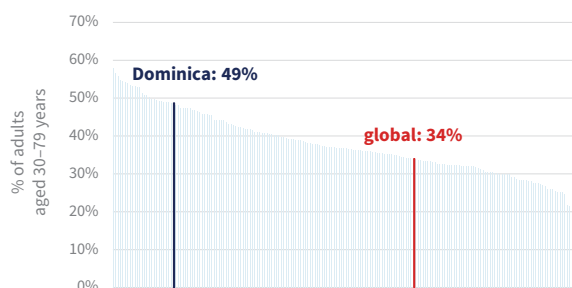
Total population (2024):

66 210

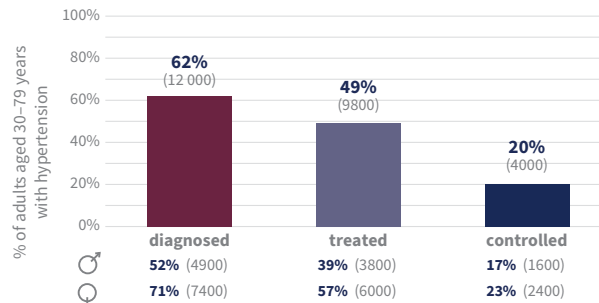
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 49% ♀ 46% ♀ 52%

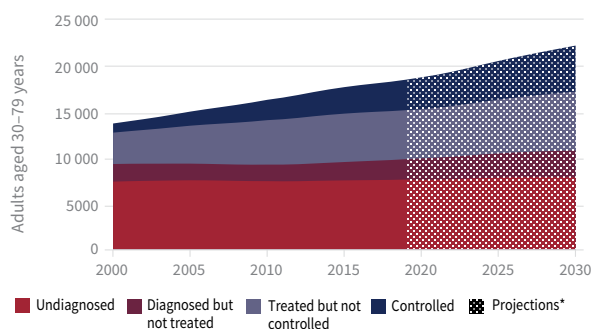
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 20 000 adults aged 30–79 years with hypertension, approximately 16 000 do not have the condition controlled^b

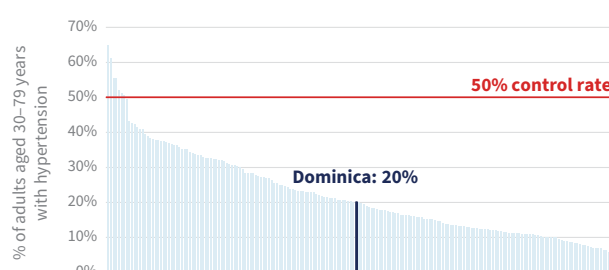


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	55	54	55	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	32	18	45	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	31	21	39	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Dominican Republic

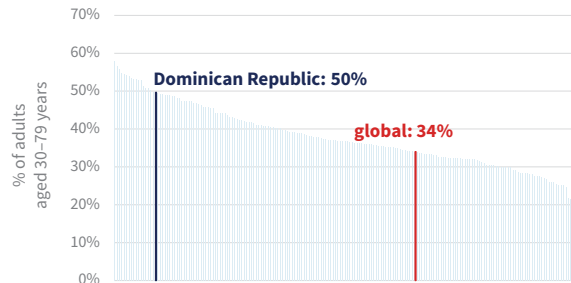
Hypertension profile

Total population (2024): 11 430 000

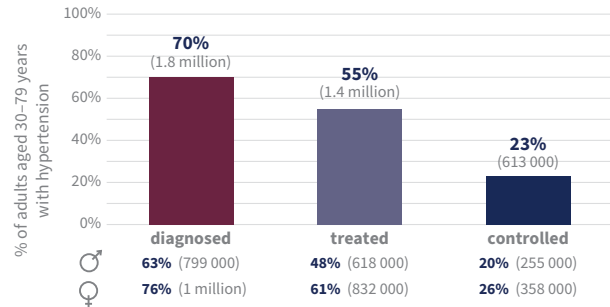
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 50% ♀ 49% ♀ 50%

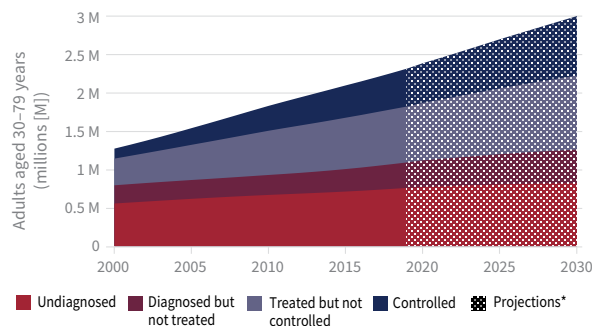
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.6 million adults aged 30–79 years with hypertension, approximately 2 million do not have the condition controlled^b

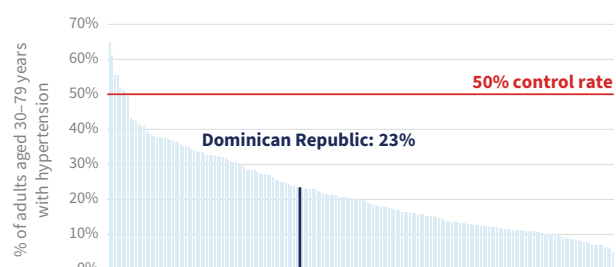


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	67 390	37 700	29 690	2021
Cardiovascular disease deaths	19 880	10 460	9420	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	51	52	51	2021
Risk of premature death from NCDs (%) ^c	17	21	14	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	11	14	7	2022
Obesity, adults aged 18+ years (%)	29	23	35	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	37	31	43	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Ecuador

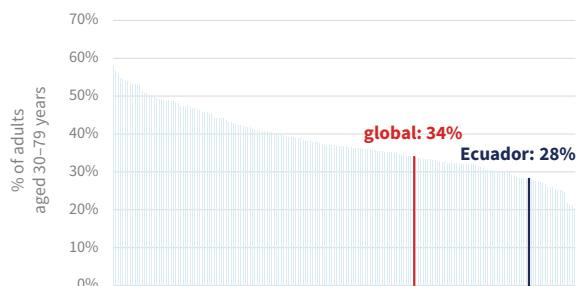
Hypertension profile

Total population (2024): 18 140 000

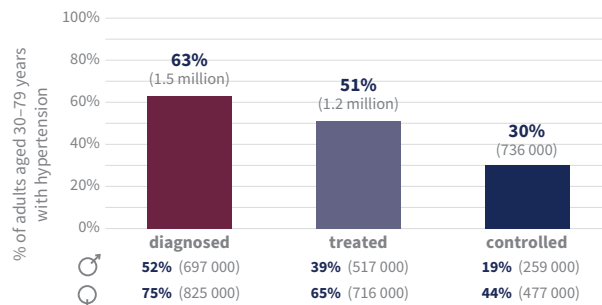
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 28% ♂ 31% ♀ 25%

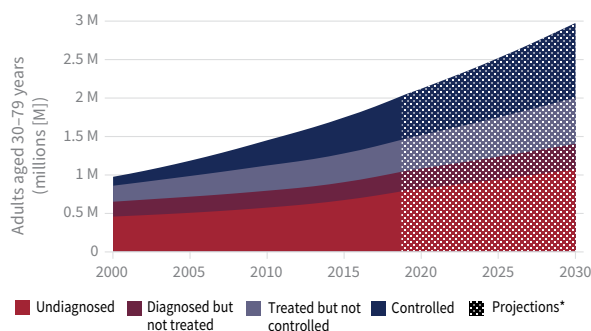
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.4 million adults aged 30–79 years with hypertension, approximately 1.7 million do not have the condition controlled^b

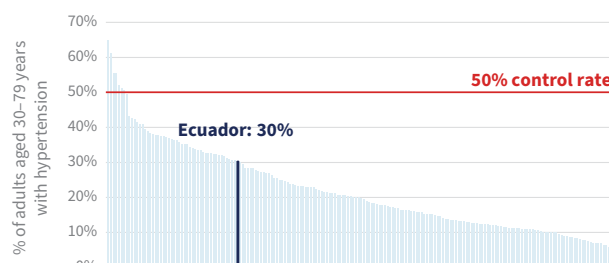


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	116 200	65 950	50 260	2021
Cardiovascular disease deaths	30 050	15 890	14 160	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	46	44	49	2021
Risk of premature death from NCDs (%) ^c	13	15	12	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	8	2021
Current tobacco use, adults aged 15+ years (%)	10	18	3	2022
Obesity, adults aged 18+ years (%)	27	22	32	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	23	18	28	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Egypt

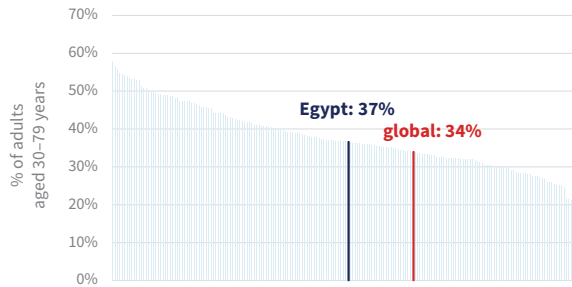
Hypertension profile

Total population (2024): 116 500 000

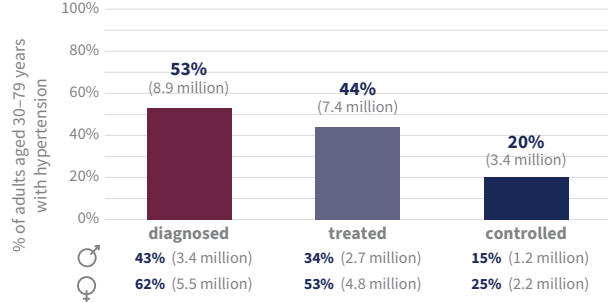
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♀ 35% ♀ 39%

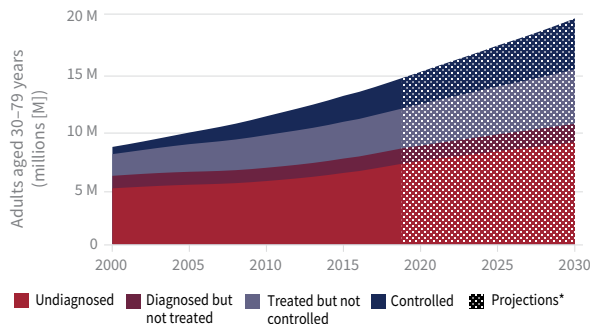
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 16.8 million adults aged 30–79 years with hypertension, approximately 13.4 million do not have the condition controlled^b

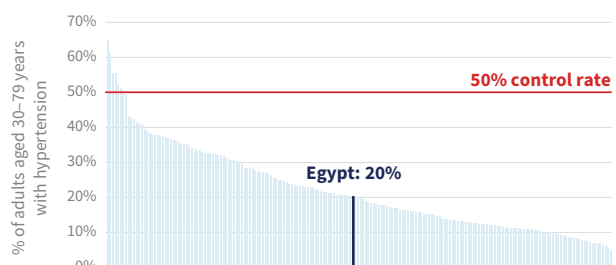


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	746 500	417 600	328 900	2021
Cardiovascular disease deaths	246 800	132 200	114 600	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	53	60	2021
Risk of premature death from NCDs (%) ^c	26	31	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%) ^d	25	49	0	2022
Obesity, adults aged 18+ years (%)	43	30	56	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	34	30	37	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

El Salvador

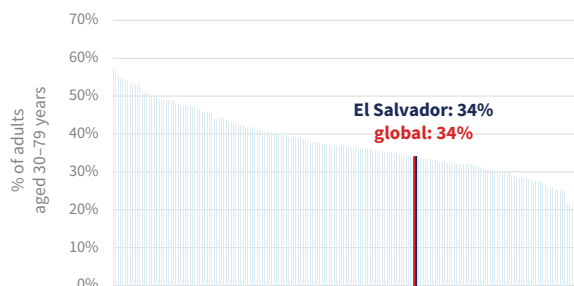
Hypertension profile

Total population (2024): 6 338 000

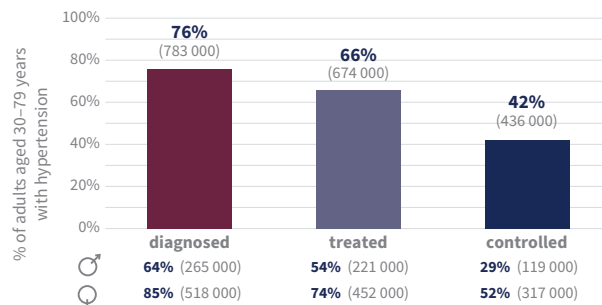
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 34% ♂ 31% ♀ 35%

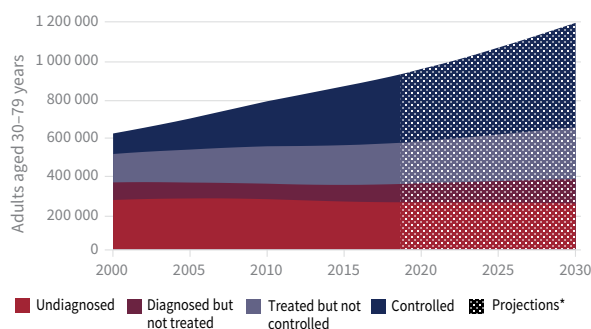
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1 million adults aged 30–79 years with hypertension, approximately 590 000 do not have the condition controlled^b

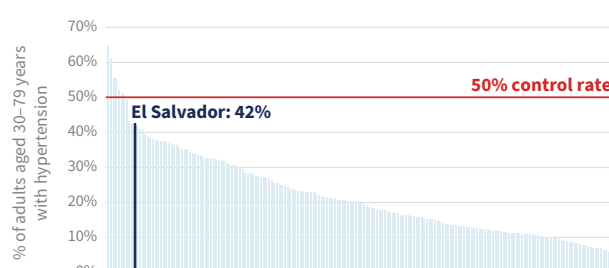


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	46 490	25 860	20 630	2021
Cardiovascular disease deaths	7840	3830	4010	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	52	52	52	2021
Risk of premature death from NCDs (%) ^c	13	15	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%) ^d	9	16	2	2022
Obesity, adults aged 18+ years (%)	30	22	37	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	39	32	46	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Equatorial Guinea

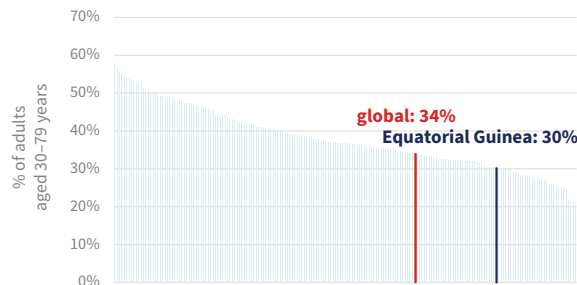
Hypertension profile

Total population (2024): 1 893 000

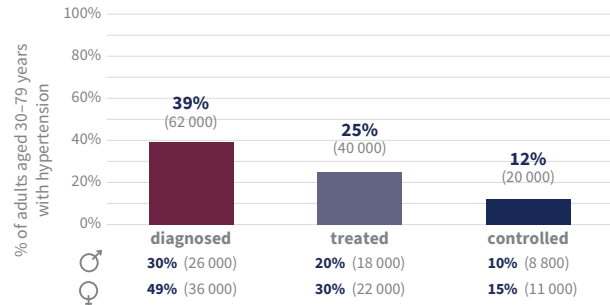
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 30% ♀ 27% ♀ 34%

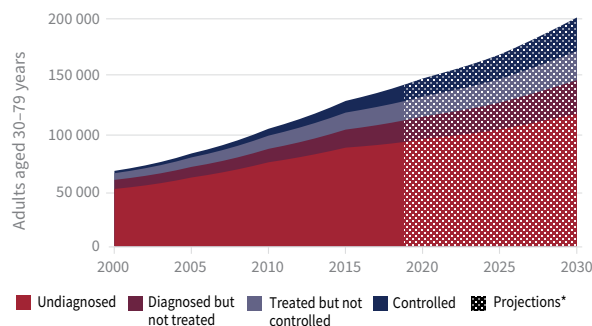
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 162 000 adults aged 30–79 years with hypertension, approximately 142 000 do not have the condition controlled^b

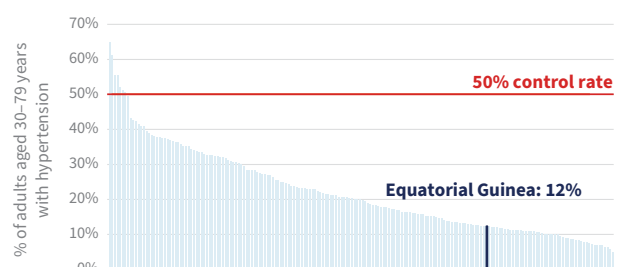


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	15 520	8620	6900	2021
Cardiovascular disease deaths	2010	950	1060	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	55	62	2021
Risk of premature death from NCDs (%) ^c	20	21	20	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	17	7	29	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	20	15	24	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Eritrea

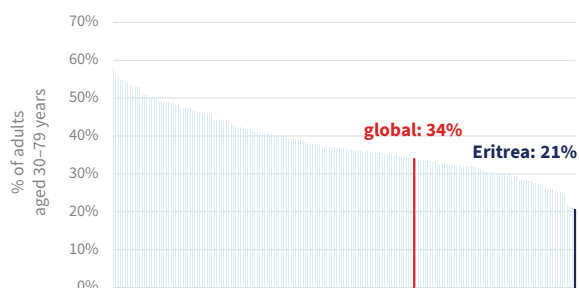
Hypertension profile

Total population (2024): 3 536 000

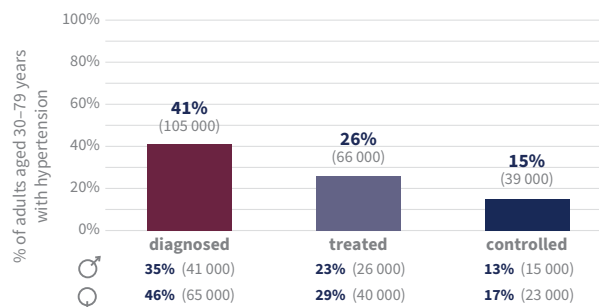
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 21% ♂ 19% ♀ 22%

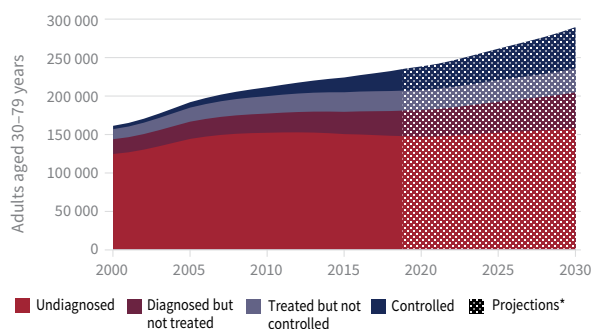
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 256 000 adults aged 30–79 years with hypertension, approximately 217 000 do not have the condition controlled^b

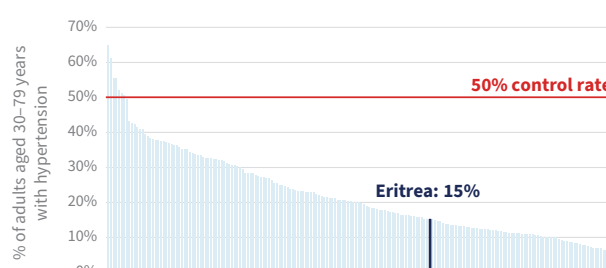


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	27 410	14 580	12 830	2021
Cardiovascular disease deaths	6080	2790	3290	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	46	60	2021
Risk of premature death from NCDs (%) ^c	27	29	26	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	4	2	6	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	12	7	16	2022

National response

Targets

National target for blood pressure	No response
National target for salt consumption	No response

Policies

Operational cardiovascular disease policy	No response
Operational salt reduction policy	No response

Treatment

Guidelines for management of hypertension	No response
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No response
Conducted recent, national survey on salt/sodium intake	No response
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No response

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Estonia

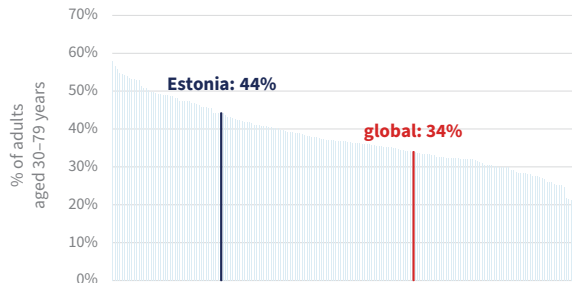
Hypertension profile

Total population (2024): 1 361 000

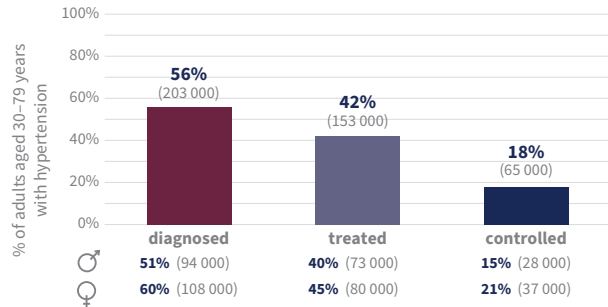
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 44% ♀ 47% ♀ 42%

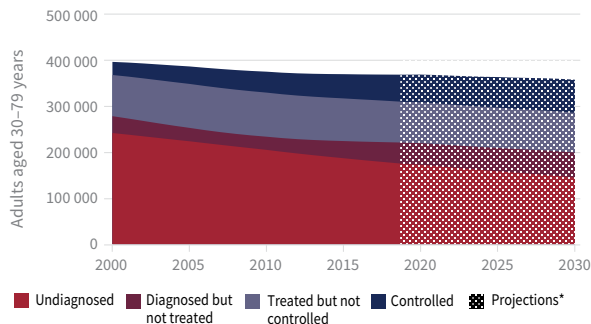
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 363 000 adults aged 30–79 years with hypertension, approximately 298 000 do not have the condition controlled^b

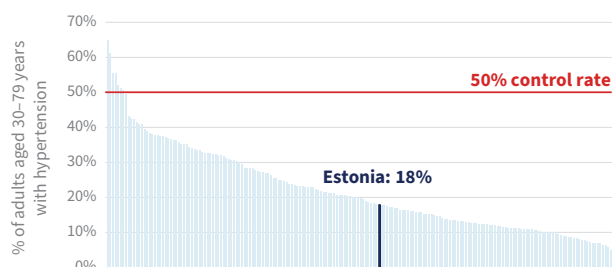


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	18 490	8760	9730	2021
Cardiovascular disease deaths	8470	3350	5120	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	68	63	71	2021
Risk of premature death from NCDs (%) ^c	16	23	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	28	34	23	2022
Obesity, adults aged 18+ years (%)	27	25	28	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	10	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	16	17	15	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Eswatini

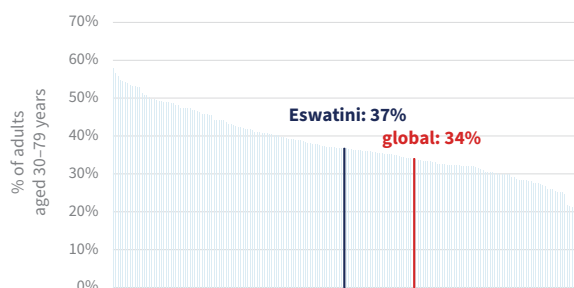
Hypertension profile

Total population (2024): 1 243 000

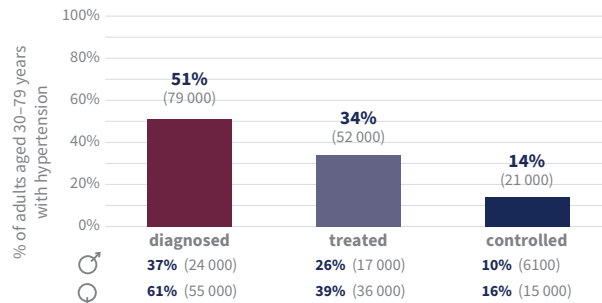
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♂ 32% ♀ 41%

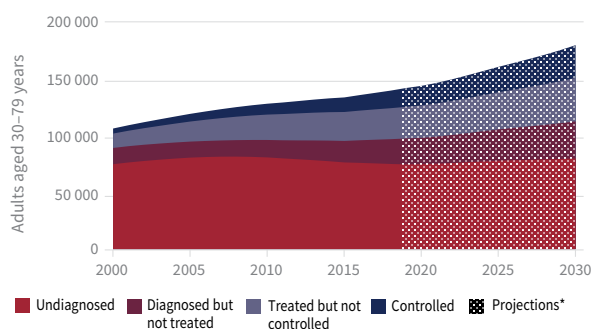
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 155 000 adults aged 30–79 years with hypertension, approximately 134 000 do not have the condition controlled^b

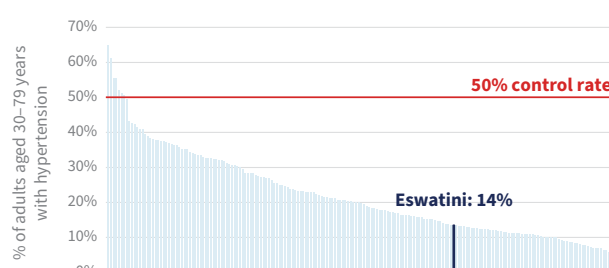


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	15 780	8580	7200	2021
Cardiovascular disease deaths	2050	1020	1040	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	62	58	66	2021
Risk of premature death from NCDs (%) ^c	32	38	28	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	10	17	2	2022
Obesity, adults aged 18+ years (%)	27	13	41	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	19	15	23	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Ethiopia

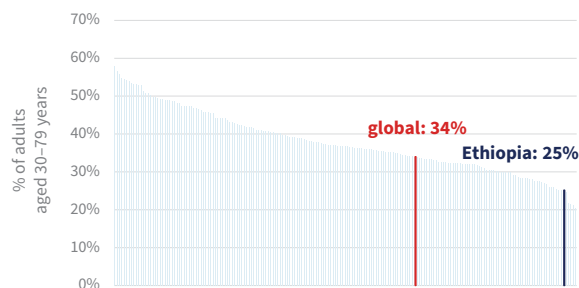
Hypertension profile

Total population (2024): 132 100 000

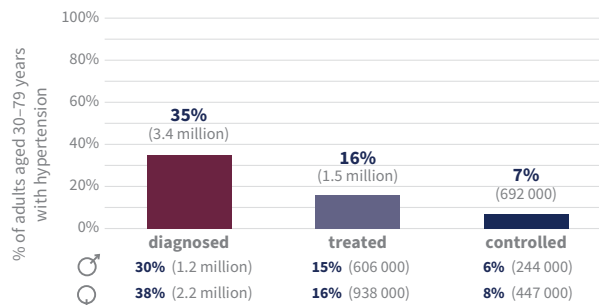
Prevalence of hypertension among adults aged 30–79 years (2024)^a

25% 21% 29%

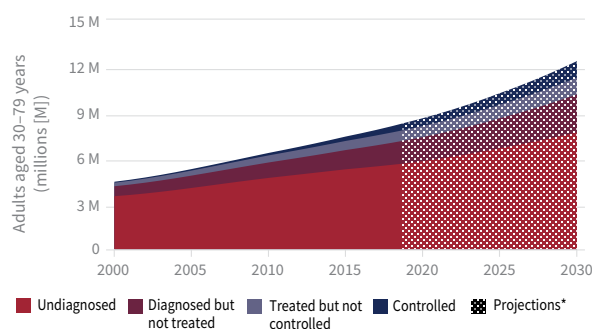
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 9.8 million adults aged 30–79 years with hypertension, approximately 9.1 million do not have the condition controlled^b

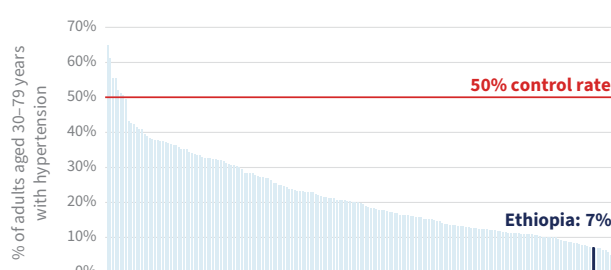


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	686 000	370 900	315 000	2021
Cardiovascular disease deaths	82 620	37 690	44 920	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	49	42	56	2021
Risk of premature death from NCDs (%) ^c	17	16	17	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	5	9	2	2022
Obesity, adults aged 18+ years (%)	2	1	4	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	9	7	12	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

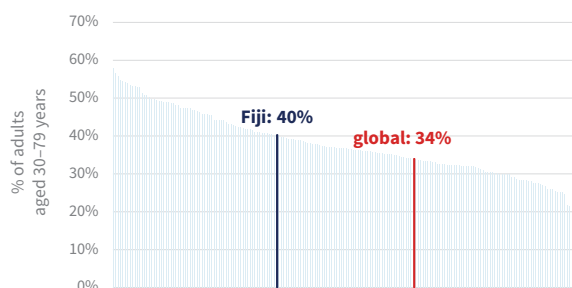
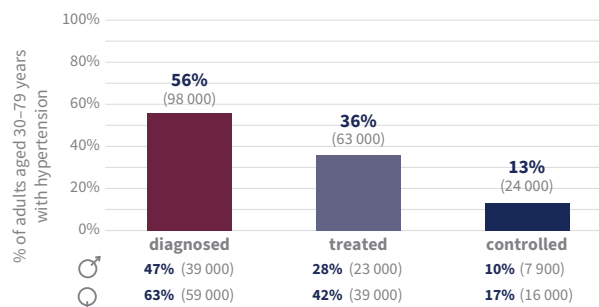
† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

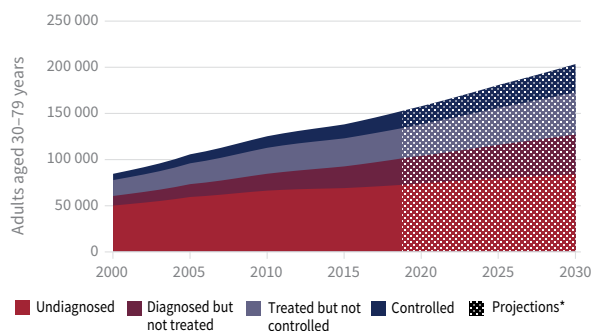
World Health Organization: Hypertension profiles, 2025

Prevalence of hypertension among adults aged 30–79 years (2024)^a

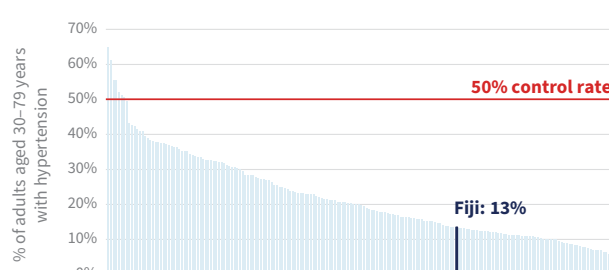
♂ 40% ♂ 38% ♀ 43%

Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^aOf the 176 000 adults aged 30–79 years with hypertension, approximately 152 000 do not have the condition controlled^b

Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b

Mortality†

	both sexes	males	females	year
Total deaths	9410	5020	4400	2021
Cardiovascular disease deaths	2610	1500	1120	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	55	60	2021
Risk of premature death from NCDs (%) ^c	38	41	35	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	28	42	13	2022
Obesity, adults aged 18+ years (%)	34	26	42	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	16	9	22	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

Finland

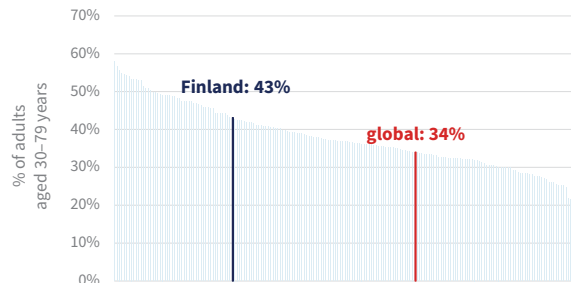
Hypertension profile

Total population (2024): 5 617 000

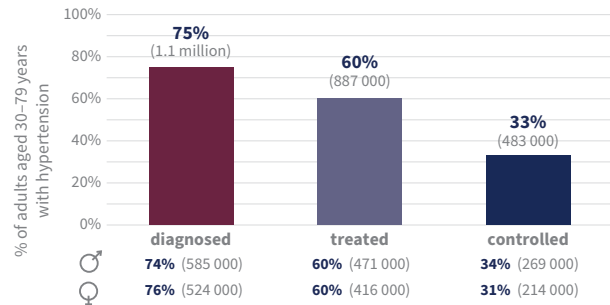
Prevalence of hypertension among adults aged 30–79 years (2024)^a

43% 46% 40%

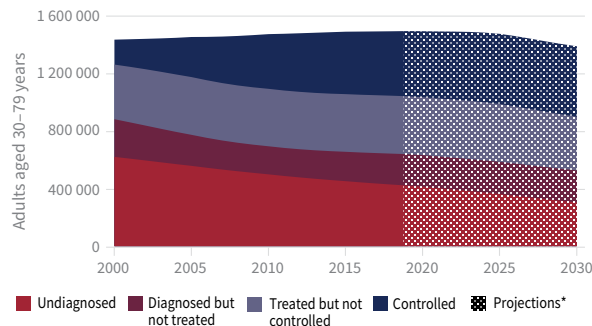
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.5 million adults aged 30–79 years with hypertension, approximately 999 000 do not have the condition controlled^b

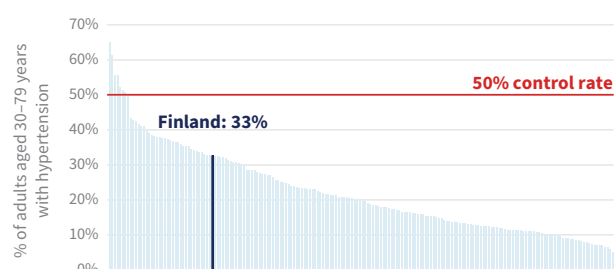


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	57 690	29 180	28 500	2021
Cardiovascular disease deaths	22 030	10 750	11 280	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	51	55	2021
Risk of premature death from NCDs (%) ^c	10	13	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	22	26	19	2022
Obesity, adults aged 18+ years (%)	24	23	25	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	10	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	10	11	8	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

France

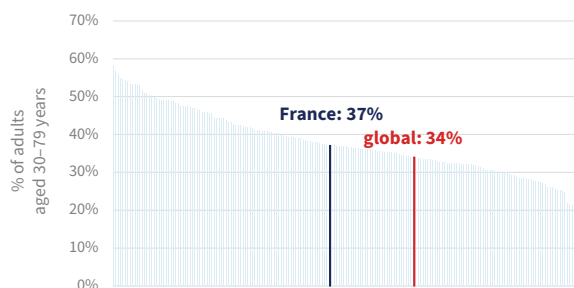
Hypertension profile

Total population (2024): 66 550 000

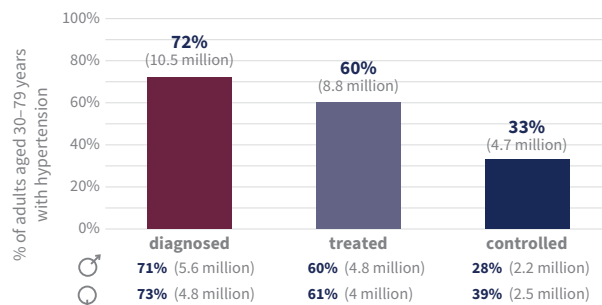
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♀ 42% ♀ 33%

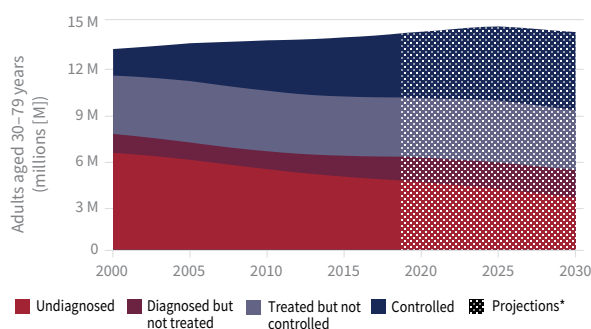
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 14.5 million adults aged 30–79 years with hypertension, approximately 9.8 million do not have the condition controlled^b

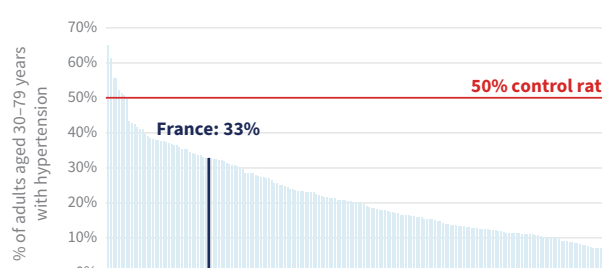


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	648 600	327 000	321 600	2021
Cardiovascular disease deaths	150 900	70 800	80 080	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	44	44	44	2021
Risk of premature death from NCDs (%) ^c	10	13	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	9	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	35	36	34	2022
Obesity, adults aged 18+ years (%)	11	11	10	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	23	20	26	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Don't know

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Gabon

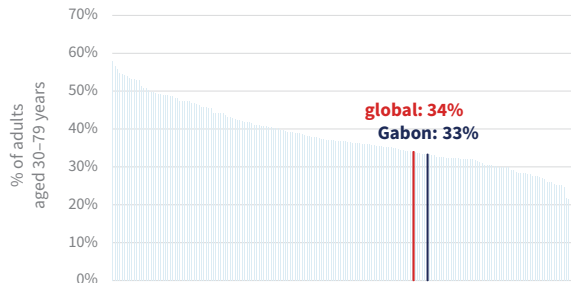
Hypertension profile

Total population (2024): 2 539 000

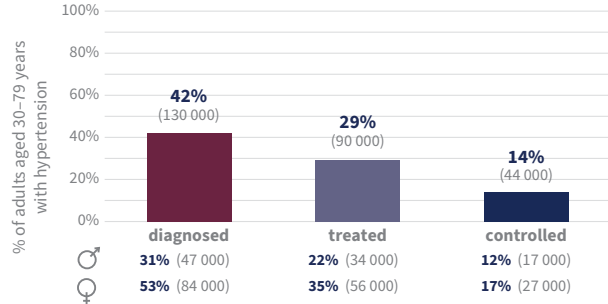
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 33% ♀ 31% ♀ 35%

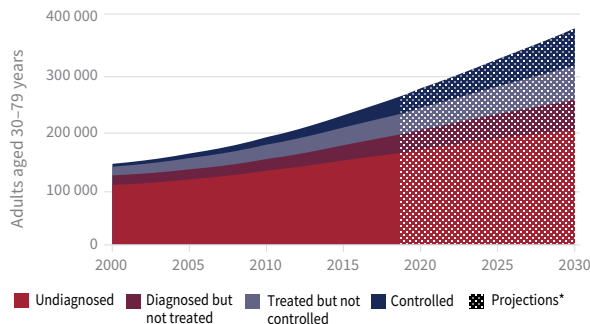
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 311 000 adults aged 30–79 years with hypertension, approximately 266 000 do not have the condition controlled^b

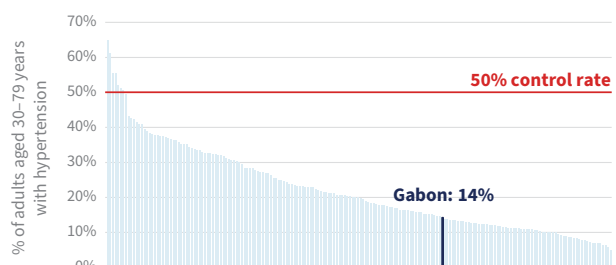


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	18 370	10 450	7920	2021
Cardiovascular disease deaths	2760	1380	1380	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	57	63	2021
Risk of premature death from NCDs (%) ^c	18	20	16	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	20	10	30	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	21	17	25	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Gambia

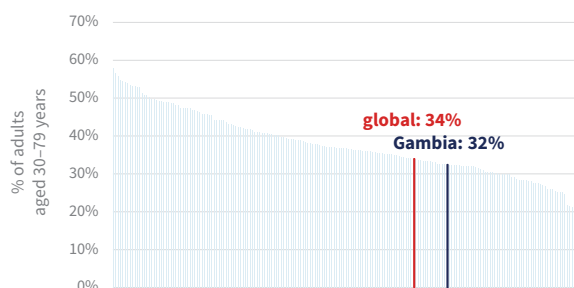
Hypertension profile

Total population (2024): 2 760 000

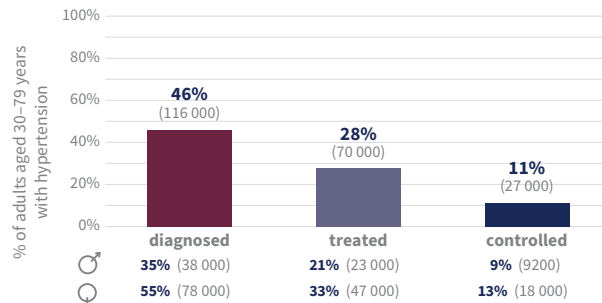
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♀ 29% ♀ 36%

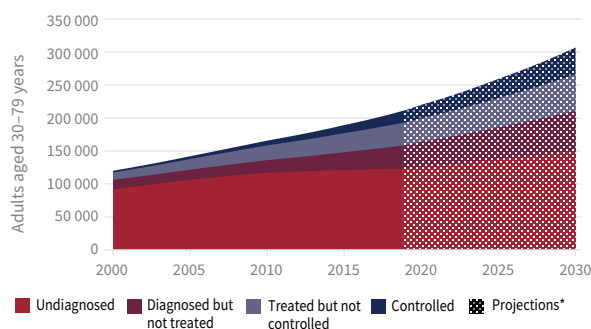
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 250 000 adults aged 30–79 years with hypertension, approximately 223 000 do not have the condition controlled^b

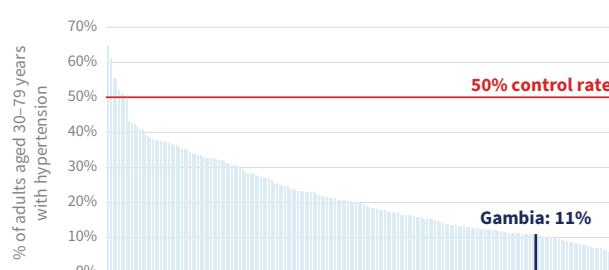


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	17 310	9350	7960	2021
Cardiovascular disease deaths	3090	1450	1640	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	57	62	2021
Risk of premature death from NCDs (%) ^c	22	23	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	11	20	1	2022
Obesity, adults aged 18+ years (%)	13	9	18	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	21	17	25	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Georgia

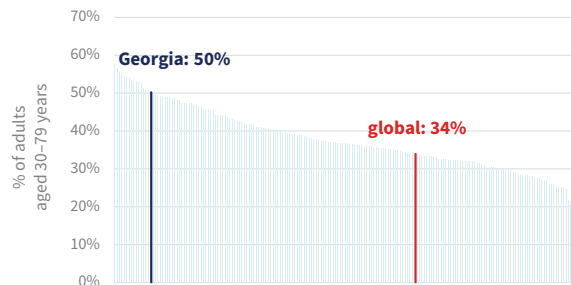
Hypertension profile

Total population (2024): 3 808 000

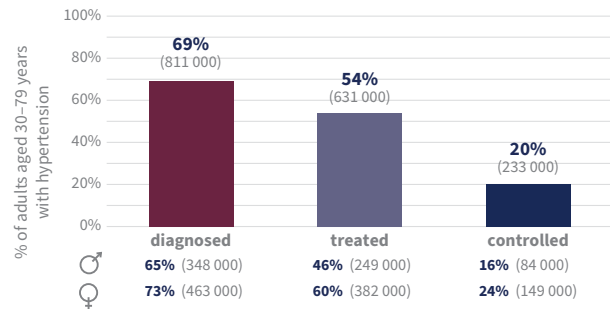
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 50% ♀ 50%

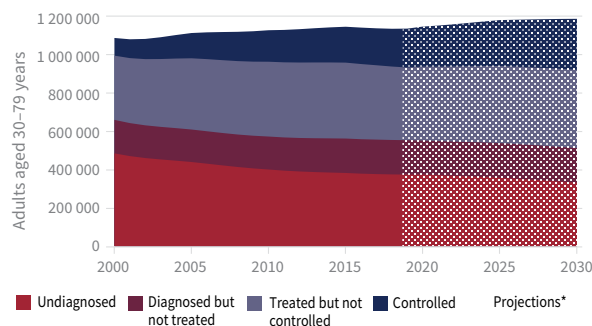
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.2 million adults aged 30–79 years with hypertension, approximately 938 000 do not have the condition controlled^b

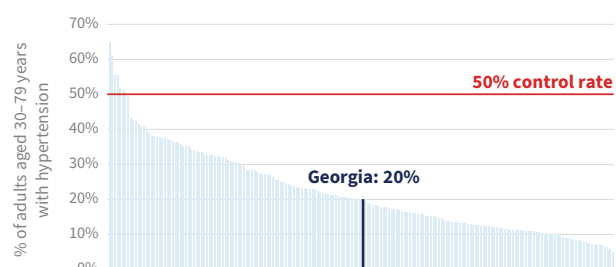


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	63 170	31 440	31 730	2021
Cardiovascular disease deaths	27 550	12 790	14 760	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	64	63	64	2021
Risk of premature death from NCDs (%) ^c	22	33	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	32	56	8	2022
Obesity, adults aged 18+ years (%)	39	35	42	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	16	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	24	24	24	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Germany

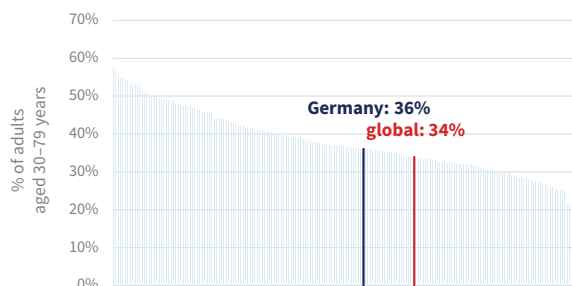
Hypertension profile

Total population (2024): 84 550 000

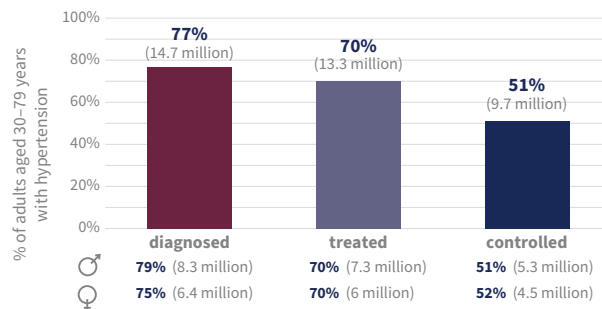
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♀ 40% ♀ 33%

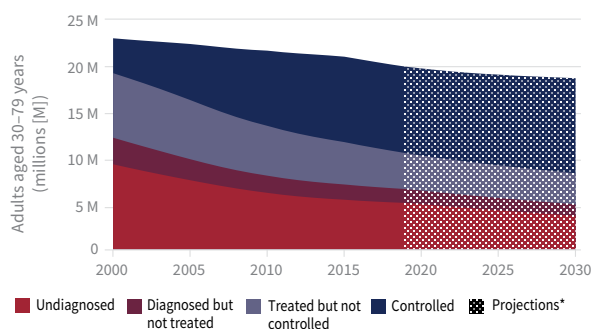
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 19 million adults aged 30–79 years with hypertension, approximately 9.3 million do not have the condition controlled^b

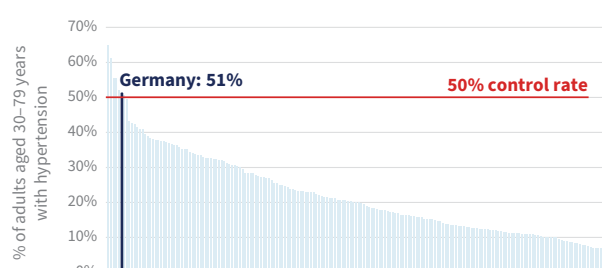


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	1 038 000	524 000	514 500	2021
Cardiovascular disease deaths	350 100	166 000	184 200	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	50	56	2021
Risk of premature death from NCDs (%) ^c	12	15	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	21	23	19	2022
Obesity, adults aged 18+ years (%)	24	26	23	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	12	12	12	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Ghana

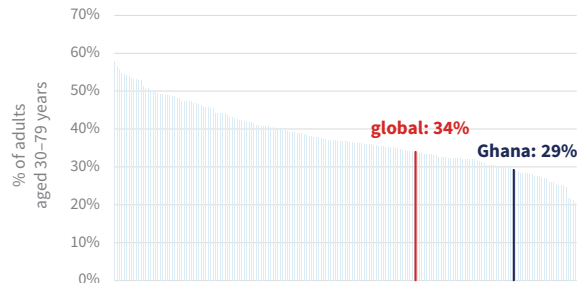
Hypertension profile

Total population (2024): 34 430 000

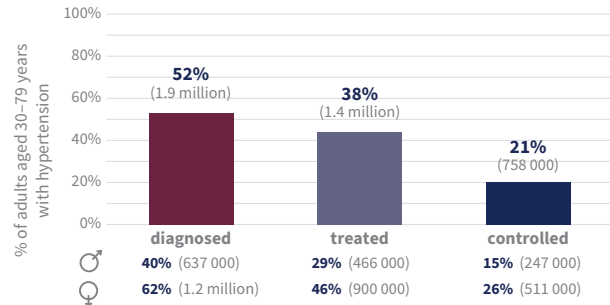
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 29% ♀ 32%

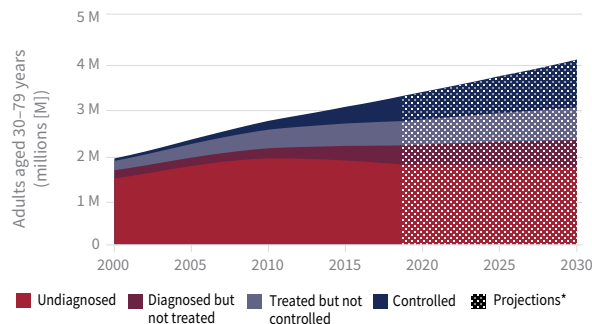
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.6 million adults aged 30–79 years with hypertension, approximately 2.8 million do not have the condition controlled^b

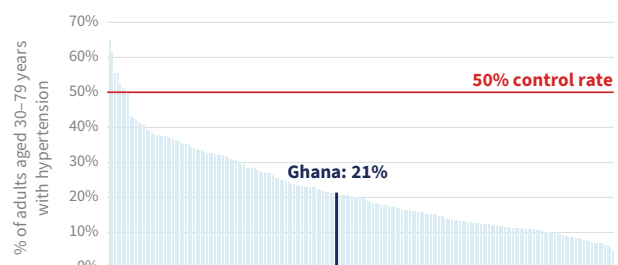


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	217 600	120 100	97 530	2021
Cardiovascular disease deaths	45 760	23 780	21 980	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	52	63	2021
Risk of premature death from NCDs (%) ^c	22	25	20	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	8	8	2021
Current tobacco use, adults aged 15+ years (%)	3	7	0	2022
Obesity, adults aged 18+ years (%)	12	5	19	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	21	18	24	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Greece

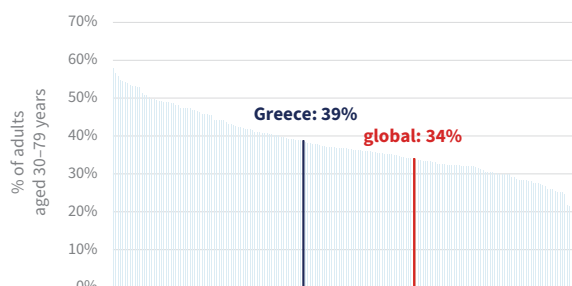
Hypertension profile

Total population (2024): 10 050 000

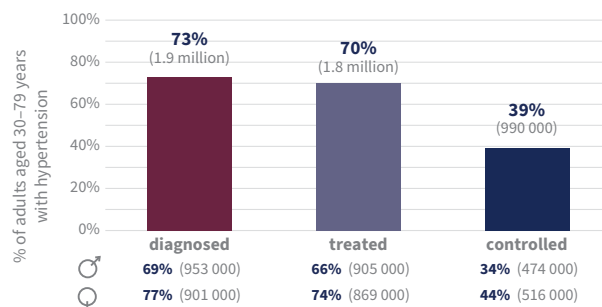
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 39% ♂ 43% ♀ 35%

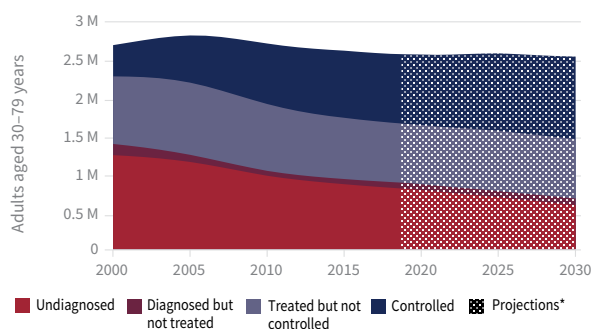
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.5 million adults aged 30–79 years with hypertension, approximately 1.6 million do not have the condition controlled^b

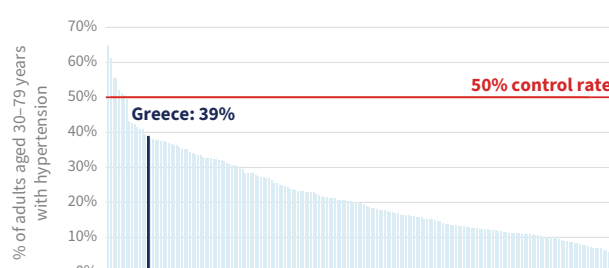


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	156 800	70 060	86 700	2021
Cardiovascular disease deaths	55 110	21 610	33 500	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	47	45	49	2021
Risk of premature death from NCDs (%) ^c	12	16	8	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%)	33	35	31	2022
Obesity, adults aged 18+ years (%)	34	33	34	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	35	33	37	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Grenada

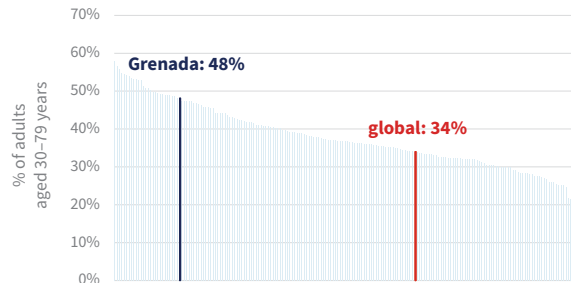
Hypertension profile

Total population (2024): 117 200

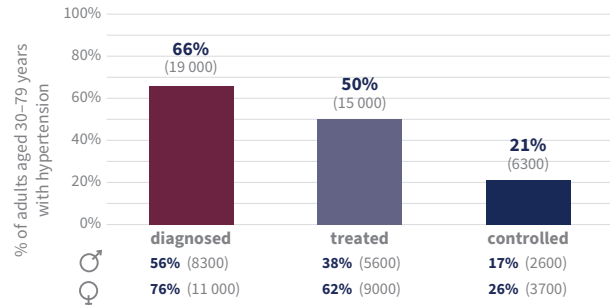
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 48% ♀ 49% ♀ 48%

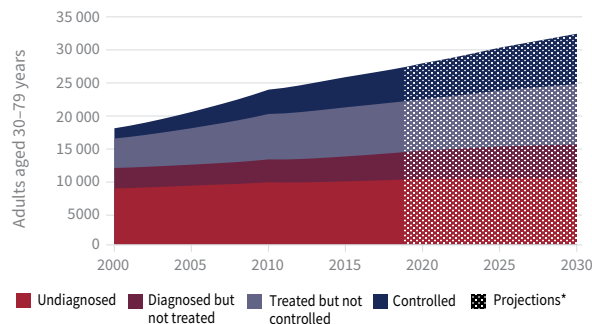
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 29 000 adults aged 30–79 years with hypertension, approximately 23 000 do not have the condition controlled^b

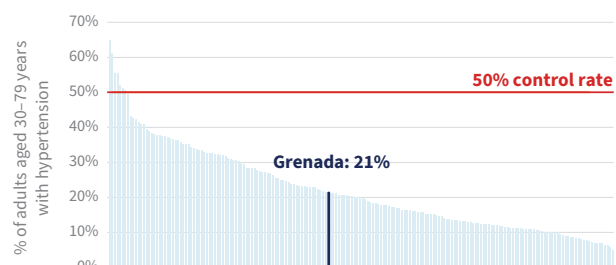


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	1320	700	620	2021
Cardiovascular disease deaths	340	170	170	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	52	51	53	2021
Risk of premature death from NCDs (%) ^c	17	18	16	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	30	19	42	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	36	29	43	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Guatemala

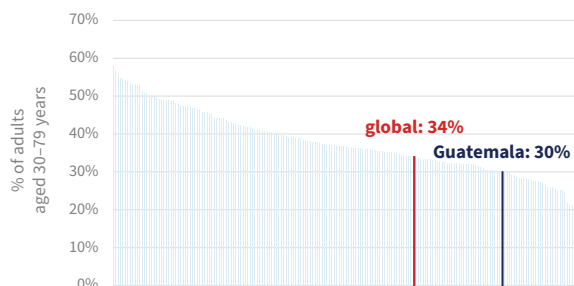
Hypertension profile

Total population (2024): 18 410 000

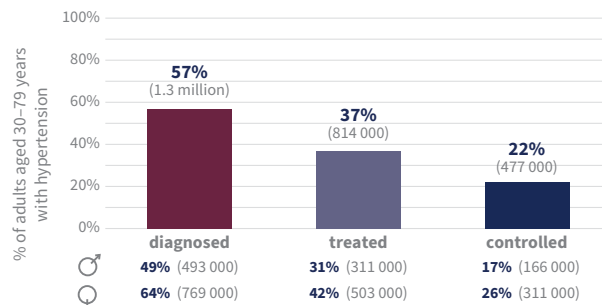
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 30% ♀ 29% ♀ 31%

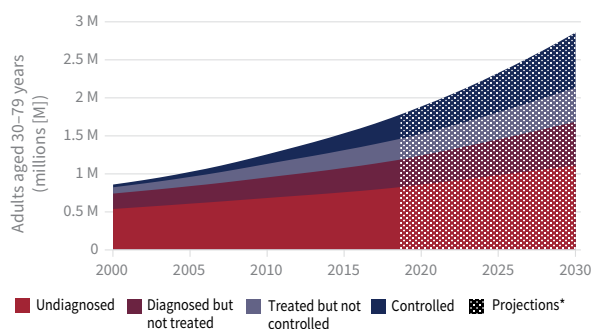
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.2 million adults aged 30–79 years with hypertension, approximately 1.7 million do not have the condition controlled^b

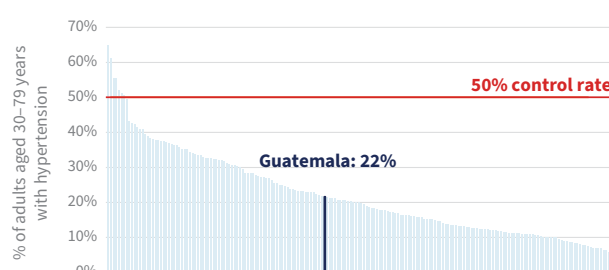


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	109 500	62 930	46 610	2021
Cardiovascular disease deaths	11 710	5320	6390	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	48	46	49	2021
Risk of premature death from NCDs (%) ^c	15	12	16	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%)	12	22	2	2022
Obesity, adults aged 18+ years (%)	25	21	29	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	37	28	45	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Guinea

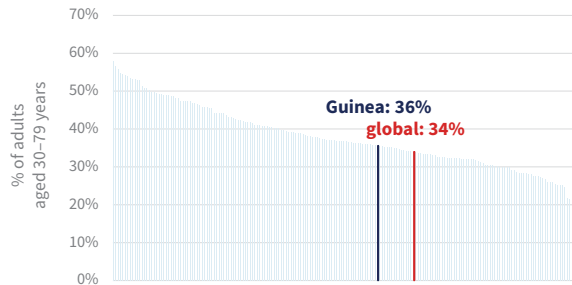
Hypertension profile

Total population (2024): 14 750 000

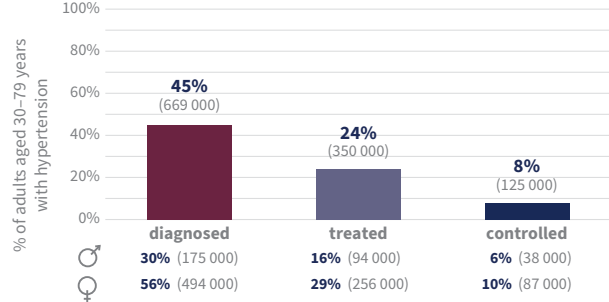
Prevalence of hypertension among adults aged 30–79 years (2024)^a

36% 32% 39%

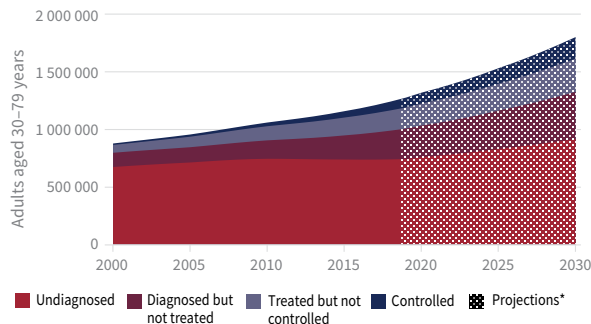
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.5 million adults aged 30–79 years with hypertension, approximately 1.4 million do not have the condition controlled^b

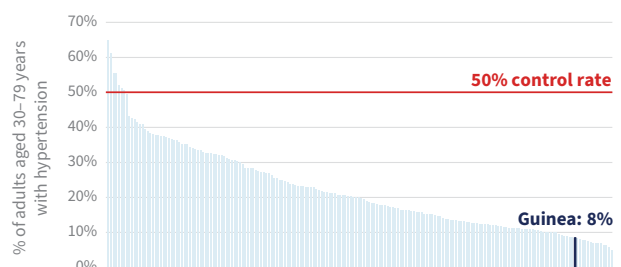


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	121 200	60 980	60 230	2021
Cardiovascular disease deaths	17 780	7390	10 390	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	50	56	2021
Risk of premature death from NCDs (%) ^c	24	23	24	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	8	5	12	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	17	14	19	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Guinea-Bissau

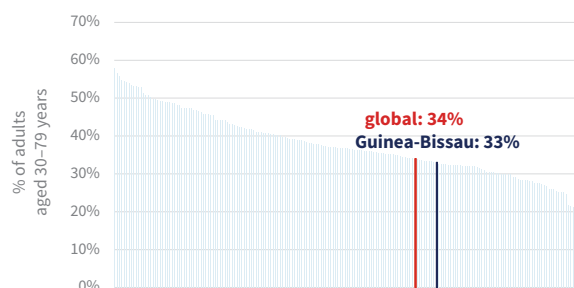
Hypertension profile

Total population (2024): 2 201 000

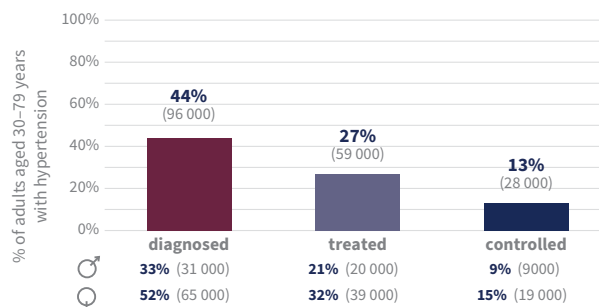
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 33% ♀ 30% ♀ 35%

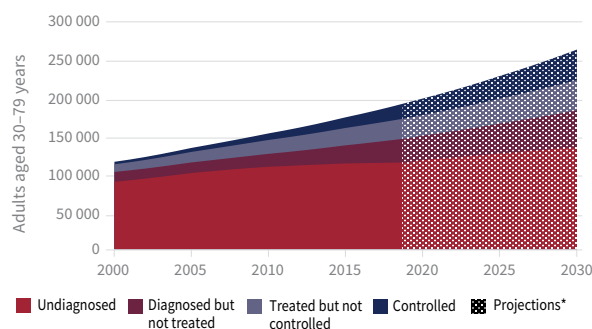
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 219 000 adults aged 30–79 years with hypertension, approximately 191 000 do not have the condition controlled^b

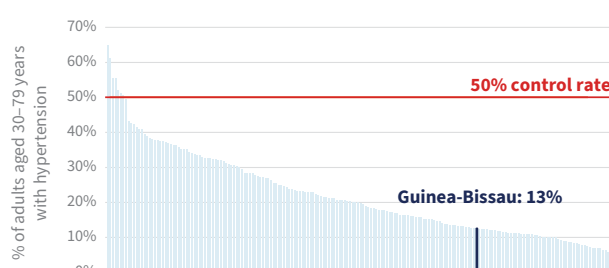


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	19 440	10 250	9 190	2021
Cardiovascular disease deaths	2720	1340	1380	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	54	60	2021
Risk of premature death from NCDs (%) ^c	25	28	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	8	16	1	2022
Obesity, adults aged 18+ years (%)	10	7	13	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	18	15	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Guyana

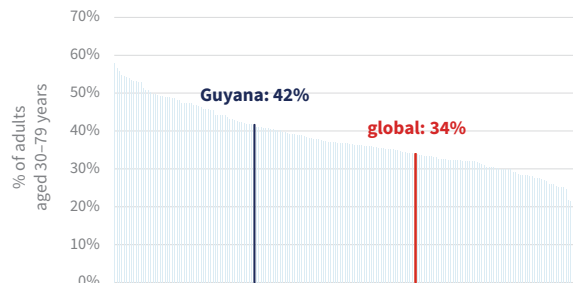
Hypertension profile

Total population (2024): 831 100

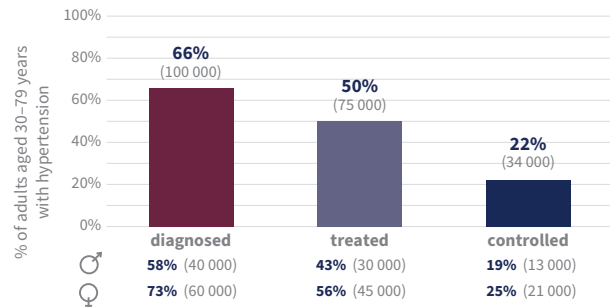
Prevalence of hypertension among adults aged 30–79 years (2024)^a

42% 39% 44%

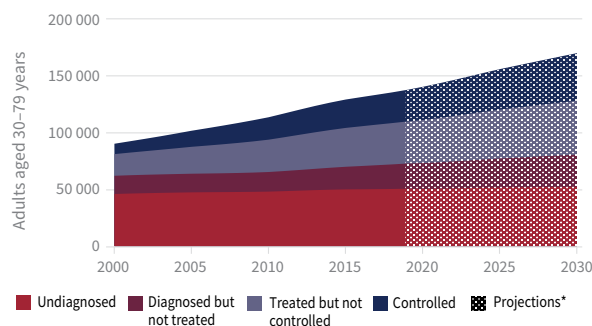
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 151 000 adults aged 30–79 years with hypertension, approximately 117 000 do not have the condition controlled^b

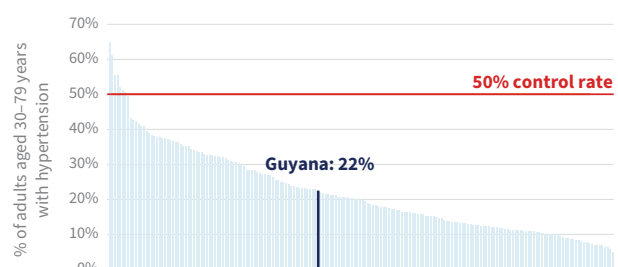


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	7720	4230	3480	2021
Cardiovascular disease deaths	1710	850	850	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	55	57	2021
Risk of premature death from NCDs (%) ^c	25	27	24	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	11	20	2	2022
Obesity, adults aged 18+ years (%)	28	17	38	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	35	24	45	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Haiti

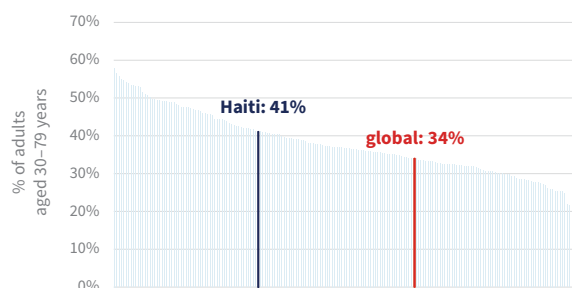
Hypertension profile

Total population (2024): 11 770 000

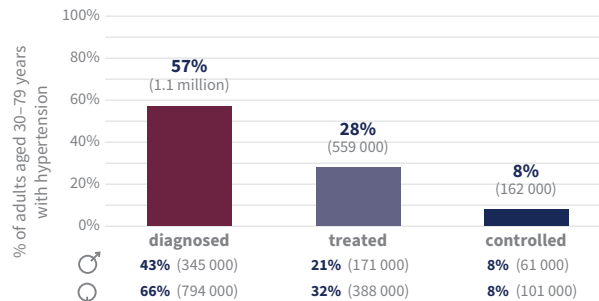
Prevalence of hypertension among adults aged 30–79 years (2024)^a

41% 35% 47%

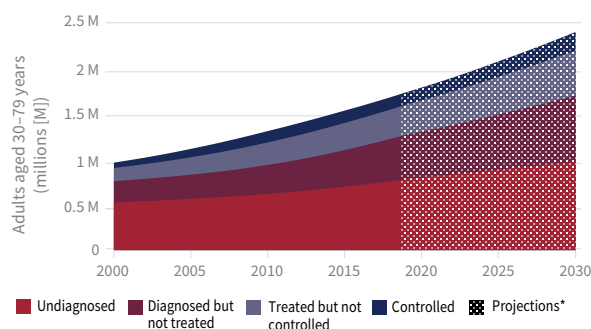
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2 million adults aged 30–79 years with hypertension, approximately 1.8 million do not have the condition controlled^b

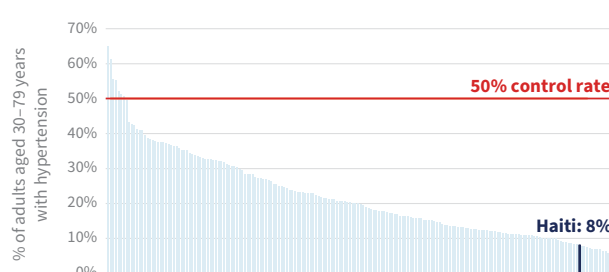


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	102 200	49 400	52 810	2021
Cardiovascular disease deaths	27 830	11 100	16 740	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	52	58	2021
Risk of premature death from NCDs (%) ^c	32	29	34	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	8	14	3	2022
Obesity, adults aged 18+ years (%)	10	6	14	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	28	20	36	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Don't know

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Honduras

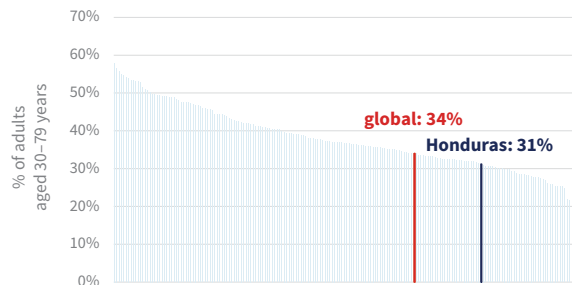
Hypertension profile

Total population (2024): 10 830 000

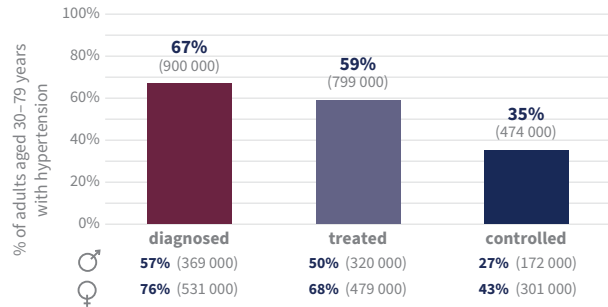
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 31% ♀ 30% ♀ 32%

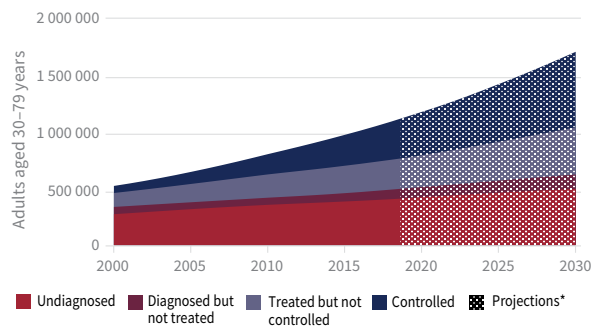
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.3 million adults aged 30–79 years with hypertension, approximately 874 000 do not have the condition controlled^b

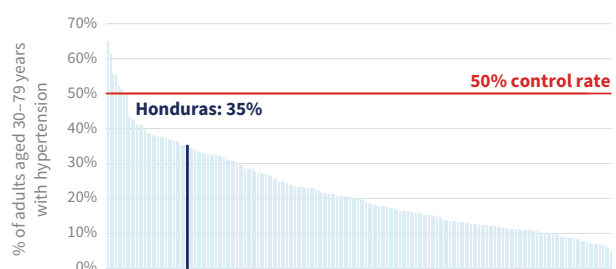


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	61 040	31 780	29 260	2021
Cardiovascular disease deaths	12 090	6 010	6080	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	56	56	2021
Risk of premature death from NCDs (%) ^c	18	19	17	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%) ^d	12	23	2	2022
Obesity, adults aged 18+ years (%)	29	22	35	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	37	31	43	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Hungary

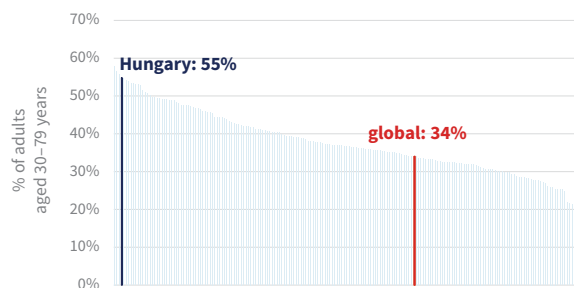
Hypertension profile

Total population (2024): 9 676 000

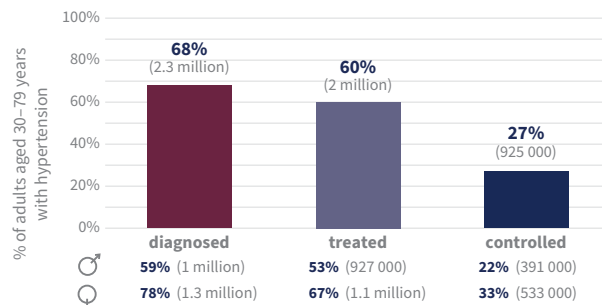
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 55% ♀ 60% 50%

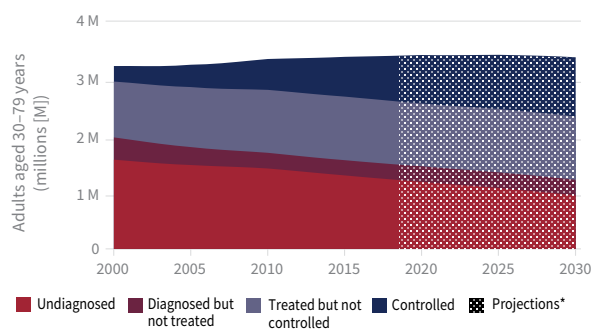
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.4 million adults aged 30–79 years with hypertension, approximately 2.5 million do not have the condition controlled^b

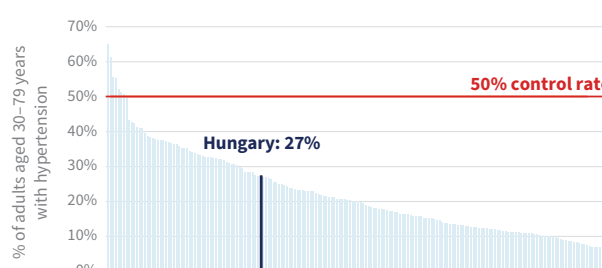


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	153 700	76 830	76 870	2021
Cardiovascular disease deaths	64 760	29 740	35 020	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	63	61	66	2021
Risk of premature death from NCDs (%) ^c	22	29	15	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	14	16	11	2021
Current tobacco use, adults aged 15+ years (%) ^d	32	36	28	2022
Obesity, adults aged 18+ years (%)	36	39	35	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	29	28	31	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Iceland

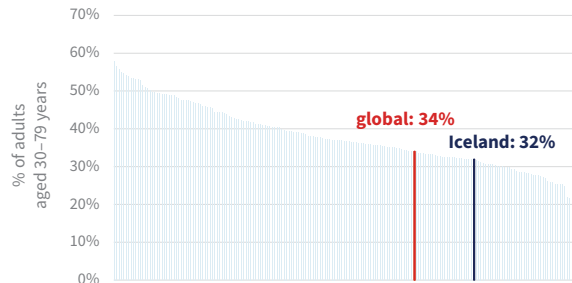
Hypertension profile

Total population (2024): 393 400

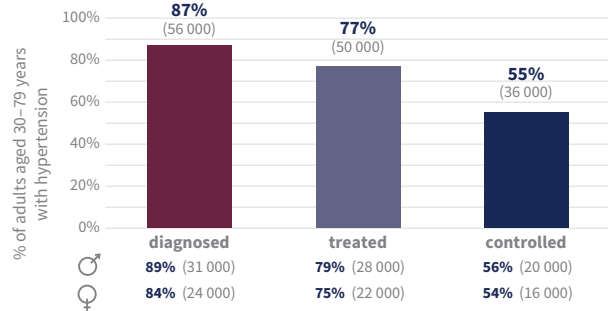
Prevalence of hypertension among adults aged 30–79 years (2024)^a

32% 35% 29%

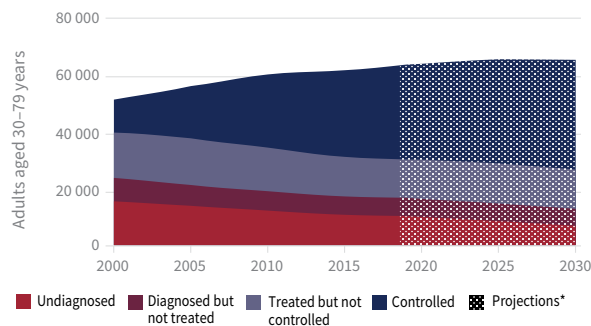
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 64 000 adults aged 30–79 years with hypertension, approximately 29 000 do not have the condition controlled^b

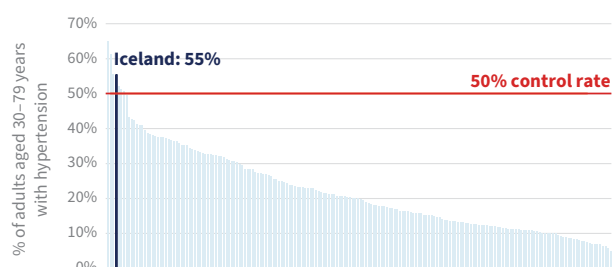


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	2400	1220	1180	2021
Cardiovascular disease deaths	690	360	330	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	47	47	48	2021
Risk of premature death from NCDs (%) ^c	9	9	8	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	9	9	9	2022
Obesity, adults aged 18+ years (%)	23	24	21	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	26	24	28	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

India

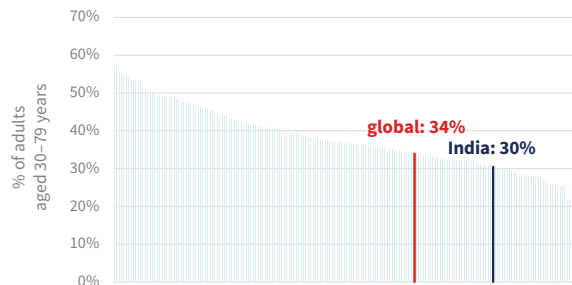
Hypertension profile

Total population (2024): 1 451 000 000

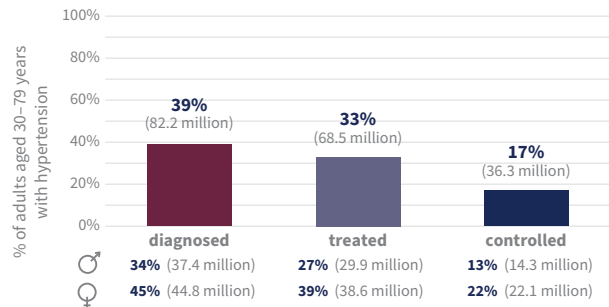
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 30% ♀ 31% ♀ 30%

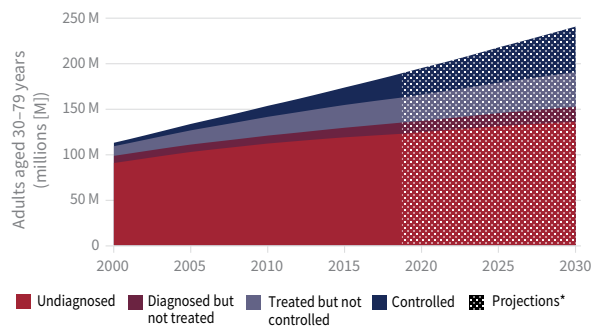
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 210.2 million adults aged 30–79 years with hypertension, approximately 173.9 million do not have the condition controlled^b

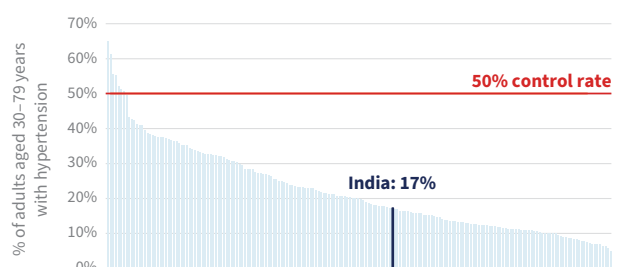


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	13 040 000	7 099 000	5 944 000	2021
Cardiovascular disease deaths	2 785 000	1 427 000	1 358 000	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	48	46	51	2021
Risk of premature death from NCDs (%) ^c	24	24	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	10	9	2021
Current tobacco use, adults aged 15+ years (%)	24	38	11	2022
Obesity, adults aged 18+ years (%)	7	5	9	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	49	42	57	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Indonesia

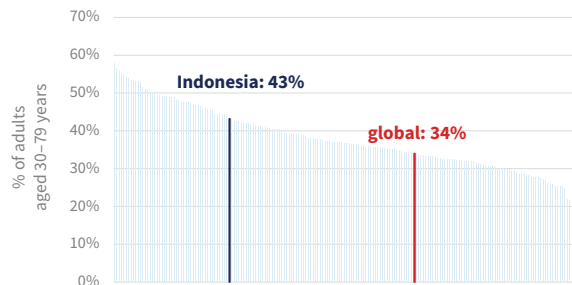
Hypertension profile

Total population (2024): 283 500 000

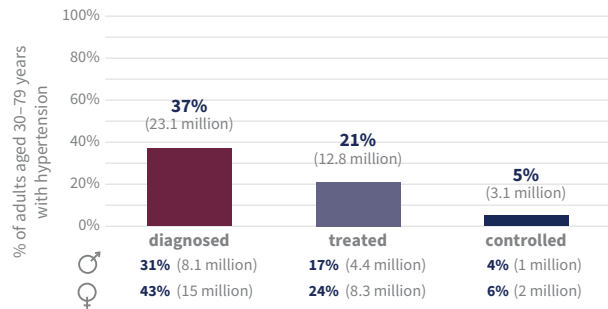
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 43% ♀ 49%

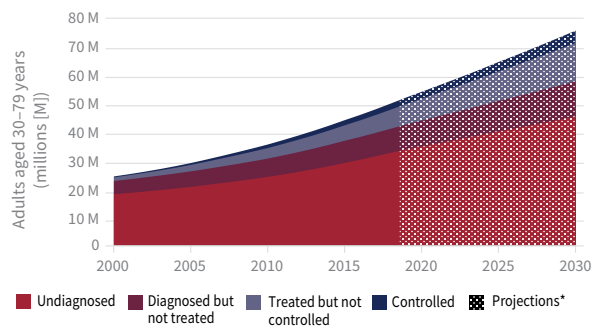
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 61.5 million adults aged 30–79 years with hypertension, approximately 58.5 million do not have the condition controlled^b

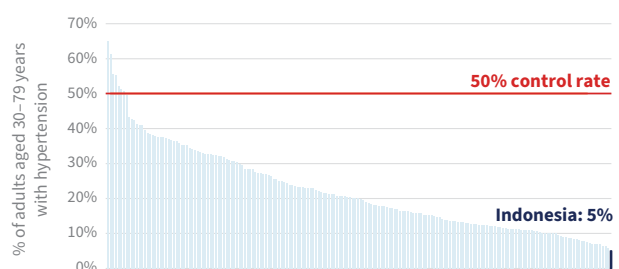


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	2 639 000	1 364 000	1 275 000	2021
Cardiovascular disease deaths	721 700	314 600	407 000	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	67	64	69	2021
Risk of premature death from NCDs (%) ^c	22	23	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%)	38	73	3	2022
Obesity, adults aged 18+ years (%)	12	7	16	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	19	22	16	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Iran (Islamic Republic of)

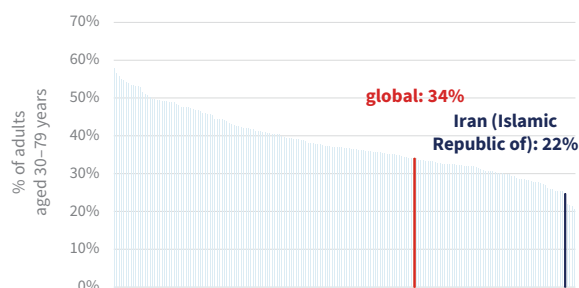
Hypertension profile

Total population (2024): 91 570 000

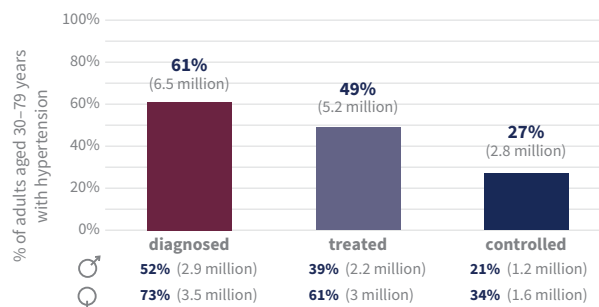
Prevalence of hypertension among adults aged 30–79 years (2024)^a

22% 24% 20%

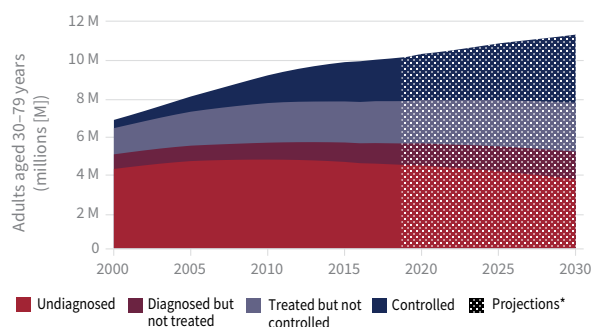
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 10.6 million adults aged 30–79 years with hypertension, approximately 7.7 million do not have the condition controlled^b

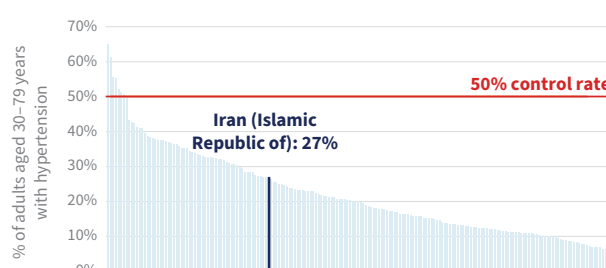


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	515 200	278 100	237 100	2021
Cardiovascular disease deaths	134 200	59 810	74 440	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	51	55	2021
Risk of premature death from NCDs (%) ^c	14	15	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	13	24	3	2022
Obesity, adults aged 18+ years (%)	25	18	32	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	46	36	57	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Iraq

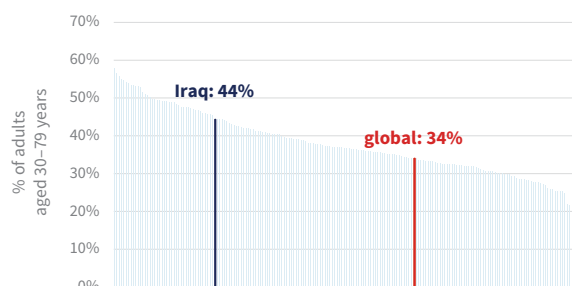
Hypertension profile

Total population (2024): 46 040 000

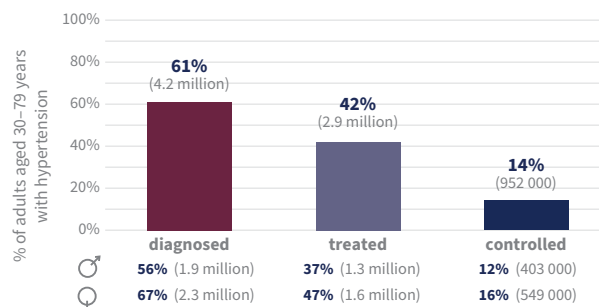
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 44% ♀ 45% ♀ 44%

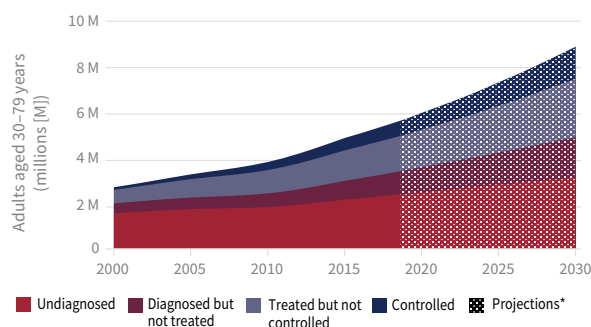
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 6.9 million adults aged 30–79 years with hypertension, approximately 6 million do not have the condition controlled^b

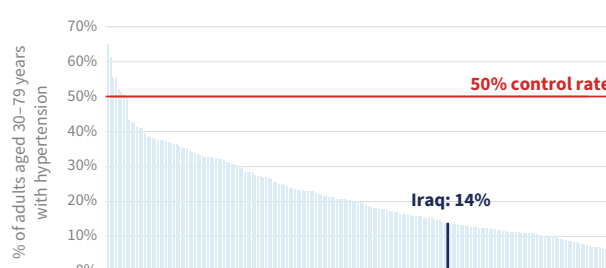


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	185 300	100 600	84 710	2021
Cardiovascular disease deaths	65 350	32 690	32 650	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	62	62	62	2021
Risk of premature death from NCDs (%) ^c	23	27	20	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	19	37	2	2022
Obesity, adults aged 18+ years (%)	37	29	45	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	52	42	62	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Ireland

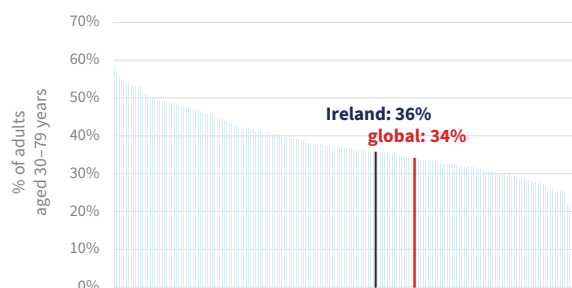
Hypertension profile

Total population (2024): 5 255 000

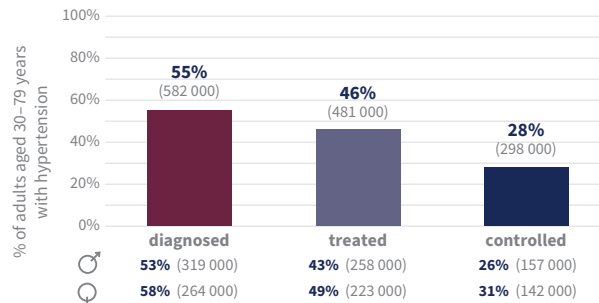
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♂ 41% ♀ 30%

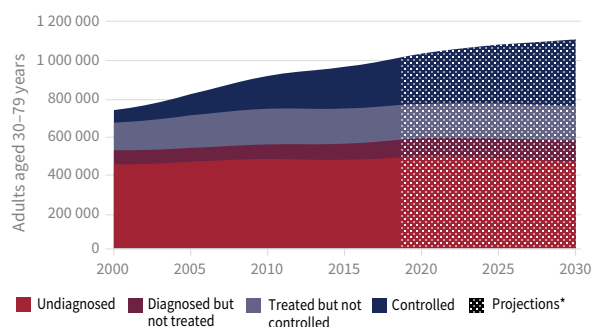
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.1 million adults aged 30–79 years with hypertension, approximately 756 000 do not have the condition controlled^b

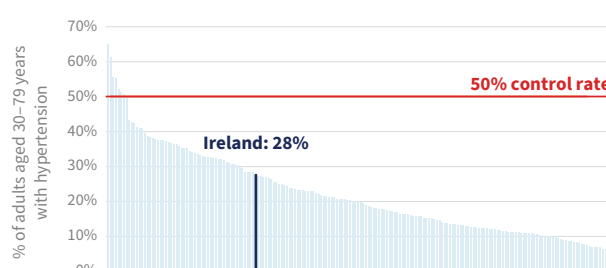


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	35 650	18 630	17 010	2021
Cardiovascular disease deaths	8790	4750	4040	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	48	49	47	2021
Risk of premature death from NCDs (%) ^c	10	11	8	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	9	6	2021
Current tobacco use, adults aged 15+ years (%) ^d	19	22	17	2022
Obesity, adults aged 18+ years (%)	31	32	29	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	22	20	24	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Israel

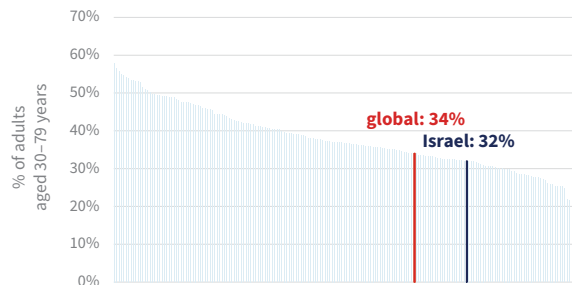
Hypertension profile

Total population (2024): 9 387 000

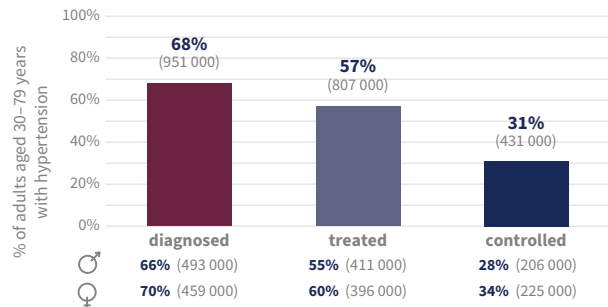
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♂ 35% ♀ 29%

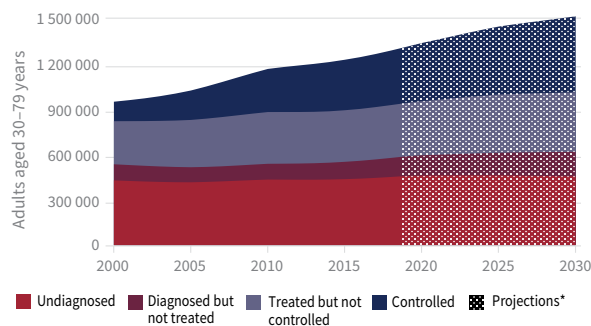
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.4 million adults aged 30–79 years with hypertension, approximately 975 000 do not have the condition controlled^b

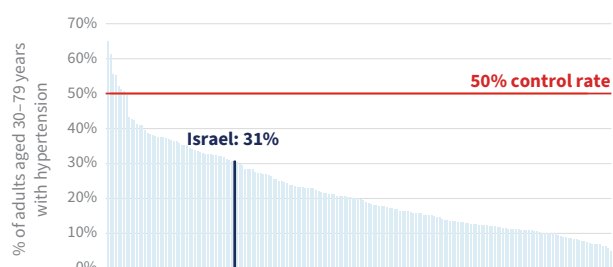


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	53 740	19 540	34 200	2021
Cardiovascular disease deaths	11 650	3540	8100	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	49	48	49	2021
Risk of premature death from NCDs (%) ^c	8	9	6	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	20	27	14	2022
Obesity, adults aged 18+ years (%)	23	24	23	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	27	24	29	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Italy

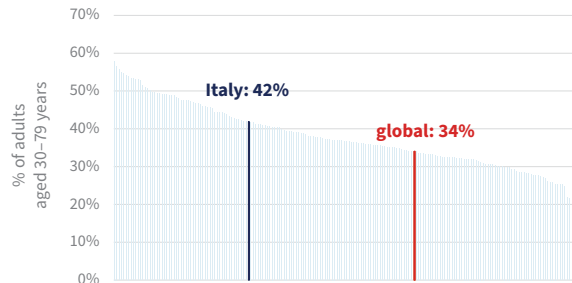
Hypertension profile

Total population (2024): 59 340 000

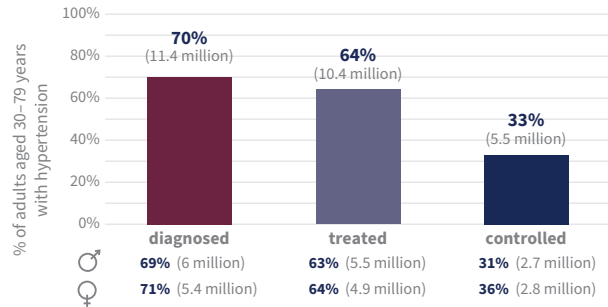
Prevalence of hypertension among adults aged 30–79 years (2024)^a

42% 46% 38%

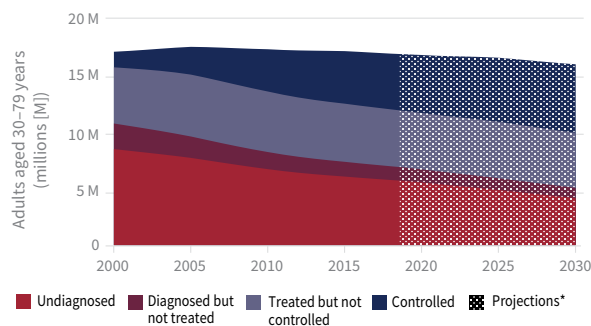
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 16.4 million adults aged 30–79 years with hypertension, approximately 10.9 million do not have the condition controlled^b

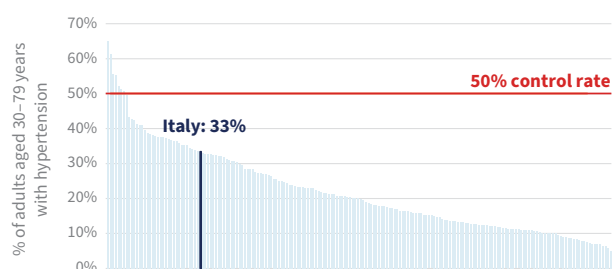


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	710 300	352 600	357 600	2021
Cardiovascular disease deaths	212 100	95 430	116 700	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	48	46	50	2021
Risk of premature death from NCDs (%) ^c	9	11	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%) ^d	22	26	19	2022
Obesity, adults aged 18+ years (%)	22	20	23	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	40	36	44	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Jamaica

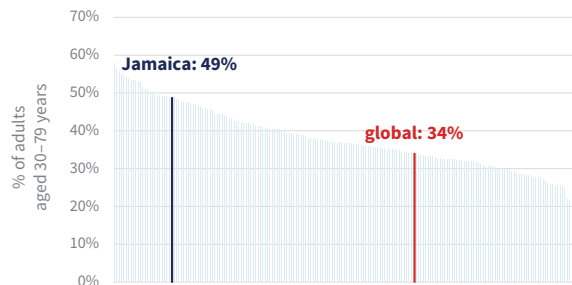
Hypertension profile

Total population (2024): 2 839 000

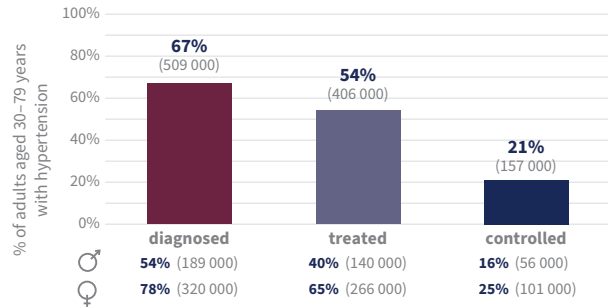
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 49% ♀ 46% 51%

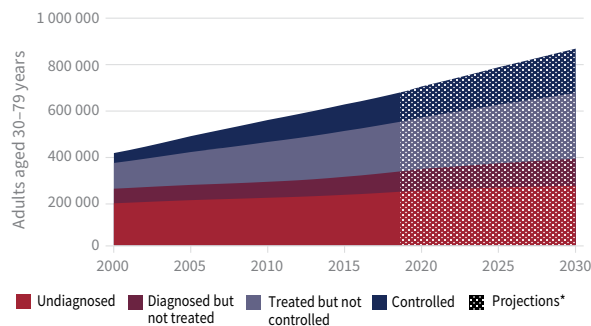
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 756 000 adults aged 30–79 years with hypertension, approximately 600 000 do not have the condition controlled^b

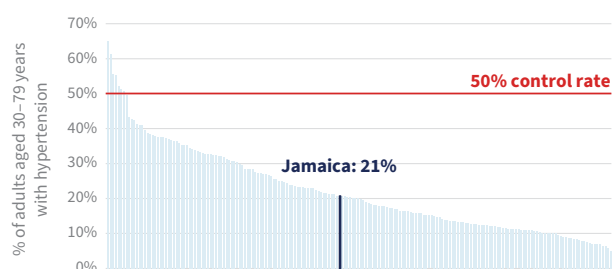


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	26 990	14 430	12 560	2021
Cardiovascular disease deaths	7690	3820	3870	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	55	54	57	2021
Risk of premature death from NCDs (%) ^c	20	23	18	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%) ^d	10	16	4	2022
Obesity, adults aged 18+ years (%)	34	19	49	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	39	31	46	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Japan

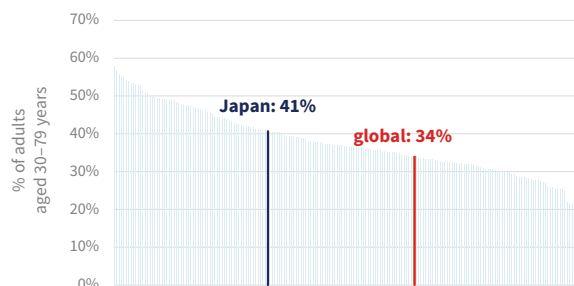
Hypertension profile

Total population (2024): 123 800 000

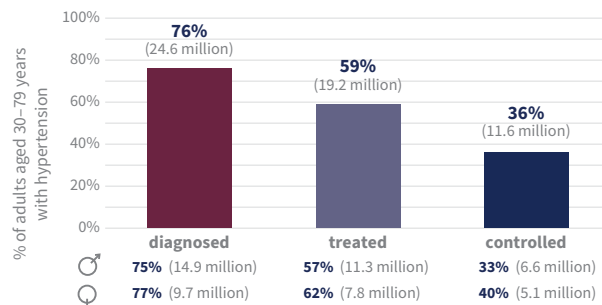
Prevalence of hypertension among adults aged 30–79 years (2024)^a

41% 50% 32%

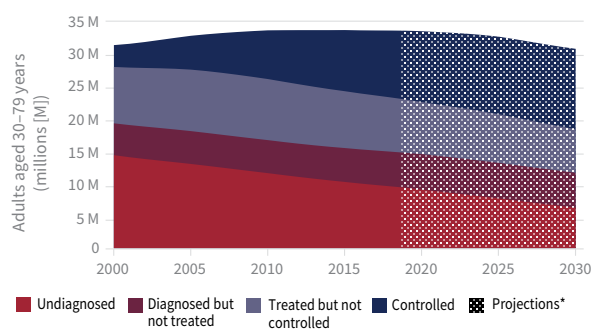
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 32.4 million adults aged 30–79 years with hypertension, approximately 20.8 million do not have the condition controlled^b

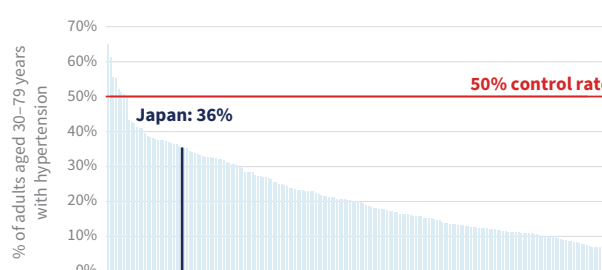


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	1 388 000	719 700	668 100	2021
Cardiovascular disease deaths	394 800	181 800	213 000	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	44	47	41	2021
Risk of premature death from NCDs (%) ^c	8	11	5	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%) ^d	19	29	10	2022
Obesity, adults aged 18+ years (%)	5	6	4	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	45	40	50	2022

National response

Targets

National target for blood pressure
National target for salt consumption

Yes
Yes

Policies

Operational cardiovascular disease policy
Operational salt reduction policy

Yes
Yes

Treatment

Guidelines for management of hypertension

Don't know

Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Jordan

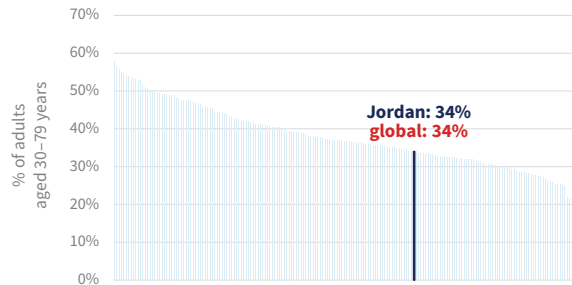
Hypertension profile

Total population (2024): 11 550 000

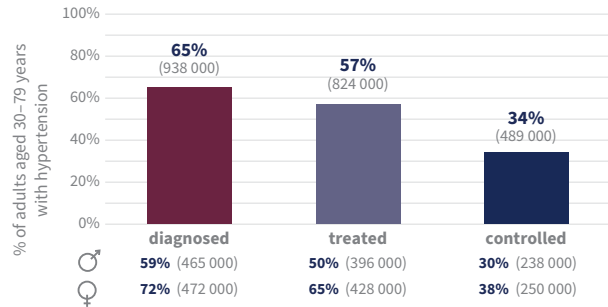
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 34% ♀ 31%

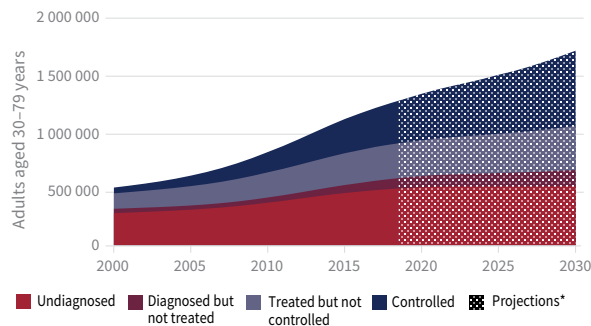
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.4 million adults aged 30–79 years with hypertension, approximately 958 000 do not have the condition controlled^b

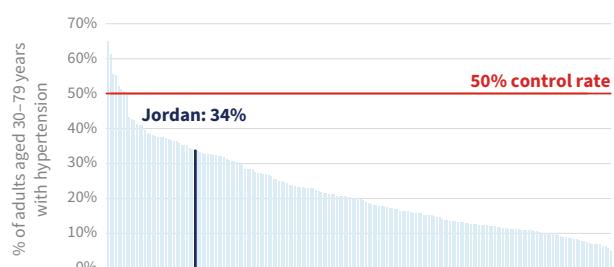


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	39 450	21 330	18 120	2021
Cardiovascular disease deaths	8130	3430	4700	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	56	61	2021
Risk of premature death from NCDs (%) ^c	12	12	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%) ^d	36	58	14	2022
Obesity, adults aged 18+ years (%)	36	31	40	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	28	30	26	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Kazakhstan

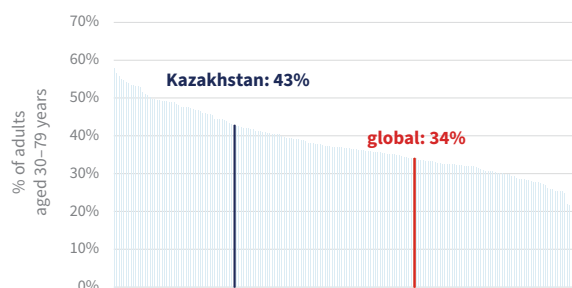
Hypertension profile

Total population (2024): 20 590 000

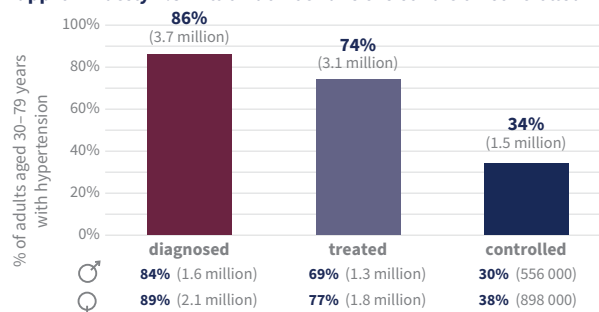
Prevalence of hypertension among adults aged 30–79 years (2024)^a

43% 40% 45%

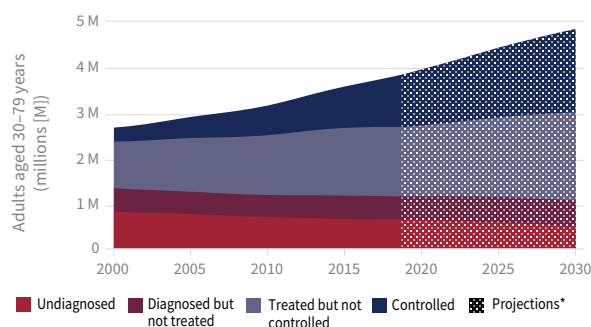
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 4.3 million adults aged 30–79 years with hypertension, approximately 2.8 million do not have the condition controlled^b

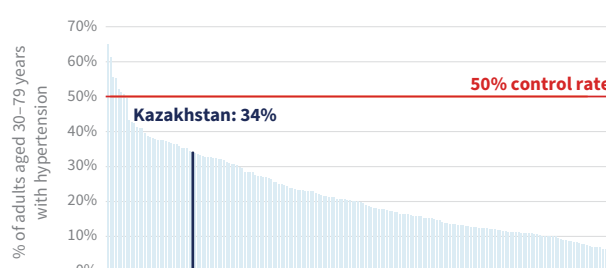


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	186 900	95 830	91 110	2021
Cardiovascular disease deaths	62 910	26 760	36 160	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	53	63	2021
Risk of premature death from NCDs (%) ^c	21	28	15	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	22	37	7	2022
Obesity, adults aged 18+ years (%)	19	19	20	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	28	29	28	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Kenya

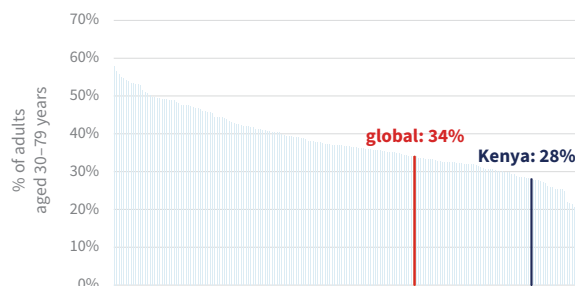
Hypertension profile

Total population (2024): 56 430 000

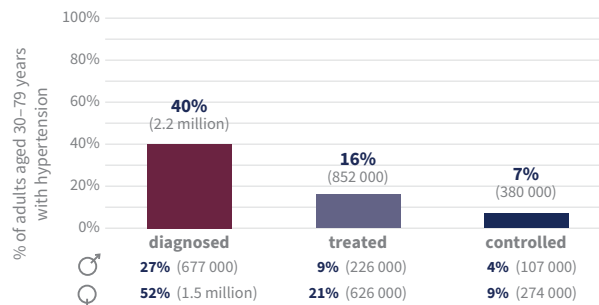
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 28% ♀ 29%

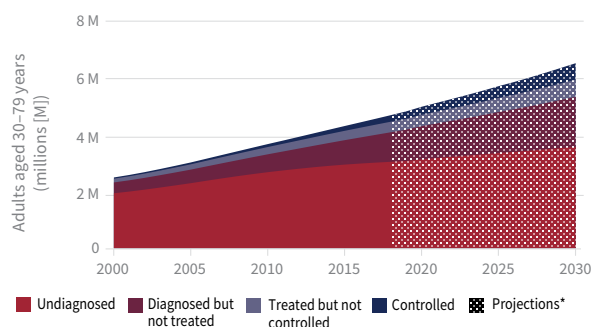
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 5.5 million adults aged 30–79 years with hypertension, approximately 5.1 million do not have the condition controlled^b

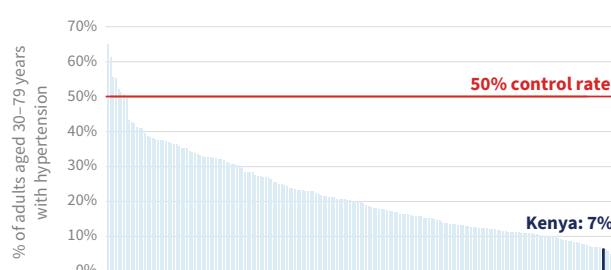


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	306 600	166 500	140 100	2021
Cardiovascular disease deaths	34 870	14 630	20 240	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	54	64	2021
Risk of premature death from NCDs (%) ^c	18	18	18	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	4	8	2021
Current tobacco use, adults aged 15+ years (%)	11	19	3	2022
Obesity, adults aged 18+ years (%)	11	5	17	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	9	8	9	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Kiribati

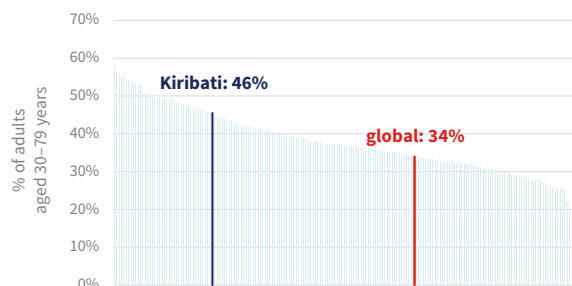
Hypertension profile

Total population (2024): 134 500

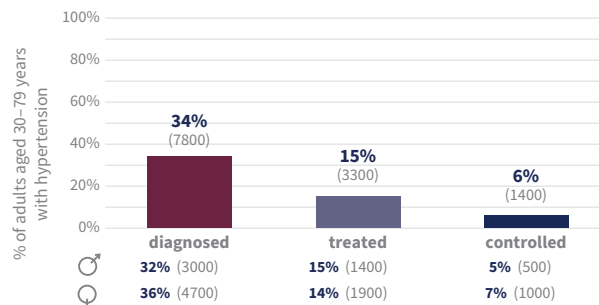
Prevalence of hypertension among adults aged 30–79 years (2024)^a

46% 41% 49%

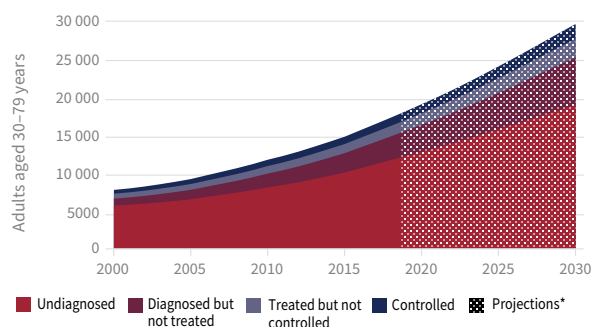
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 23 000 adults aged 30–79 years with hypertension, approximately 21 000 do not have the condition controlled^b

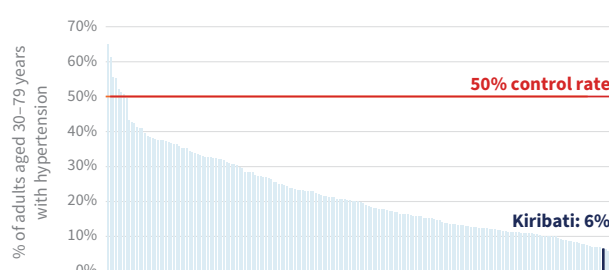


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	1280	670	610	2021
Cardiovascular disease deaths	340	200	130	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	43	46	39	2021
Risk of premature death from NCDs (%) ^c	44	51	38	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	40	53	27	2022
Obesity, adults aged 18+ years (%)	46	36	55	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	32	21	41	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Kuwait

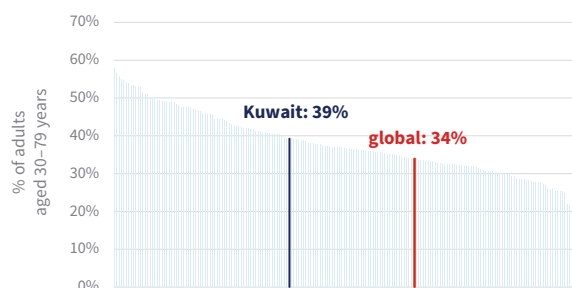
Hypertension profile

Total population (2024): 4 935 000

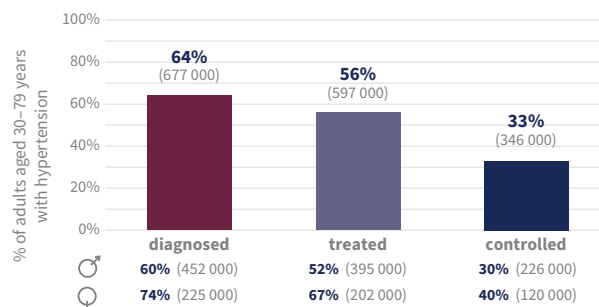
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 39% ♂ 44% ♀ 32%

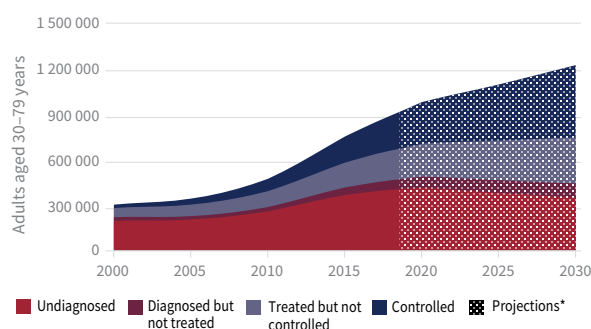
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.1 million adults aged 30–79 years with hypertension, approximately 711 000 do not have the condition controlled^b

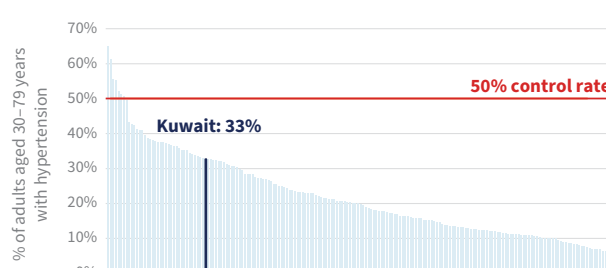


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	11 410	8160	3260	2021
Cardiovascular disease deaths	3370	2880	480	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	51	59	2021
Risk of premature death from NCDs (%) ^c	9	12	5	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	9	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	20	38	2	2022
Obesity, adults aged 18+ years (%)	45	42	52	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	63	62	65	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Kyrgyzstan

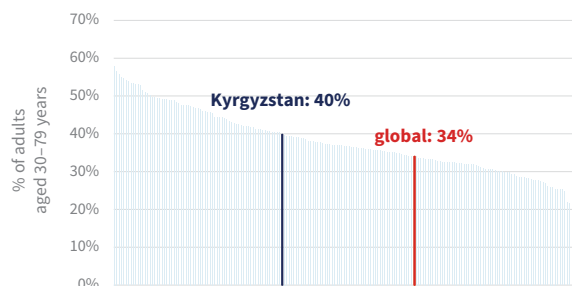
Hypertension profile

Total population (2024): 7 186 000

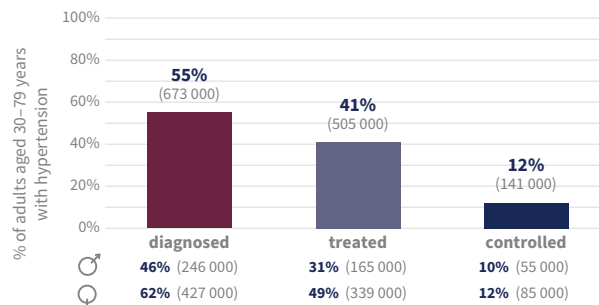
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 40% ♂ 37% ♀ 43%

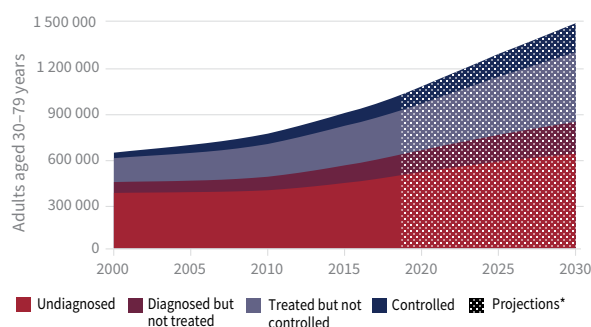
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.2 million adults aged 30–79 years with hypertension, approximately 1.1 million do not have the condition controlled^b

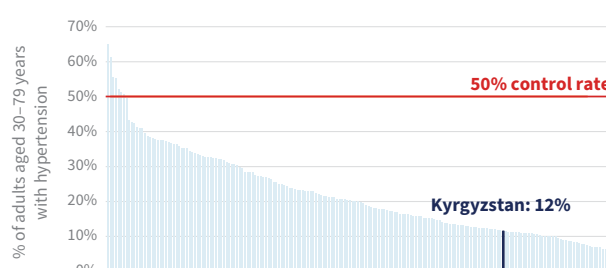


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	38 840	22 660	16 180	2021
Cardiovascular disease deaths	13 350	7440	5910	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	51	57	2021
Risk of premature death from NCDs (%) ^c	19	25	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	27	51	3	2022
Obesity, adults aged 18+ years (%)	24	22	27	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	20	17	22	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Lao People's Democratic Republic

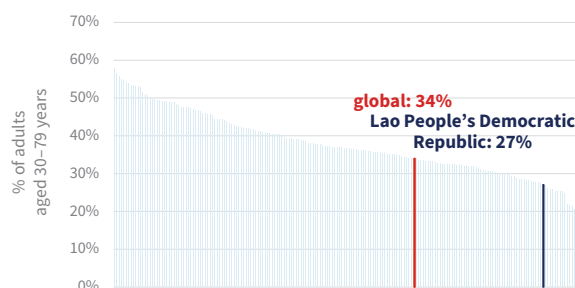
Hypertension profile

Total population (2024): 7 770 000

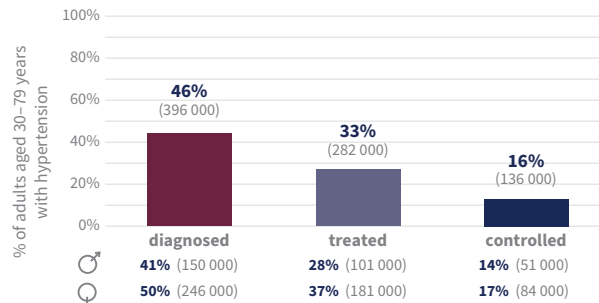
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 27% ♀ 30%

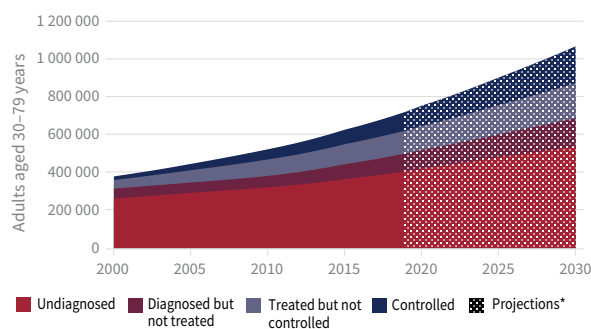
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 858 000 adults aged 30–79 years with hypertension, approximately 723 000 do not have the condition controlled^b

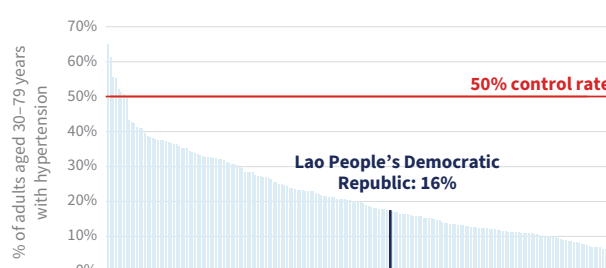


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	47 500	26 150	21 350	2021
Cardiovascular disease deaths	14 030	7240	6790	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	55	56	55	2021
Risk of premature death from NCDs (%) ^c	27	30	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%)	27	45	9	2022
Obesity, adults aged 18+ years (%)	8	6	10	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	16	9	22	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Latvia

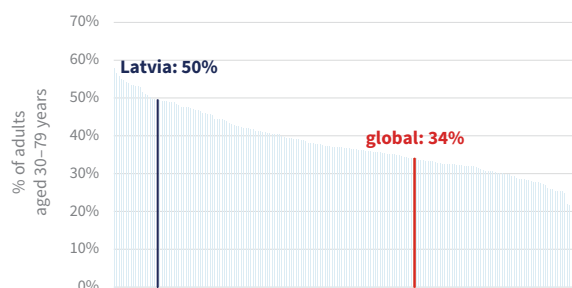
Hypertension profile

Total population (2024): 1 872 000

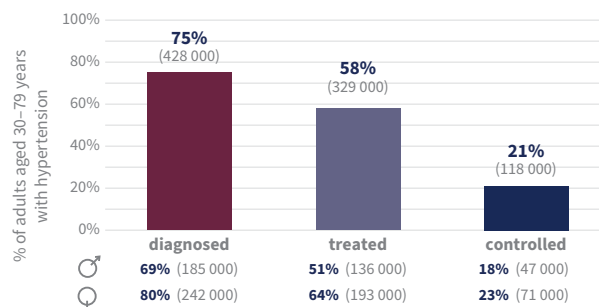
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 50% ♀ 51% ♀ 48%

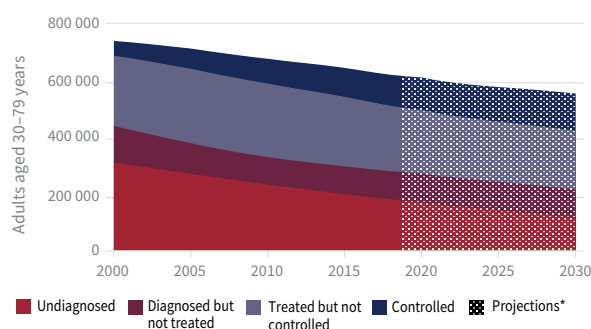
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 572 000 adults aged 30–79 years with hypertension, approximately 453 000 do not have the condition controlled^b

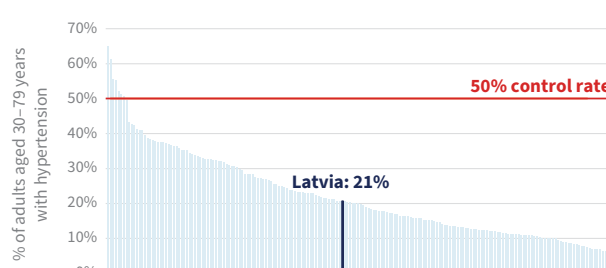


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	34 390	16 050	18 340	2021
Cardiovascular disease deaths	17 310	7240	10 060	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	54	61	2021
Risk of premature death from NCDs (%) ^c	23	33	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	6	2021
Current tobacco use, adults aged 15+ years (%)	34	47	21	2022
Obesity, adults aged 18+ years (%)	30	28	32	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	15	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	14	15	14	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Lebanon

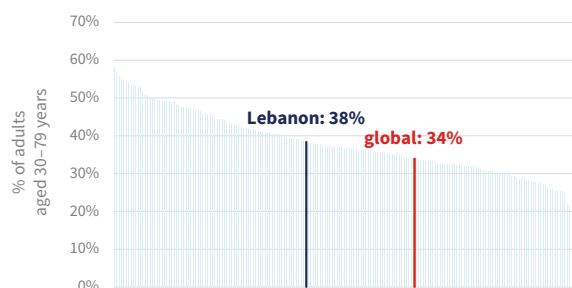
Hypertension profile

Total population (2024): 5 806 000

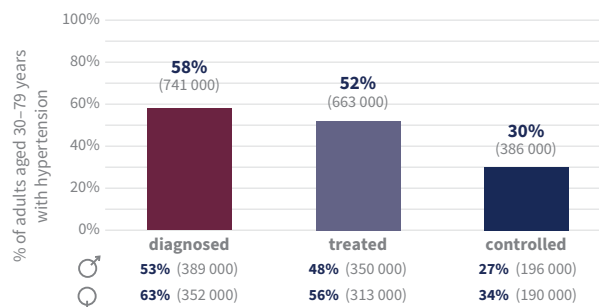
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 38% ♂ 43% ♀ 33%

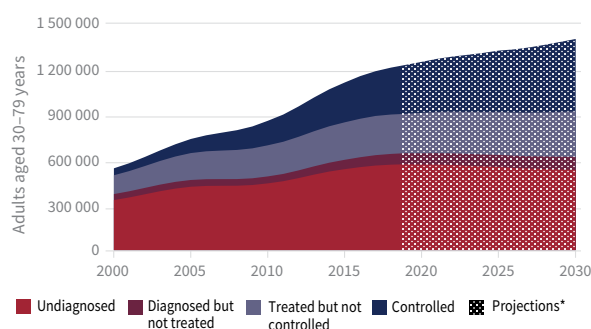
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.3 million adults aged 30–79 years with hypertension, approximately 901 000 do not have the condition controlled^b

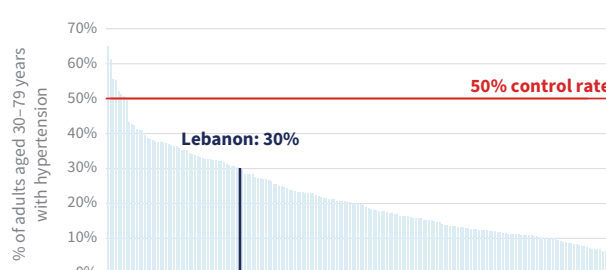


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	43 890	24 220	19 670	2021
Cardiovascular disease deaths	8610	4690	3920	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	51	53	49	2021
Risk of premature death from NCDs (%) ^c	12	15	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%) ^d	34	43	26	2022
Obesity, adults aged 18+ years (%)	31	29	33	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	59	58	59	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Lesotho

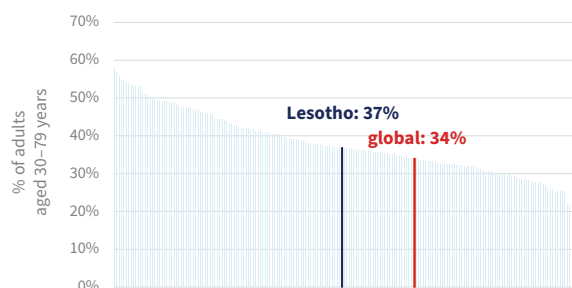
Hypertension profile

Total population (2024): 2 337 000

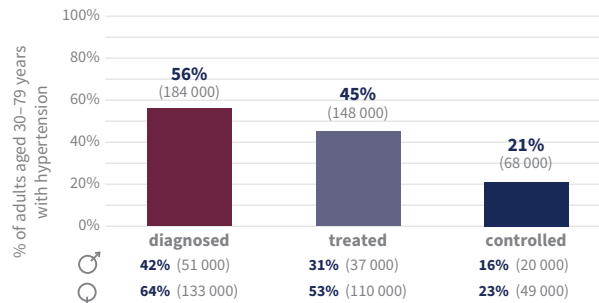
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♀ 45%

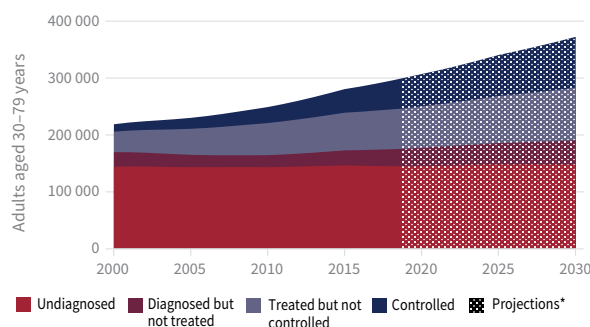
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 329 000 adults aged 30–79 years with hypertension, approximately 261 000 do not have the condition controlled^b

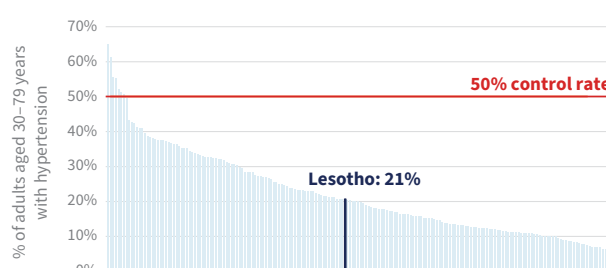


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	33 440	17 290	16 150	2021
Cardiovascular disease deaths	4810	1890	2920	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	54	63	2021
Risk of premature death from NCDs (%) ^c	36	40	34	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	24	44	5	2022
Obesity, adults aged 18+ years (%)	19	7	31	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	8	9	7	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Liberia

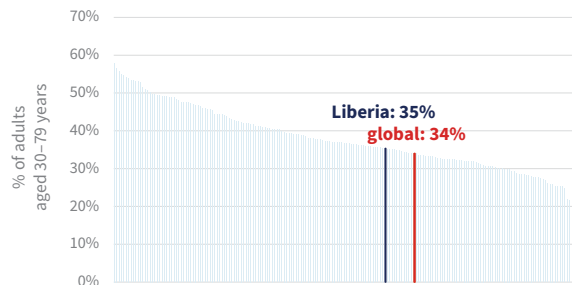
Hypertension profile

Total population (2024): 5 613 000

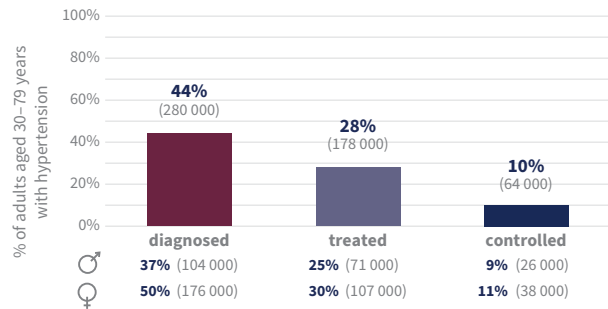
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 35% ♂ 32% ♀ 39%

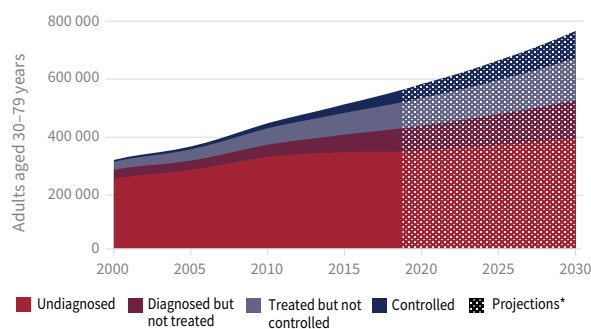
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 635 000 adults aged 30–79 years with hypertension, approximately 571 000 do not have the condition controlled^b

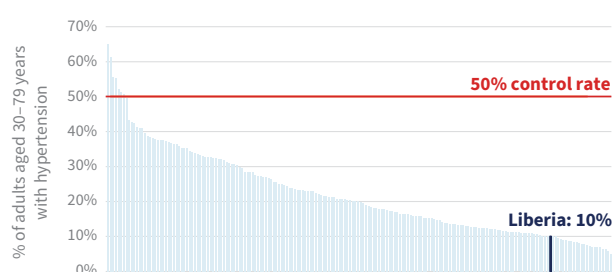


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	39 370	20 110	19 250	2021
Cardiovascular disease deaths	5810	2530	3280	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	57	60	2021
Risk of premature death from NCDs (%) ^c	22	20	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	8	15	2	2022
Obesity, adults aged 18+ years (%)	16	12	20	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	15	14	16	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Libya

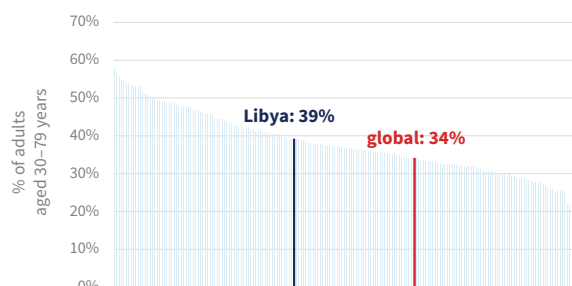
Hypertension profile

Total population (2024): 7 381 000

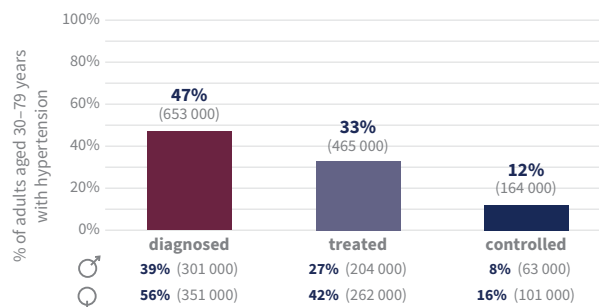
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 39% ♂ 43% ♀ 35%

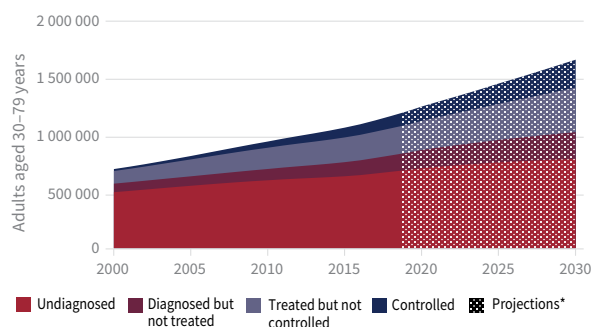
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.4 million adults aged 30–79 years with hypertension, approximately 1.2 million do not have the condition controlled^b

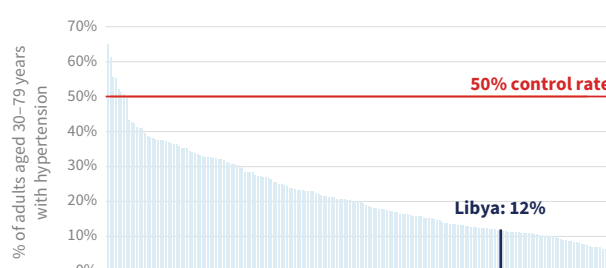


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	40 690	22 520	18 170	2021
Cardiovascular disease deaths	12 480	6330	6150	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	58	60	2021
Risk of premature death from NCDs (%) ^c	20	21	18	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	36	27	45	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	46	37	54	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Lithuania

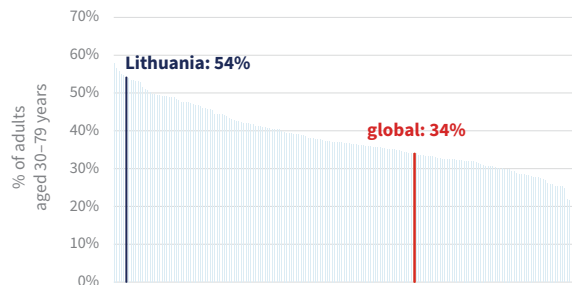
Hypertension profile

Total population (2024): 2 859 000

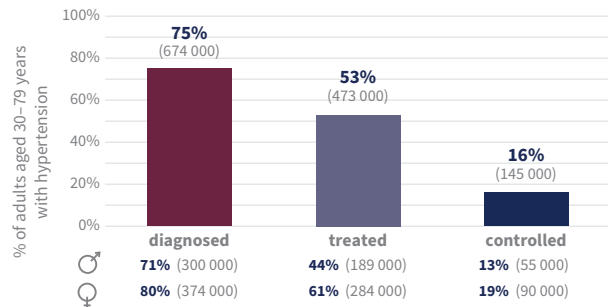
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 54% ♀ 56% 52%

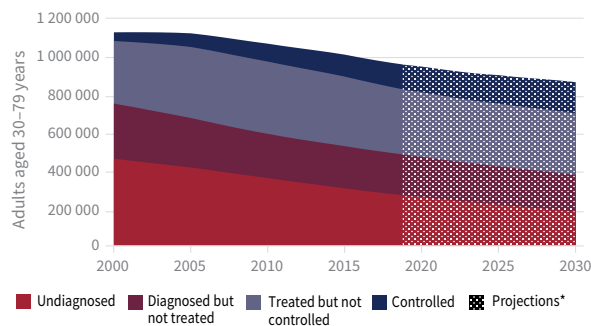
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 892 000 adults aged 30–79 years with hypertension, approximately 748 000 do not have the condition controlled^b

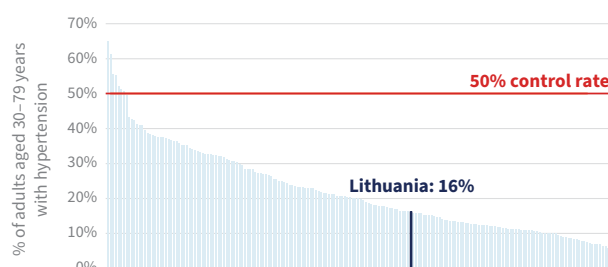


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	48 020	22 540	25 480	2021
Cardiovascular disease deaths	23 880	9880	13 990	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	57	60	2021
Risk of premature death from NCDs (%) ^c	20	29	12	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	31	41	22	2022
Obesity, adults aged 18+ years (%)	31	30	32	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	12	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	20	21	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Luxembourg

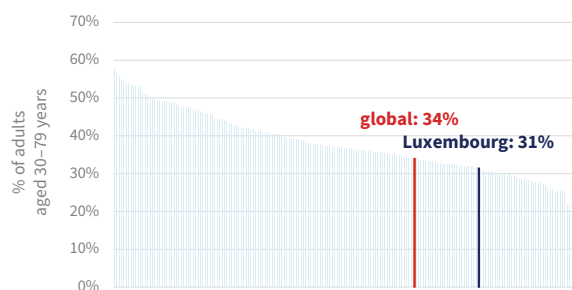
Hypertension profile

Total population (2024): 673 000

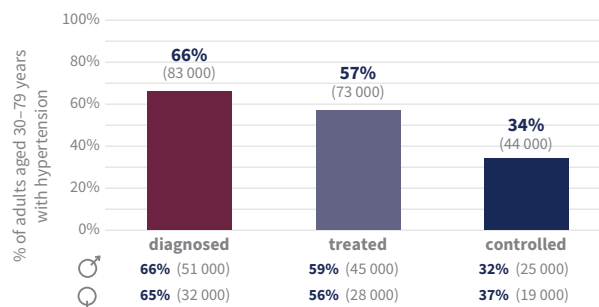
Prevalence of hypertension among adults aged 30–79 years (2024)^a

31% 37% 25%

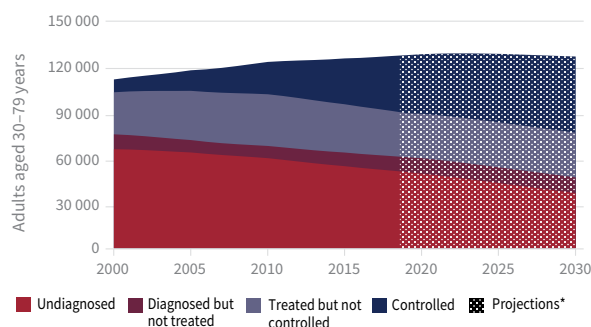
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 127 000 adults aged 30–79 years with hypertension, approximately 83 000 do not have the condition controlled^b

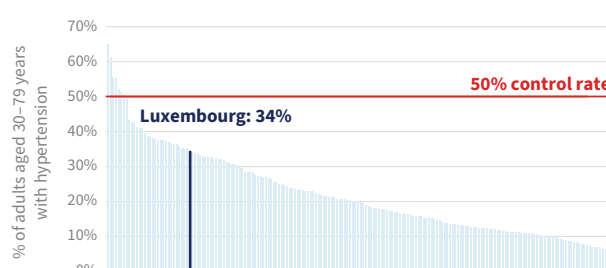


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	4340	2210	2120	2021
Cardiovascular disease deaths	1060	530	530	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	47	48	45	2021
Risk of premature death from NCDs (%) ^c	8	10	6	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	23	24	22	2022
Obesity, adults aged 18+ years (%)	20	22	18	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	14	14	14	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Madagascar

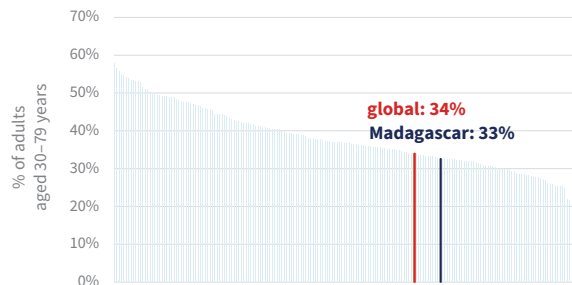
Hypertension profile

Total population (2024): 31 960 000

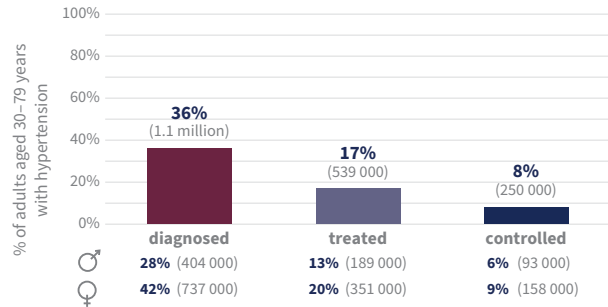
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 33% ♀ 30% 35%

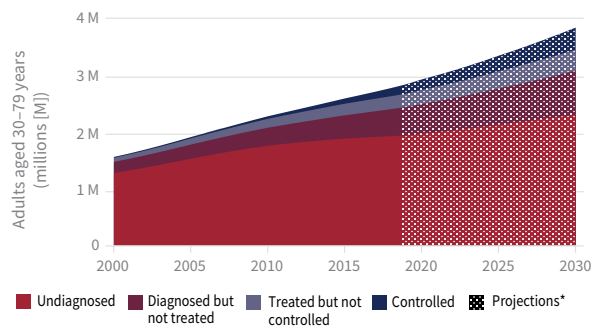
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.2 million adults aged 30–79 years with hypertension, approximately 3 million do not have the condition controlled^b

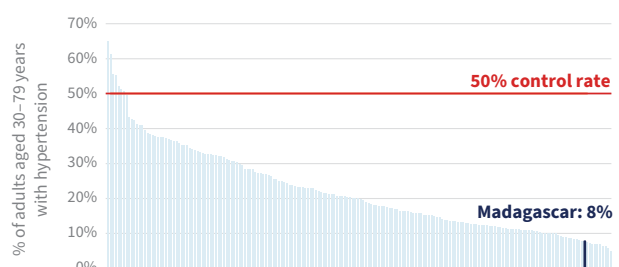


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	229 300	118 900	110 400	2021
Cardiovascular disease deaths	44 670	21 730	22 950	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	50	62	2021
Risk of premature death from NCDs (%) ^c	26	26	26	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	27	43	11	2022
Obesity, adults aged 18+ years (%)	4	4	4	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	14	13	15	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Malawi

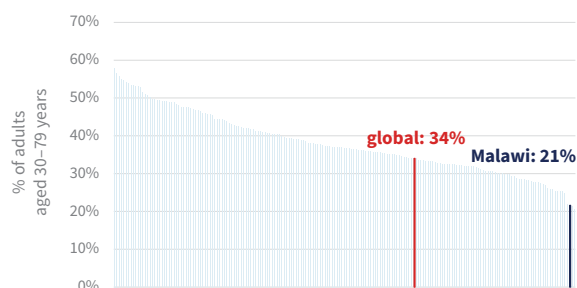
Hypertension profile

Total population (2024): 21 660 000

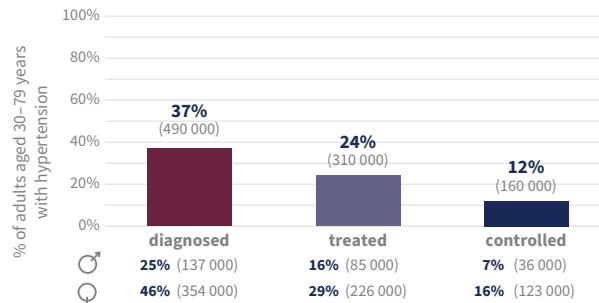
Prevalence of hypertension among adults aged 30–79 years (2024)^a

21% 19% 24%

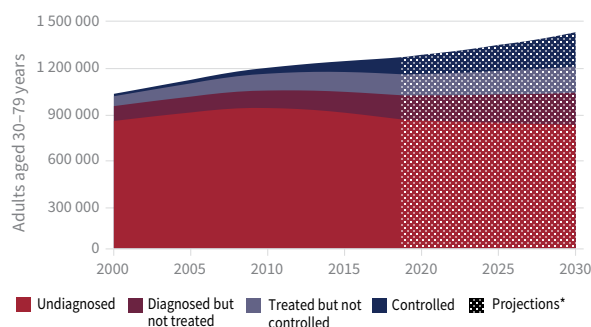
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.3 million adults aged 30–79 years with hypertension, approximately 1.2 million do not have the condition controlled^b

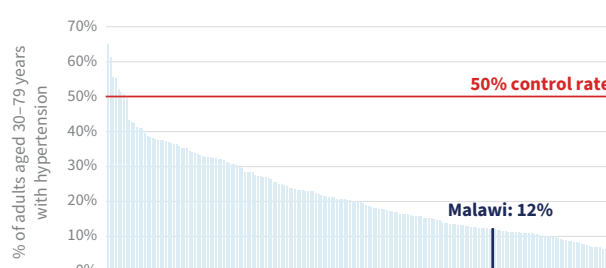


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	142 400	75 560	66 880	2021
Cardiovascular disease deaths	19 870	9670	10 200	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	56	65	2021
Risk of premature death from NCDs (%) ^c	25	27	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	10	16	3	2022
Obesity, adults aged 18+ years (%)	6	2	10	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	3	2	3	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Malaysia

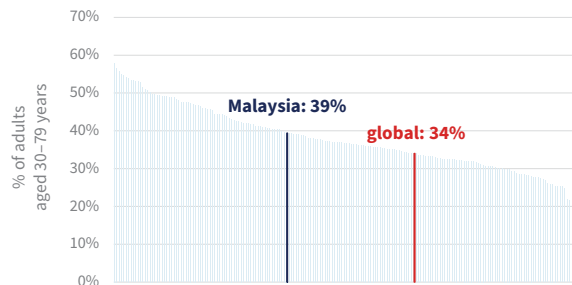
Hypertension profile

Total population (2024): 35 560 000

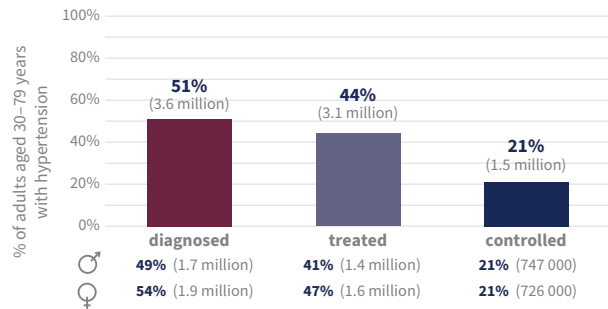
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 39% ♀ 40%

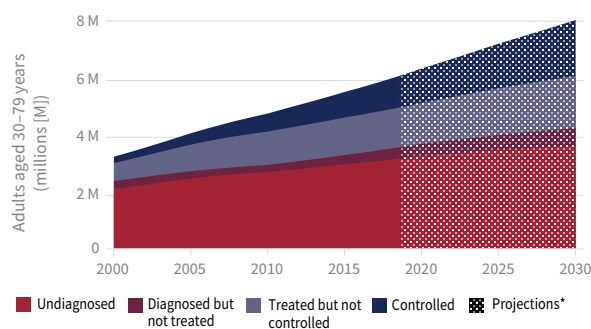
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 6.9 million adults aged 30–79 years with hypertension, approximately 5.5 million do not have the condition controlled^b

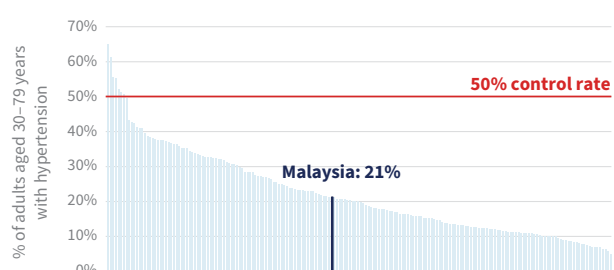


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	235 400	132 800	102 600	2021
Cardiovascular disease deaths	73 370	40 650	32 720	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	62	61	64	2021
Risk of premature death from NCDs (%) ^c	20	24	16	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%)	22	43	1	2022
Obesity, adults aged 18+ years (%)	22	18	27	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	40	37	42	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Maldives

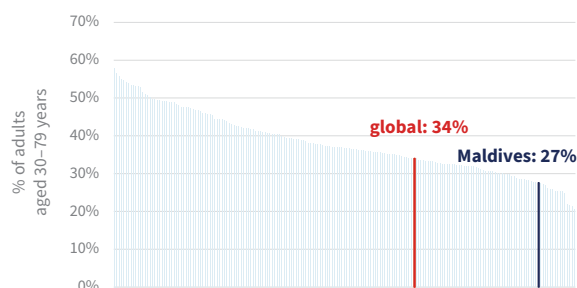
Hypertension profile

Total population (2024): 527 800

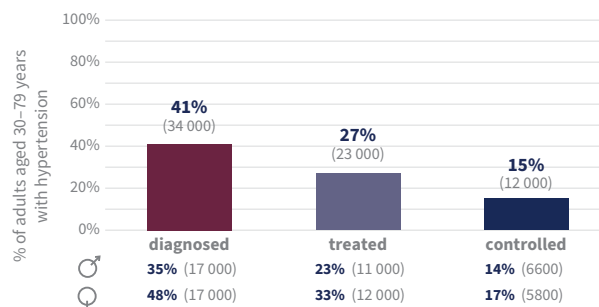
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 27% ♀ 32%

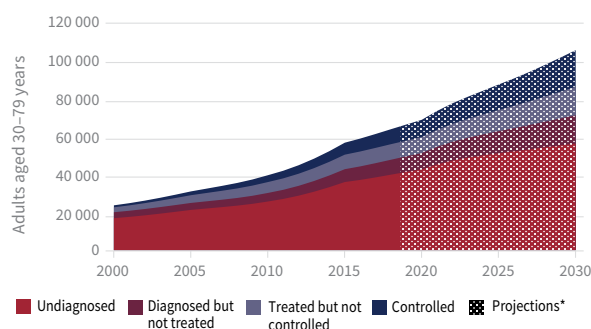
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 83 000 adults aged 30–79 years with hypertension, approximately 71 000 do not have the condition controlled^b

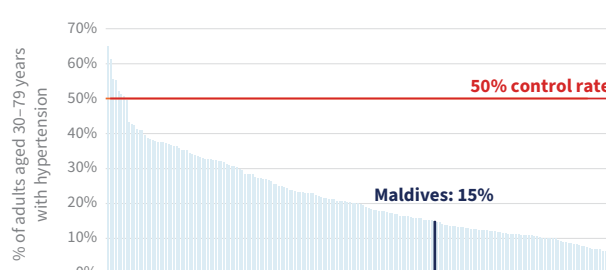


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	2800	1640	1160	2021
Cardiovascular disease deaths	1070	630	440	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	55	54	57	2021
Risk of premature death from NCDs (%) ^c	9	11	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	11	11	10	2021
Current tobacco use, adults aged 15+ years (%)	26	42	10	2022
Obesity, adults aged 18+ years (%)	18	13	24	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	25	25	24	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Mali

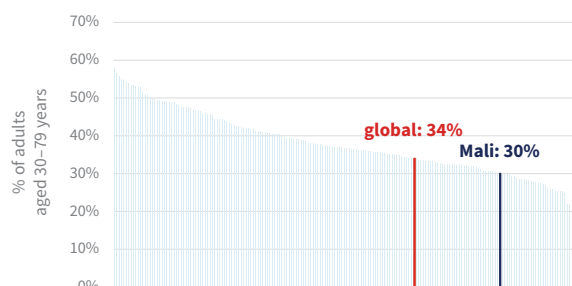
Hypertension profile

Total population (2024): 24 480 000

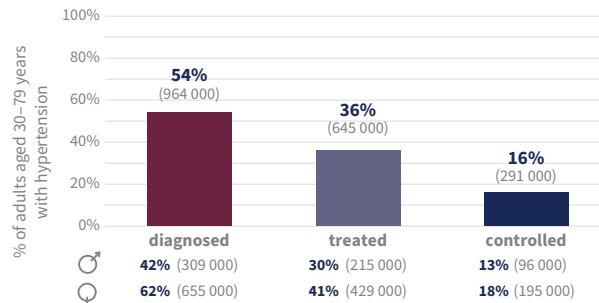
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 30% ♂ 25% ♀ 35%

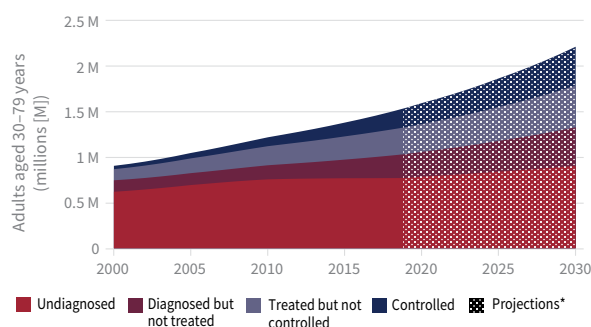
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.8 million adults aged 30–79 years with hypertension, approximately 1.5 million do not have the condition controlled^b

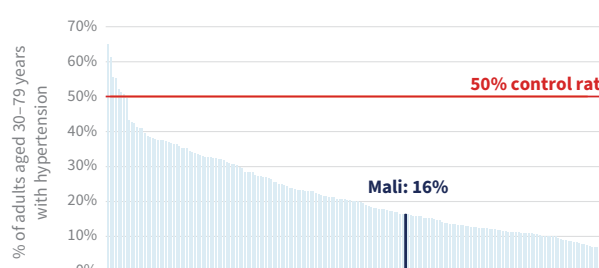


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	182 200	93 460	88 760	2021
Cardiovascular disease deaths	16 380	6520	9850	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	48	56	2021
Risk of premature death from NCDs (%) ^c	23	20	25	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	8	15	1	2022
Obesity, adults aged 18+ years (%)	10	9	11	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	30	26	34	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Malta

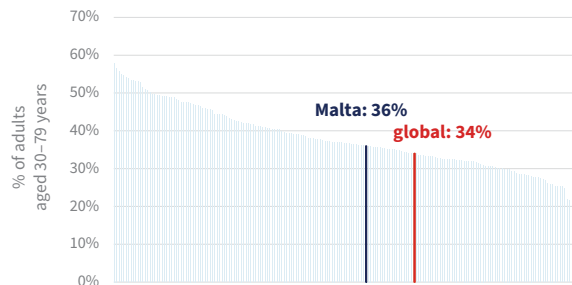
Hypertension profile

Total population (2024): 539 600

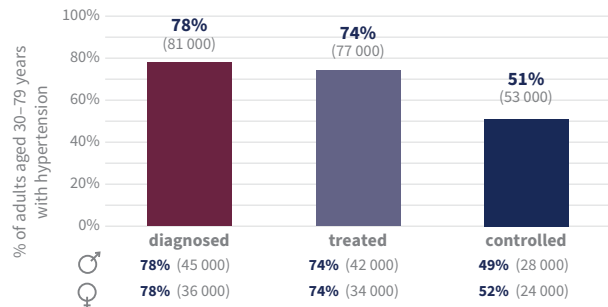
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♀ 39% 32%

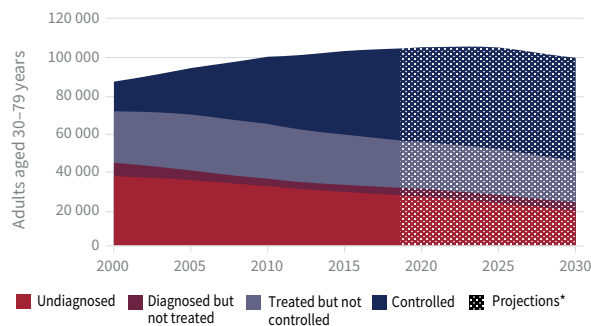
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 104 000 adults aged 30–79 years with hypertension, approximately 51 000 do not have the condition controlled^b

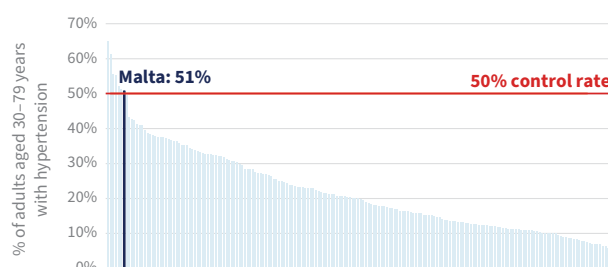


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	4210	2160	2050	2021
Cardiovascular disease deaths	1240	600	640	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	50	51	2021
Risk of premature death from NCDs (%) ^c	10	12	8	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%) ^d	25	26	23	2022
Obesity, adults aged 18+ years (%)	35	37	32	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	41	38	44	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Marshall Islands

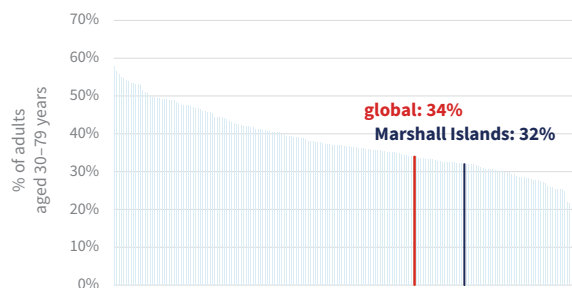
Hypertension profile

Total population (2024): 37 550

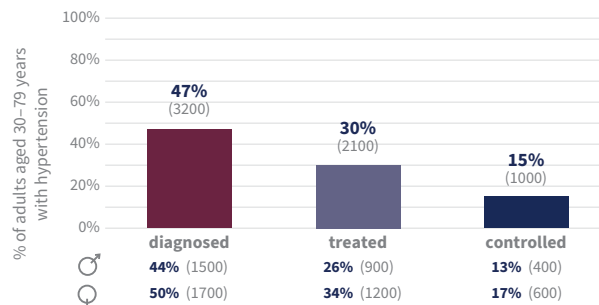
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♂ 31% ♀ 33%

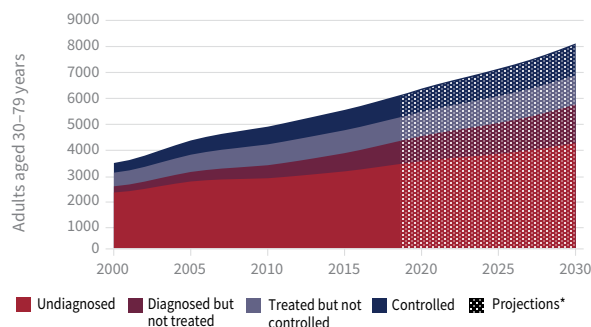
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 6800 adults aged 30–79 years with hypertension, approximately 5800 do not have the condition controlled^b

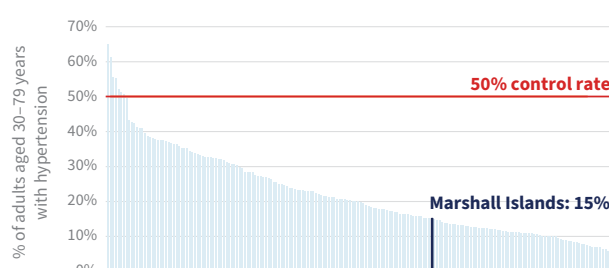


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	44	44	44	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%)	30	51	9	2022
Obesity, adults aged 18+ years (%)	47	38	56	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	no data	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	24	17	32	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No response

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Mauritania

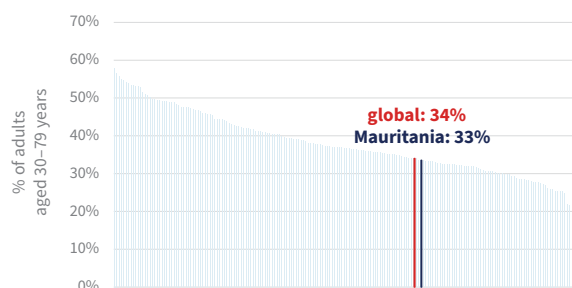
Hypertension profile

Total population (2024): 5 169 000

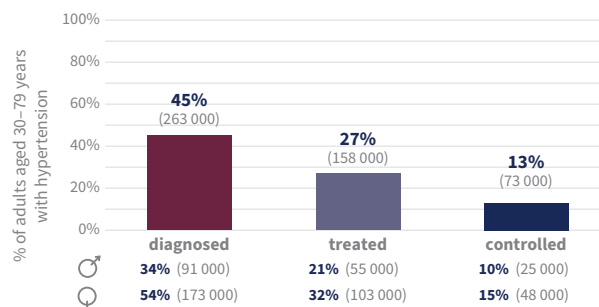
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 33% ♂ 30% ♀ 36%

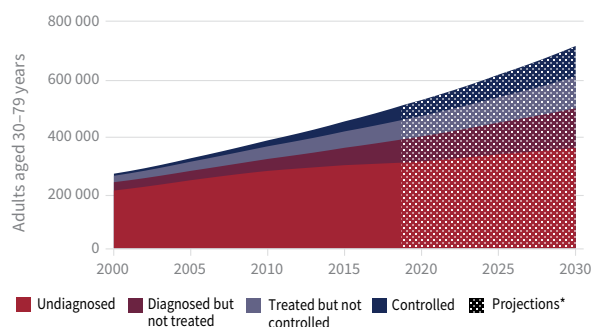
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 584 000 adults aged 30–79 years with hypertension, approximately 511 000 do not have the condition controlled^b

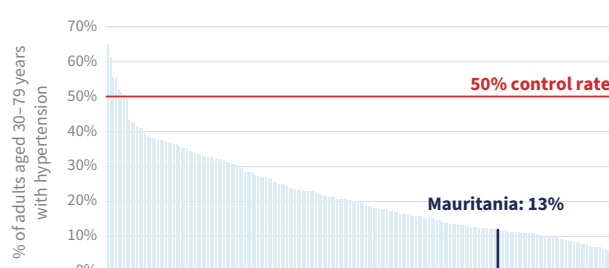


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	25 750	12 750	13 000	2021
Cardiovascular disease deaths	4990	1930	3060	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	55	62	2021
Risk of premature death from NCDs (%) ^c	19	16	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	10	17	2	2022
Obesity, adults aged 18+ years (%)	21	8	33	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	39	30	46	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP \geq 140 mmHg or DBP \geq 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 y

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Mauritius

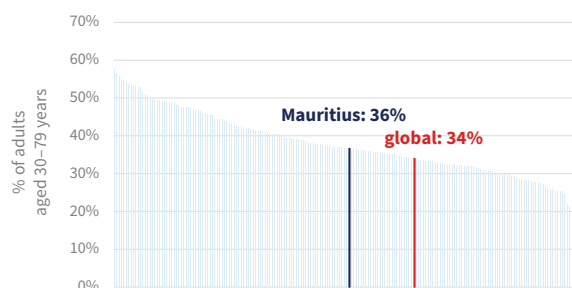
Hypertension profile

Total population (2024): 1 271 000

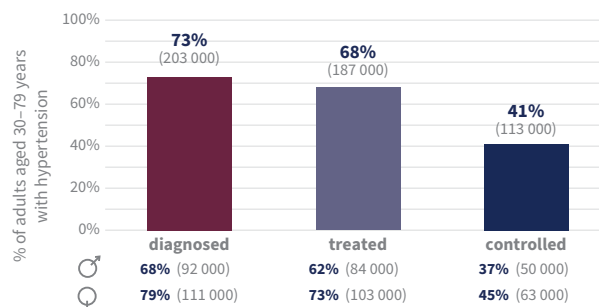
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♀ 36%

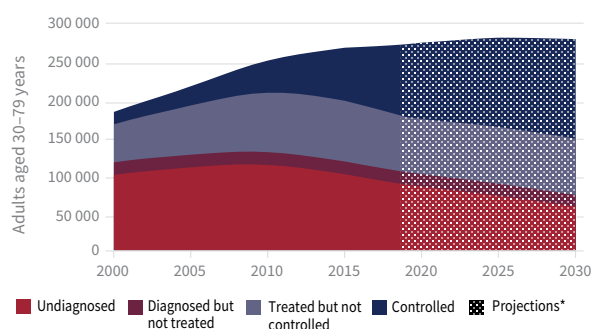
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 276 000 adults aged 30–79 years with hypertension, approximately 163 000 do not have the condition controlled^b

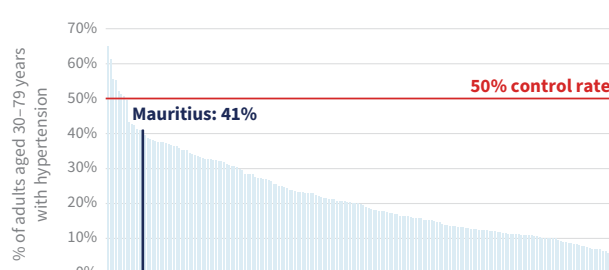


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	12 050	6910	5140	2021
Cardiovascular disease deaths	3990	2240	1750	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	56	63	2021
Risk of premature death from NCDs (%) ^c	22	27	16	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	21	39	3	2022
Obesity, adults aged 18+ years (%)	19	13	26	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	30	25	35	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Mexico

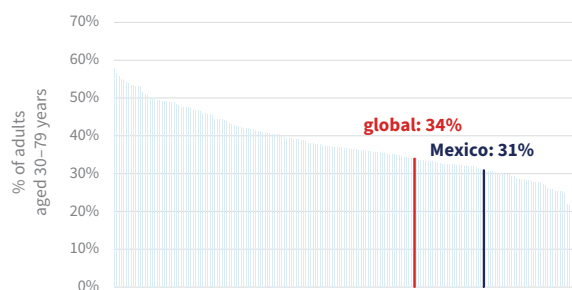
Hypertension profile

Total population (2024): 130 900 000

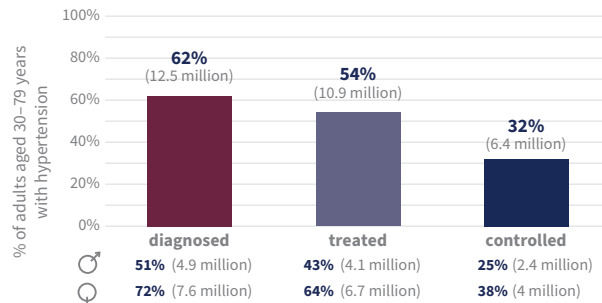
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 31% ♀ 30%

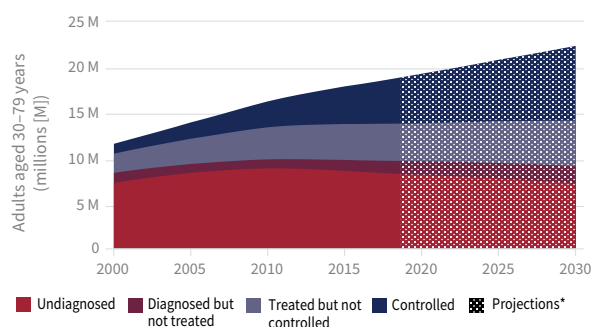
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 20.2 million adults aged 30–79 years with hypertension, approximately 13.8 million do not have the condition controlled^b

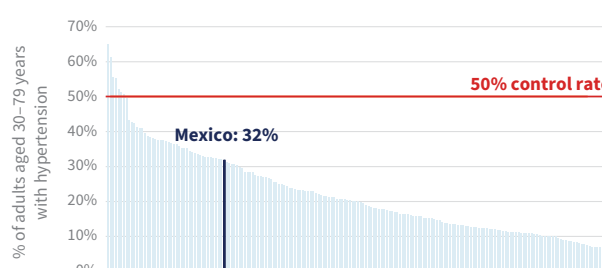


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	1 036 000	602 400	433 500	2021
Cardiovascular disease deaths	200 300	109 400	90 870	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	49	52	2021
Risk of premature death from NCDs (%) ^c	16	19	14	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	9	8	2021
Current tobacco use, adults aged 15+ years (%)	15	23	7	2022
Obesity, adults aged 18+ years (%)	36	32	40	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	28	25	31	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Micronesia (Federated States of)

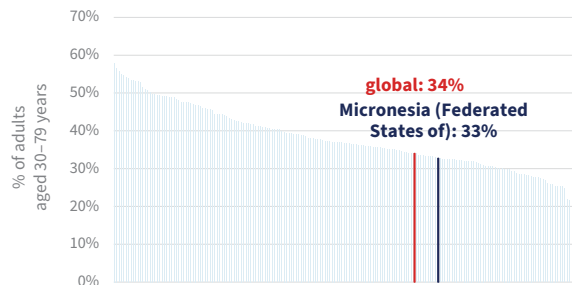
Hypertension profile

Total population (2024): 113 200

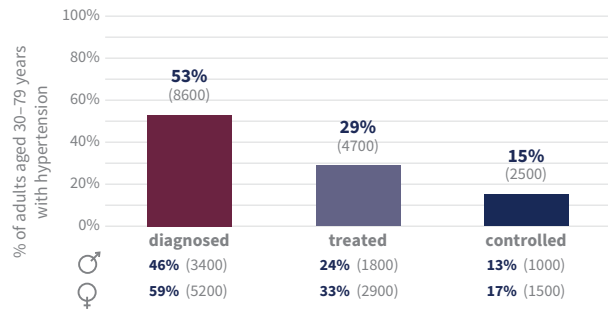
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 33% ♂ 30% ♀ 35%

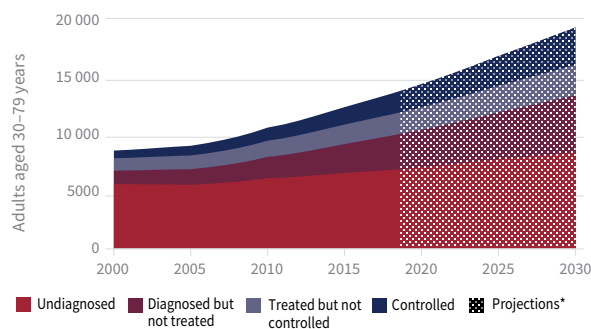
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 16 000 adults aged 30–79 years with hypertension, approximately 14 000 do not have the condition controlled^b

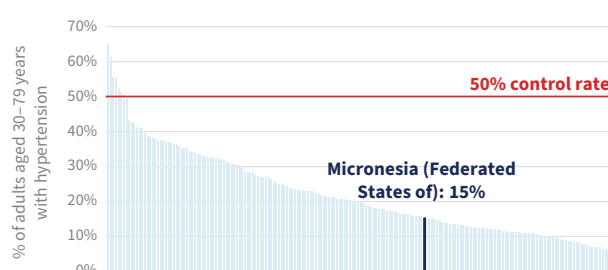


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	910	490	420	2021
Cardiovascular disease deaths	350	190	160	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	43	44	43	2021
Risk of premature death from NCDs (%) ^c	41	46	35	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	46	37	54	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	29	23	36	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Monaco

Hypertension profile

Total population (2024): 38 630

Prevalence of hypertension among adults aged 30–79 years (2024)^a

no data no data no data

Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a

Data not available

Of the no data adults aged 30–79 years with hypertension, approximately no data do not have the condition controlled^b

Data not available

Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)

Data not available

Hypertension control rates – country comparison (both sexes)^b

Data not available

Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	49	47	50	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	no data	no data	no data	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	no data	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	no data	no data	no data	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Mongolia

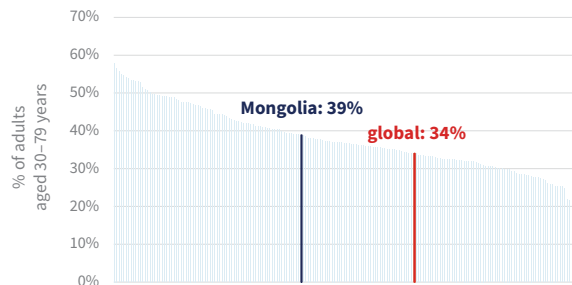
Hypertension profile

Total population (2024): 3 476 000

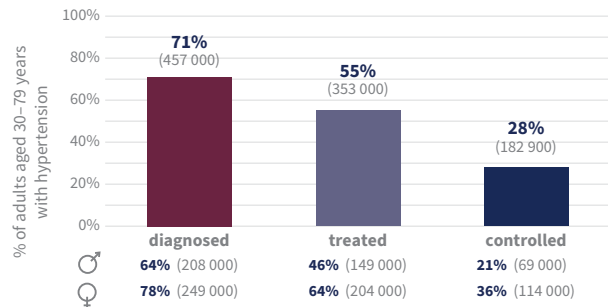
Prevalence of hypertension among adults aged 30–79 years (2024)^a

39% 41% 37%

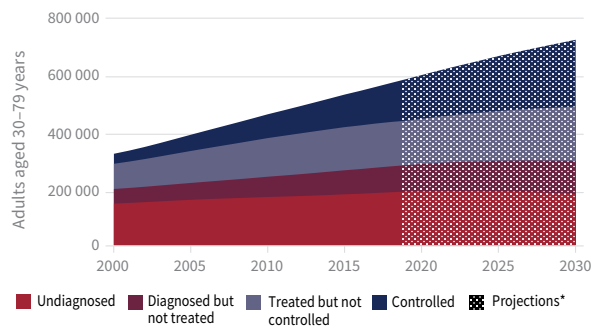
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 645 000 adults aged 30–79 years with hypertension, approximately 462 000 do not have the condition controlled^b

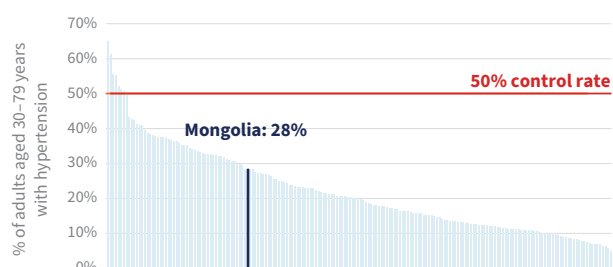


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	21 890	12 390	9500	2021
Cardiovascular disease deaths	7270	3780	3490	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	56	57	2021
Risk of premature death from NCDs (%) ^c	26	34	20	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	30	52	7	2022
Obesity, adults aged 18+ years (%)	24	21	26	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	27	26	29	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Montenegro

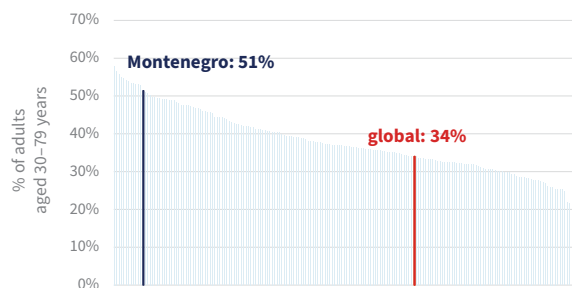
Hypertension profile

Total population (2024): 638 500

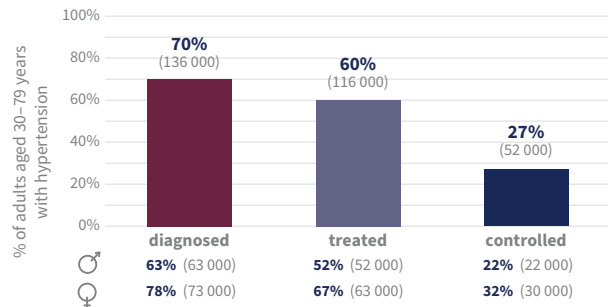
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 51% ♀ 54% 49%

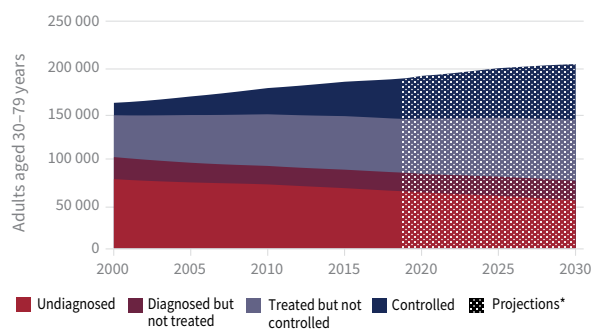
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 194 000 adults aged 30–79 years with hypertension, approximately 142 000 do not have the condition controlled^b

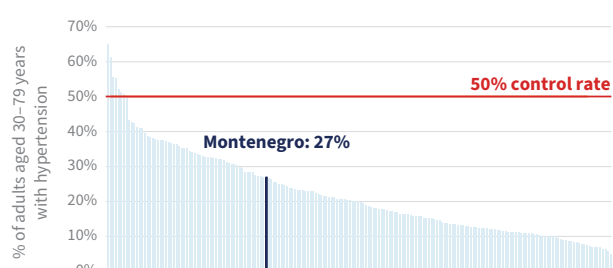


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	8660	4280	4380	2021
Cardiovascular disease deaths	3380	1300	2070	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	55	58	2021
Risk of premature death from NCDs (%) ^c	18	23	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	13	15	10	2021
Current tobacco use, adults aged 15+ years (%)	32	31	33	2022
Obesity, adults aged 18+ years (%)	21	23	20	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	23	22	24	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Morocco

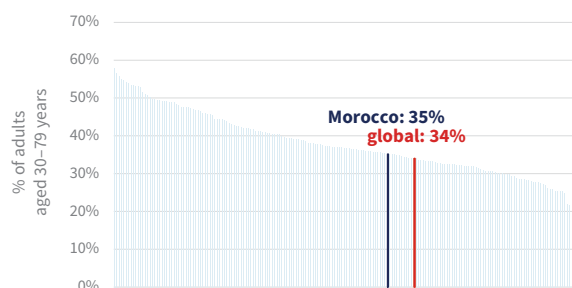
Hypertension profile

Total population (2024): 38 080 000

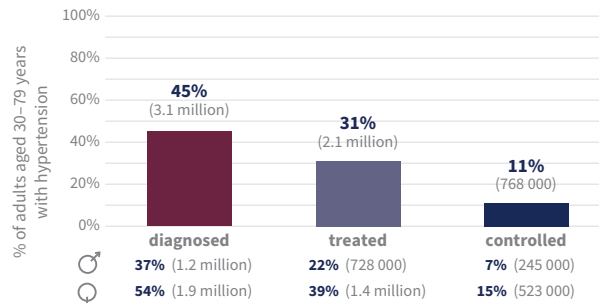
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 35% ♀ 35%

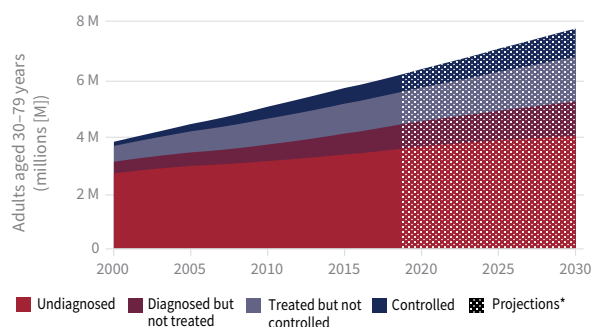
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 6.8 million adults aged 30–79 years with hypertension, approximately 6 million do not have the condition controlled^b

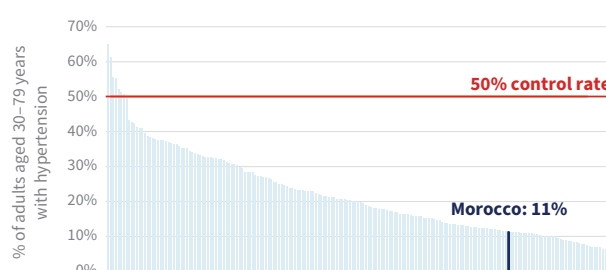


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	252 200	129 100	123 100	2021
Cardiovascular disease deaths	110 500	50 510	60 000	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	62	58	65	2021
Risk of premature death from NCDs (%) ^c	22	23	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%) ^d	13	25	1	2022
Obesity, adults aged 18+ years (%)	22	13	31	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	25	20	29	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Mozambique

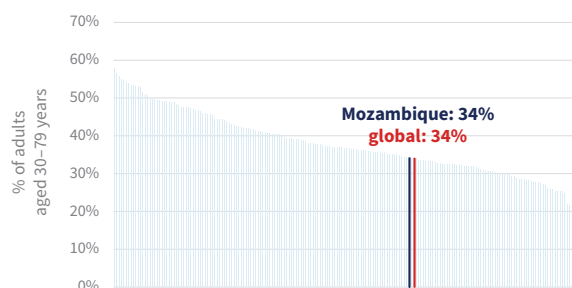
Hypertension profile

Total population (2024): 34 630 000

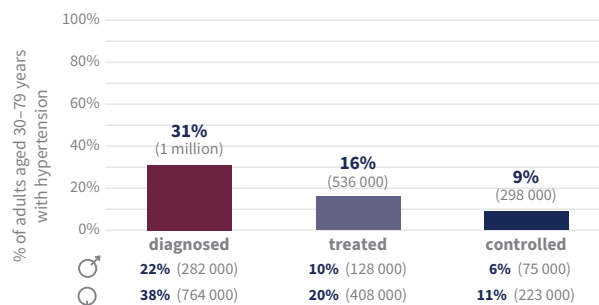
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 34% ♂ 29% ♀ 38%

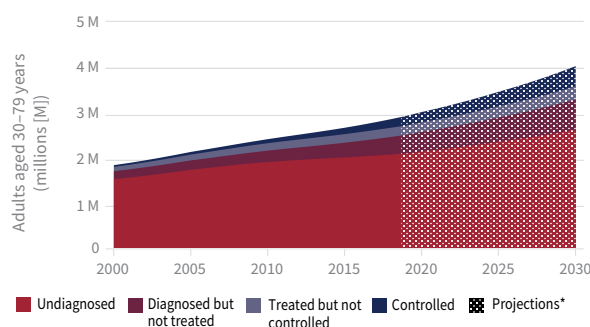
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.3 million adults aged 30–79 years with hypertension, approximately 3 million do not have the condition controlled^b

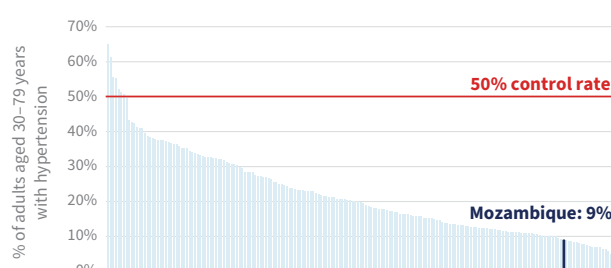


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	296 400	154 400	142 000	2021
Cardiovascular disease deaths	37 950	18 450	19 490	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	64	61	67	2021
Risk of premature death from NCDs (%) ^c	27	34	22	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	9	5	12	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	10	8	11	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Myanmar

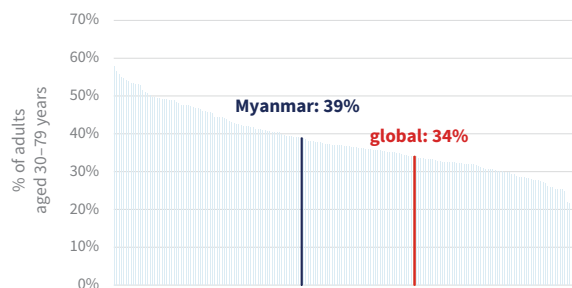
Hypertension profile

Total population (2024): 54 500 000

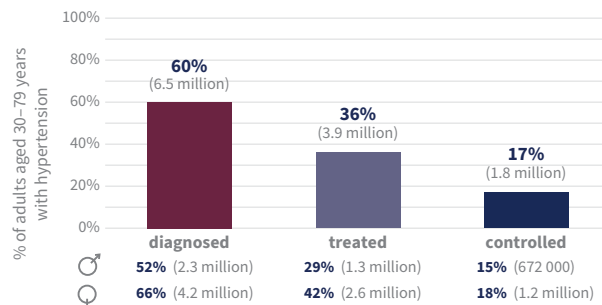
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 39% ♂ 35% ♀ 43%

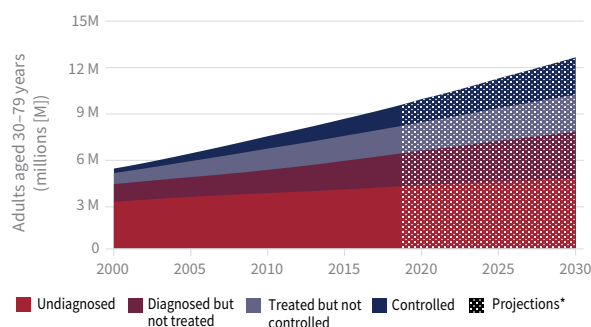
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 10.8 million adults aged 30–79 years with hypertension, approximately 8.9 million do not have the condition controlled^b

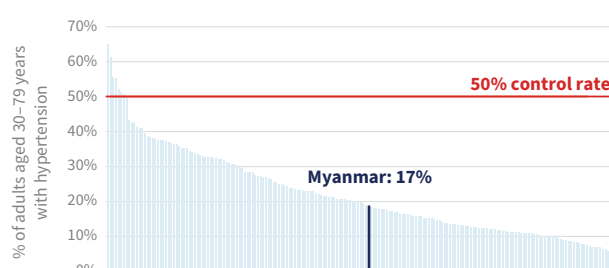


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	449 600	253 900	195 700	2021
Cardiovascular disease deaths	117 000	58 500	58 480	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	58	58	2021
Risk of premature death from NCDs (%) ^c	24	28	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%)	44	70	19	2022
Obesity, adults aged 18+ years (%)	8	5	10	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	22	20	24	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Namibia

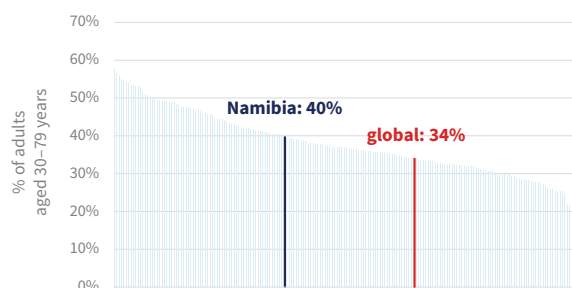
Hypertension profile

Total population (2024): 3 030 000

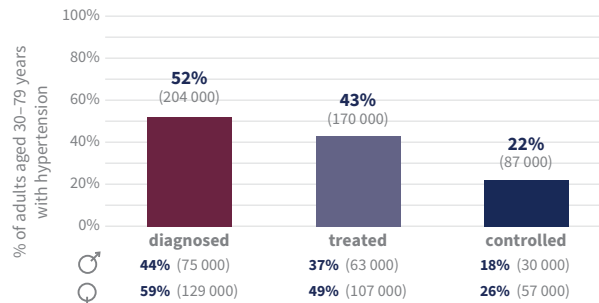
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 40% ♀ 42%

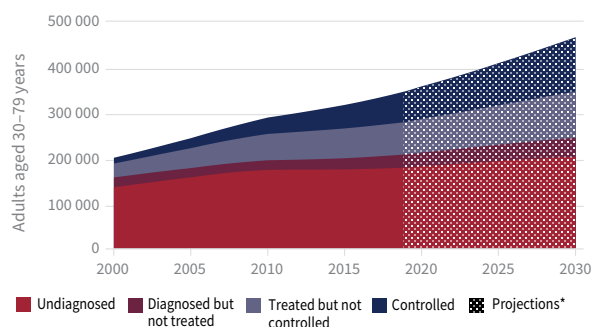
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 391 000 adults aged 30–79 years with hypertension, approximately 304 000 do not have the condition controlled^b

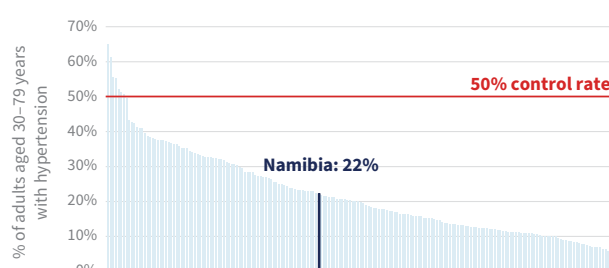


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	27 310	14 490	12 820	2021
Cardiovascular disease deaths	3020	1200	1820	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	56	60	2021
Risk of premature death from NCDs (%) ^c	23	25	22	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	14	23	5	2022
Obesity, adults aged 18+ years (%)	15	9	21	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	12	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	25	21	29	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Nauru

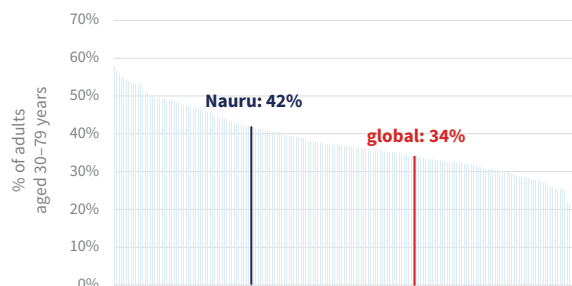
Hypertension profile

Total population (2024): 11 950

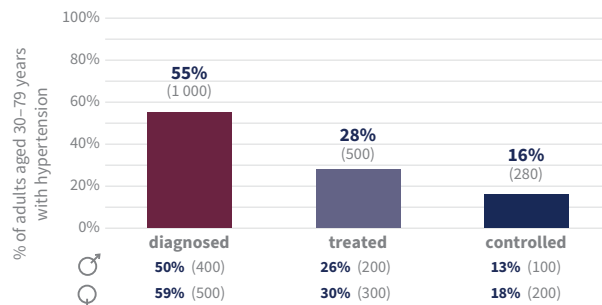
Prevalence of hypertension among adults aged 30–79 years (2024)^a

42% 43% 41%

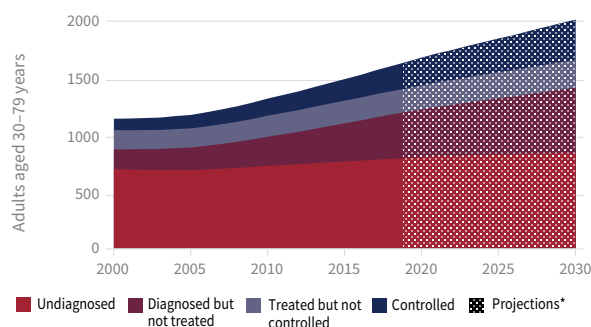
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1800 adults aged 30–79 years with hypertension, approximately 1500 do not have the condition controlled^b

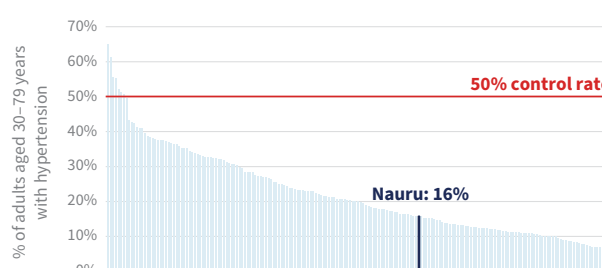


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	56	56	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%)	48	49	48	2022
Obesity, adults aged 18+ years (%)	70	69	71	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	35	28	43	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Nepal

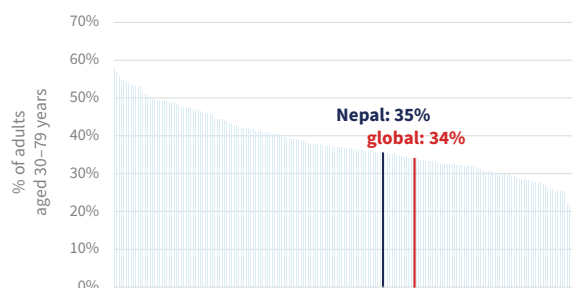
Hypertension profile

Total population (2024): 29 650 000

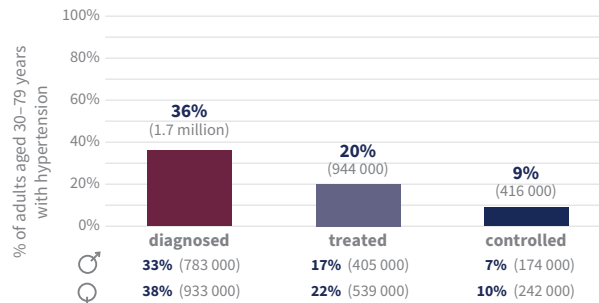
Prevalence of hypertension among adults aged 30–79 years (2024)^a

35% 39% 32%

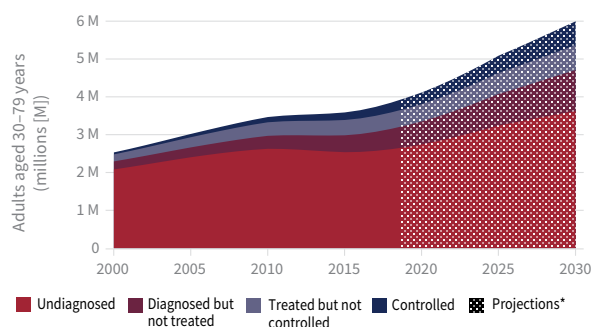
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 4.8 million adults aged 30–79 years with hypertension, approximately 4.4 million do not have the condition controlled^b

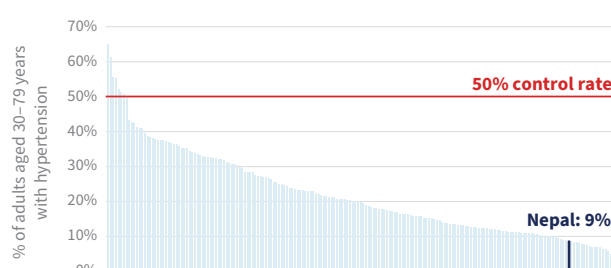


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	198 900	104 500	94 370	2021
Cardiovascular disease deaths	43 340	20 900	22 450	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	40	44	34	2021
Risk of premature death from NCDs (%) ^c	19	20	19	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	9	8	2021
Current tobacco use, adults aged 15+ years (%)	28	46	11	2022
Obesity, adults aged 18+ years (%)	7	5	8	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	8	10	6	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Netherlands (Kingdom of the)

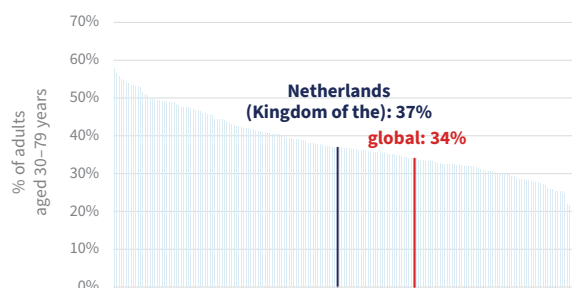
Hypertension profile

Total population (2024): 18 230 000

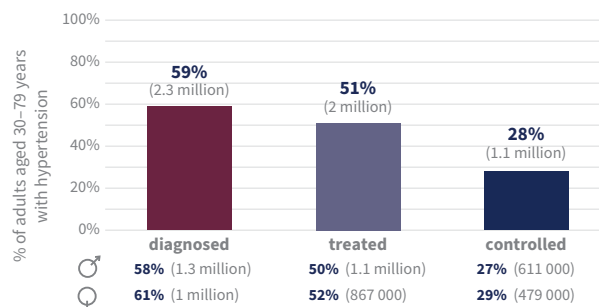
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♀ 43% 31%

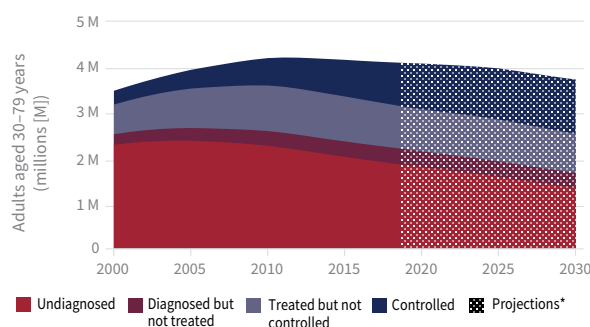
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.9 million adults aged 30–79 years with hypertension, approximately 2.8 million do not have the condition controlled^b

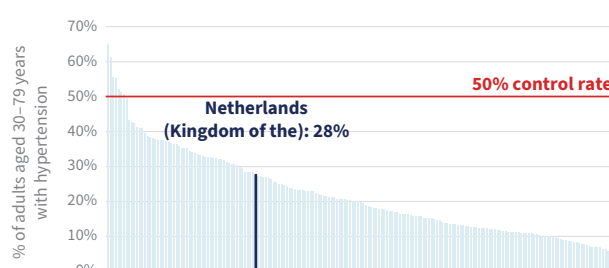


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	171 200	85 530	85 620	2021
Cardiovascular disease deaths	36 450	17 770	18 680	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	43	45	42	2021
Risk of premature death from NCDs (%) ^c	10	11	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	21	24	19	2022
Obesity, adults aged 18+ years (%)	17	17	17	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	9	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	9	8	11	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

New Zealand

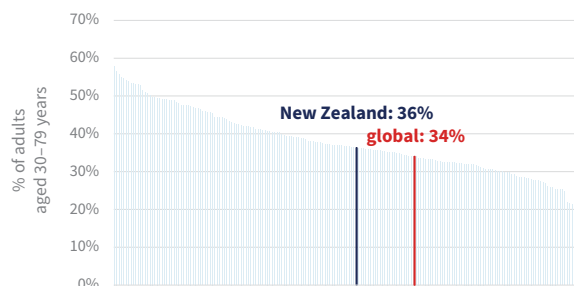
Hypertension profile

Total population (2024): 5 214 000

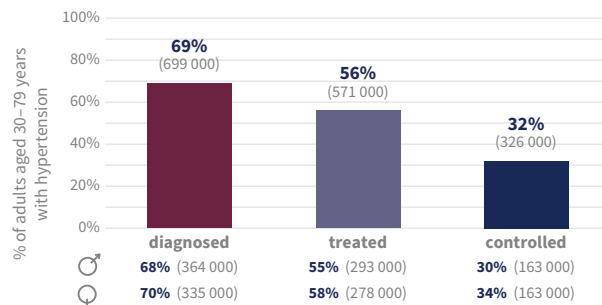
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♀ 39% ♀ 33%

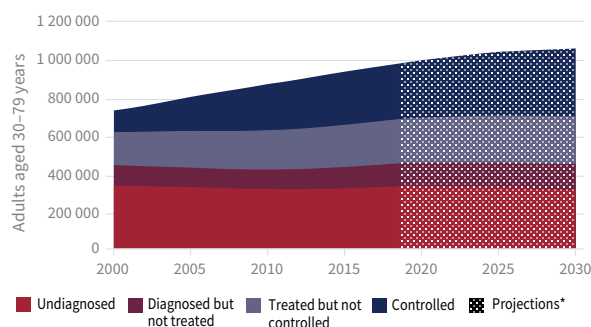
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1 million adults aged 30–79 years with hypertension, approximately 691 000 do not have the condition controlled^b

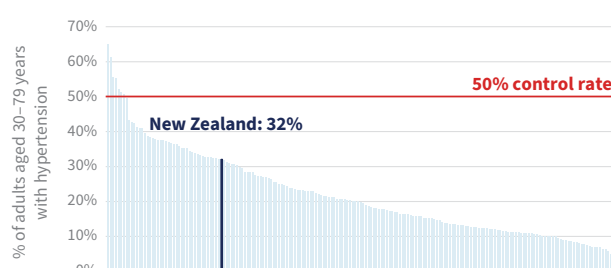


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	34 600	18 360	16 240	2021
Cardiovascular disease deaths	9670	5230	4440	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	43	43	43	2021
Risk of premature death from NCDs (%) ^c	10	12	8	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	9	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	12	13	11	2022
Obesity, adults aged 18+ years (%)	34	33	35	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	9	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	19	18	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Nicaragua

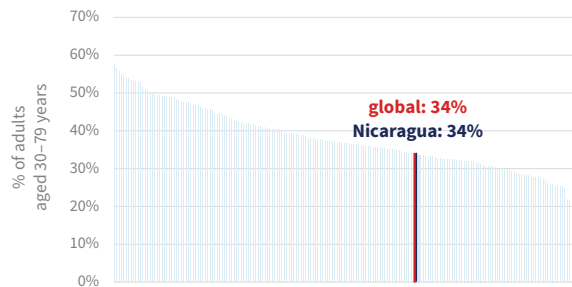
Hypertension profile

Total population (2024): 6 916 000

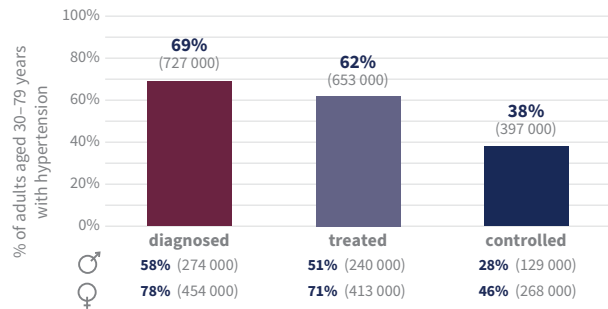
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 34% ♂ 32% ♀ 35%

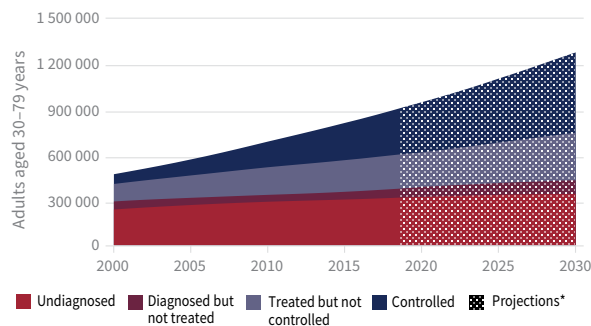
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.1 million adults aged 30–79 years with hypertension, approximately 655 000 do not have the condition controlled^b

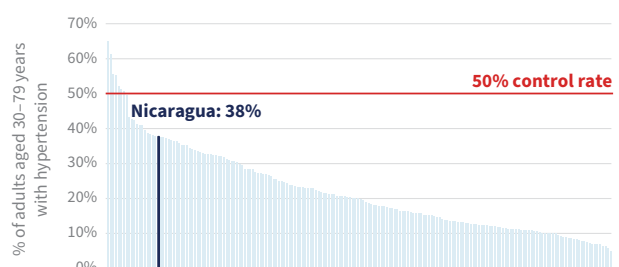


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	29 100	15 840	13 260	2021
Cardiovascular disease deaths	5600	2440	3150	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	55	57	2021
Risk of premature death from NCDs (%) ^c	13	13	12	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	32	27	37	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	39	33	44	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Don't know

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Niger

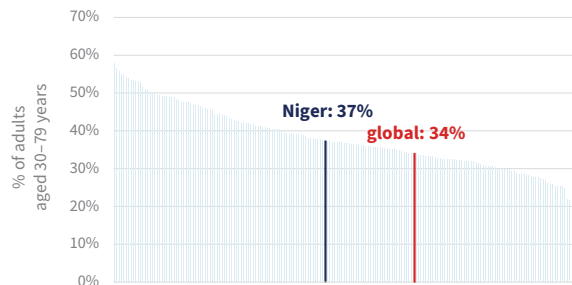
Hypertension profile

Total population (2024): 27 030 000

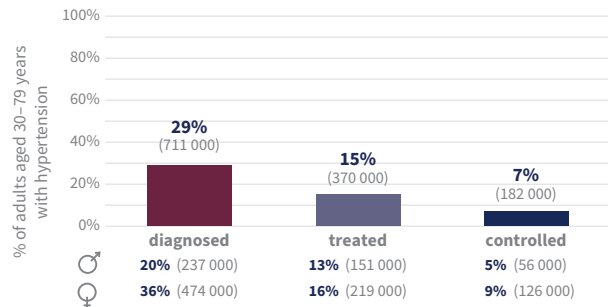
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♀ 36% ♀ 39%

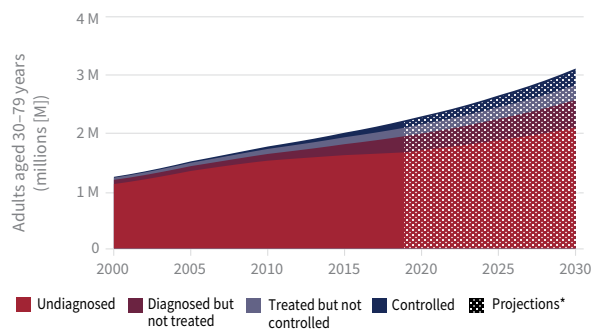
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.5 million adults aged 30–79 years with hypertension, approximately 2.3 million do not have the condition controlled^b

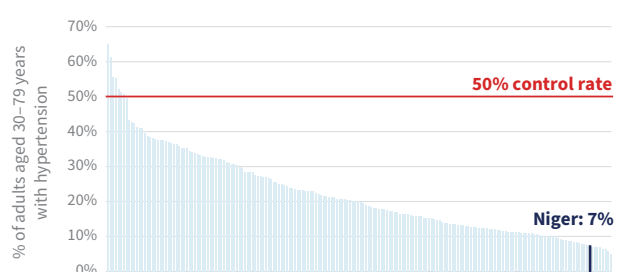


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	230 500	119 400	111 100	2021
Cardiovascular disease deaths	21 220	8 850	12 370	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	49	58	2021
Risk of premature death from NCDs (%) ^c	20	19	22	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	8	14	1	2022
Obesity, adults aged 18+ years (%)	5	4	7	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	16	13	19	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Nigeria

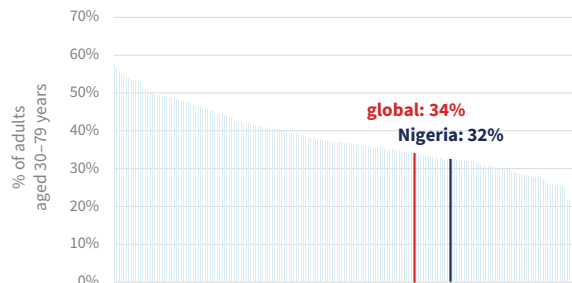
Hypertension profile

Total population (2024): 232 700 000

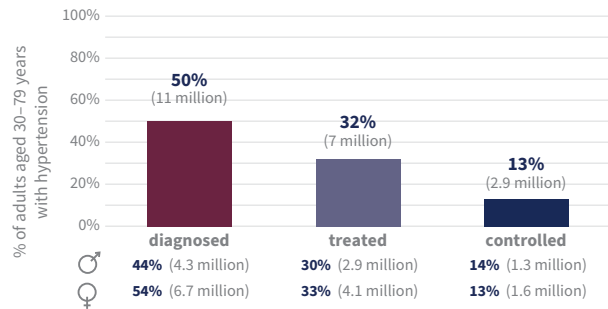
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♂ 28% ♀ 36%

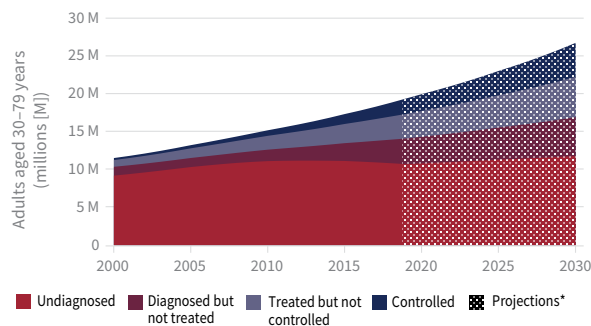
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 22 million adults aged 30–79 years with hypertension, approximately 19.1 million do not have the condition controlled^b

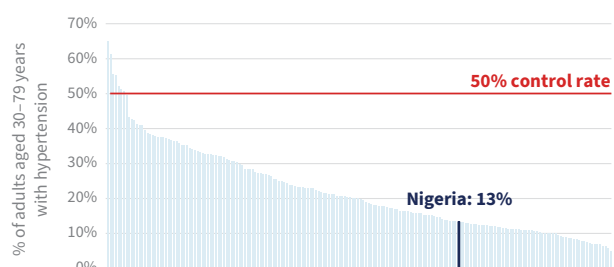


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	1 689 000	898 400	790 300	2021
Cardiovascular disease deaths	185 200	99 760	85 480	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	56	59	2021
Risk of premature death from NCDs (%) ^c	18	19	17	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	6	2021
Current tobacco use, adults aged 15+ years (%)	3	6	1	2022
Obesity, adults aged 18+ years (%)	11	7	15	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	18	16	21	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Niue

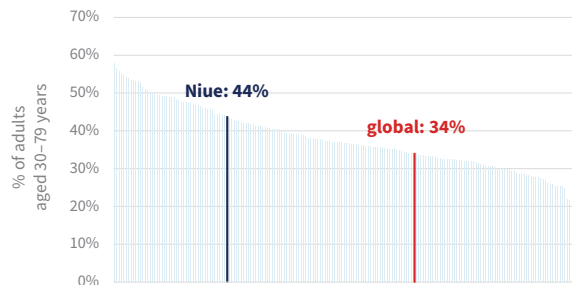
Hypertension profile

Total population (2024): 1820

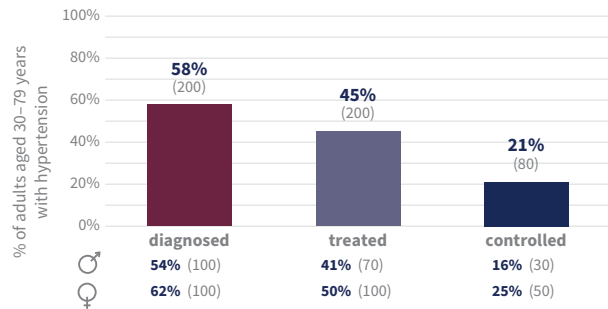
Prevalence of hypertension among adults aged 30–79 years (2024)^a

44% 41% 46%

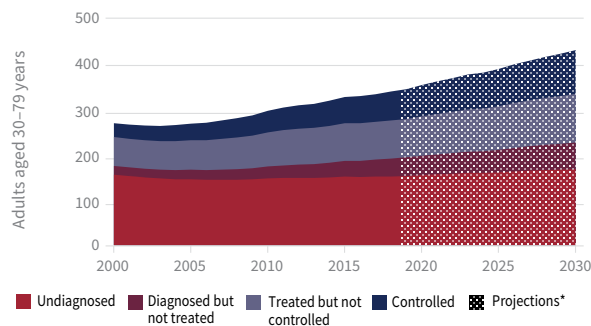
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 370 adults aged 30–79 years with hypertension, approximately 300 do not have the condition controlled^b

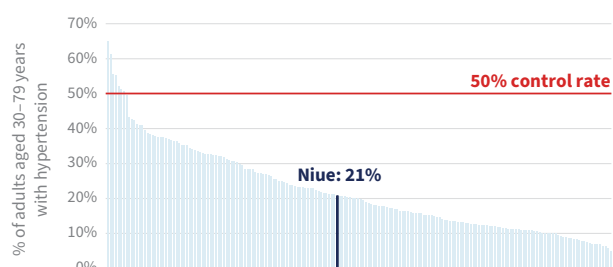


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	56	58	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	66	64	69	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	7	6	8	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

North Macedonia

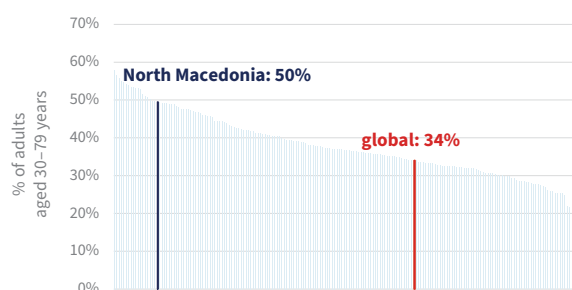
Hypertension profile

Total population (2024): 1 823 000

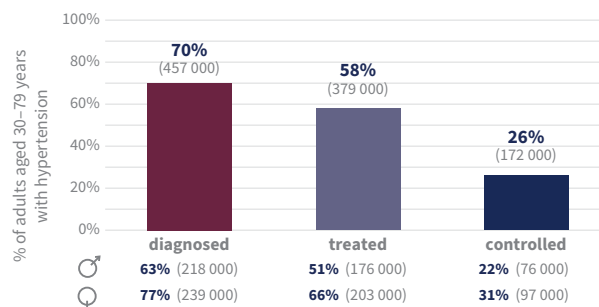
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 50% ♀ 53% ♀ 46%

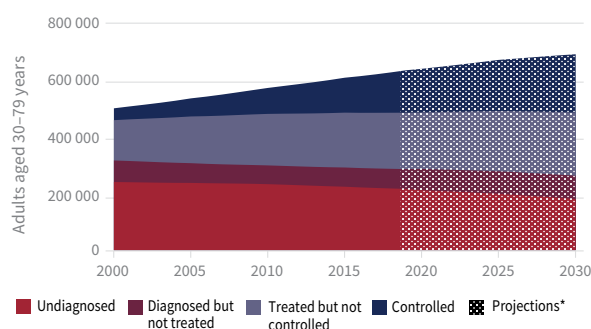
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 655 000 adults aged 30–79 years with hypertension, approximately 483 000 do not have the condition controlled^b

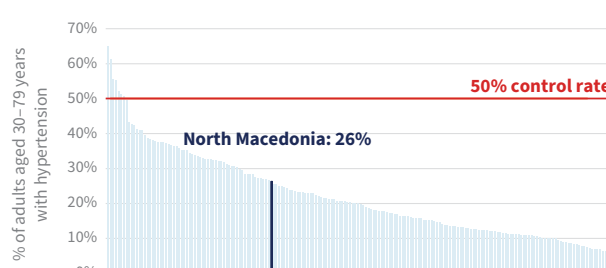


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	28 220	13 850	14 380	2021
Cardiovascular disease deaths	10 040	4310	5730	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	59	61	2021
Risk of premature death from NCDs (%) ^c	20	24	15	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	13	15	10	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	31	30	31	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	26	21	32	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Norway

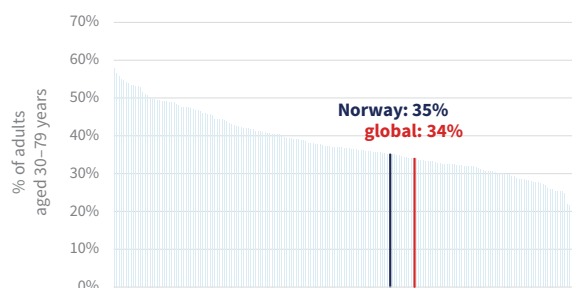
Hypertension profile

Total population (2024): 5 577 000

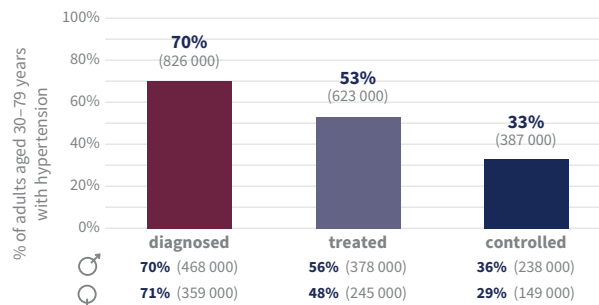
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 35% ♂ 39% ♀ 31%

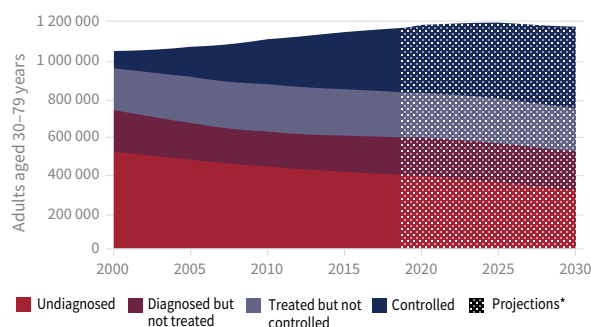
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.2 million adults aged 30–79 years with hypertension, approximately 789 000 do not have the condition controlled^b

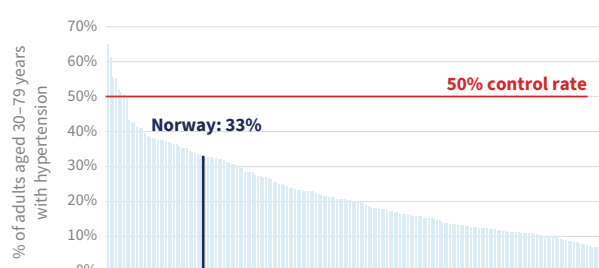


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	41 650	20 380	21 270	2021
Cardiovascular disease deaths	10 430	5100	5330	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	45	45	45	2021
Risk of premature death from NCDs (%) ^c	8	9	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	9	6	2021
Current tobacco use, adults aged 15+ years (%) ^d	14	15	14	2022
Obesity, adults aged 18+ years (%)	20	21	18	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	35	32	38	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Oman

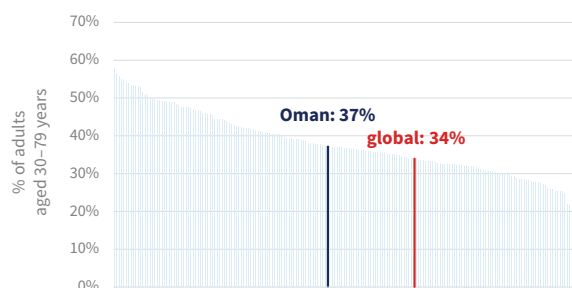
Hypertension profile

Total population (2024): 5 282 000

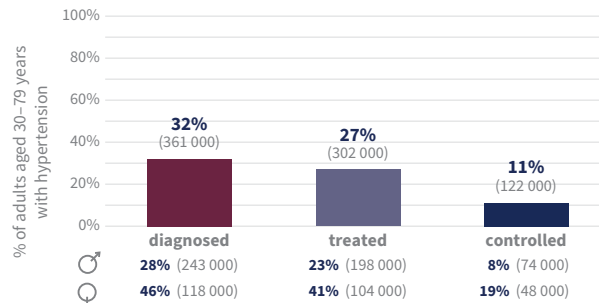
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♂ 40% ♀ 30%

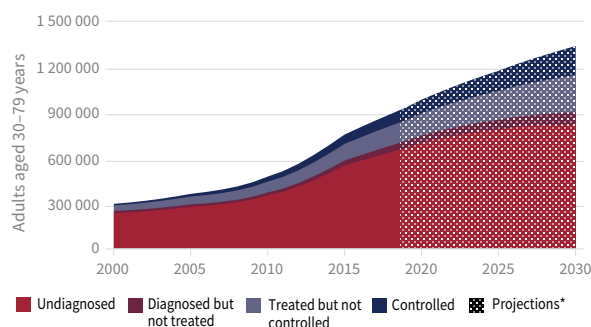
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.1 million adults aged 30–79 years with hypertension, approximately 1 million do not have the condition controlled^b

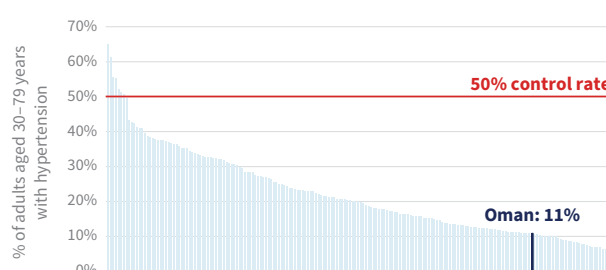


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	17 430	11 140	6290	2021
Cardiovascular disease deaths	4510	2580	1930	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	55	58	2021
Risk of premature death from NCDs (%) ^c	15	15	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	8	17	0	2022
Obesity, adults aged 18+ years (%)	30	26	39	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	41	35	50	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Pakistan

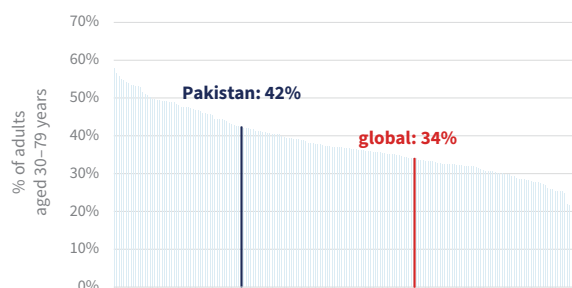
Hypertension profile

Total population (2024): 251 300 000

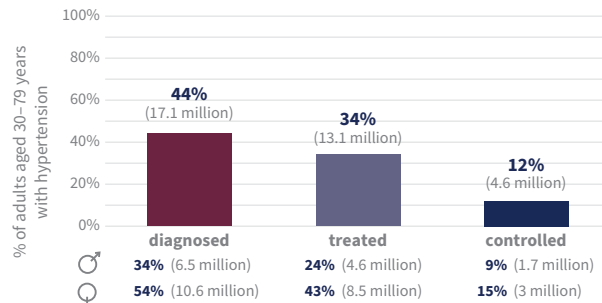
Prevalence of hypertension among adults aged 30–79 years (2024)^a

42% 41% 44%

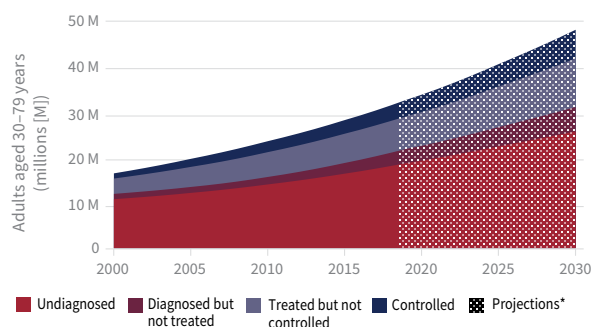
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 38.6 million adults aged 30–79 years with hypertension, approximately 33.9 million do not have the condition controlled^b

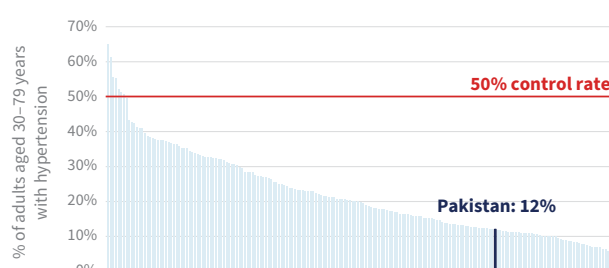


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	1 675 000	867 600	807 600	2021
Cardiovascular disease deaths	402 000	188 500	213 500	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	51	50	52	2021
Risk of premature death from NCDs (%) ^c	26	26	25	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	9	8	2021
Current tobacco use, adults aged 15+ years (%)	19	31	7	2022
Obesity, adults aged 18+ years (%)	22	19	25	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	46	34	57	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Palau

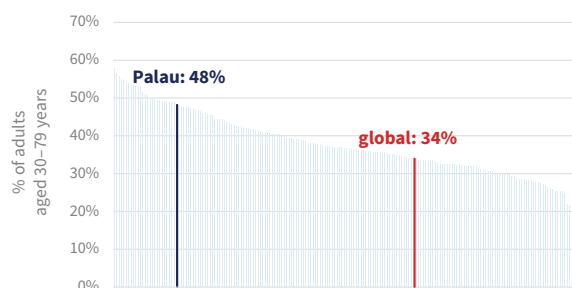
Hypertension profile

Total population (2024): 17 700

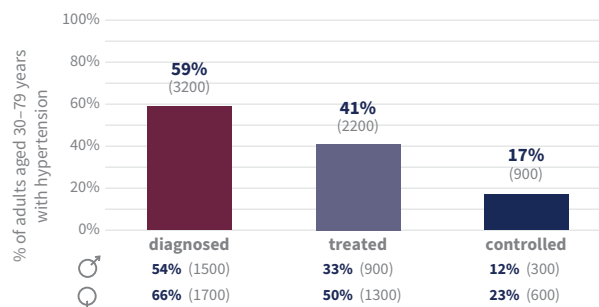
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 48% ♂ 47% ♀ 49%

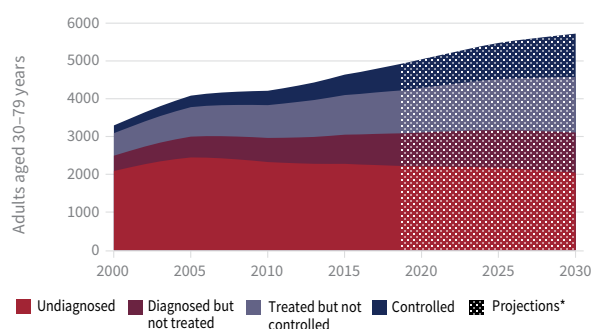
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



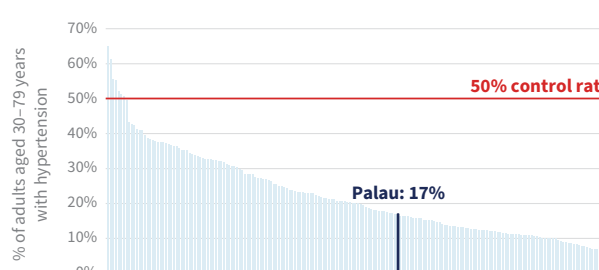
Of the 5300 adults aged 30–79 years with hypertension, approximately 4400 do not have the condition controlled^b



Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



Hypertension control rates – country comparison (both sexes)^b



*Projections assume a continuation of past trends.

Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	52	51	54	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	17	27	8	2022
Obesity, adults aged 18+ years (%)	42	40	45	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	no data	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	26	17	36	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Panama

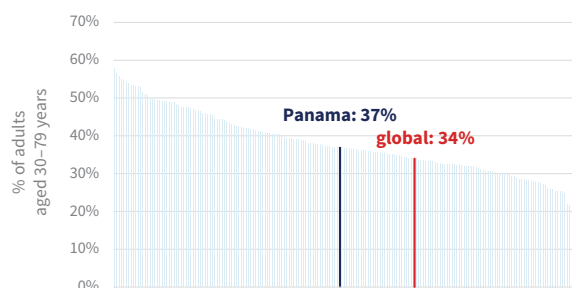
Hypertension profile

Total population (2024): 4 516 000

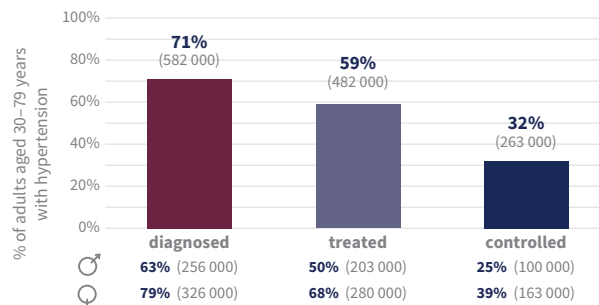
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♀ 37%

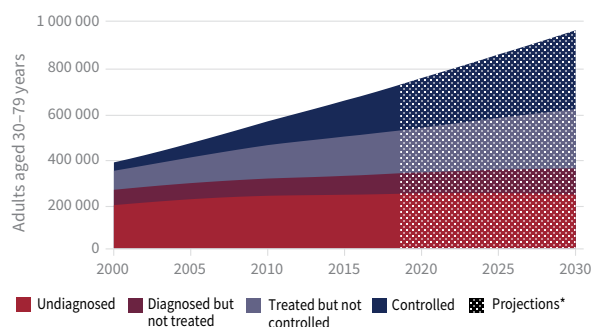
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 821 000 adults aged 30–79 years with hypertension, approximately 558 000 do not have the condition controlled^b

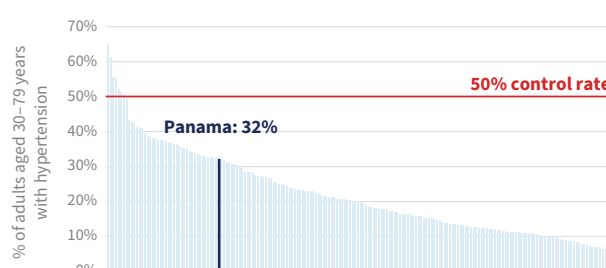


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	23 920	13 470	10 450	2021
Cardiovascular disease deaths	6230	3380	2850	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	52	55	2021
Risk of premature death from NCDs (%) ^c	11	13	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%)	5	8	2	2022
Obesity, adults aged 18+ years (%)	36	29	43	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	58	48	67	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Papua New Guinea

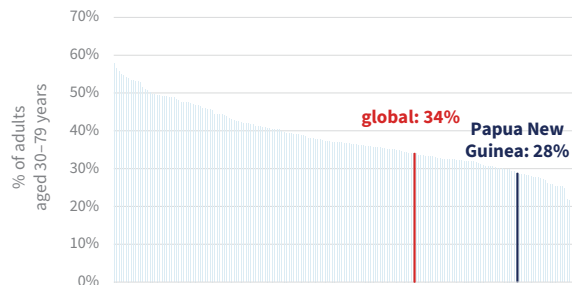
Hypertension profile

Total population (2024): 10 580 000

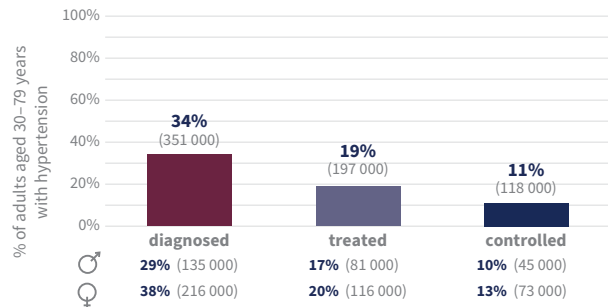
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 28% ♀ 31%

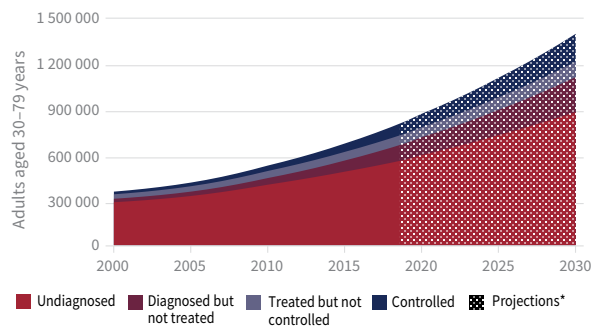
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1 million adults aged 30–79 years with hypertension, approximately 921 000 do not have the condition controlled^b

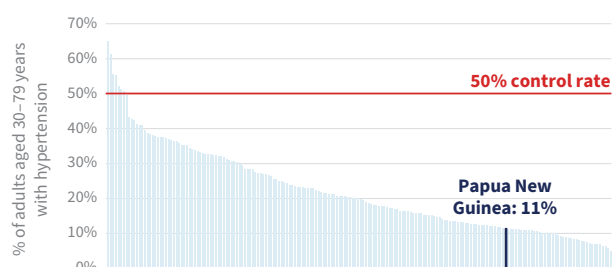


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	66 840	37 510	29 330	2021
Cardiovascular disease deaths	12 240	6420	5820	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	37	36	38	2021
Risk of premature death from NCDs (%) ^c	29	28	29	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	40	54	25	2022
Obesity, adults aged 18+ years (%)	20	15	25	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	12	8	17	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Paraguay

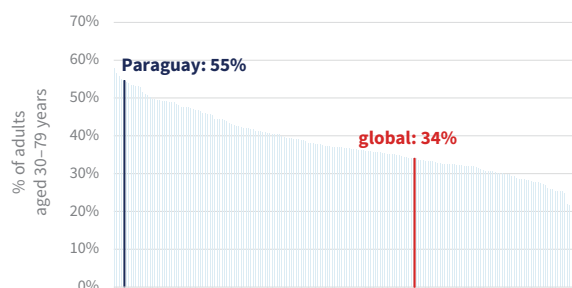
Hypertension profile

Total population (2024): 6 929 000

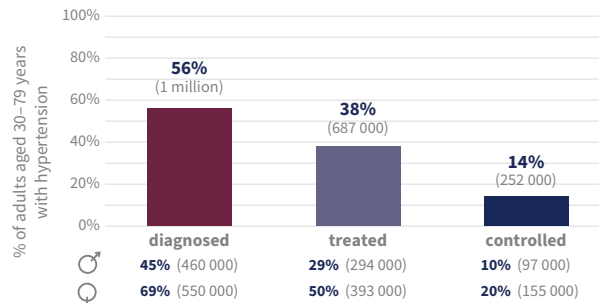
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 55% ♀ 61% 48%

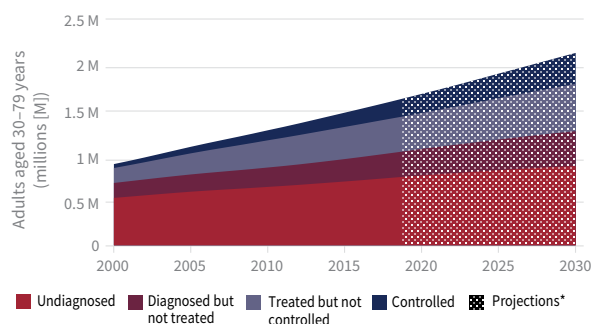
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.8 million adults aged 30–79 years with hypertension, approximately 1.6 million do not have the condition controlled^b

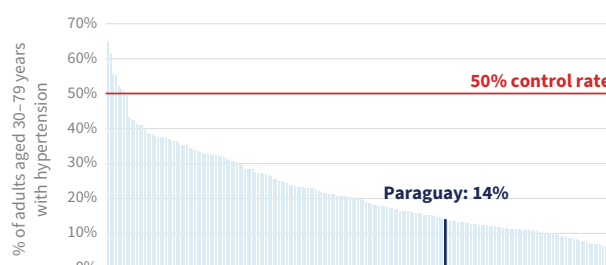


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	49 200	27 500	21 700	2021
Cardiovascular disease deaths	9510	5070	4440	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	52	58	2021
Risk of premature death from NCDs (%) ^c	16	19	14	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	8	2021
Current tobacco use, adults aged 15+ years (%) ^d	11	18	4	2022
Obesity, adults aged 18+ years (%)	32	29	35	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	36	32	40	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Peru

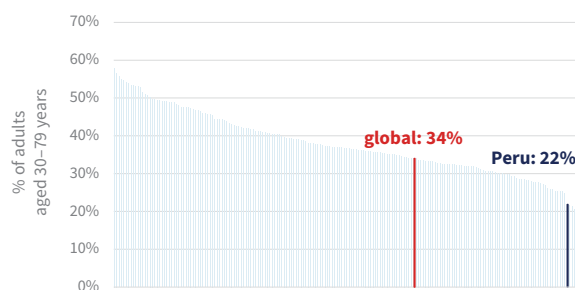
Hypertension profile

Total population (2024): 34 220 000

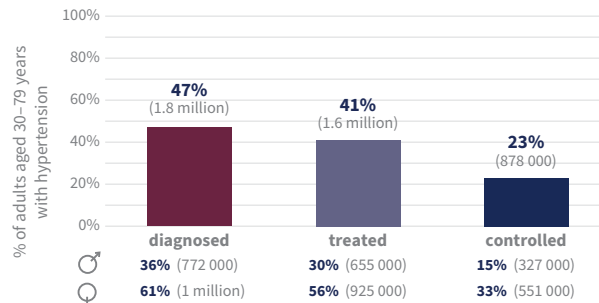
Prevalence of hypertension among adults aged 30–79 years (2024)^a

22% 24% 19%

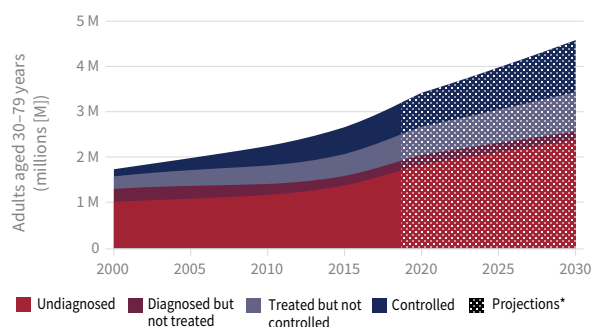
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.8 million adults aged 30–79 years with hypertension, approximately 2.9 million do not have the condition controlled^b

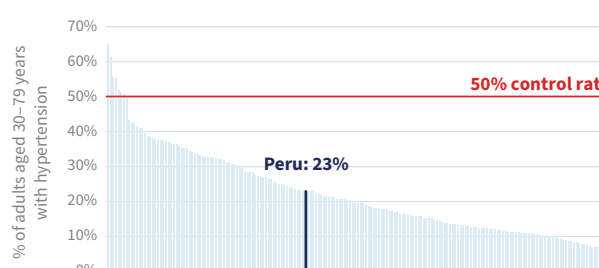


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	290 900	165 900	125 100	2021
Cardiovascular disease deaths	31 490	15 050	16 440	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	48	52	2021
Risk of premature death from NCDs (%) ^c	12	12	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	8	2021
Current tobacco use, adults aged 15+ years (%) ^d	7	12	3	2022
Obesity, adults aged 18+ years (%)	27	23	31	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	34	32	37	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Philippines

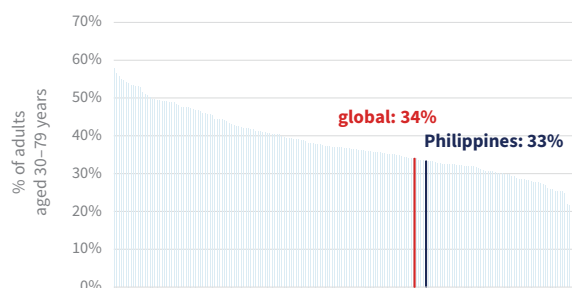
Hypertension profile

Total population (2024): 115 800 000

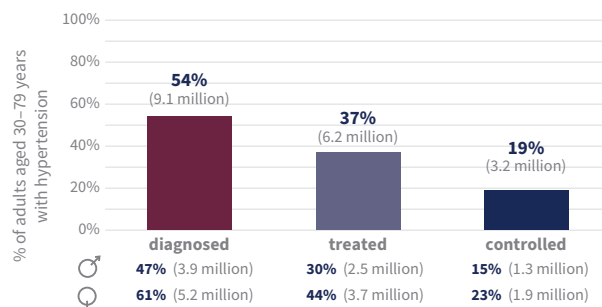
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 33% ♀ 34% ♀ 33%

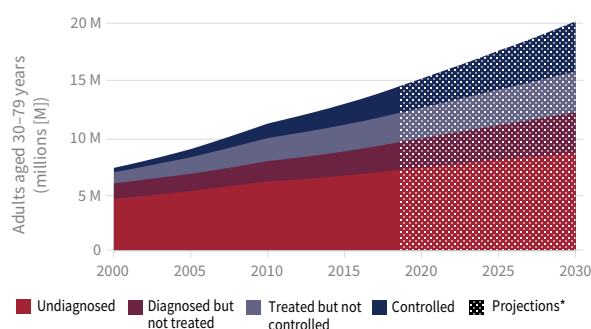
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 16.8 million adults aged 30–79 years with hypertension, approximately 13.6 million do not have the condition controlled^b

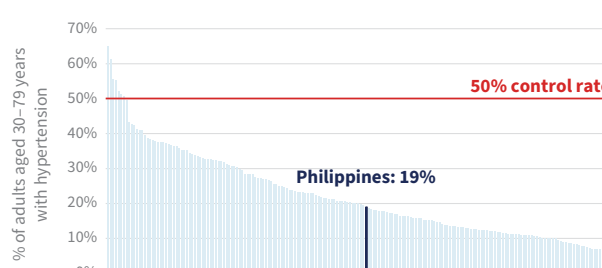


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	908 900	506 300	402 600	2021
Cardiovascular disease deaths	304 600	171 400	133 200	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	51	50	52	2021
Risk of premature death from NCDs (%) ^c	32	39	25	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	20	36	5	2022
Obesity, adults aged 18+ years (%)	9	7	10	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	45	36	55	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No response

a. Hypertension is defined as having SBP \geq 140 mmHg or DBP \geq 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Poland

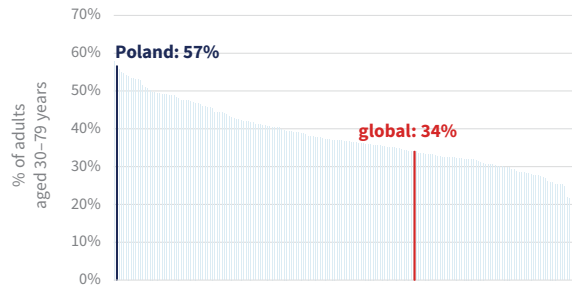
Hypertension profile

Total population (2024): 38 540 000

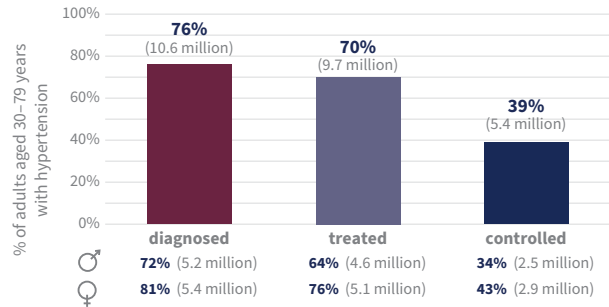
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 57% ♀ 61% 53%

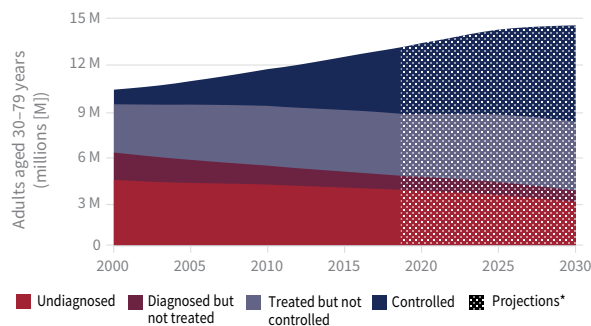
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 13.9 million adults aged 30–79 years with hypertension, approximately 8.6 million do not have the condition controlled^b

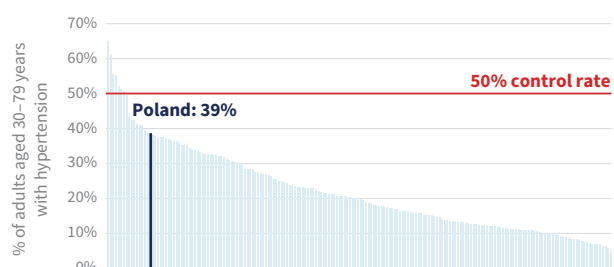


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	513 400	266 000	247 500	2021
Cardiovascular disease deaths	189 200	86 620	102 600	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	48	48	48	2021
Risk of premature death from NCDs (%) ^c	17	23	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	11	13	9	2021
Current tobacco use, adults aged 15+ years (%)	24	27	20	2022
Obesity, adults aged 18+ years (%)	31	34	29	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	12	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	37	36	38	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Portugal

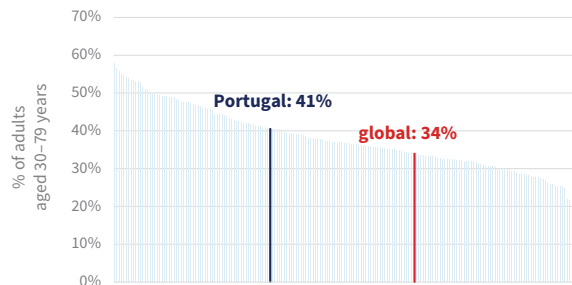
Hypertension profile

Total population (2024): 10 430 000

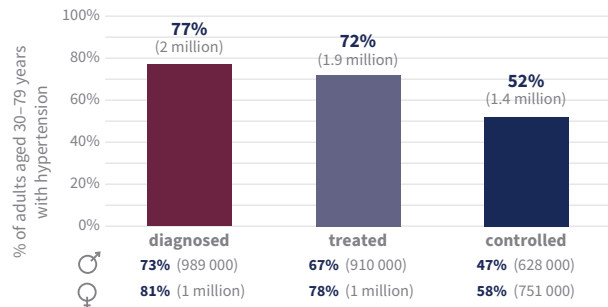
Prevalence of hypertension among adults aged 30–79 years (2024)^a

41% 44% 37%

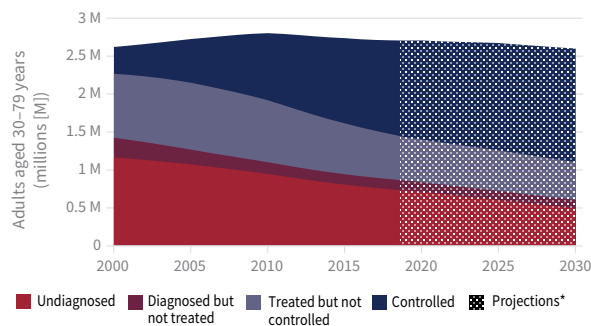
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.6 million adults aged 30–79 years with hypertension, approximately 1.3 million do not have the condition controlled^b

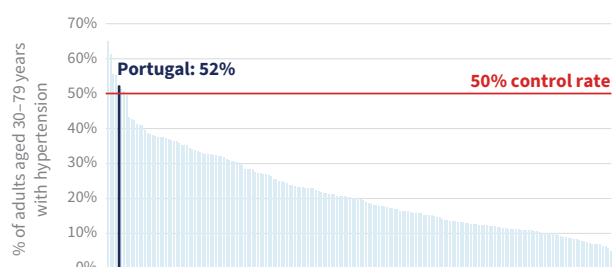


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	123 000	61 650	61 360	2021
Cardiovascular disease deaths	32 850	14 850	18 000	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	46	47	46	2021
Risk of premature death from NCDs (%) ^c	11	15	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	11	8	2021
Current tobacco use, adults aged 15+ years (%) ^d	26	31	21	2022
Obesity, adults aged 18+ years (%)	27	25	29	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	52	46	57	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Qatar

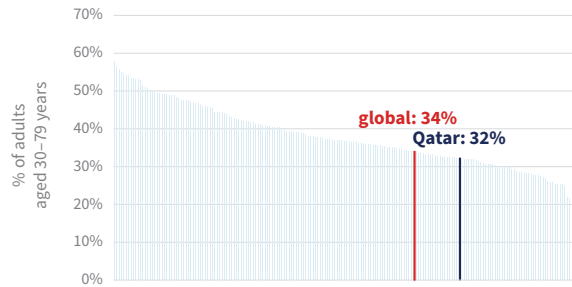
Hypertension profile

Total population (2024): 3 048 000

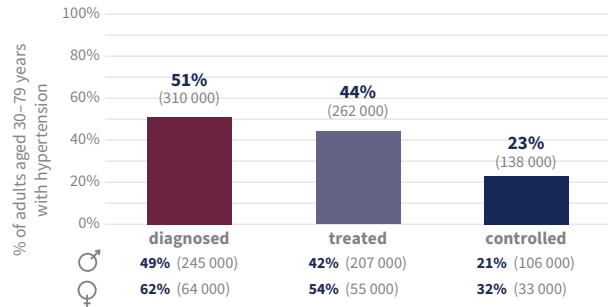
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♀ 34% ♀ 26%

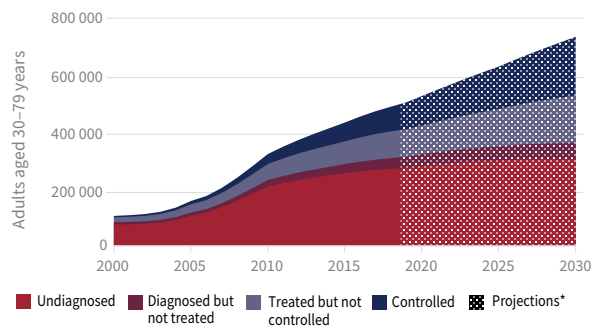
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 602 000 adults aged 30–79 years with hypertension, approximately 464 000 do not have the condition controlled^b

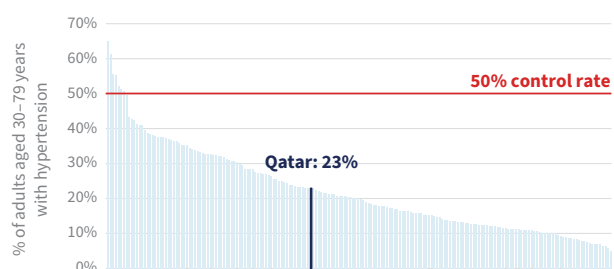


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	4810	3490	1320	2021
Cardiovascular disease deaths	1160	850	300	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	51	51	53	2021
Risk of premature death from NCDs (%) ^c	12	12	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	5	2021
Current tobacco use, adults aged 15+ years (%)	13	23	2	2022
Obesity, adults aged 18+ years (%)	44	42	51	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	53	50	63	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Republic of Korea

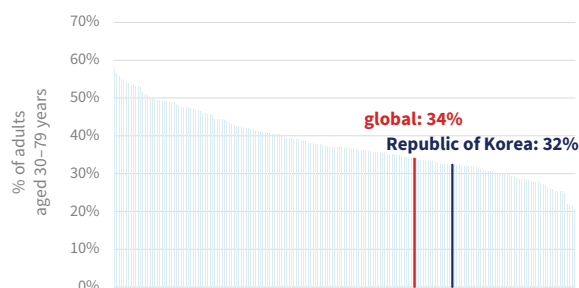
Hypertension profile

Total population (2024): 51 720 000

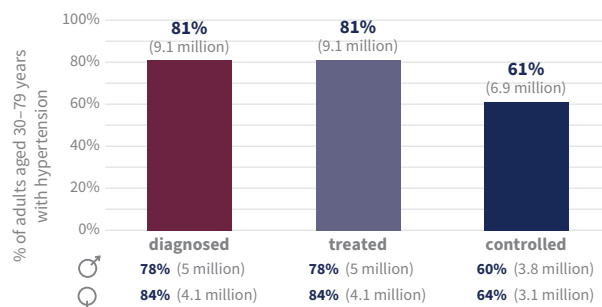
Prevalence of hypertension among adults aged 30–79 years (2024)^a

32% 37% 28%

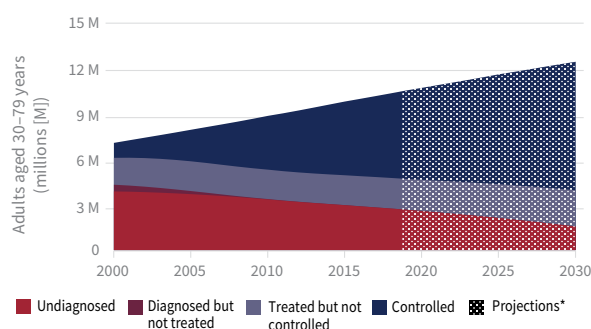
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 11.3 million adults aged 30–79 years with hypertension, approximately 4.4 million do not have the condition controlled^b

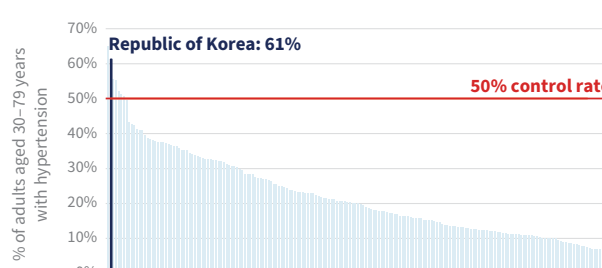


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	318 500	173 000	145 500	2021
Cardiovascular disease deaths	70 330	32 730	37 600	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	43	40	45	2021
Risk of premature death from NCDs (%) ^c	7	10	4	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	12	13	11	2021
Current tobacco use, adults aged 15+ years (%) ^d	20	34	6	2022
Obesity, adults aged 18+ years (%)	7	8	6	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	58	56	60	2022

National response

Targets

National target for blood pressure	Don't know
National target for salt consumption	Don't know

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Don't know

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Republic of Moldova

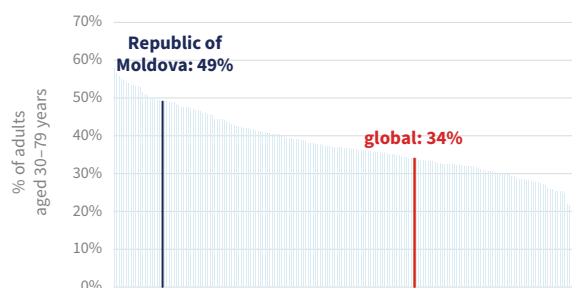
Hypertension profile

Total population (2024): 3 035 000

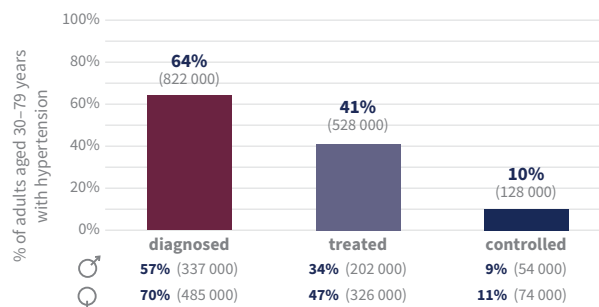
Prevalence of hypertension among adults aged 30–79 years (2024)^a

49% 48% 50%

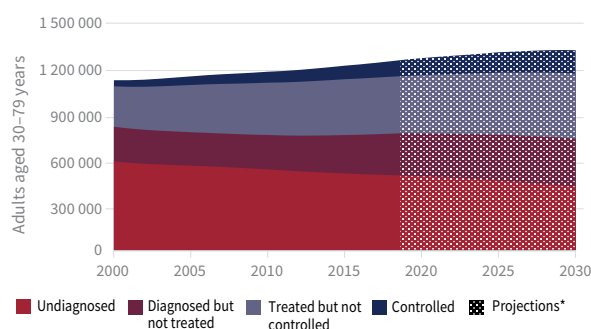
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.3 million adults aged 30–79 years with hypertension, approximately 1.2 million do not have the condition controlled^b

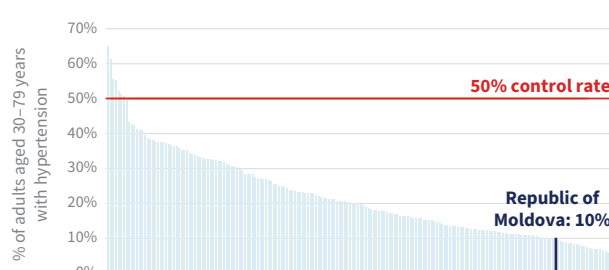


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	48 690	24 230	24 460	2021
Cardiovascular disease deaths	24 420	11 050	13 370	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	65	63	67	2021
Risk of premature death from NCDs (%) ^c	25	34	17	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	30	52	7	2022
Obesity, adults aged 18+ years (%)	26	22	29	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	14	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	11	12	10	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Romania

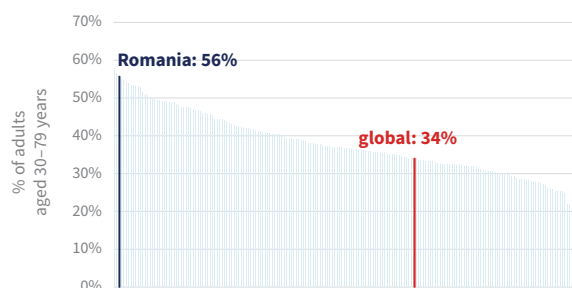
Hypertension profile

Total population (2024): 19 020 000

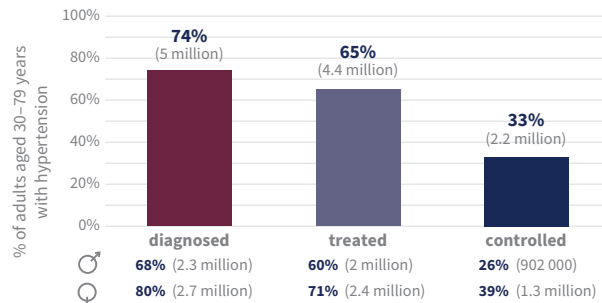
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 56% ♀ 58% ♀ 53%

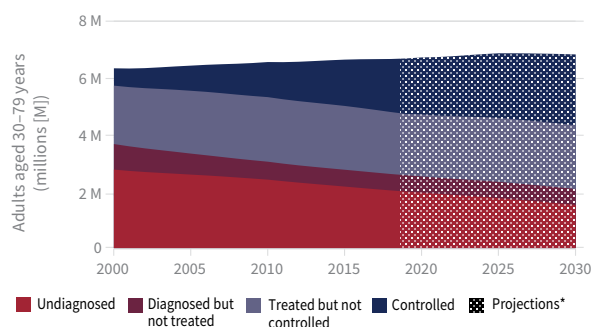
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 6.7 million adults aged 30–79 years with hypertension, approximately 4.6 million do not have the condition controlled^b

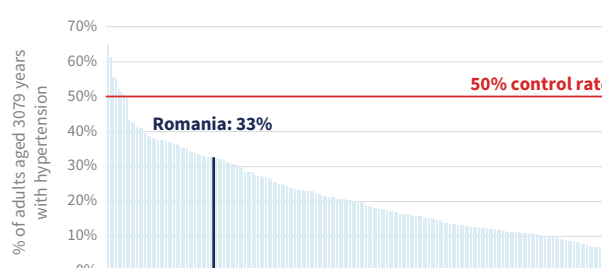


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	327 900	169 800	158 100	2021
Cardiovascular disease deaths	143 800	65 440	78 390	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	61	58	64	2021
Risk of premature death from NCDs (%) ^c	22	29	15	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	13	15	10	2021
Current tobacco use, adults aged 15+ years (%)	30	39	22	2022
Obesity, adults aged 18+ years (%)	38	40	37	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	17	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	37	37	37	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Russian Federation

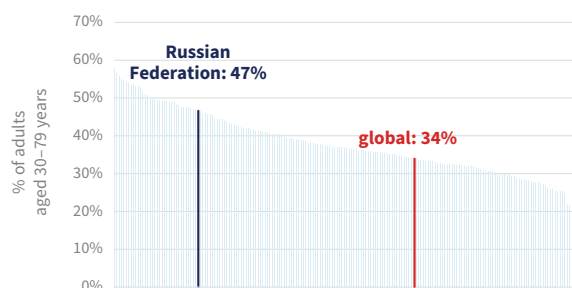
Hypertension profile

Total population (2024): 144 800 000

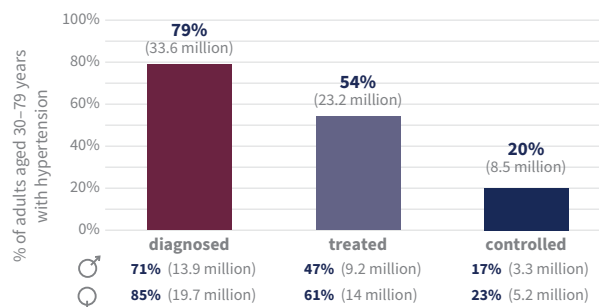
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 47% ♀ 46%

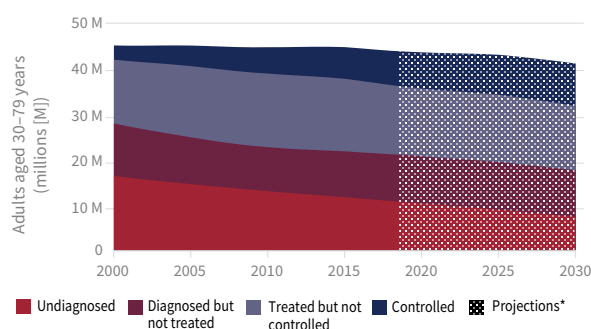
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 42.6 million adults aged 30–79 years with hypertension, approximately 34.1 million do not have the condition controlled^b

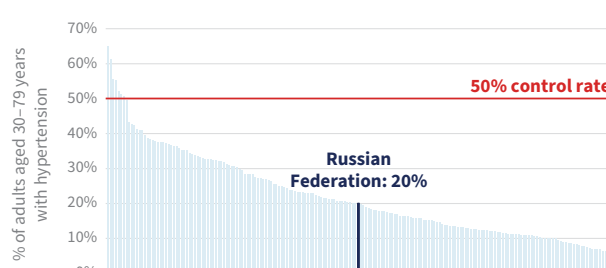


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	2 453 000	1 171 000	1 282 000	2021
Cardiovascular disease deaths	910 100	390 600	519 500	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	51	56	2021
Risk of premature death from NCDs (%) ^c	22	32	15	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%)	29	41	17	2022
Obesity, adults aged 18+ years (%)	28	25	30	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	18	18	18	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Rwanda

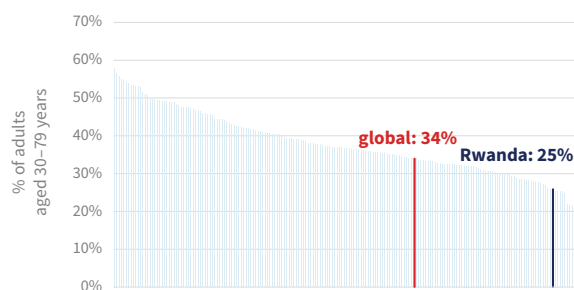
Hypertension profile

Total population (2024): 14 260 000

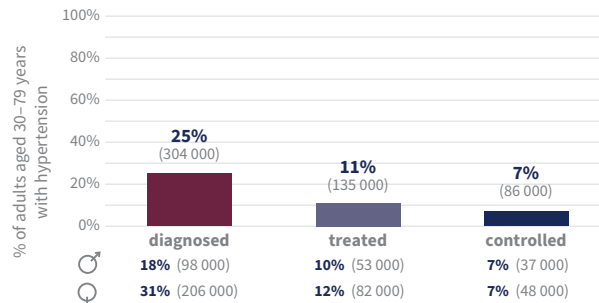
Prevalence of hypertension among adults aged 30–79 years (2024)^a

25% 24% 27%

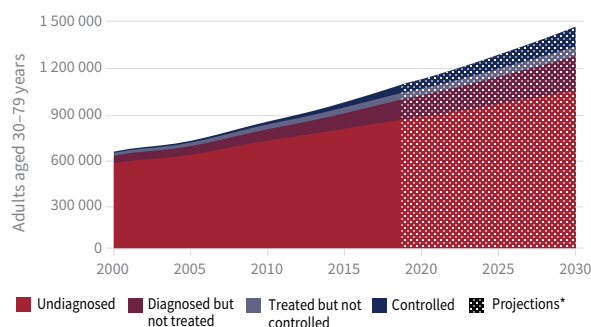
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.2 million adults aged 30–79 years with hypertension, approximately 1.1 million do not have the condition controlled^b

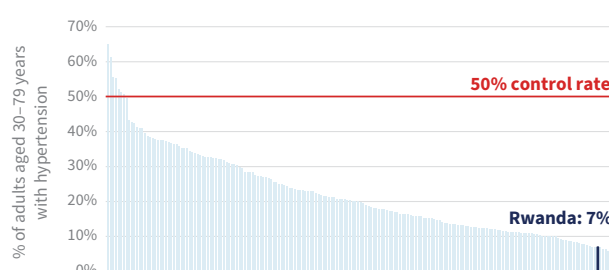


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	79 490	40 530	38 970	2021
Cardiovascular disease deaths	14 570	6240	8330	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	55	48	61	2021
Risk of premature death from NCDs (%) ^c	20	22	19	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	14	21	8	2022
Obesity, adults aged 18+ years (%)	5	1	7	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	9	8	10	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Saint Kitts and Nevis

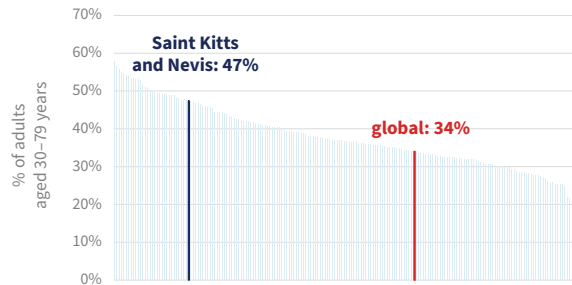
Hypertension profile

Total population (2024): 46 840

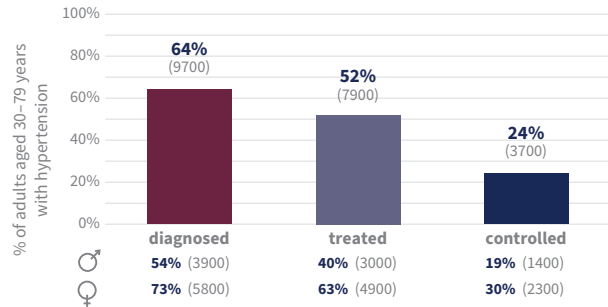
Prevalence of hypertension among adults aged 30–79 years (2024)^a

47% 46% 49%

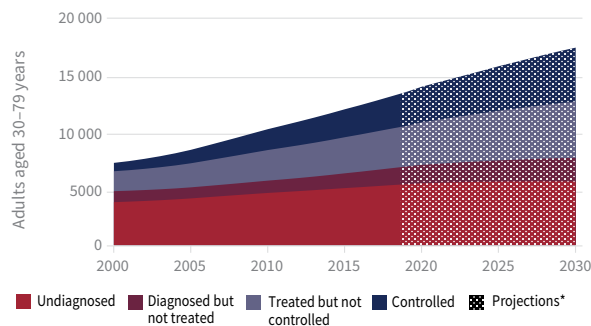
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 15 000 adults aged 30–79 years with hypertension, approximately 11 000 do not have the condition controlled^b

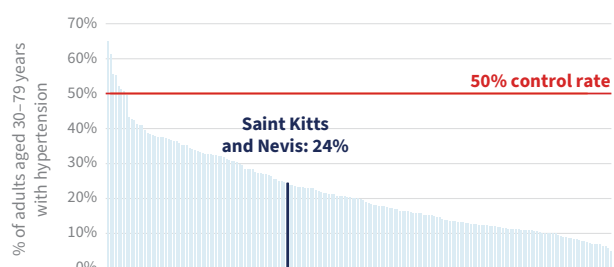


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	55	57	52	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	47	37	55	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	42	34	49	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Saint Lucia

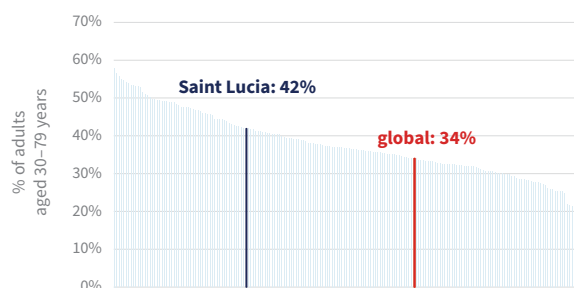
Hypertension profile

Total population (2024): 179 700

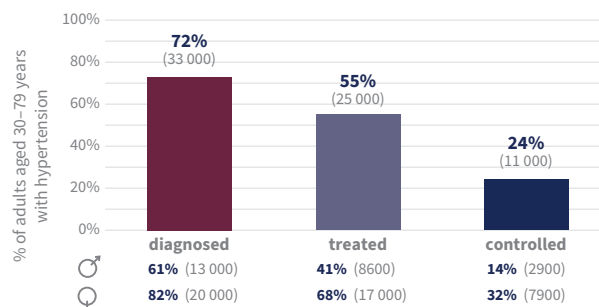
Prevalence of hypertension among adults aged 30–79 years (2024)^a

42% 40% 44%

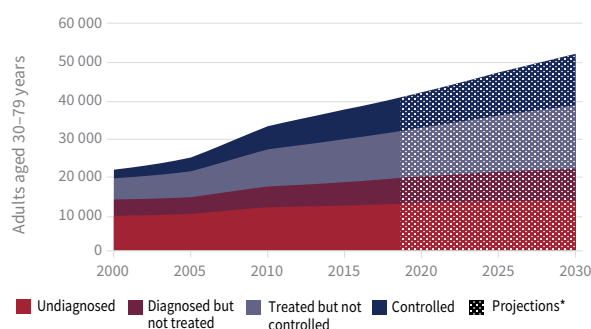
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 45 000 adults aged 30–79 years with hypertension, approximately 34 000 do not have the condition controlled^b

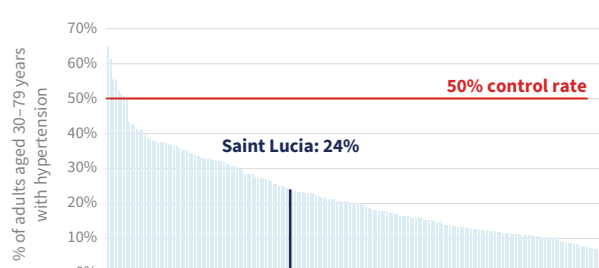


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	1 710	950	750	2021
Cardiovascular disease deaths	340	140	200	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	52	51	54	2021
Risk of premature death from NCDs (%) ^c	16	15	16	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	14	25	3	2022
Obesity, adults aged 18+ years (%)	34	21	47	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	21	18	24	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Saint Vincent and the Grenadines

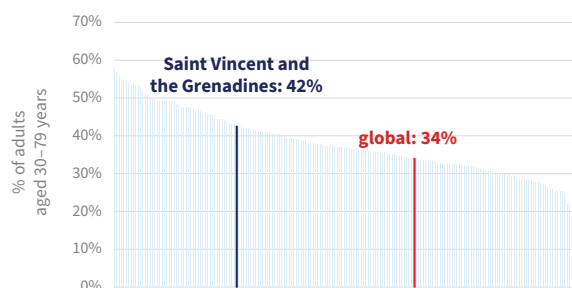
Hypertension profile

Total population (2024): 100 600

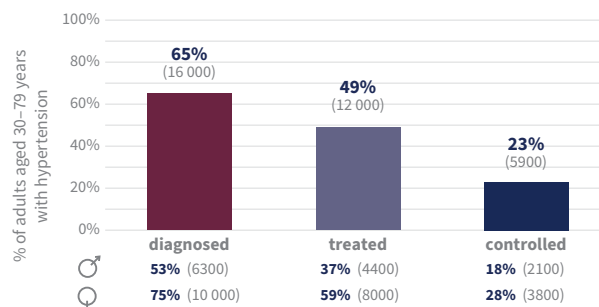
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 42% ♂ 40% ♀ 46%

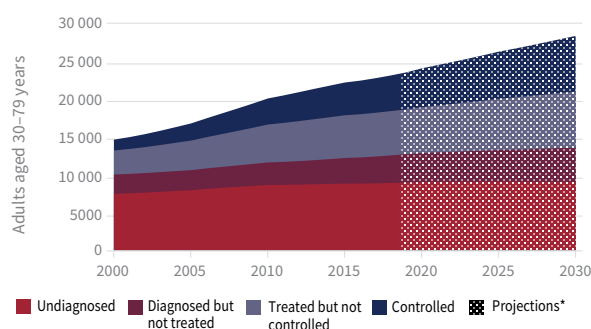
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 25 000 adults aged 30–79 years with hypertension, approximately 20 000 do not have the condition controlled^b

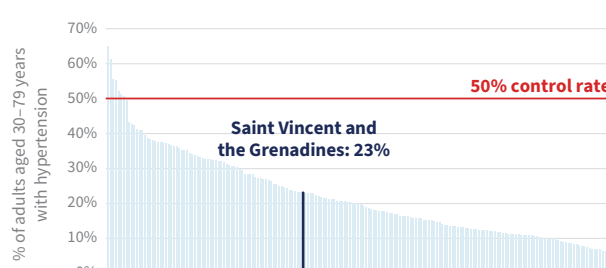


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	1010	560	440	2021
Cardiovascular disease deaths	370	190	180	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	56	56	2021
Risk of premature death from NCDs (%) ^c	24	26	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	34	19	49	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	30	21	40	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Samoa

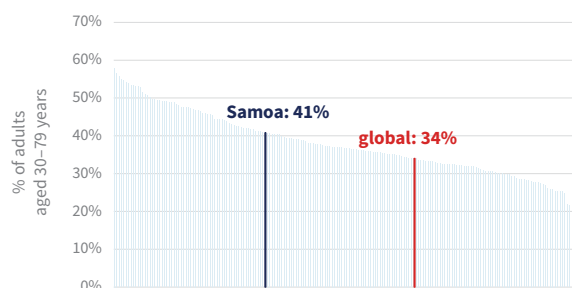
Hypertension profile

Total population (2024): 218 000

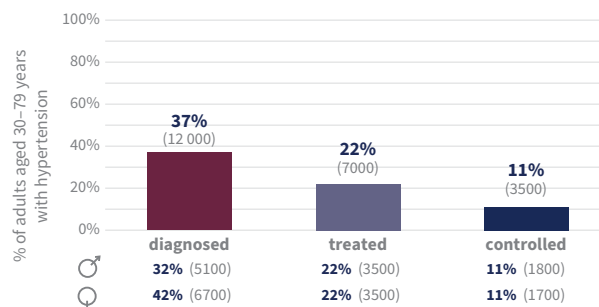
Prevalence of hypertension among adults aged 30–79 years (2024)^a

41% 40% 42%

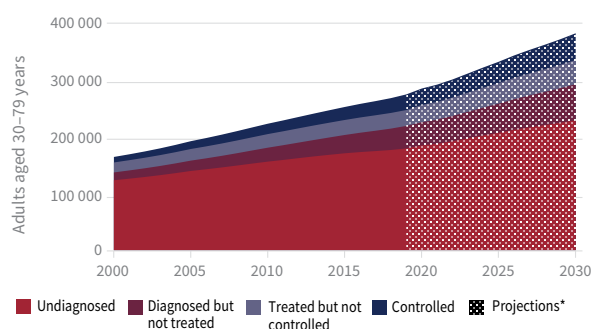
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 32 000 adults aged 30–79 years with hypertension, approximately 28 000 do not have the condition controlled^b

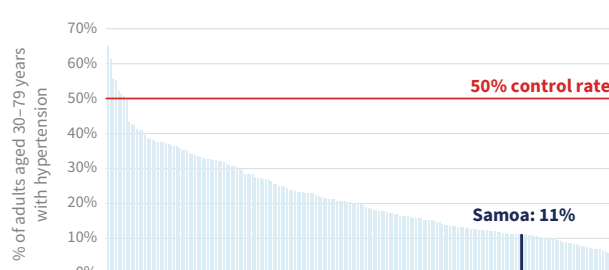


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	1430	710	720	2021
Cardiovascular disease deaths	540	270	270	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	51	52	51	2021
Risk of premature death from NCDs (%) ^c	32	34	30	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	5	5	5	2021
Current tobacco use, adults aged 15+ years (%)	23	32	13	2022
Obesity, adults aged 18+ years (%)	61	50	73	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	13	9	18	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

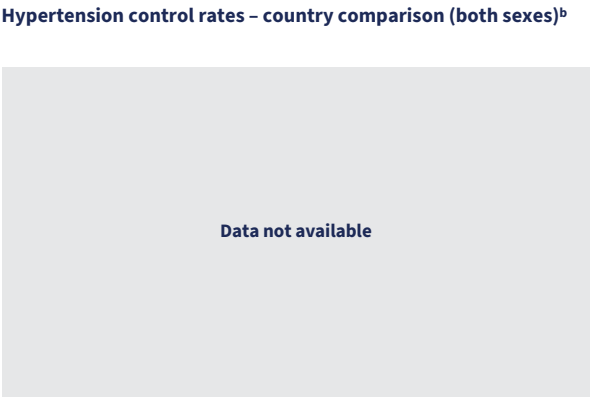
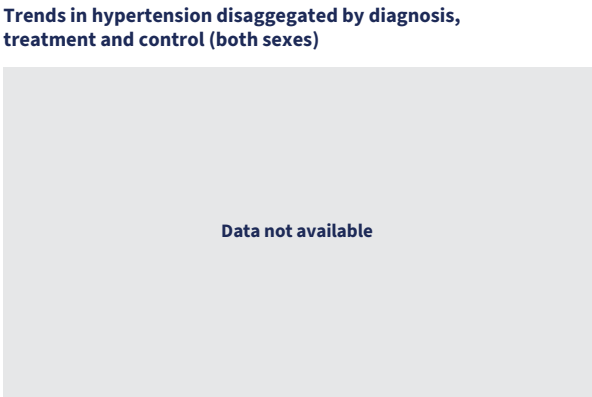
b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Prevalence of hypertension among adults aged 30–79 years (2024)^a



Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	47	45	48	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	no data	no data	no data	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	no data	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	26	23	28	2022

National response

Targets		Policies	
National target for blood pressure	No	Operational cardiovascular disease policy	Yes
National target for salt consumption	No	Operational salt reduction policy	No
Treatment			
Guidelines for management of hypertension	No		
Surveillance			
Conducted recent, national survey measuring raised blood pressure/hypertension	No		
Conducted recent, national survey on salt/sodium intake	No		
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes		
Standardized patient information system broadly available at the primary health carelevel that captures CVD-related patient data	Yes		

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.
b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.
c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

Sao Tome and Principe

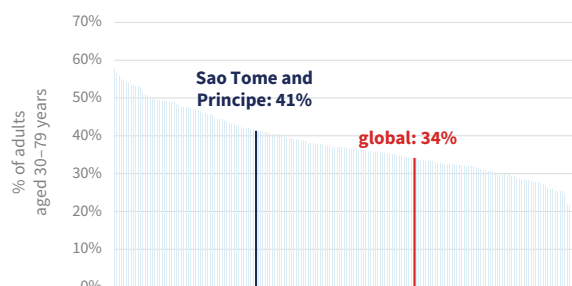
Hypertension profile

Total population (2024): 235 500

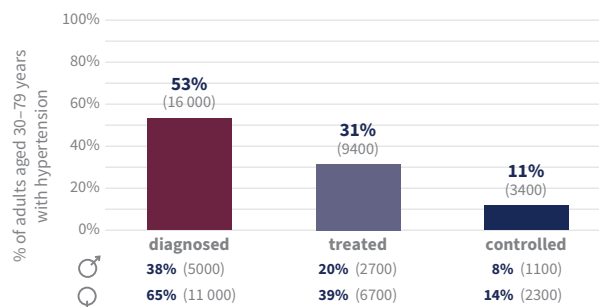
Prevalence of hypertension among adults aged 30–79 years (2024)^a

41% 37% 46%

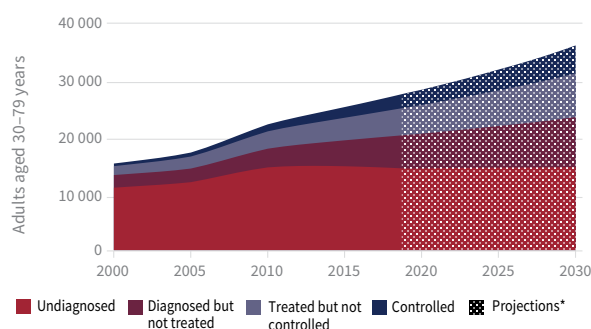
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 31 000 adults aged 30–79 years with hypertension, approximately 27 000 do not have the condition controlled^b

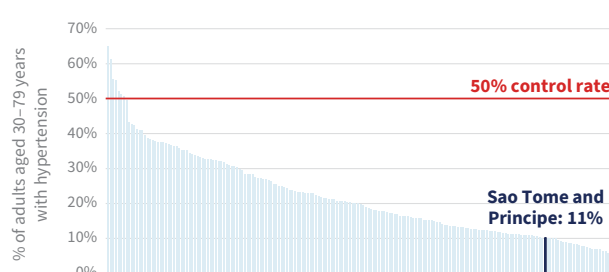


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	1120	580	540	2021
Cardiovascular disease deaths	260	100	160	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	57	56	2021
Risk of premature death from NCDs (%) ^c	20	20	19	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	8	14	2	2022
Obesity, adults aged 18+ years (%)	15	9	21	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	18	14	22	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Don't know

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Don't know

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Saudi Arabia

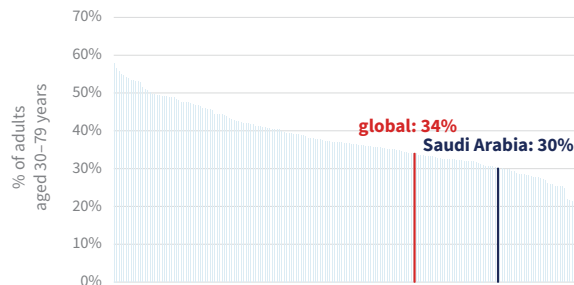
Hypertension profile

Total population (2024): 33 960 000

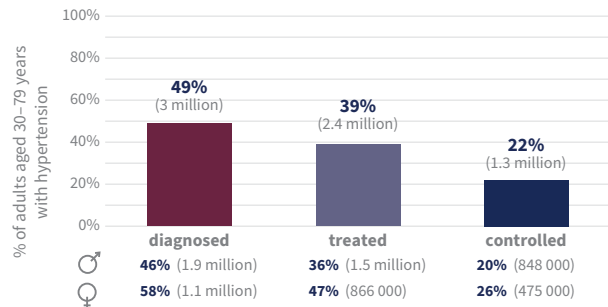
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 30% ♀ 34% 24%

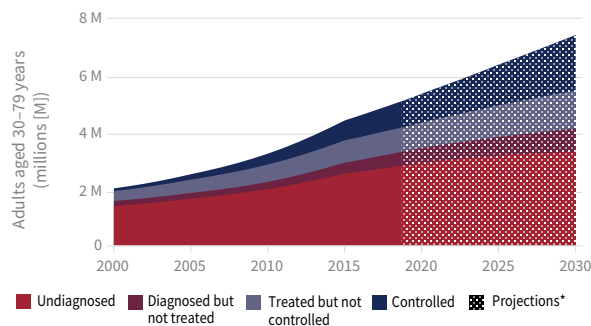
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 6.1 million adults aged 30–79 years with hypertension, approximately 4.7 million do not have the condition controlled^b

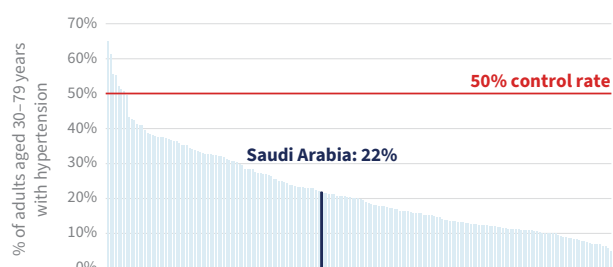


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	85 470	53 010	32 450	2021
Cardiovascular disease deaths	26 220	15 850	10 370	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	52	54	47	2021
Risk of premature death from NCDs (%) ^c	14	14	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	15	28	2	2022
Obesity, adults aged 18+ years (%)	41	39	44	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	no data	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	52	47	58	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Senegal

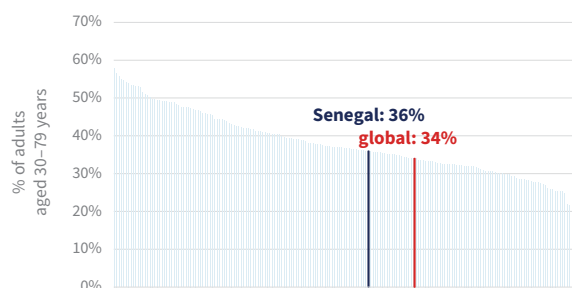
Hypertension profile

Total population (2024): 18 500 000

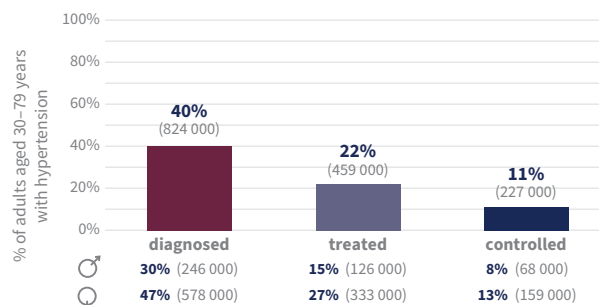
Prevalence of hypertension among adults aged 30–79 years (2024)^a

36% 32% 40%

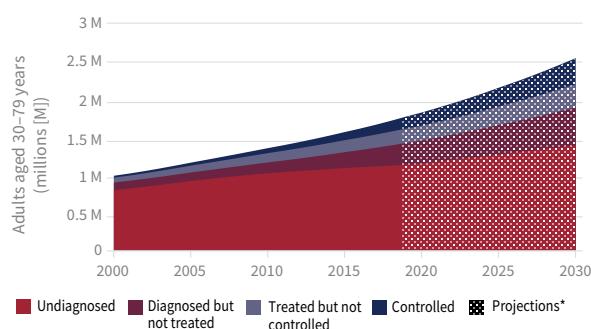
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2 million adults aged 30–79 years with hypertension, approximately 1.8 million do not have the condition controlled^b

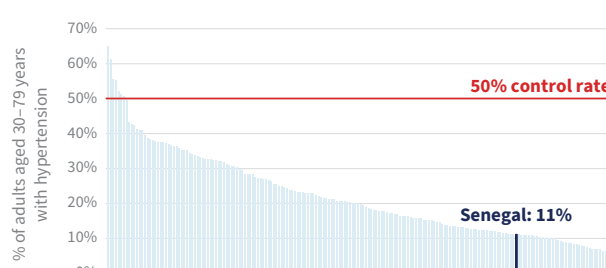


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	100 500	55 930	44 530	2021
Cardiovascular disease deaths	21 180	10 800	10 390	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	56	64	2021
Risk of premature death from NCDs (%) ^c	21	21	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	7	12	1	2022
Obesity, adults aged 18+ years (%)	9	3	14	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	17	11	22	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Serbia

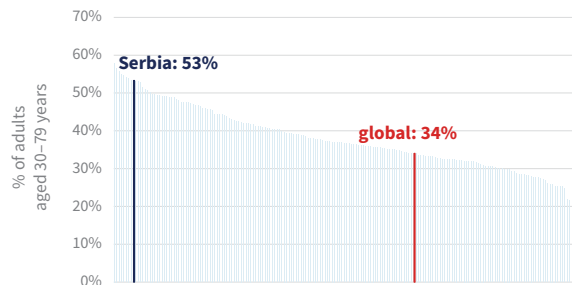
Hypertension profile

Total population (2024): 6 736 000

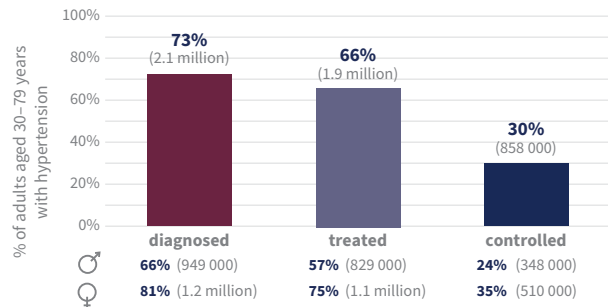
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 53% ♀ 55% 52%

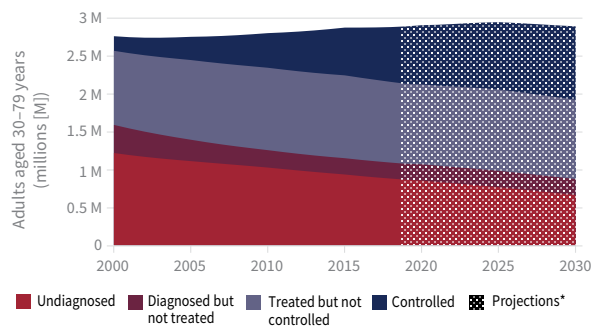
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.9 million adults aged 30–79 years with hypertension, approximately 2 million do not have the condition controlled^b

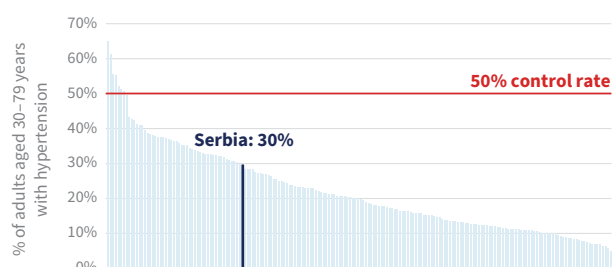


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	137 800	69 320	68 510	2021
Cardiovascular disease deaths	56 150	24 470	31 680	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	59	62	2021
Risk of premature death from NCDs (%) ^c	21	26	15	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	13	15	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	40	40	39	2022
Obesity, adults aged 18+ years (%)	26	28	24	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	9	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	45	42	48	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Seychelles

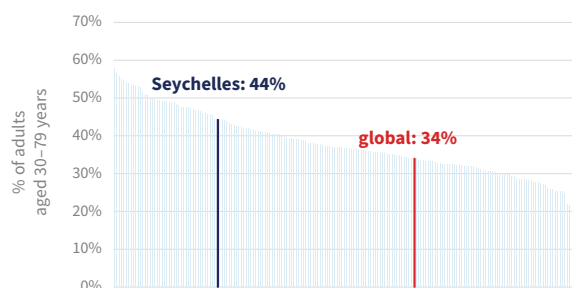
Hypertension profile

Total population (2024): 130 400

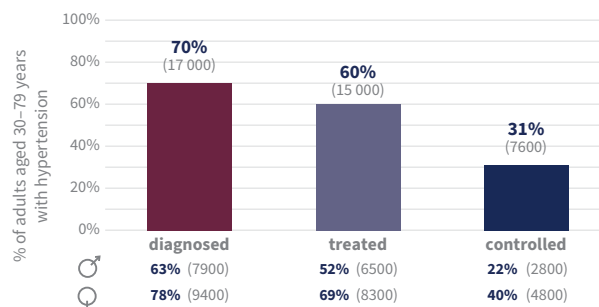
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 44% ♀ 44% 45%

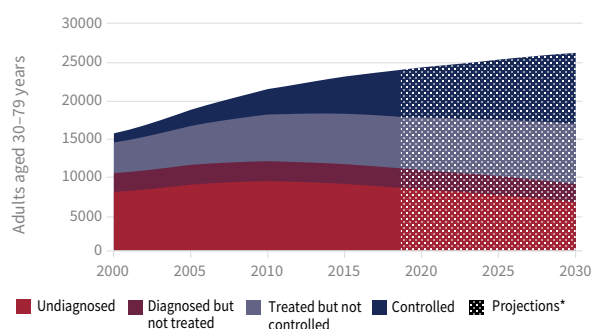
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 25 000 adults aged 30–79 years with hypertension, approximately 17 000 do not have the condition controlled^b

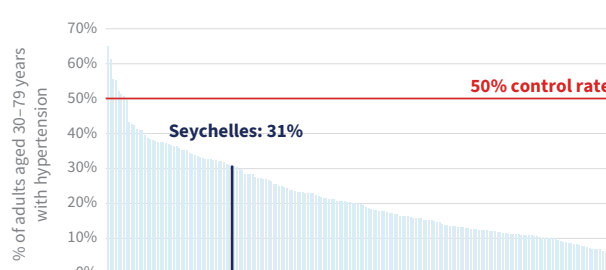


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	930	460	470	2021
Cardiovascular disease deaths	260	110	150	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	64	63	66	2021
Risk of premature death from NCDs (%) ^c	16	18	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%)	20	35	6	2022
Obesity, adults aged 18+ years (%)	30	21	41	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	20	20	21	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Sierra Leone

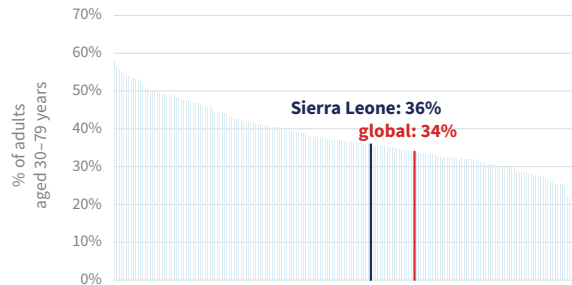
Hypertension profile

Total population (2024): 8 642 000

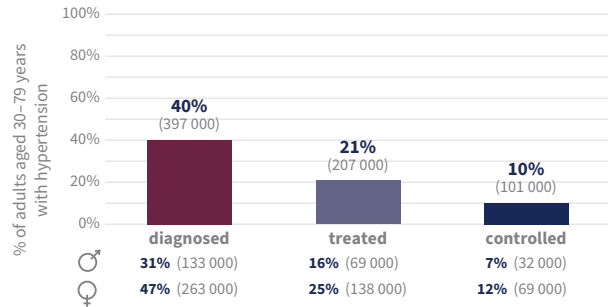
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♂ 32% ♀ 40%

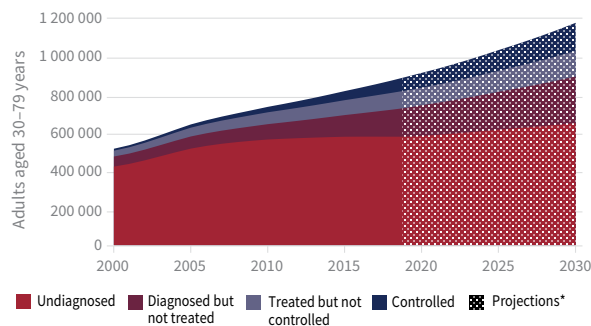
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 991 000 adults aged 30–79 years with hypertension, approximately 890 000 do not have the condition controlled^b

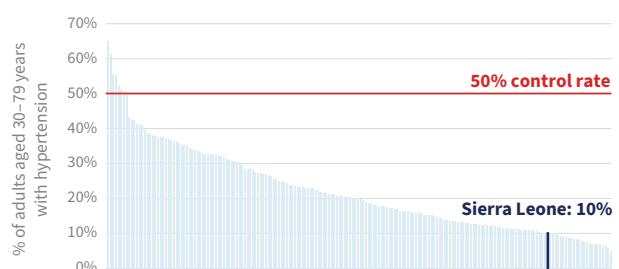


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	69 560	35 230	34 330	2021
Cardiovascular disease deaths	11 840	5200	6640	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	61	58	63	2021
Risk of premature death from NCDs (%) ^c	24	23	25	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	13	20	6	2022
Obesity, adults aged 18+ years (%)	6	2	11	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	13	9	17	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Singapore

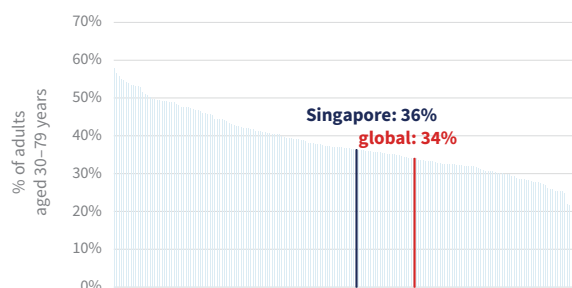
Hypertension profile

Total population (2024): 5 832 000

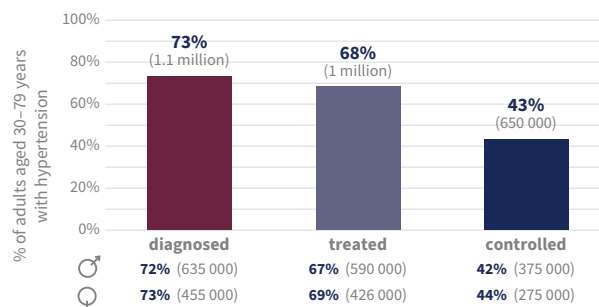
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♂ 40% ♀ 32%

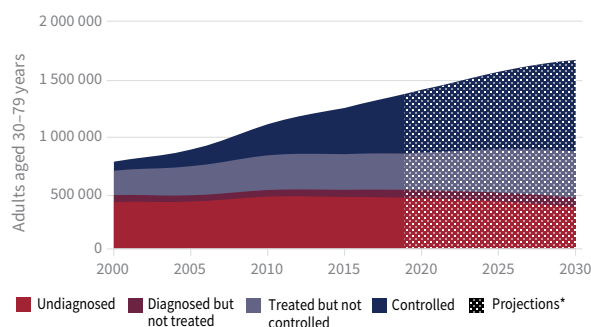
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.5 million adults aged 30–79 years with hypertension, approximately 854 000 do not have the condition controlled^b

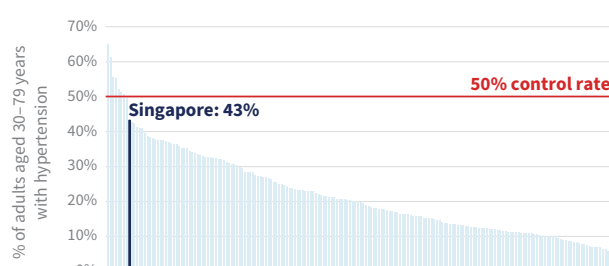


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	24 100	13 510	10 590	2021
Cardiovascular disease deaths	8060	4810	3250	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	41	41	42	2021
Risk of premature death from NCDs (%) ^c	10	13	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	11	12	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	16	28	5	2022
Obesity, adults aged 18+ years (%)	14	15	12	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	23	24	22	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Slovakia

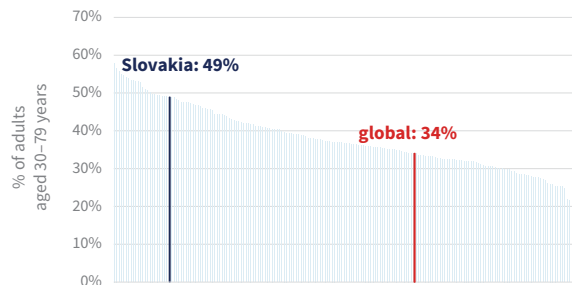
Hypertension profile

Total population (2024): 5 507 000

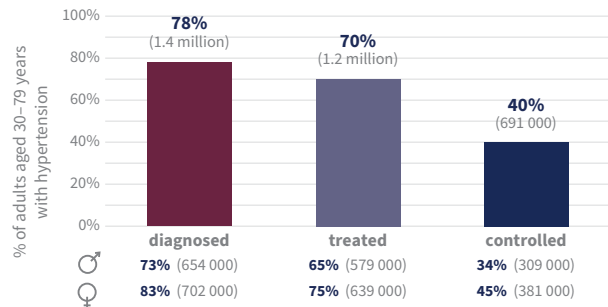
Prevalence of hypertension among adults aged 30–79 years (2024)^a

49% 52% 46%

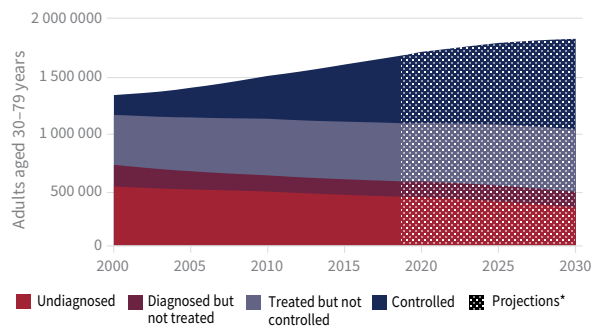
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.7 million adults aged 30–79 years with hypertension, approximately 1.1 million do not have the condition controlled^b

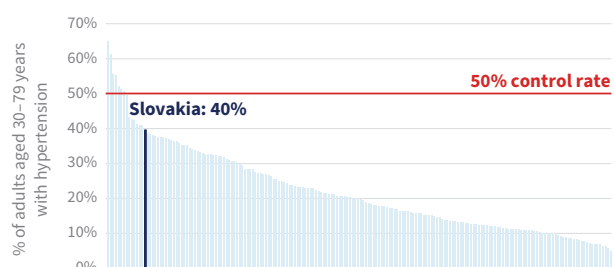


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	73 360	37 710	35 660	2021
Cardiovascular disease deaths	26 700	12 470	14 230	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	57	59	2021
Risk of premature death from NCDs (%) ^c	17	23	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	12	15	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	32	36	29	2022
Obesity, adults aged 18+ years (%)	30	33	28	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	23	22	24	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Don't know

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Slovenia

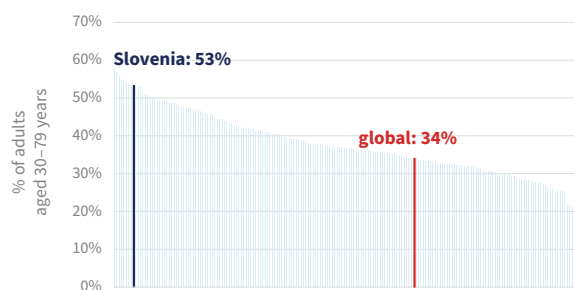
Hypertension profile

Total population (2024): 2 119 000

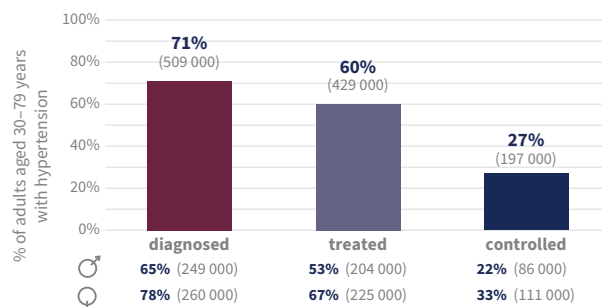
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 53% ♀ 56% 50%

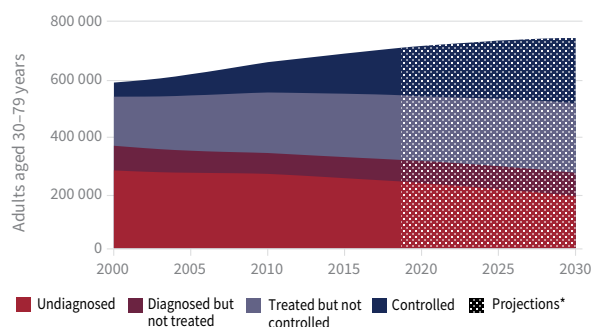
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 718 000 adults aged 30–79 years with hypertension, approximately 521 000 do not have the condition controlled^b

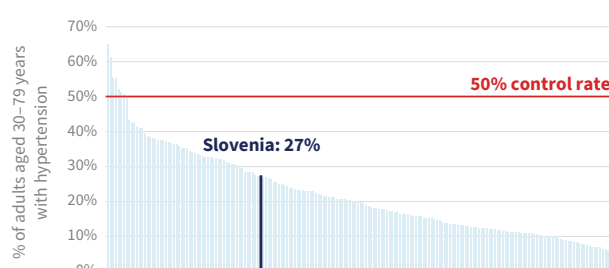


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	22 650	11 490	11 160	2021
Cardiovascular disease deaths	7040	3090	3950	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	51	50	52	2021
Risk of premature death from NCDs (%) ^c	12	15	8	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	13	15	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	20	22	19	2022
Obesity, adults aged 18+ years (%)	22	28	17	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	19	18	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Solomon Islands

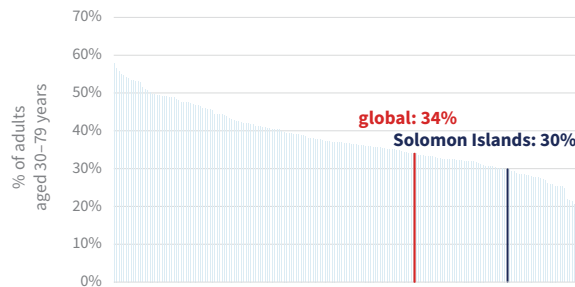
Hypertension profile

Total population (2024): 819 200

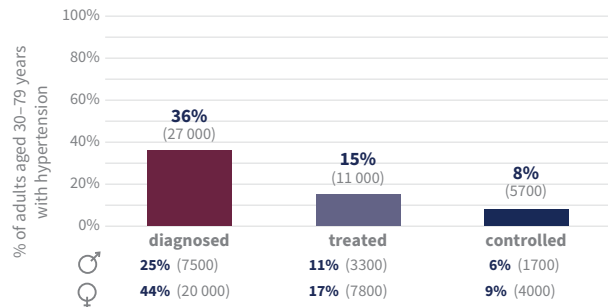
Prevalence of hypertension among adults aged 30–79 years (2024)^a

30% 24% 35%

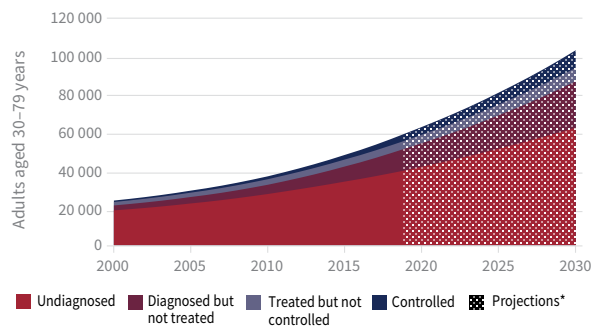
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 76 000 adults aged 30–79 years with hypertension, approximately 70 000 do not have the condition controlled^b

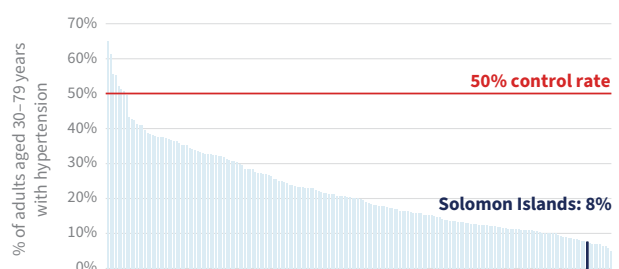


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	5810	3360	2460	2021
Cardiovascular disease deaths	2200	1260	930	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	41	37	45	2021
Risk of premature death from NCDs (%) ^c	41	45	36	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	37	54	19	2022
Obesity, adults aged 18+ years (%)	22	16	27	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	17	13	22	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Somalia

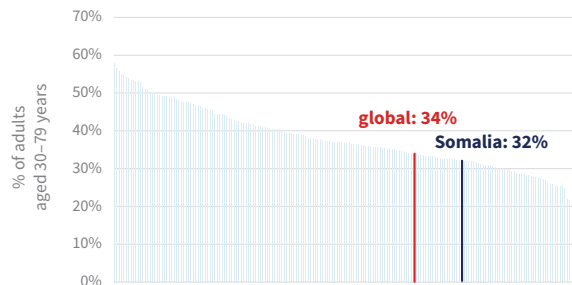
Hypertension profile

Total population (2024): 19 010 000

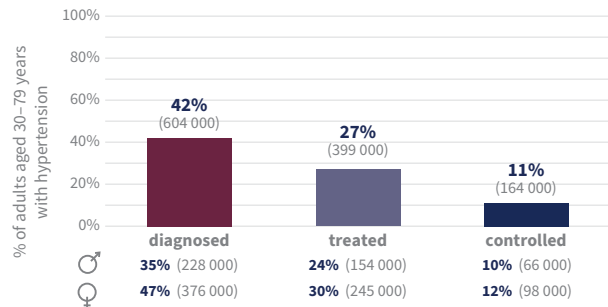
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♀ 29% 35%

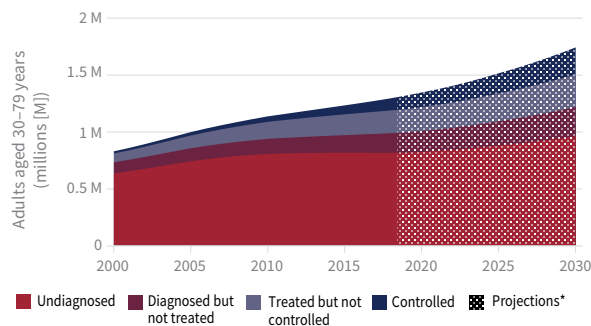
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.5 million adults aged 30–79 years with hypertension, approximately 1.3 million do not have the condition controlled^b

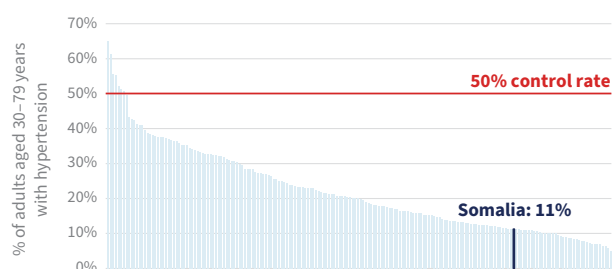


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	209 700	113 400	96 270	2021
Cardiovascular disease deaths	17 800	8300	9500	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	48	59	2021
Risk of premature death from NCDs (%) ^c	28	28	27	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	13	5	20	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	18	14	22	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

South Africa

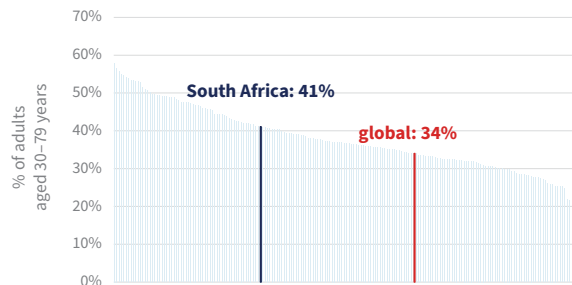
Hypertension profile

Total population (2024): 64 010 000

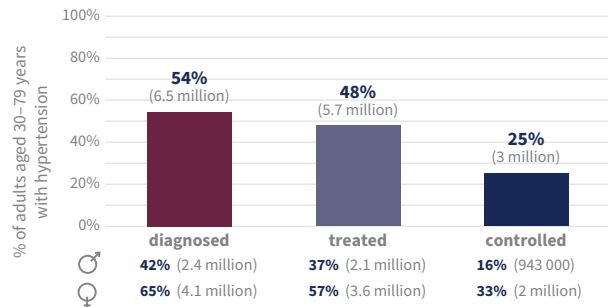
Prevalence of hypertension among adults aged 30–79 years (2024)^a

41% 41% 41%

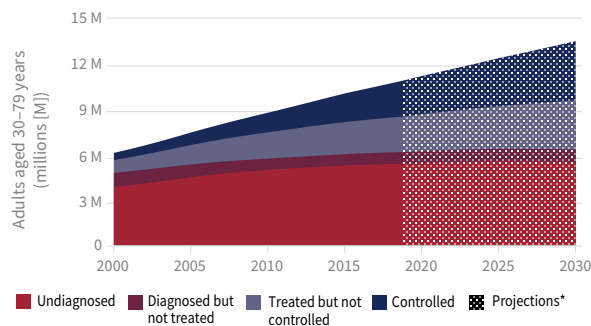
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 12 million adults aged 30–79 years with hypertension, approximately 9 million do not have the condition controlled^b

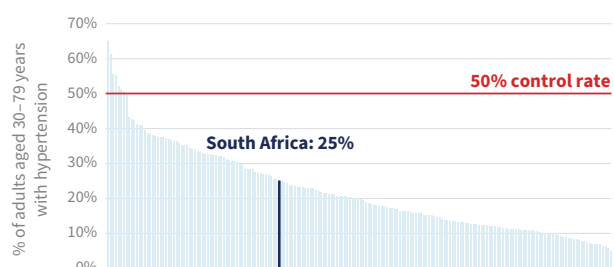


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	778 900	380 500	398 400	2021
Cardiovascular disease deaths	101 700	30 140	71 540	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	62	58	65	2021
Risk of premature death from NCDs (%) ^c	23	20	25	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	6	2021
Current tobacco use, adults aged 15+ years (%) ^d	21	35	7	2022
Obesity, adults aged 18+ years (%)	30	13	46	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	45	41	48	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

South Sudan

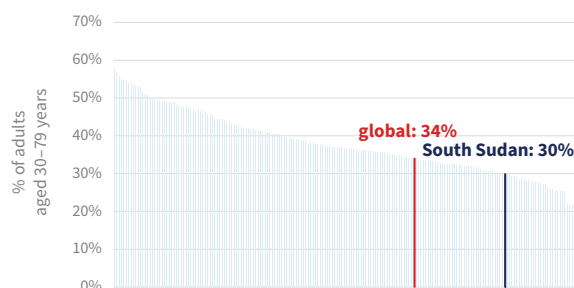
Hypertension profile

Total population (2024): 11 940 000

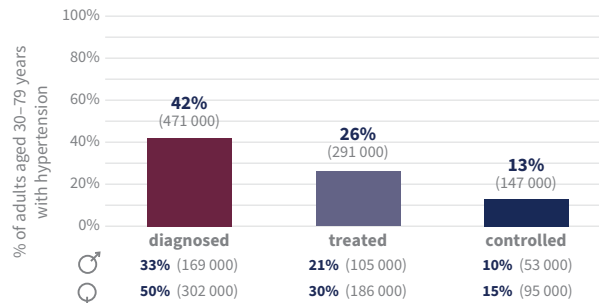
Prevalence of hypertension among adults aged 30–79 years (2024)^a

30% 28% 32%

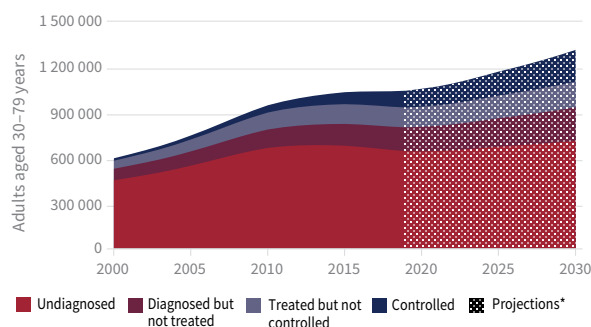
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



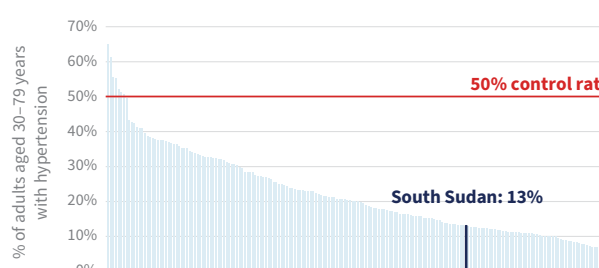
Of the 1.1 million adults aged 30–79 years with hypertension, approximately 977 000 do not have the condition controlled^b



Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



Hypertension control rates – country comparison (both sexes)^b



*Projections assume a continuation of past trends.

Mortality†

	both sexes	males	females	year
Total deaths	100 500	52 740	47 710	2021
Cardiovascular disease deaths	10 140	5160	4980	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	50	58	2021
Risk of premature death from NCDs (%) ^c	22	26	20	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	8	5	11	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	16	13	19	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Spain

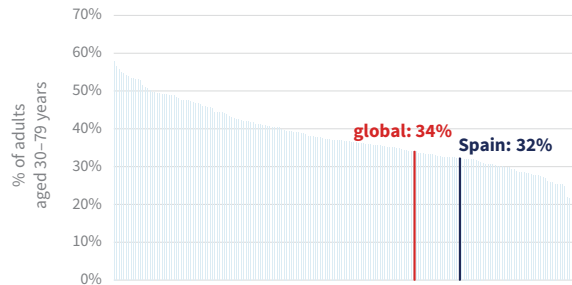
Hypertension profile

Total population (2024): 47 910 000

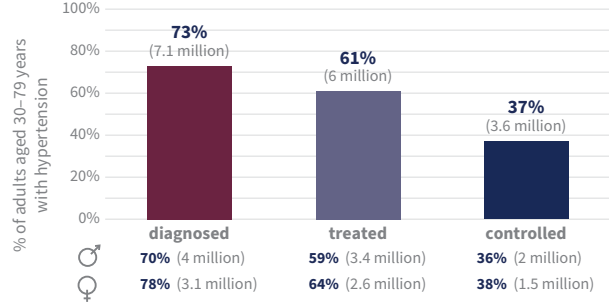
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 32% ♀ 38% ♀ 26%

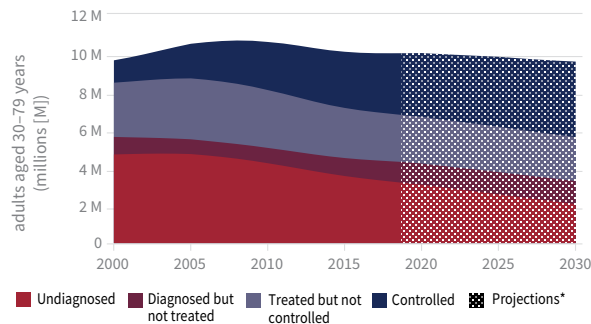
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 9.8 million adults aged 30–79 years with hypertension, approximately 6.2 million do not have the condition controlled^b

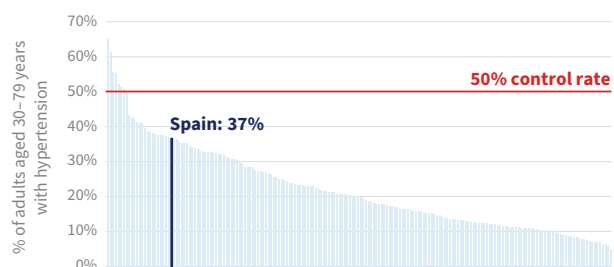


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	451 700	231 800	219 900	2021
Cardiovascular disease deaths	118 400	55 430	62 980	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	44	44	45	2021
Risk of premature death from NCDs (%) ^c	9	12	6	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	28	29	28	2022
Obesity, adults aged 18+ years (%)	19	22	17	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	22	19	24	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Sri Lanka

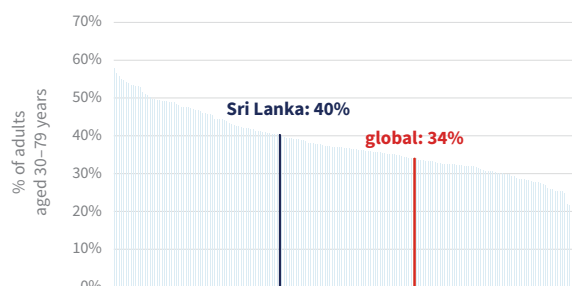
Hypertension profile

Total population (2024): 23 100 000

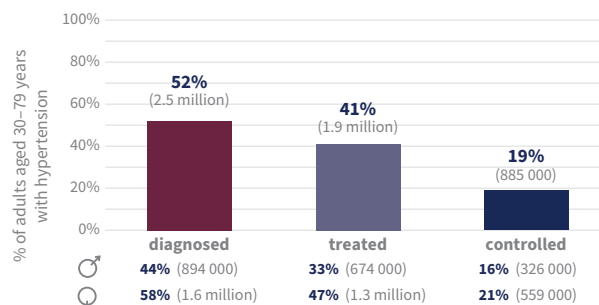
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 40% ♀ 43%

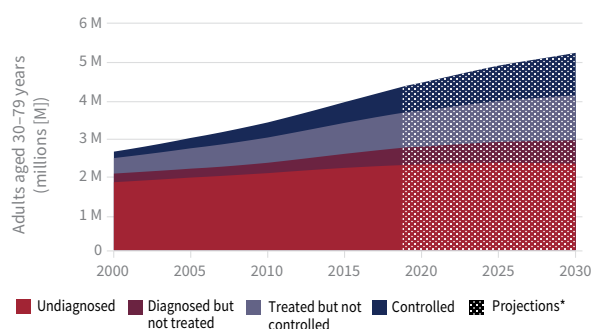
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 4.7 million adults aged 30–79 years with hypertension, approximately 3.8 million do not have the condition controlled^b

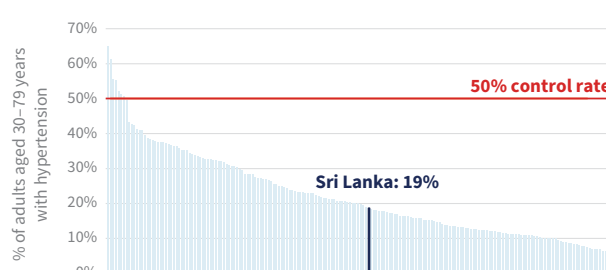


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	148 900	79 580	69 320	2021
Cardiovascular disease deaths	51 430	25 200	26 220	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	58	61	2021
Risk of premature death from NCDs (%) ^c	14	17	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%)	20	37	2	2022
Obesity, adults aged 18+ years (%)	11	7	14	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	37	29	45	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Sudan

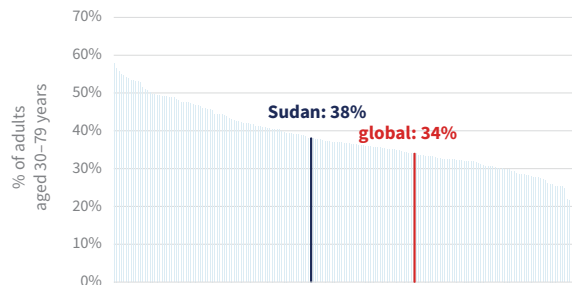
Hypertension profile

Total population (2024): 50 450 000

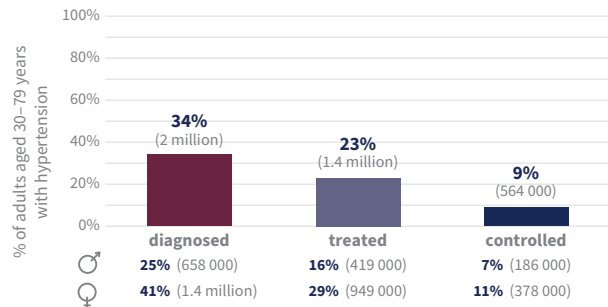
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 38% ♀ 41%

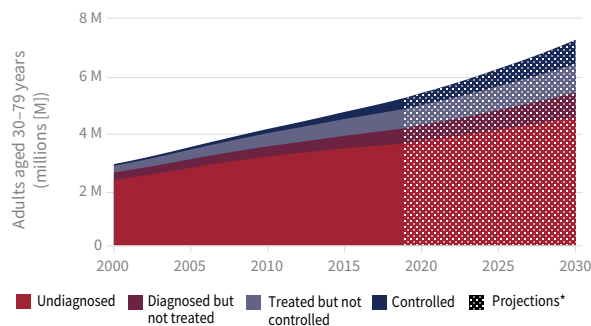
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 6 million adults aged 30–79 years with hypertension, approximately 5.4 million do not have the condition controlled^b

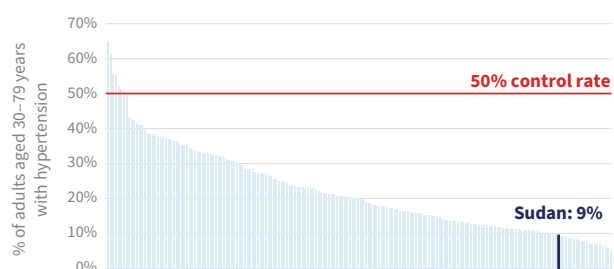


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	276 800	150 300	126 500	2021
Cardiovascular disease deaths	68 110	32 240	35 870	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	61	59	63	2021
Risk of premature death from NCDs (%) ^c	21	20	22	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	16	10	20	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	19	17	21	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Suriname

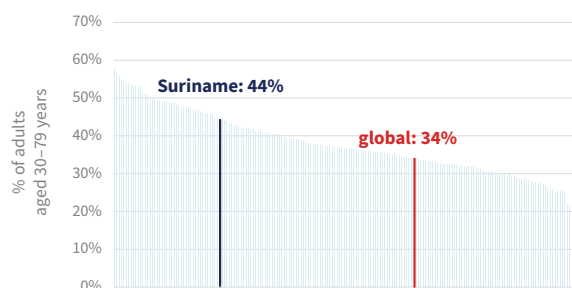
Hypertension profile

Total population (2024): 634 400

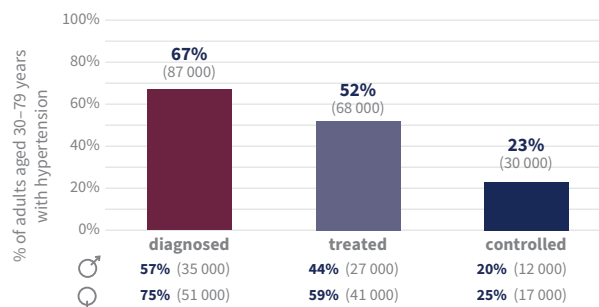
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 44% ♂ 43% ♀ 46%

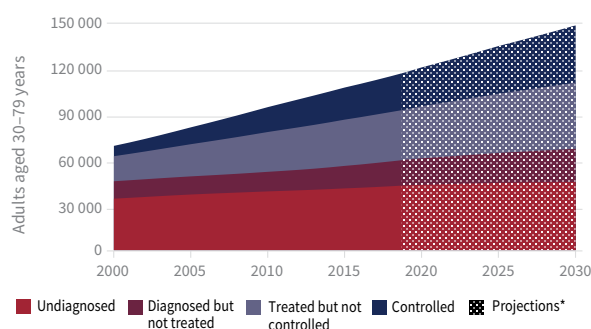
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 130 000 adults aged 30–79 years with hypertension, approximately 100 000 do not have the condition controlled^b

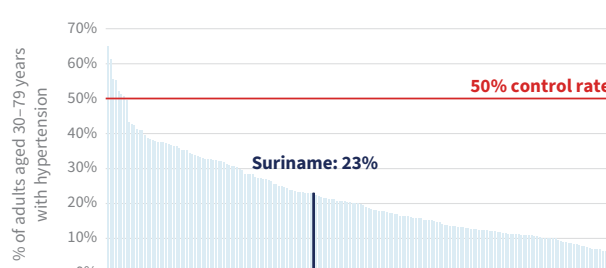


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	5190	2850	2340	2021
Cardiovascular disease deaths	990	430	560	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	48	48	48	2021
Risk of premature death from NCDs (%) ^c	19	19	19	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	29	19	39	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	49	42	55	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Sweden

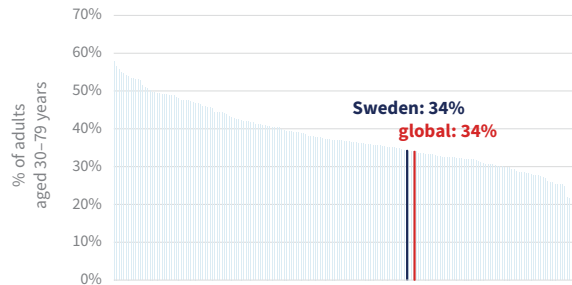
Hypertension profile

Total population (2024): 10 610 000

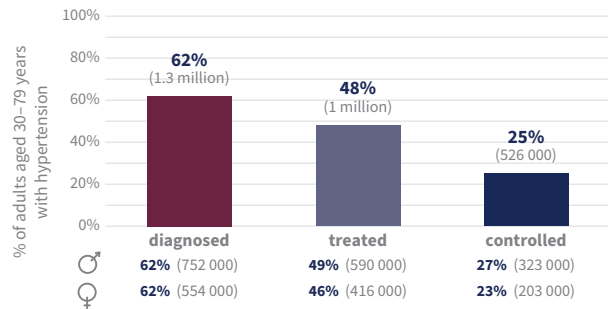
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 34% ♀ 29%

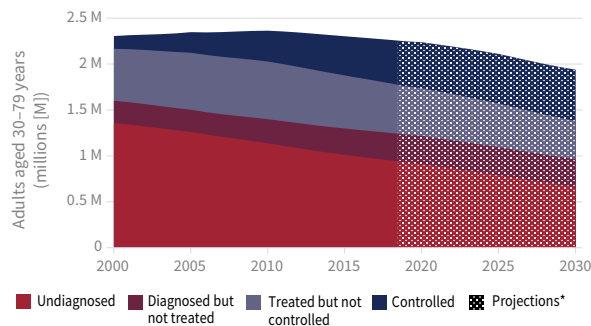
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.1 million adults aged 30–79 years with hypertension, approximately 1.6 million do not have the condition controlled^b

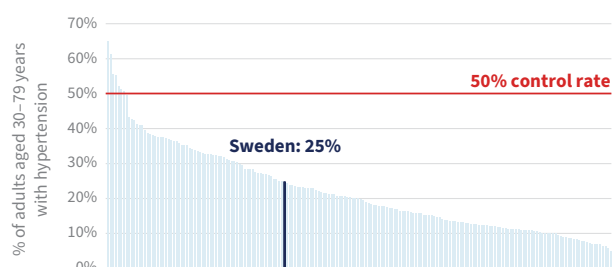


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	92 120	46 590	45 520	2021
Cardiovascular disease deaths	27 790	14 010	13 780	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	49	48	50	2021
Risk of premature death from NCDs (%) ^c	8	9	7	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	9	7	2021
Current tobacco use, adults aged 15+ years (%)	23	29	16	2022
Obesity, adults aged 18+ years (%)	16	18	15	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	10	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	9	9	8	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Don't know

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Switzerland

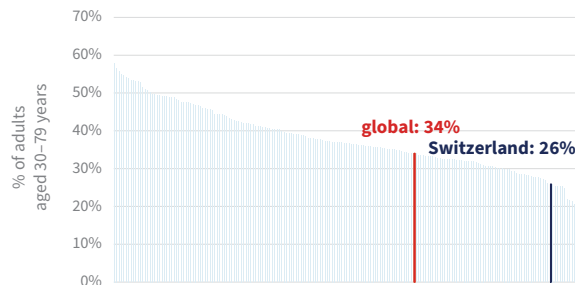
Hypertension profile

Total population (2024): 8 922 000

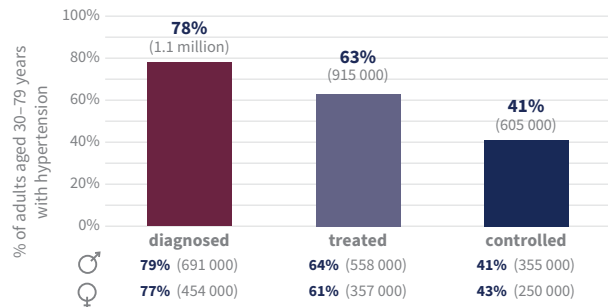
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 26% ♂ 31% ♀ 21%

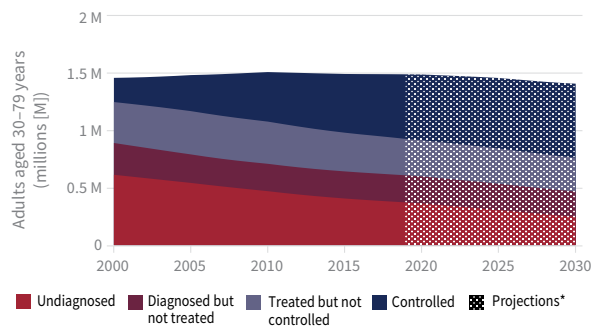
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.5 million adults aged 30–79 years with hypertension, approximately 855 000 do not have the condition controlled^b

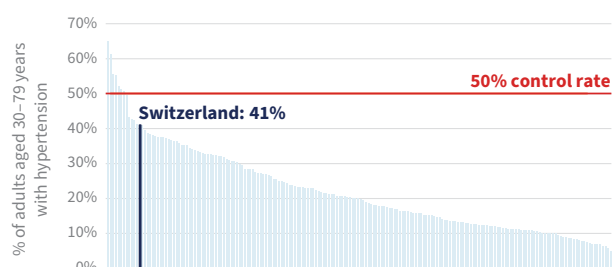


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	71 490	35 280	36 210	2021
Cardiovascular disease deaths	20 470	9530	10 940	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	46	45	47	2021
Risk of premature death from NCDs (%) ^c	8	9	6	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	10	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	26	28	23	2022
Obesity, adults aged 18+ years (%)	14	17	11	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	9	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	19	18	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Syrian Arab Republic

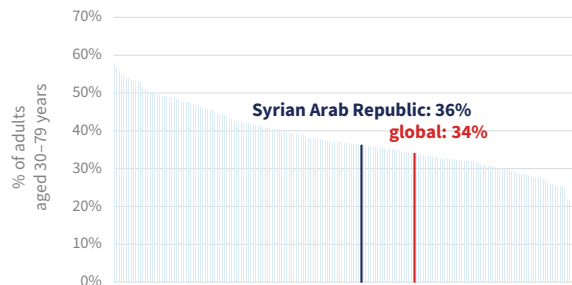
Hypertension profile

Total population (2024): 24 670 000

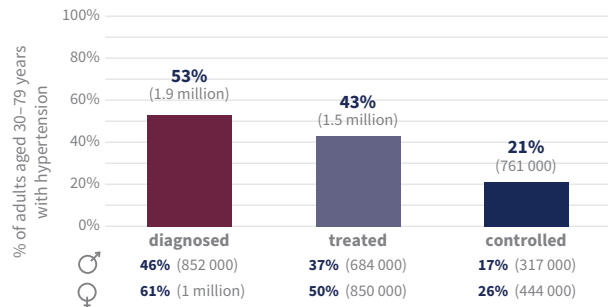
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♀ 39% ♀ 34%

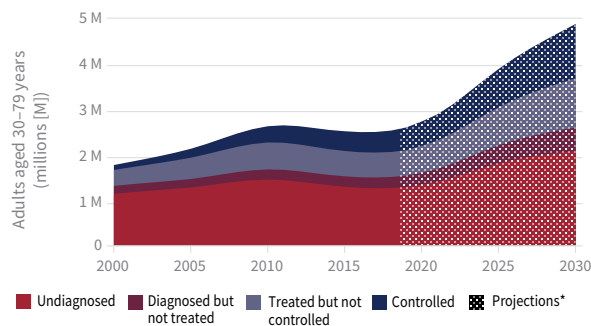
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.6 million adults aged 30–79 years with hypertension, approximately 2.8 million do not have the condition controlled^b

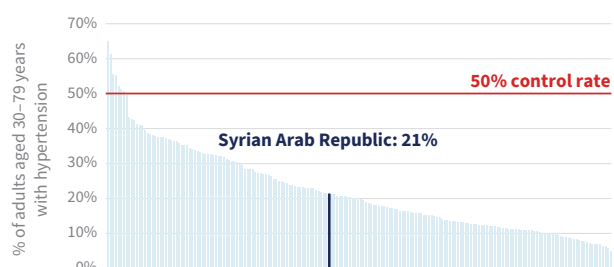


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	109 000	56 020	52 950	2021
Cardiovascular disease deaths	46 960	21 900	25 060	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	53	55	2021
Risk of premature death from NCDs (%) ^c	21	25	18	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	31	24	38	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	38	33	42	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Tajikistan

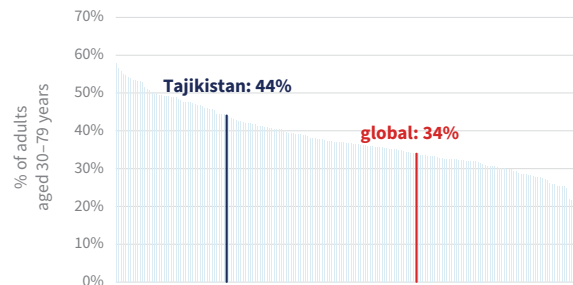
Hypertension profile

Total population (2024): 10 590 000

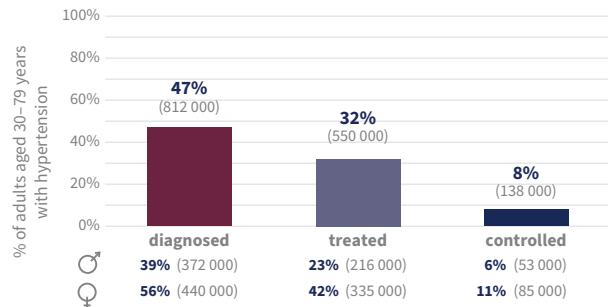
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 44% ♂ 49% ♀ 39%

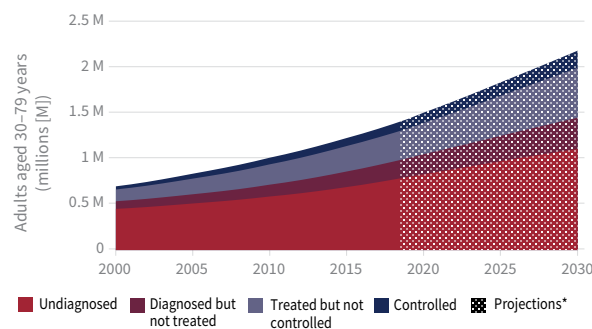
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.7 million adults aged 30–79 years with hypertension, approximately 1.6 million do not have the condition controlled^b

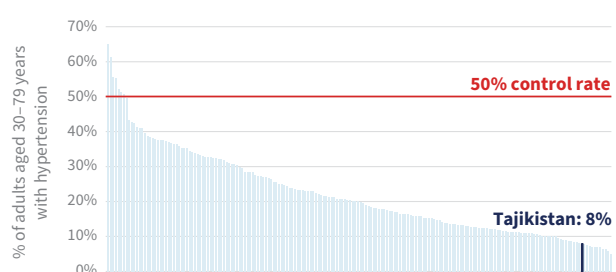


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	44 790	23 570	21 220	2021
Cardiovascular disease deaths	14 630	6530	8090	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	58	61	2021
Risk of premature death from NCDs (%) ^c	18	19	17	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	21	18	24	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	36	26	45	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Thailand

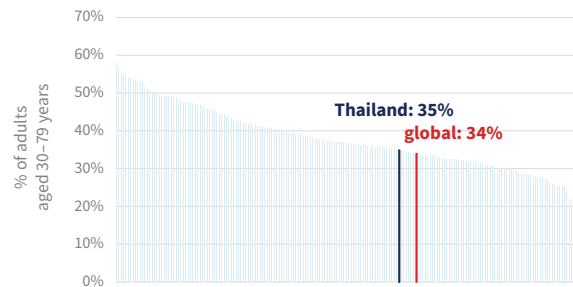
Hypertension profile

Total population (2024): 71 670 000

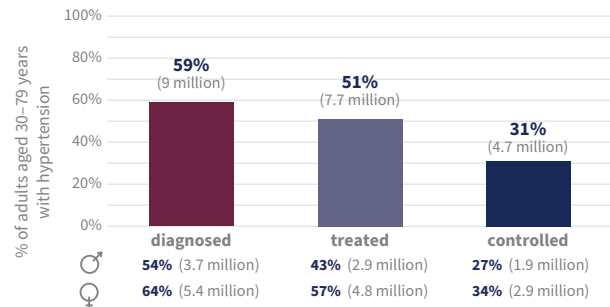
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 35% ♂ 33% ♀ 37%

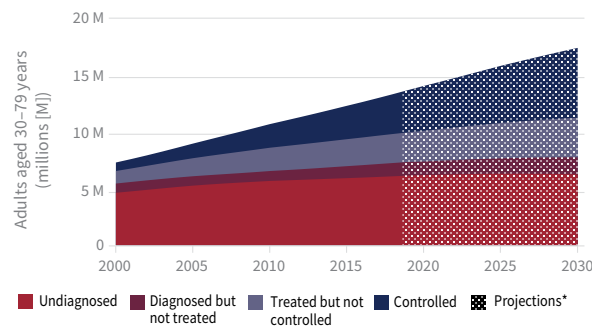
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 15.2 million adults aged 30–79 years with hypertension, approximately 10.5 million do not have the condition controlled^b

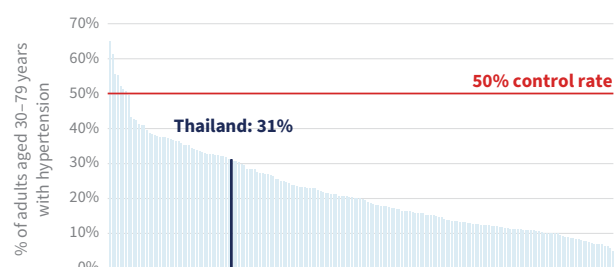


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	633 200	342 800	290 500	2021
Cardiovascular disease deaths	134 700	66 630	68 080	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	47	47	47	2021
Risk of premature death from NCDs (%) ^c	15	18	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%) ^d	19	37	2	2022
Obesity, adults aged 18+ years (%)	15	11	18	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	8	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	29	28	29	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Timor-Leste

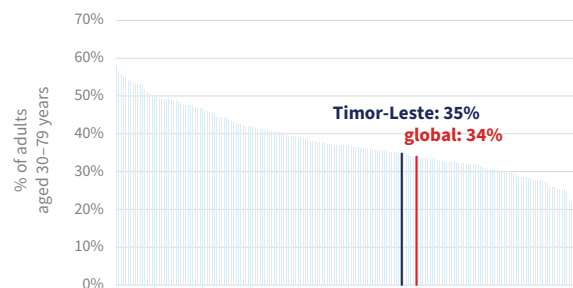
Hypertension profile

Total population (2024): 1 401 000

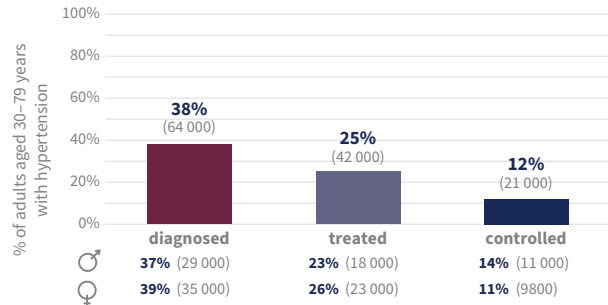
Prevalence of hypertension among adults aged 30–79 years (2024)^a

35% 33% 37%

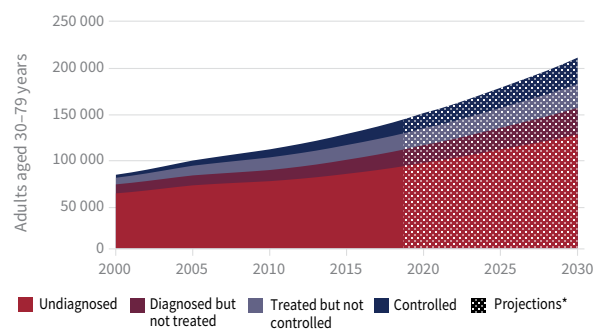
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 168 000 adults aged 30–79 years with hypertension, approximately 148 000 do not have the condition controlled^b

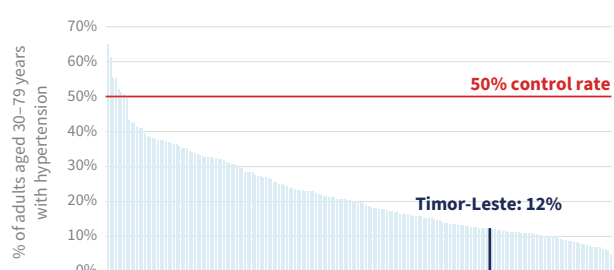


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	9330	4960	4370	2021
Cardiovascular disease deaths	2560	1230	1330	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	60	59	2021
Risk of premature death from NCDs (%) ^c	20	21	20	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%)	39	67	11	2022
Obesity, adults aged 18+ years (%)	2	2	3	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	27	21	33	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Togo

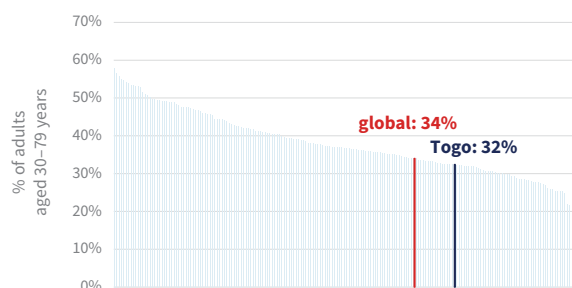
Hypertension profile

Total population (2024): 9 515 000

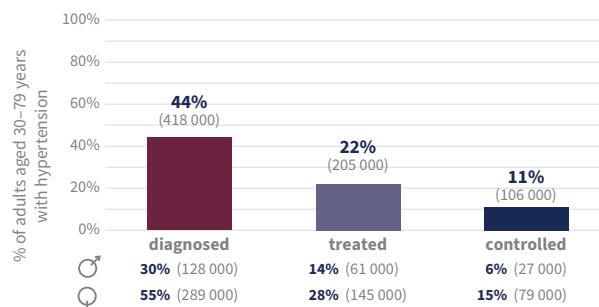
Prevalence of hypertension among adults aged 30–79 years (2024)^a

32% 30% 35%

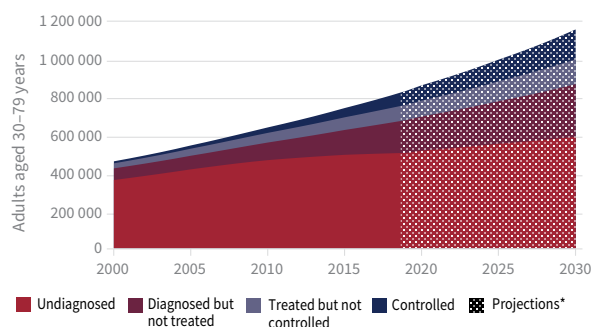
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 954 000 adults aged 30–79 years with hypertension, approximately 849 000 do not have the condition controlled^b

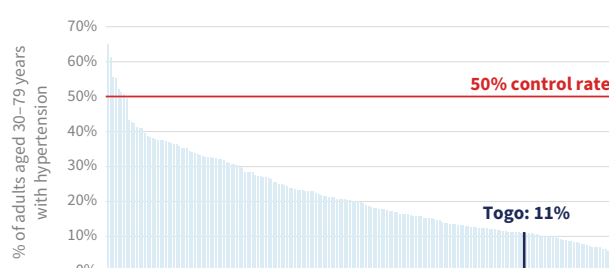


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	63 230	35 640	27 590	2021
Cardiovascular disease deaths	12 320	6660	5660	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	60	56	63	2021
Risk of premature death from NCDs (%) ^c	25	28	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	7	2021
Current tobacco use, adults aged 15+ years (%)	6	12	1	2022
Obesity, adults aged 18+ years (%)	10	5	16	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	15	12	17	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Tonga

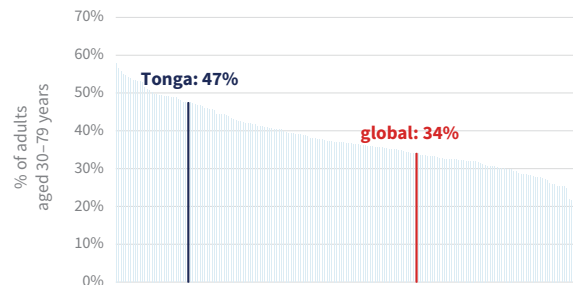
Hypertension profile

Total population (2024): 104 200

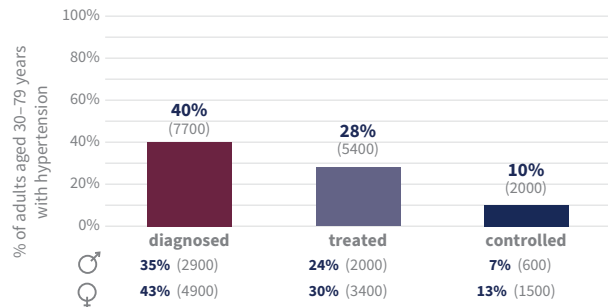
Prevalence of hypertension among adults aged 30–79 years (2024)^a

47% 42% 52%

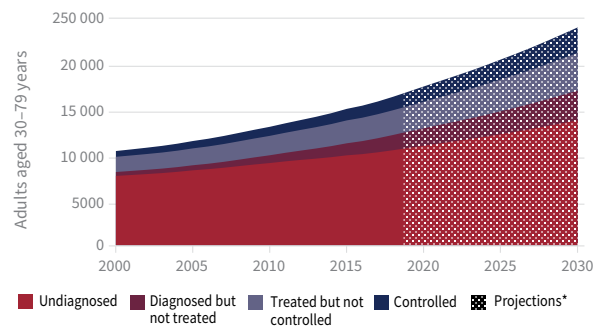
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 20 000 adults aged 30–79 years with hypertension, approximately 17 000 do not have the condition controlled^b

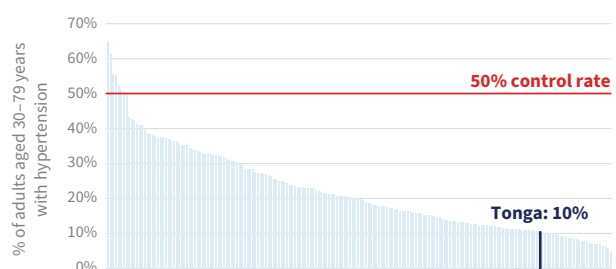


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	660	350	310	2021
Cardiovascular disease deaths	190	110	80	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	52	53	2021
Risk of premature death from NCDs (%) ^c	27	31	23	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	31	47	16	2022
Obesity, adults aged 18+ years (%)	71	61	79	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	31	23	38	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Trinidad and Tobago

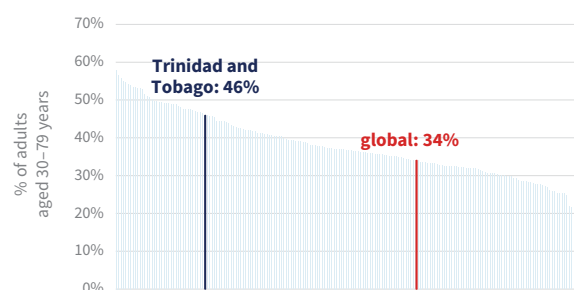
Hypertension profile

Total population (2024): 1 508 000

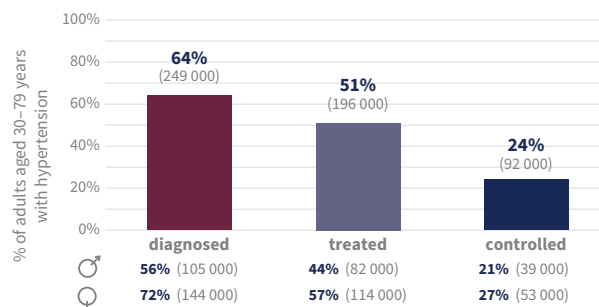
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 46% ♀ 45% ♀ 46%

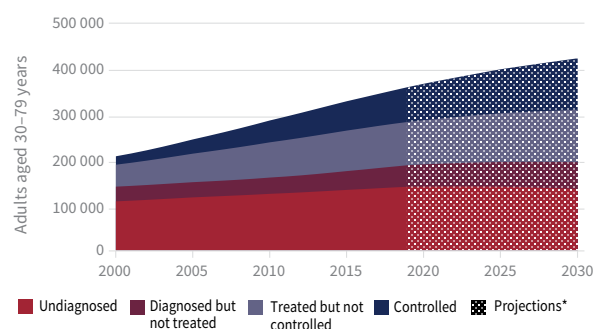
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 387 000 adults aged 30–79 years with hypertension, approximately 295 000 do not have the condition controlled^b

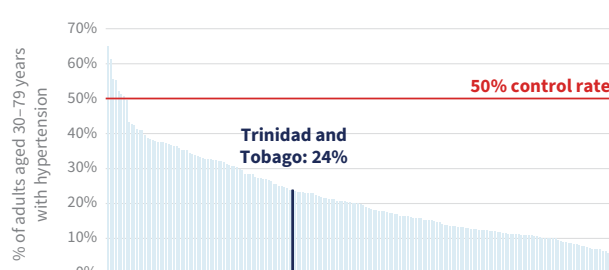


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	13 570	7600	5970	2021
Cardiovascular disease deaths	3130	1650	1480	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	62	50	2021
Risk of premature death from NCDs (%) ^c	20	24	17	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	29	23	35	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	45	35	54	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Tunisia

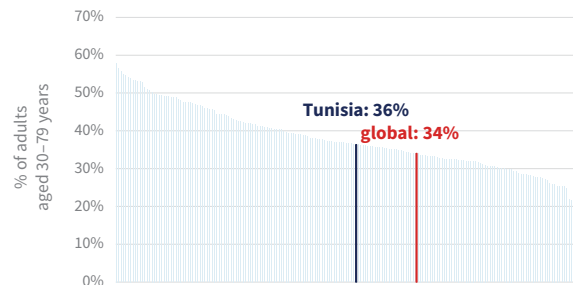
Hypertension profile

Total population (2024): 12 280 000

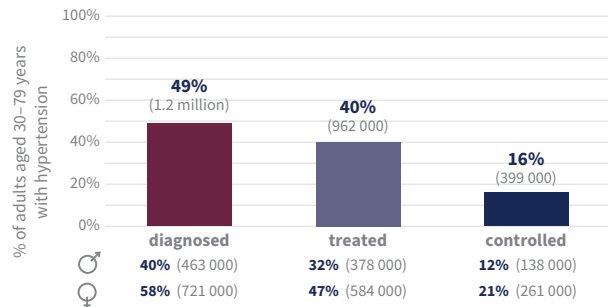
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 36% ♀ 36%

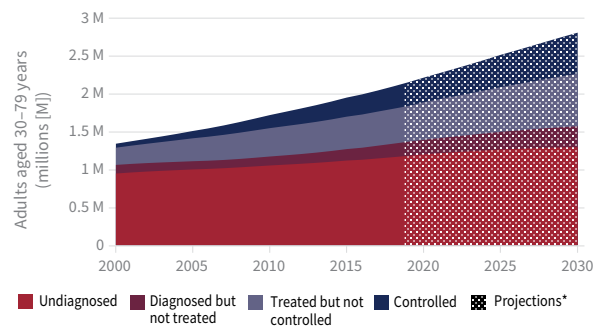
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.4 million adults aged 30–79 years with hypertension, approximately 2 million do not have the condition controlled^b

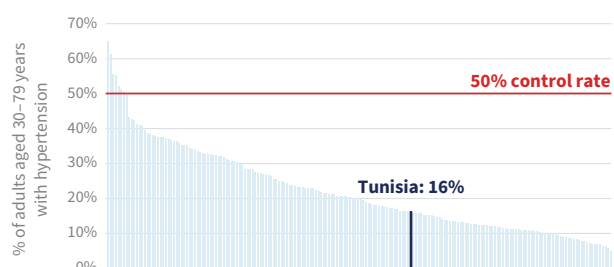


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	89 090	50 380	38 710	2021
Cardiovascular disease deaths	26 710	12 630	14 080	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	52	51	55	2021
Risk of premature death from NCDs (%) ^c	13	15	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%) ^d	21	40	2	2022
Obesity, adults aged 18+ years (%)	28	20	36	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	33	29	38	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Türkiye

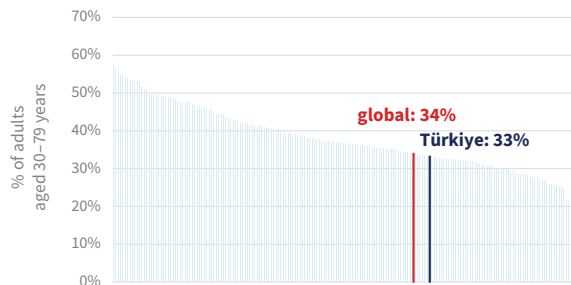
Hypertension profile

Total population (2024): 87 470 000

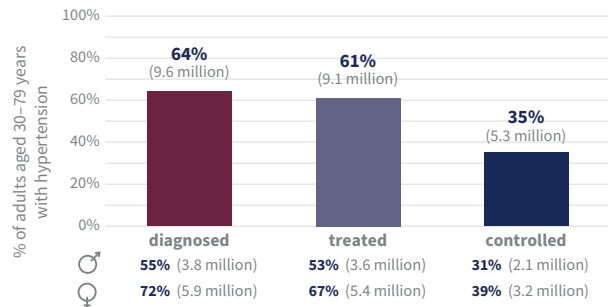
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 33% ♂ 31% ♀ 35%

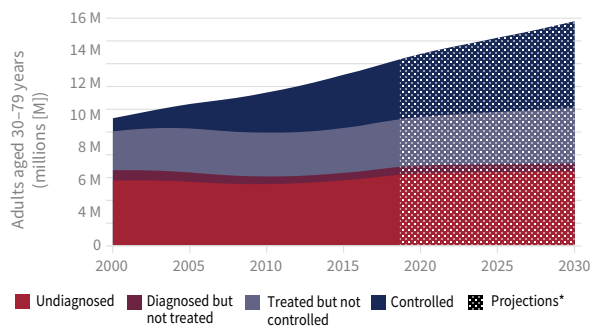
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 15 million adults aged 30–79 years with hypertension, approximately 9.7 million do not have the condition controlled^b

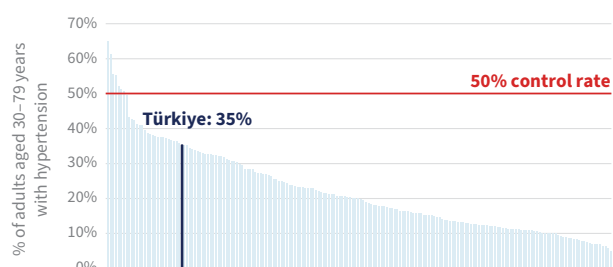


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	664 900	355 100	309 800	2021
Cardiovascular disease deaths	193 300	87 030	106 300	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	52	57	2021
Risk of premature death from NCDs (%) ^c	15	21	10	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	5	6	4	2021
Current tobacco use, adults aged 15+ years (%)	31	41	20	2022
Obesity, adults aged 18+ years (%)	34	26	43	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	44	35	53	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Turkmenistan

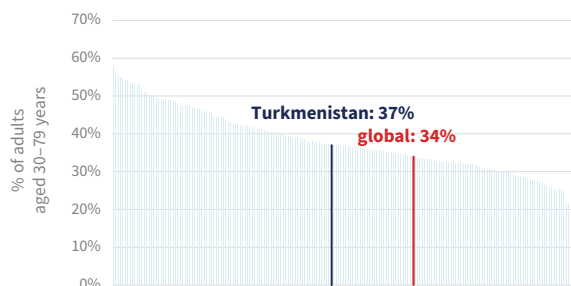
Hypertension profile

Total population (2024): 7 494 000

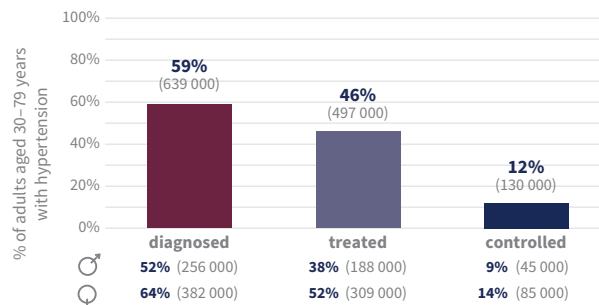
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♀ 35% ♀ 39%

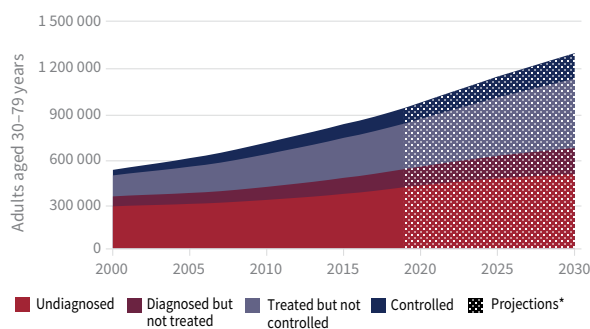
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.1 million adults aged 30–79 years with hypertension, approximately 955 000 do not have the condition controlled^b

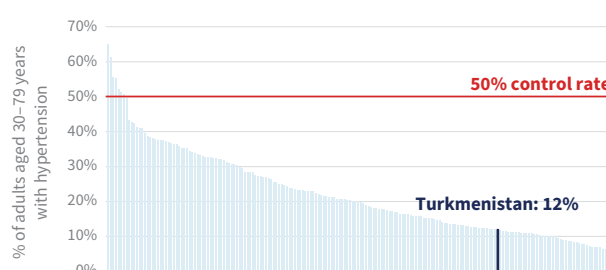


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	42 900	22 890	20 010	2021
Cardiovascular disease deaths	16 660	7790	8870	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	56	60	2021
Risk of premature death from NCDs (%) ^c	26	31	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	6	11	1	2022
Obesity, adults aged 18+ years (%)	20	17	23	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	3	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	12	11	13	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Tuvalu

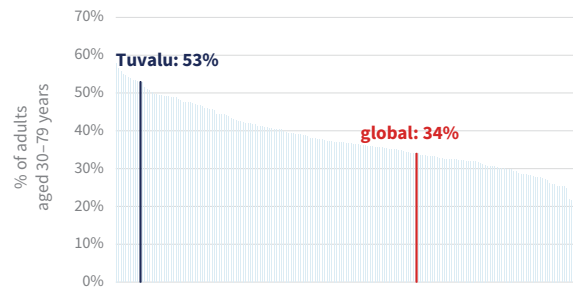
Hypertension profile

Total population (2024): 9650

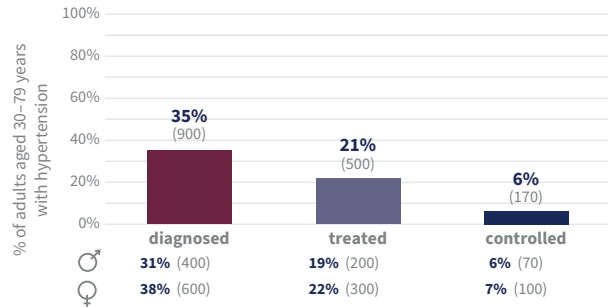
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 53% ♂ 50% ♀ 55%

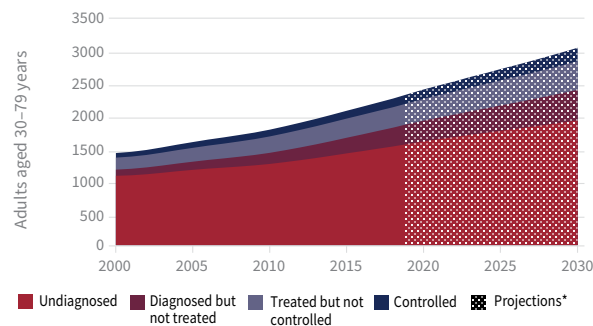
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2600 adults aged 30–79 years with hypertension, approximately 2500 do not have the condition controlled^b

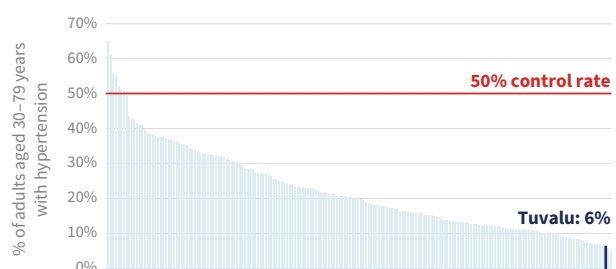


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	no data	no data	no data	2021
Cardiovascular disease deaths	no data	no data	no data	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	52	51	53	2021
Risk of premature death from NCDs (%) ^c	no data	no data	no data	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%) ^d	34	48	19	2022
Obesity, adults aged 18+ years (%)	64	57	71	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	24	16	33	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Don't know

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Uganda

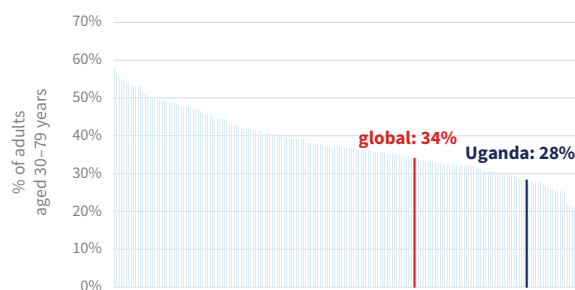
Hypertension profile

Total population (2024): 50 020 000

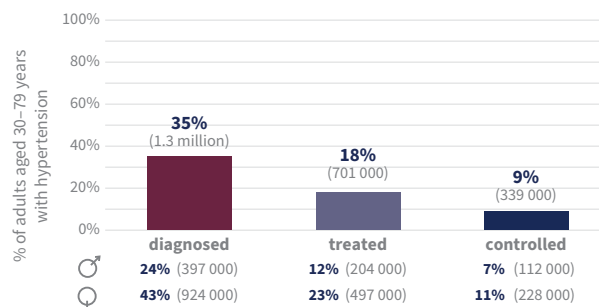
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 28% ♀ 30%

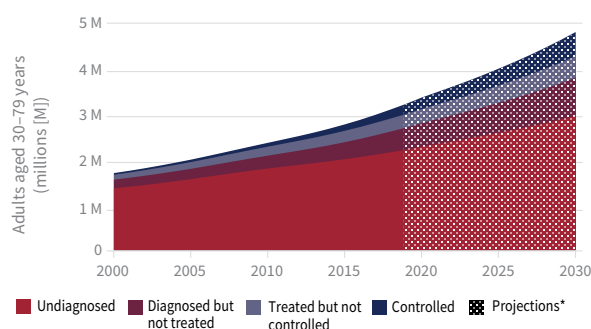
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 3.8 million adults aged 30–79 years with hypertension, approximately 3.5 million do not have the condition controlled^b

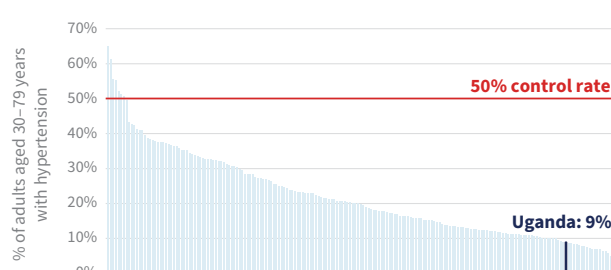


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	251 600	136 900	114 700	2021
Cardiovascular disease deaths	28 300	14 150	14 150	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	56	50	62	2021
Risk of premature death from NCDs (%) ^c	22	25	19	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	8	12	3	2022
Obesity, adults aged 18+ years (%)	7	4	10	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	6	6	5	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Ukraine

Hypertension profile

Total population (2024): 37 860 000

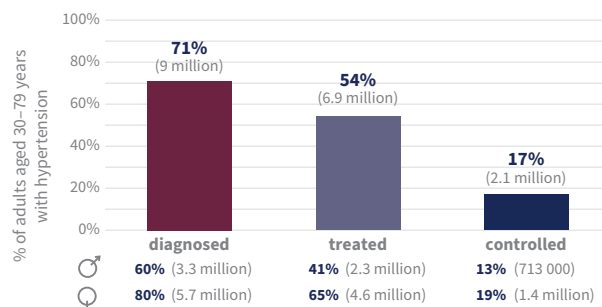
Prevalence of hypertension among adults aged 30–79 years (2024)^a

46% 44% 47%

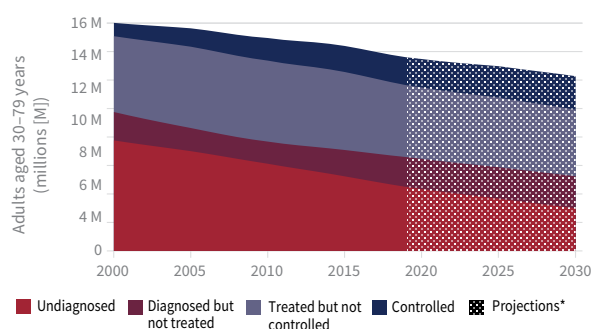
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 12.7 million adults aged 30–79 years with hypertension, approximately 10.6 million do not have the condition controlled^b

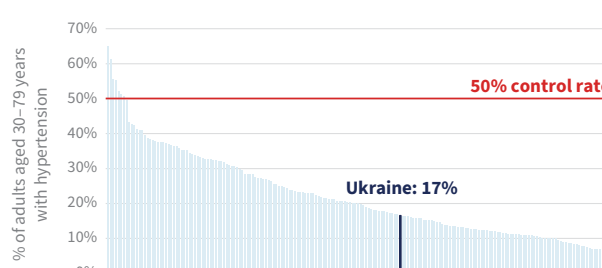


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	771 700	369 800	401 900	2021
Cardiovascular disease deaths	407 500	173 700	233 800	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	57	55	59	2021
Risk of premature death from NCDs (%) ^c	25	35	17	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%)	25	38	12	2022
Obesity, adults aged 18+ years (%)	29	23	34	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	7	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	13	13	13	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

United Arab Emirates

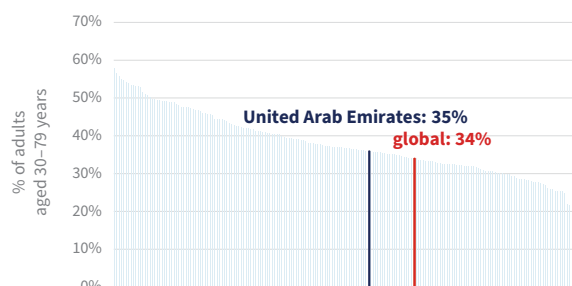
Hypertension profile

Total population (2024): 11 030 000

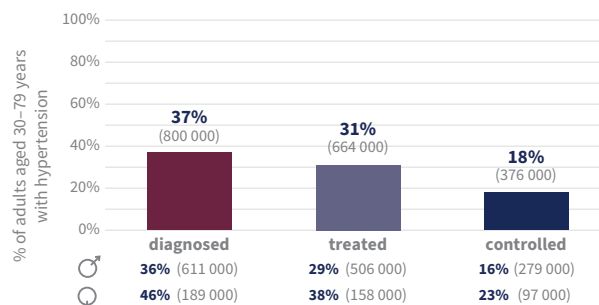
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 35% ♂ 39% ♀ 25%

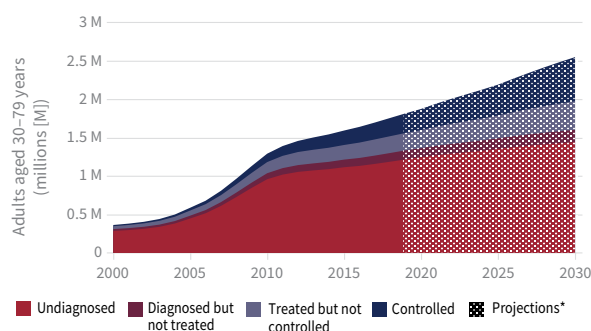
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.1 million adults aged 30–79 years with hypertension, approximately 1.8 million do not have the condition controlled^b

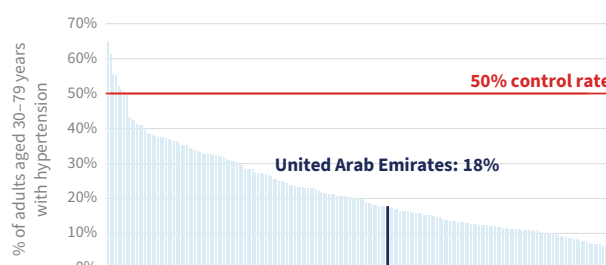


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	14 230	9850	4380	2021
Cardiovascular disease deaths	4430	3340	1100	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	48	53	2021
Risk of premature death from NCDs (%) ^c	12	13	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	5	2021
Current tobacco use, adults aged 15+ years (%) ^d	9	15	3	2022
Obesity, adults aged 18+ years (%)	32	29	38	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	1	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	66	63	74	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

United Kingdom of Great Britain and Northern Ireland

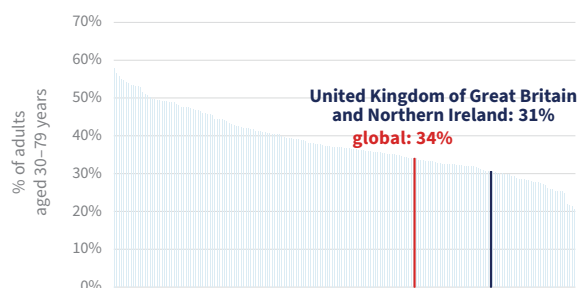
Hypertension profile

Total population (2024): 69 140 000

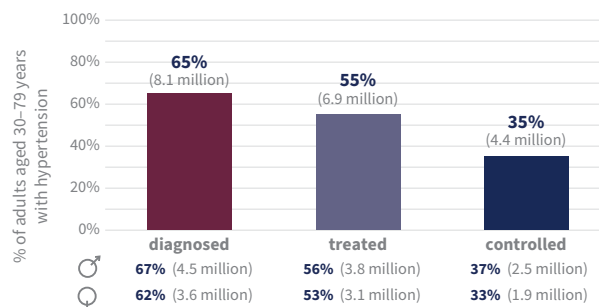
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 31% ♀ 34% 28%

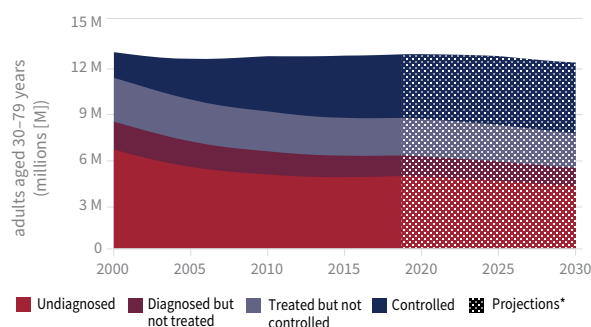
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 12.6 million adults aged 30–79 years with hypertension, approximately 8.1 million do not have the condition controlled^b

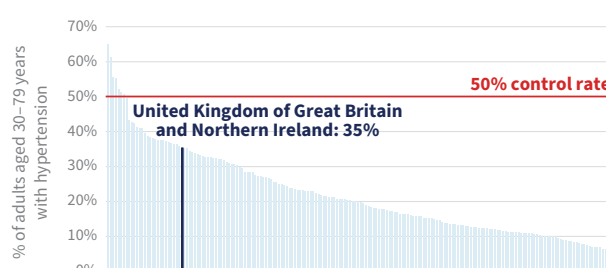


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	689 700	345 800	343 900	2021
Cardiovascular disease deaths	147 500	77 870	69 640	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	41	41	41	2021
Risk of premature death from NCDs (%) ^c	11	13	9	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	6	2021
Current tobacco use, adults aged 15+ years (%) ^d	14	16	12	2022
Obesity, adults aged 18+ years (%)	29	28	29	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	19	18	20	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

d. Tobacco use estimates are not available. Tobacco smoking estimates are substituted for missing tobacco use estimates.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

United Republic of Tanzania

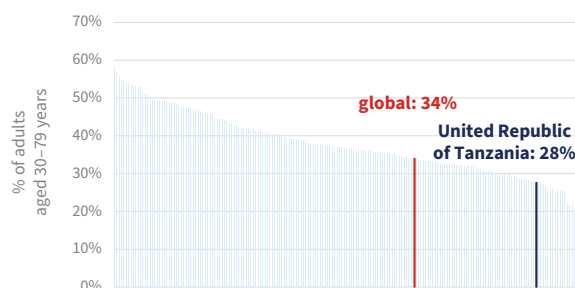
Hypertension profile

Total population (2024): 68 560 000

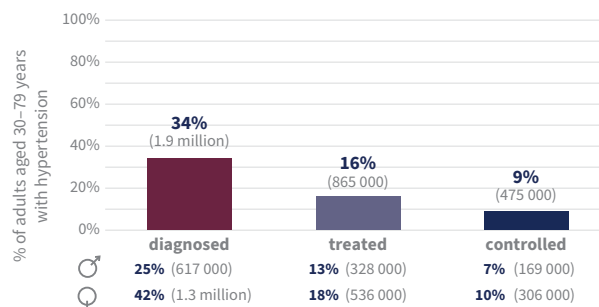
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 28% ♂ 25% ♀ 30%

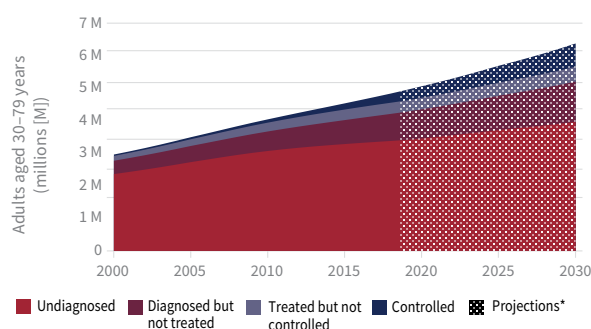
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 5.5 million adults aged 30–79 years with hypertension, approximately 5 million do not have the condition controlled^b

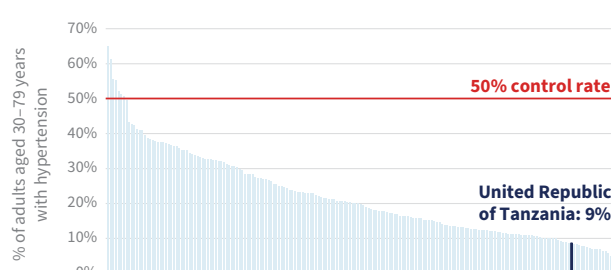


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	370 400	188 600	181 800	2021
Cardiovascular disease deaths	53 150	25 650	27 510	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	55	50	60	2021
Risk of premature death from NCDs (%) ^c	19	20	18	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	8	8	2021
Current tobacco use, adults aged 15+ years (%)	9	15	3	2022
Obesity, adults aged 18+ years (%)	11	6	17	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	4	5	4	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

United States of America

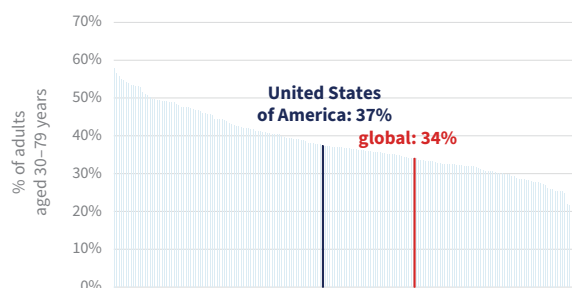
Hypertension profile

Total population (2024): 345 400 000

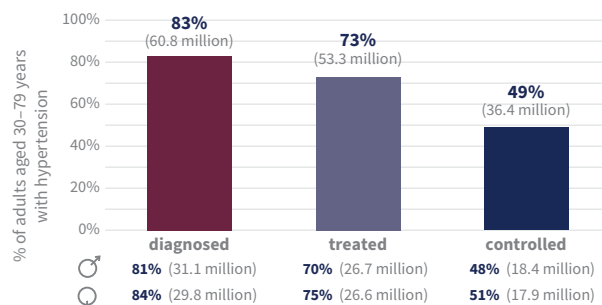
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 37% ♀ 39% ♀ 35%

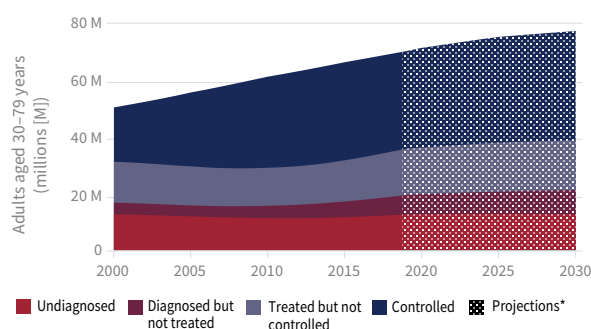
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 73.5 million adults aged 30–79 years with hypertension, approximately 37.1 million do not have the condition controlled^b

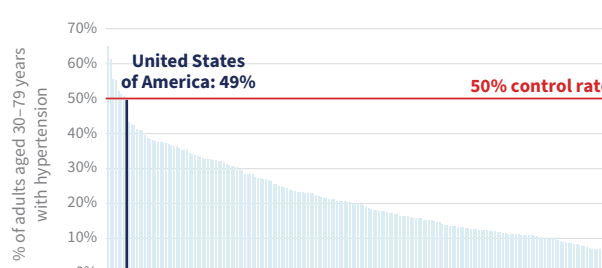


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	3 447 000	1 840 000	1 607 000	2021
Cardiovascular disease deaths	911 700	483 700	428 000	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	46	43	49	2021
Risk of premature death from NCDs (%) ^c	14	16	11	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	8	2021
Current tobacco use, adults aged 15+ years (%)	24	30	19	2022
Obesity, adults aged 18+ years (%)	43	42	44	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	10	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	34	28	40	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Don't know

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Uruguay

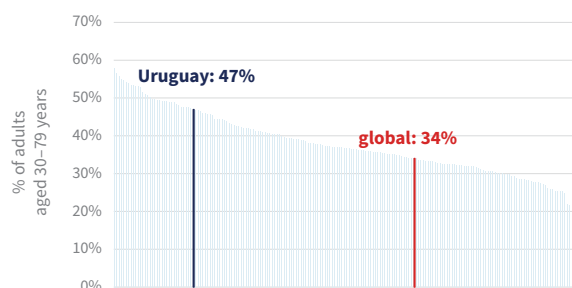
Hypertension profile

Total population (2024): 3 387 000

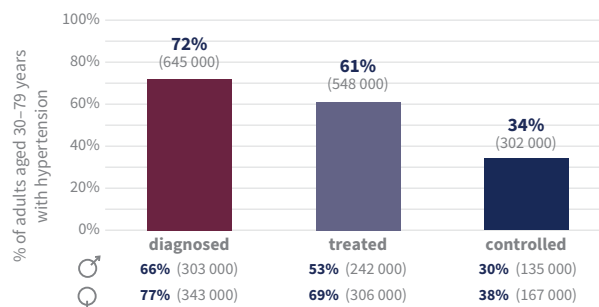
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 47% ♀ 49% 45%

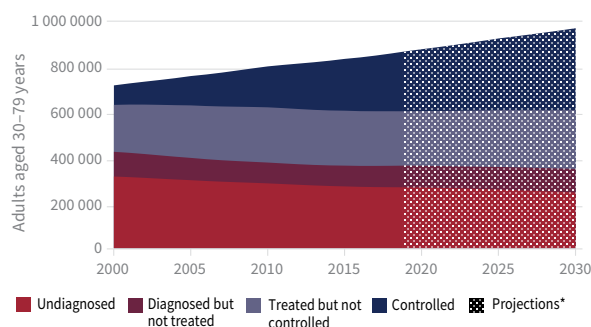
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 902 000 adults aged 30–79 years with hypertension, approximately 599 000 do not have the condition controlled^b

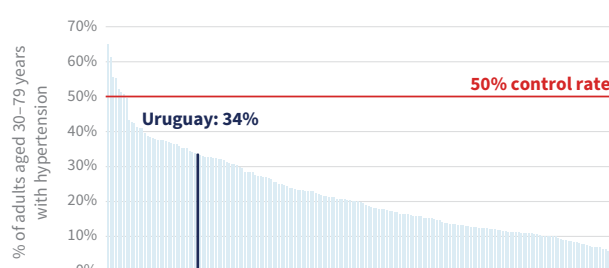


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality

	both sexes	males	females	year
Total deaths	40 760	20 830	19 930	2021
Cardiovascular disease deaths	9020	4320	4700	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	50	48	52	2021
Risk of premature death from NCDs (%) ^c	17	21	14	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	8	2021
Current tobacco use, adults aged 15+ years (%)	21	23	18	2022
Obesity, adults aged 18+ years (%)	35	31	38	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	6	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	34	31	37	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Uzbekistan

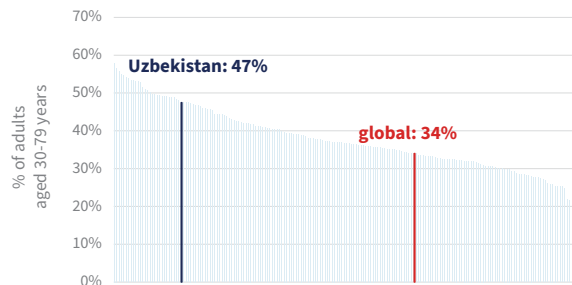
Hypertension profile

Total population (2024): 36 360 000

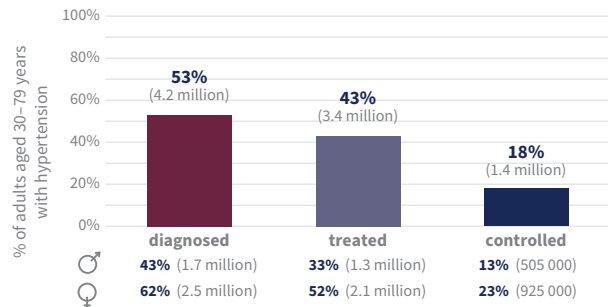
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 47% ♀ 49% 46%

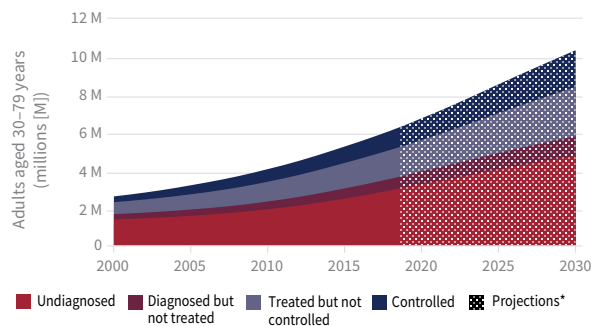
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 8 million adults aged 30–79 years with hypertension, approximately 6.6 million do not have the condition controlled^b

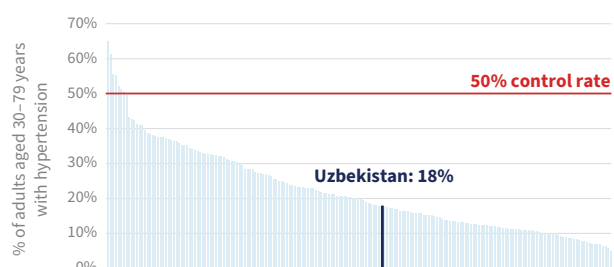


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	217 100	108 200	108 900	2021
Cardiovascular disease deaths	116 200	53 570	62 620	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	54	53	55	2021
Risk of premature death from NCDs (%) ^c	25	28	21	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	9	10	7	2021
Current tobacco use, adults aged 15+ years (%)	17	32	1	2022
Obesity, adults aged 18+ years (%)	29	25	32	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	32	26	37	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	Yes
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Vanuatu

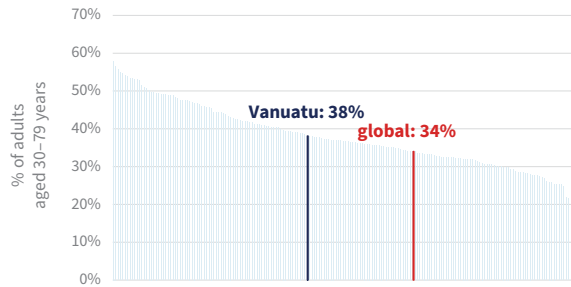
Hypertension profile

Total population (2024): 327 800

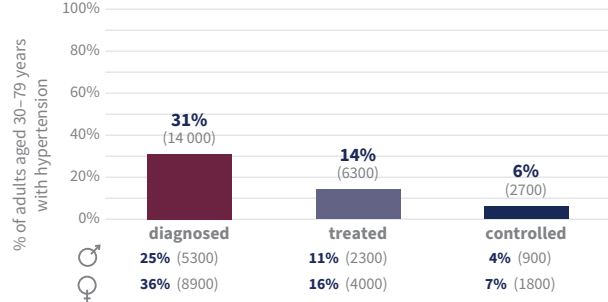
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 38% ♀ 36% 40%

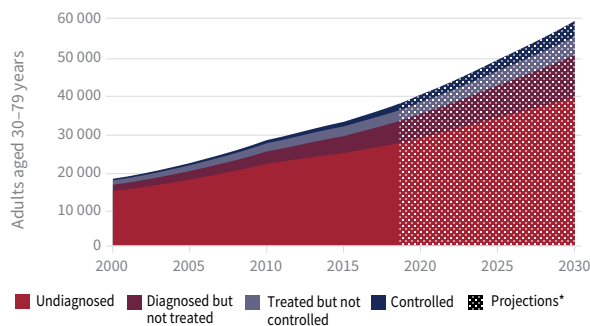
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 46 000 adults aged 30–79 years with hypertension, approximately 44 000 do not have the condition controlled^b

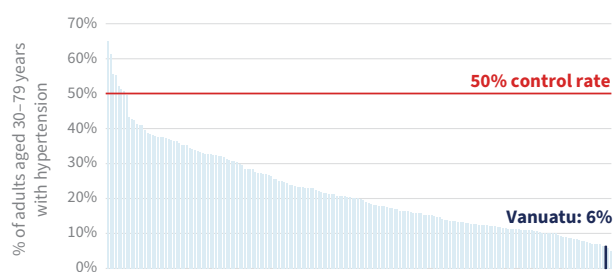


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	2230	1390	850	2021
Cardiovascular disease deaths	870	560	310	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	56	61	2021
Risk of premature death from NCDs (%) ^c	37	43	30	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	8	7	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	20	15	25	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	8	6	9	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Venezuela (Bolivarian Republic of)

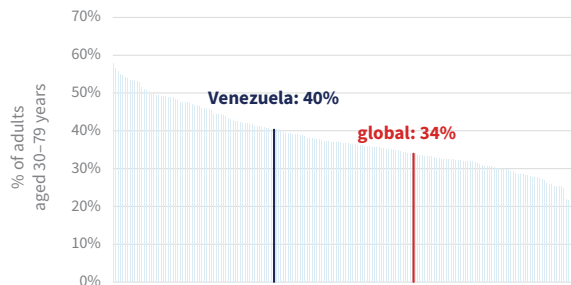
Hypertension profile

Total population (2024): 28 410 000

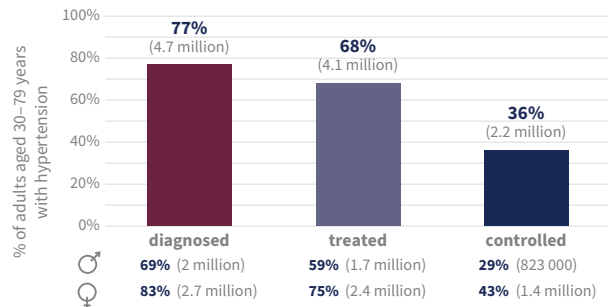
Prevalence of hypertension among adults aged 30–79 years (2024)^a

40% 40% 41%

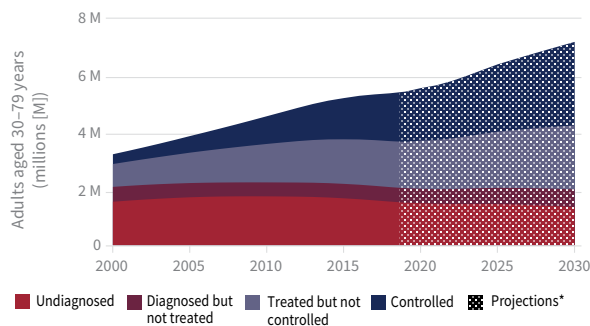
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 6.1 million adults aged 30–79 years with hypertension, approximately 3.9 million do not have the condition controlled^b

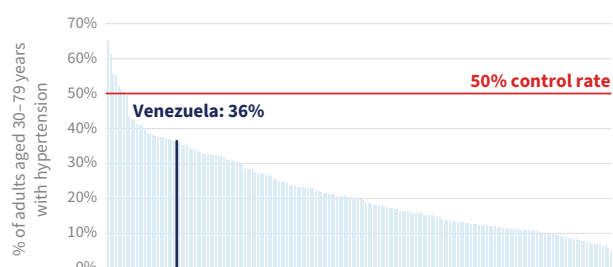


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	227 100	132 700	94 430	2021
Cardiovascular disease deaths	69 220	38 170	31 060	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	58	57	58	2021
Risk of premature death from NCDs (%) ^c	19	23	15	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	9	2021
Current tobacco use, adults aged 15+ years (%)	no data	no data	no data	2022
Obesity, adults aged 18+ years (%)	23	20	25	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	2	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	46	38	53	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

See Explanatory Notes for indicator definitions

World Health Organization: Hypertension profiles, 2025

Viet Nam

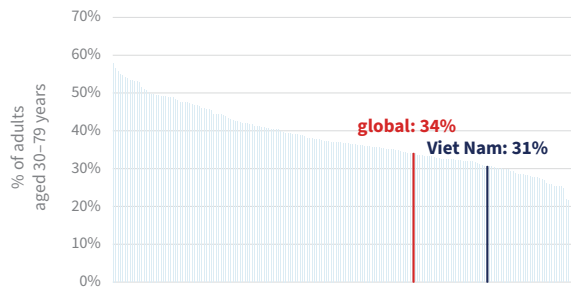
Hypertension profile

Total population (2024): 101 000 000

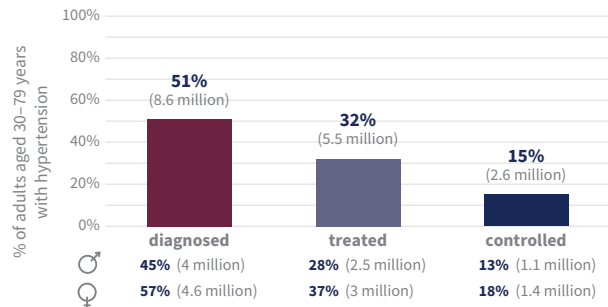
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 31% ♀ 33% 28%

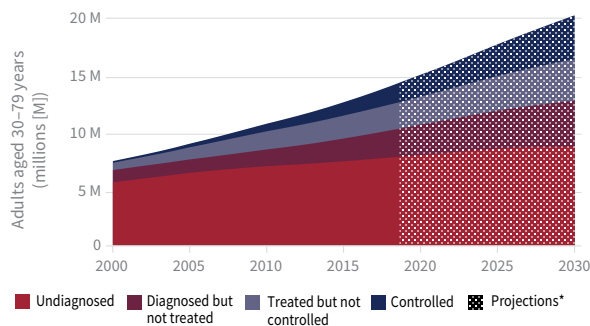
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 16.9 million adults aged 30–79 years with hypertension, approximately 14.4 million do not have the condition controlled^b

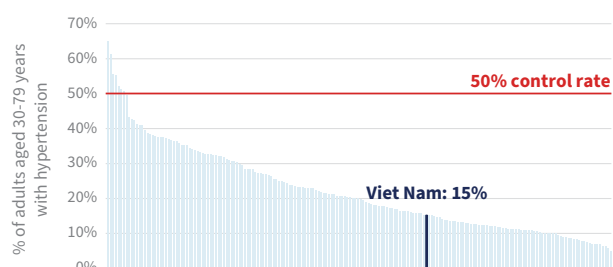


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	703 500	381 900	321 600	2021
Cardiovascular disease deaths	260 400	136 900	123 500	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	63	63	64	2021
Risk of premature death from NCDs (%) ^c	20	28	13	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	10	11	10	2021
Current tobacco use, adults aged 15+ years (%)	23	43	2	2022
Obesity, adults aged 18+ years (%)	2	2	2	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	11	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	30	26	35	2022

National response

Targets

National target for blood pressure	Yes
National target for salt consumption	Yes

Policies

Operational cardiovascular disease policy	Yes
Operational salt reduction policy	Yes

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	Yes
Conducted recent, national survey on salt/sodium intake	Yes
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Yemen

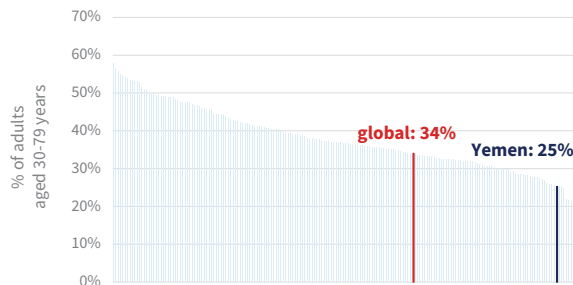
Hypertension profile

Total population (2024): 40 580 000

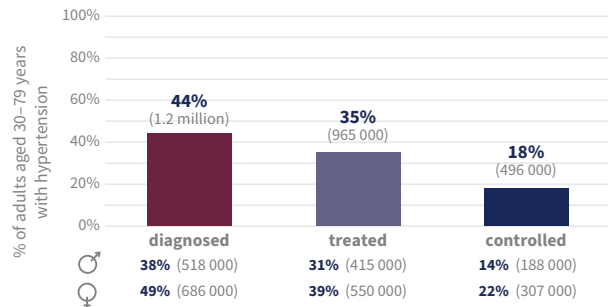
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 25% ♀ 25%

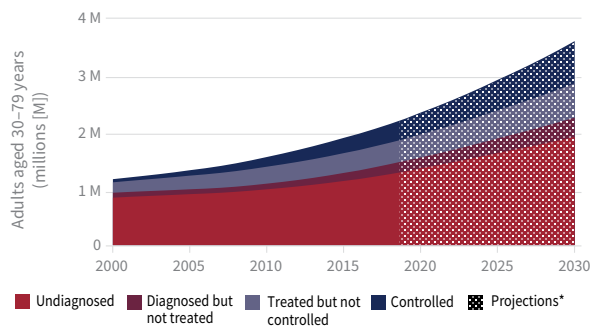
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 2.7 million adults aged 30–79 years with hypertension, approximately 2.3 million do not have the condition controlled^b

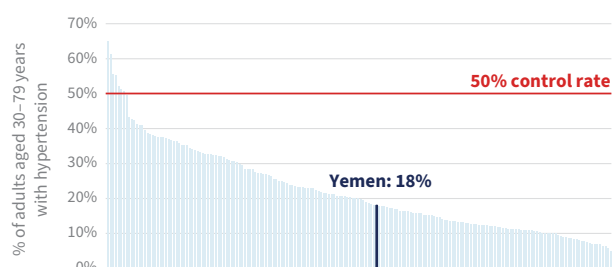


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	224 600	127 100	97 470	2021
Cardiovascular disease deaths	56 570	27 780	28 790	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	52	48	57	2021
Risk of premature death from NCDs (%) ^c	26	28	24	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	6	7	5	2021
Current tobacco use, adults aged 15+ years (%)	21	35	8	2022
Obesity, adults aged 18+ years (%)	12	9	14	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	0	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	29	24	34	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	No
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	No

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

World Health Organization: Hypertension profiles, 2025

[See Explanatory Notes for indicator definitions](#)

Zambia

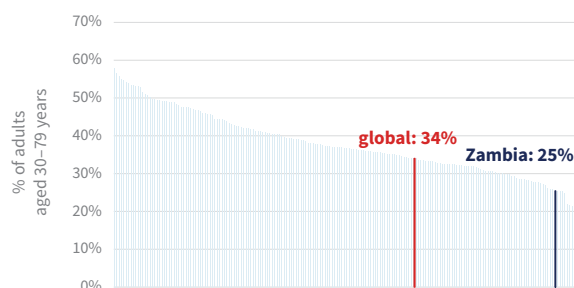
Hypertension profile

Total population (2024): 21 310 000

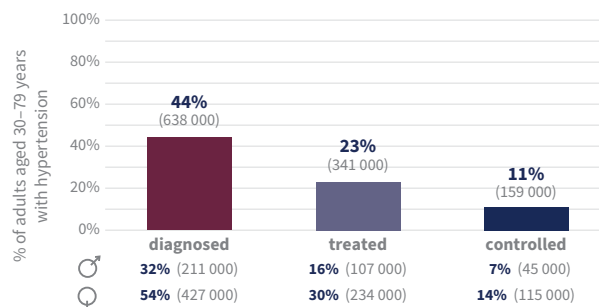
Prevalence of hypertension among adults aged 30–79 years (2024)^a

25% 24% 26%

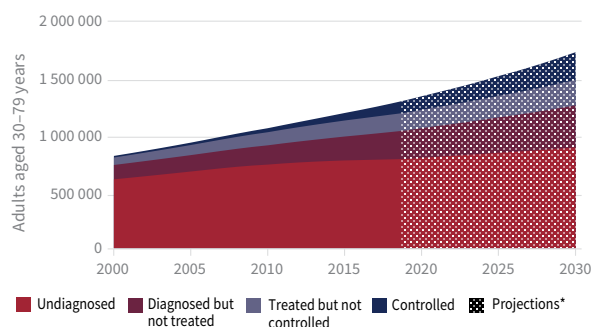
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.5 million adults aged 30–79 years with hypertension, approximately 1.3 million do not have the condition controlled^b

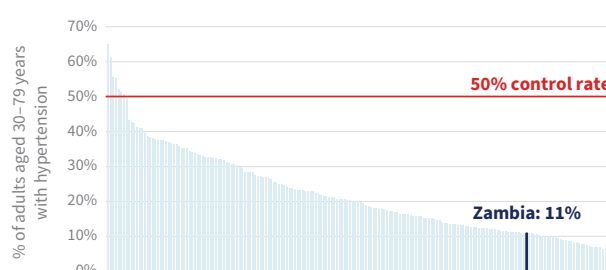


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	139 600	74 270	65 370	2021
Cardiovascular disease deaths	15 180	7330	7850	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	53	49	57	2021
Risk of premature death from NCDs (%) ^c	24	26	22	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	7	7	8	2021
Current tobacco use, adults aged 15+ years (%)	15	26	4	2022
Obesity, adults aged 18+ years (%)	9	4	14	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	4	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	14	10	18	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥ 140 mmHg or DBP ≥ 90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP < 140 mmHg and DBP < 90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature death from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

World Health Organization: Hypertension profiles, 2025

Zimbabwe

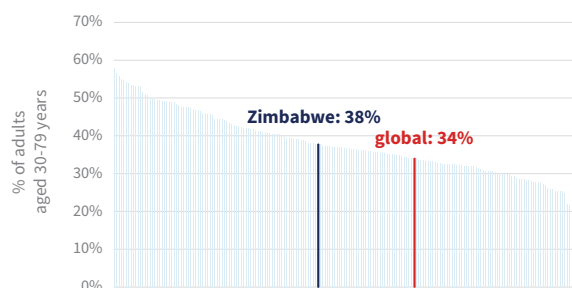
Hypertension profile

Total population (2024): 16 630 000

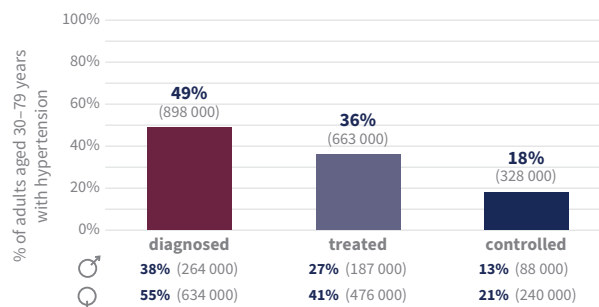
Prevalence of hypertension among adults aged 30–79 years (2024)^a

♂ 38% ♂ 32% ♀ 42%

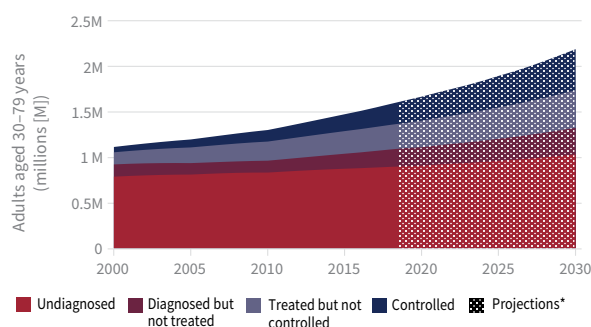
Prevalence of hypertension (adults aged 30–79 years) – country comparison (both sexes)^a



Of the 1.9 million adults aged 30–79 years with hypertension, approximately 1.5 million do not have the condition controlled^b

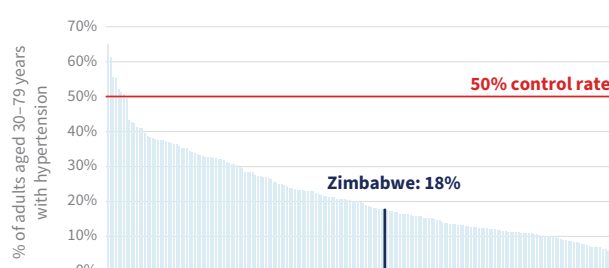


Trends in hypertension disaggregated by diagnosis, treatment and control (both sexes)



*Projections assume a continuation of past trends.

Hypertension control rates – country comparison (both sexes)^b



Mortality†

	both sexes	males	females	year
Total deaths	153 200	76 090	77 130	2021
Cardiovascular disease deaths	23 770	9160	14 600	2021
Cardiovascular disease deaths attributable to high systolic blood pressure (%)	59	52	64	2021
Risk of premature death from NCDs (%) ^c	31	30	32	2021

Risk factors

	both sexes	males	females	year
Mean population salt intake, adults aged 25+ years (g/day)	8	8	8	2021
Current tobacco use, adults aged 15+ years (%)	11	21	1	2022
Obesity, adults aged 18+ years (%)	12	4	19	2022
Total alcohol per capita consumption, adults aged 15+ years (litres/year)	5	no data	no data	2022
Physical inactivity, adults aged 18+ (%)	18	13	21	2022

National response

Targets

National target for blood pressure	No
National target for salt consumption	No

Policies

Operational cardiovascular disease policy	No
Operational salt reduction policy	No

Treatment

Guidelines for management of hypertension	Yes
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Surveillance

Conducted recent, national survey measuring raised blood pressure/hypertension	No
Conducted recent, national survey on salt/sodium intake	No
Functioning system for generating reliable cause-specific mortality data on a routine basis	No
Standardized patient information system broadly available at the primary health care level that captures CVD-related patient data	Yes

a. Hypertension is defined as having SBP ≥140 mmHg or DBP ≥90 mmHg or taking medication for hypertension.

b. Controlled hypertension is defined as receiving treatment for hypertension and having SBP <140 mmHg and DBP <90 mmHg. Control rate is the percentage of adults aged 30–79 years with hypertension who have it controlled.

c. Risk of premature deaths from NCDs refers to Sustainable Development Goal (SDG) indicator 3.4.1, defined as the probability of dying from any of cardiovascular disease, cancer, chronic respiratory disease, or diabetes between ages 30 and 70 years.

† See Explanatory notes.

[See Explanatory Notes for indicator definitions](#)

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Annex 2: Methodology of scoping reviews of literature

Two scoping reviews were carried out to inform the evidence presented in sections 2 and 3 of the report. The methodological framework used for the reviews is the framework by Arksey & O'Malley⁹ comprising five steps: i) identifying the research questions; ii) identifying relevant studies; iii) study selection; iv) charting the data; and v) collating, summarizing, and reporting the results. The reviews conformed to international reporting guidance for evidence synthesis as appropriate (PRISMA-ScR).

1. Scoping review on barriers and facilitators to hypertension prevention and control

This scoping review aimed to address the following research questions: *"What are the barriers that impede individuals to access hypertension services across the continuum of care?"* and, *"What are the existing facilitators that improve access to hypertension services across the continuum of care?"*

Searches were conducted using MEDLINE (Ovid) database. The search strategy was framed around the combination of two main concepts: i) hypertension or high blood pressure; and ii) health service accessibility. The list of key words for each concept was developed using MeSH (Medical Subject Headings; National Library of Medicine) and informed by other reviews on similar topics. Both databases were searched for entries since 2015. In addition, searches were performed to identify relevant grey literature. Various publication types were included: peer-reviewed journal articles; qualitative, quantitative, and mixed-method studies; systematic reviews; and reports produced by organizations and governments.

2. Scoping review on barriers and facilitators in access to hypertension medicines across the pharmaceutical chain

This scoping review aimed to address the following research questions: *"What are the barriers that impede access to hypertension medicines across the pharmaceutical chain?"* and, *"What are the existing facilitators that improve*

⁹ Arksey H, O'malley L. Scoping studies: towards a methodological framework. International journal of social research methodology. 2005 Feb 1;8(1):19–32.

access to hypertension medicines across the pharmaceutical chain?” Searches were conducted using MEDLINE (Ovid) database. The search strategy was framed around the combination of three main concepts: i) hypertension or high blood pressure; ii) medicines; and iii) barriers and facilitators. The full search chain is presented below:

Medicines

Medicines OR medicine OR medication OR medications OR medicament OR pharmaceuticals OR pharmaceutical OR biopharmaceutical OR biopharmaceuticals OR drug OR drugs

AND

Hypertension

Hypertension OR hypertensive OR high blood pressure

AND

Barriers and facilitators

Barrier OR challenge OR inequity* OR Accessibility OR disparities OR Equal* OR Equit* OR Imped* OR Inaccess* OR Inequal* or Inequit* OR Obstacle OR facilitator OR enabler OR enabl*

The list of key words for each concept was developed using MeSH (Medical Subject Headings; National Library of Medicine) and informed by other reviews on similar topics. Both databases were searched for entries since 2015. In addition, searches were performed to identify relevant grey literature. Various publication types were included – peer-reviewed journal articles; qualitative, quantitative, and mixed-method studies; systematic reviews; and reports produced by organizations and governments.

Annex 3. Key steps to strengthen value chain for hypertension medicines

Annex 3 builds on section 3 of the report and provides detailed, step-by-step guidance to service and programme planners at country level on how to address different barriers across the pharmaceutical chain for hypertension medicines. Guidance is provided for each existing barrier; some actions across the different elements of the value chain may overlap. All strategies are closely aligned with existing WHO guidelines and recommendations for strengthening the provision of, and access to, essential medicines, as referenced in the respective sections below.

Annex 3 explores the challenges and potential strategies across six phases of the pharmaceutical chain of hypertension medicines:

1. Regulatory systems
2. Selection and prioritization
3. Pricing and reimbursement
4. Procurement and supply chain management
5. Prescribing
6. Dispensing

I) Challenges and potential strategies to improve the *regulatory landscape* for hypertension medicines

Challenges	Potential strategies
<p>Weak regulatory oversight challenges the safety and quality of hypertension medicines. In many low- and middle-income countries, regulatory bodies lack the capacity and expertise to conduct regulatory processes effectively. This limitation results in missing or inconsistent authorization and monitoring of drug quality, manufacturing processes, and distribution channels (1–5).</p>	<p>Strategies for countries with existing regulatory systems:</p> <p>1. Assessment and benchmarking Begin with a comprehensive assessment of the existing regulatory system using the WHO Global Benchmarking Tool (6, 7). This tool helps to identify gaps in regulatory capacity, processes, and outputs, and benchmarks the system against WHO standards.</p> <p>2. Good regulatory practices Strengthen regulatory processes through compliance with good regulatory practices in the regulation of medicines and medical products, as outlined in WHO guidance (8).</p> <p>3. Capacity-building Invest in training and technical support for regulatory staff to improve expertise in medicine evaluation, inspection, and post-marketing surveillance. This can be facilitated by WHO and technical partners, aiming for the national regulatory authority to achieve WHO-Listed Authority status (9). WHO's <i>Global competency framework for regulators of medicines</i> can be adopted (10,11).</p> <p>4. Streamline registration processes Prioritize the registration of medicines according to WHO treatment guidelines (12), including single-pill combinations, and ensure timely review of submitted dossiers. Regulatory authorities should treat these registrations as public health priorities.</p>

Challenges	Potential strategies
	<p>5. Ensure quality assurance for generic medicines</p> <p>Strengthen regulatory oversight to ensure all generics meet WHO prequalification or equivalent national/international quality standards, following WHO's Global Benchmarking Tool for evaluation of national regulatory systems (6).</p> <p>6. Quality assurance and procurement</p> <p>Negotiate framework agreements or long-term contracts with suppliers of quality-assured antihypertensive medicines, preferably those with certification of good manufacturing practices from a stringent regulatory authority, or from WHO-Listed Authority registration.</p> <p>7. Market surveillance and transparency</p> <p>Implement regular market surveillance to monitor medicine quality and regulate supply chain mark-ups to maintain affordability and quality (13,14).</p> <p>8. Regional and international collaboration</p> <p>Collaborate with regional regulatory harmonization initiatives and leverage pooled procurement mechanisms to improve access to quality-assured medicines and share regulatory resources.</p> <p>Strategies for countries that do not yet have a regulatory authority:</p> <p>1. Establish a legal and institutional framework</p> <p>Pass legislation to create a national medicines regulatory authority or equivalent body. This authority should have a clear mandate to regulate all aspects of medicines, including registration, licensing, importation, distribution, and post-marketing surveillance.</p> <p>2. Define the authority's structure and functions</p> <p>Set up the organizational structure, appoint leadership, and define the roles of technical committees and advisory bodies. The authority should include divisions for medicines evaluation, inspection, quality assurance, and enforcement.</p>

Challenges	Potential strategies
	<p>3. Develop core regulatory functions</p> <p>Establish the core regulatory functions of the body, including elements such as registration, licensing, quality assurance, inspection and surveillance.</p> <p>4. Build technical capacity</p> <p>Invest in training staff in regulatory science, inspection, dossier evaluation, and pharmacovigilance. Seek technical support from WHO and regional partners to accelerate capacity-building (15).</p> <p>5. Develop and implement regulations</p> <p>Draft and adopt regulations and guidelines for medicine registration, compliance with good manufacturing practice, importation, pricing, and advertising, drawing on WHO and international best practices. Ensure that these regulations are aligned with good regulatory practices in the regulation of medicines and medical products, as outlined in WHO guidance (8).</p> <p>6. Ensure quality assurance for generic medicines</p> <p>Strengthen regulatory oversight to ensure all generics meet WHO prequalification or equivalent national/international quality standards, following WHO's Global Benchmarking Tool for evaluation of national regulatory systems (6).</p> <p>7. Collaborate regionally and internationally</p> <p>Engage in regional regulatory harmonization initiatives and consider adopting collaborative registration procedures, such as reliance on WHO-prequalified products or approvals from stringent regulatory authorities, to fast-track access to quality medicines (16).</p> <p>8. Ensure transparency and public engagement</p> <p>Make regulatory decisions and processes transparent, educate stakeholders, and establish channels for reporting adverse drug reactions and quality concerns.</p>

Challenges	Potential strategies
<p><i>Slow and fragmented approval processes delay access to hypertension medicines</i> (17–20). In many countries, the uncoordinated process of obtaining approval for a new medicine involves multiple stages, including preclinical studies, clinical trials, and regulatory reviews, all of which can be time-consuming.</p>	<p>1. Adopt reliance or recognition mechanisms</p> <p>Allow the national regulatory authority to rely on or recognize approvals from stringent regulatory authorities such as the United States Food and Drug Administration (21) or European Medicines Agency (22) for hypertension medicines. This can dramatically shorten review times and reduce duplication of work (23).</p> <p>2. Implement expedited review pathways</p> <p>Establish fast-track or priority review processes for essential medicines, particularly those addressing unmet medical needs such as hypertension (6, 8). These pathways should set clear, shortened timelines for review and decision-making.</p> <p>3. Enhance regulatory coordination</p> <p>Streamline and coordinate the various stages of the approval process – preclinical, clinical, and regulatory review – by fostering regular communication between regulators and sponsors throughout the development and review process (8).</p>

Challenges	Potential strategies
<p><i>Excessive bureaucracy in regulatory inspections slows down the process of quality control and oversight.</i></p> <p>Lengthy processes in inspections reduce the ability of regulatory agencies to respond quickly to public health needs and patients may experience delays in obtaining critical treatments (5, 18, 24).</p>	<p>1. Establish a clear legal and regulatory framework</p> <p>Develop or amend (if already existing) comprehensive laws, regulations, and guidelines that define the scope, authority, and procedures for regulatory inspections, ensuring alignment with the WHO internationally-recognized standards (6).</p> <p>2. Adopt a risk-based inspection approach</p> <p>Shift from routine, blanket inspections to a risk-based model that prioritizes inspections based on the risk profile of establishments, products, and supply chain segments (6, 25). This allows agencies to focus resources on areas with the highest potential impact on patient safety and medicine quality.</p> <p>3. Enable reliance and mutual recognition</p> <p>Implement reliance mechanisms where the national regulatory authority recognizes inspection outcomes and certificates from trusted international or regional agencies (such as WHO-prequalified sites), reducing duplication and expediting approvals.</p> <p>4. Build inspectorate capacity</p> <p>Invest in regular training and qualification programmes for inspectors, emphasizing technical competence, ethics, and quality management principles. Participation in international training and harmonization efforts (e.g. through WHO) can further enhance skills and trust (6, 26).</p>

Challenges	Potential strategies
<p><i>Poor enforcement and weak quality assurance systems for regulatory standards enables the illegal importation and distribution of counterfeit or substandard hypertension medicines.</i> Counterfeit medicines not only fail to treat hypertension effectively, they can also cause severe adverse effects, further jeopardizing public health. When procurement mechanisms lack rigorous checks, such as supplier prequalification, product quality testing, and verification of manufacturing practices, there is a heightened possibility that medicines purchased do not meet required standards for safety, efficacy, or quality (3, 27, 28).</p>	<p>1. Adopt and implement WHO norms and standards</p> <p>Use WHO's internationally-recognized guidelines for medicine quality, safety, and efficacy as the foundation for national regulations (29). Develop clear rules for good manufacturing, distribution, and storage practices, and require compliance from all stakeholders. Ensure routine quality testing of procured hypertension medicines to ensure that only safe and effective products reach patients, protecting public health and maintaining confidence in the health system (30, 31).</p> <p>2. Enhance border and market surveillance</p> <p>Train customs officials and regulatory inspectors to detect counterfeit and substandard medicines at entry points and within the country. Implement post-marketing surveillance systems to routinely sample and test medicines in the market, following WHO recommendations (32–34).</p> <p>3. Leverage reliance and international collaboration</p> <p>Participate in WHO-led collaborative registration and reliance mechanisms, allowing the national regulatory authority to recognize approvals and inspection outcomes from trusted authorities (such as WHO-Listed Authorities), and to share intelligence on illegal activities (16, 35).</p> <p>4. Enforce strong penalties and public reporting</p> <p>Establish and apply strict penalties for illegal importation, manufacture, and distribution of counterfeit medicines. Make enforcement actions transparent and report violations publicly to deter future offences and build public trust. Ensure, where possible, digital tracking systems for medicines.</p> <p>5. Engage stakeholders and raise public awareness</p> <p>Work with health professionals, pharmacists, and the public to raise awareness about the dangers of counterfeit medicines. Provide channels for reporting suspected products and adverse events.</p>

II) Challenges and potential strategies to improve the *selection and prioritization* processes for essential hypertensive medicines

Challenges	Potential strategies
<p>Outdated or misaligned national essential medicines lists (EMLs) can exclude key hypertension drugs or contain medications that contradict current treatment guidelines. For example, some national lists may omit other, more effective antihypertensive medications, while continuing to list older, less effective options. This misalignment can result in suboptimal treatment choices, leading to less effective management of hypertension and potentially higher rates of complications (18, 36, 37).</p>	<p>1. Regularly review and compare national EML to the WHO model list</p> <p>Conduct reviews of the national EML at least every two years, aligning with the update cycle of the <i>WHO model list of essential medicines</i> (11). Compare the antihypertensive section, ensuring inclusion of all recommended first-line medicines and single-pill combinations now listed by WHO.</p> <p>2. Establish a multidisciplinary national committee</p> <p>Convene a committee of clinicians, pharmacists, policy-makers, and patient representatives to oversee EML updates, as recommended by the WHO Expert Committee on Selection and Use of Essential Medicines (38).</p> <p>3. Update the national EML to reflect WHO recommendations</p> <p>Ensure that the EML includes all antihypertensive medicines and single-pill combinations recommended by WHO. Remove or reclassify medicines that are outdated or no longer recommended in current WHO guidelines (12, 39).</p> <p>4. Align national treatment guidelines with the updated EML</p> <p>Revise national hypertension treatment guidelines to match the updated EML, following the latest WHO and international guidance on pharmacological treatment of hypertension.</p> <p>5. Communicate and implement changes</p> <p>Disseminate updated EMLs and guidelines to health care providers, procurement agencies, and supply chain managers to ensure new medicines are available and prescribed appropriately.</p>

Challenges	Potential strategies
	<p>6. Monitor access and outcomes</p> <p>Track the availability, uptake, and clinical outcomes of updated antihypertensive medicines, using WHO-recommended monitoring frameworks to ensure improved hypertension management.</p>
<p>National EMLs are often underutilized in practice. In many countries, the EMLs may not influence actual prescribing or procurement decisions. This disconnect occurs for several reasons, including weak implementation mechanisms, lack of awareness or adherence to the list by health care providers, and gaps in coordination between the health sector and procurement authorities (18, 24, 40).</p>	<p>In addition to the steps above, countries can take concrete actions to address the underutilization of EMLs in practice:</p> <p>1. Strengthen governance and oversight</p> <p>Establish or reinforce a transparent national medicines selection committee with clear leadership, consultative mandates, and monitoring responsibilities. This committee should coordinate EML implementation, regularly review its use, and ensure accountability (39).</p> <p>2. Link EML to clinical guidelines and practice</p> <p>Harmonize the EML with national standard treatment guidelines so that recommended medicines are directly reflected in clinical protocols, making it easier for prescribers to follow EML-based choices.</p> <p>3. Institutionalize EML use in procurement and reimbursement</p> <p>Make clear the legal or administrative authority of the EML, ensuring it is the basis for procurement, supply, and reimbursement decisions in public health systems.</p> <p>4. Strengthen coordination across sectors</p> <p>Foster regular communication and joint planning between health ministries, procurement agencies, and supply chain managers to ensure EML-listed medicines are prioritized and available.</p> <p>5. Monitor and evaluate compliance</p> <p>Implement routine monitoring and evaluation of prescribing and procurement patterns, using audits, and provide feedback to facilities and prescribers. Use oversight mechanisms to address non-compliance.</p>

Challenges	Potential strategies
	<p>6. Engage stakeholders</p> <p>Involve professional societies, training institutions, senior clinicians, and the public in EML revisions and implementation to build ownership and accountability.</p>
<p><i>Lack of prioritization of combination pills</i> can affect adherence and treatment outcomes. As a result, patients may be prescribed multiple separate pills, which can reduce adherence and make treatment less convenient (41–43).</p>	<p>1. Prioritize combination pills in national guidelines and EMLs</p> <p>Review and revise national hypertension treatment guidelines and EMLs to include and prioritize single-pill combinations as preferred therapy, in line with WHO’s 2021 guideline (12). Ensure dual and triple single-pill combinations are listed, reflecting their status on the WHO EML.</p> <p>2. Align procurement and supply chain practices</p> <p>Adjust procurement policies to prioritize sourcing single-pill combinations over single pills, leveraging the updated EML and guidelines. Work with suppliers to ensure single-pill combinations are available and affordable.</p> <p>3. Implement standardized treatment protocols</p> <p>Roll out simple, standardized hypertension treatment protocols at the primary care level that specify single-pill combinations as first-line or step-up therapy, as recommended by WHO and the HEARTS package. Ensure protocols are disseminated and used in all relevant health facilities.</p> <p>4. Monitor uptake and patient outcomes</p> <p>Establish monitoring systems to track the prescription and use of single-pill combinations, as well as patient adherence and blood pressure control rates. Use these data to refine policies and address barriers to single-pill combination uptake.</p>

III) Challenges and potential strategies to improve the *pricing policies and reimbursement* processes for antihypertensive medicines

Challenges	Potential strategies
<p><i>Inadequate and unstable public financing challenges the timely procurement and distribution of hypertension medicines.</i> When funding is not guaranteed or frequently delayed, suppliers may choose not to provide essential medicines, further limiting access for patients who rely on public health care systems for their hypertension treatment (18, 44–46).</p>	<p>1. Advocate for reliable and adequate, stable and predictable public financing</p> <p>Engage policy-makers to recognize hypertension as a public health priority, emphasizing the high financial burden and the cost-effectiveness of timely treatment with medicines, as recommended in the WHO hypertension guidelines (12). In addition, secure multi-year budget commitments for essential hypertension medicines, integrating these needs into national health budgets and universal health coverage plans.</p> <p>2. Pool procurement and aggregate demand</p> <p>Make use of strategic procurement options as relevant at country level. Where possible, participate in pooled procurement mechanisms, such as regional or multicountry initiatives, to stabilize supply and leverage better prices to improve the bargaining power and confidence with the suppliers. This is an approach supported by WHO where appropriate and exemplified by the Strategic Fund of the Pan American Health Organization (PAHO) (46). Consolidate demand across public programmes to increase purchasing power and reduce price volatility.</p> <p>3. Establish long-term, competitive supply agreements</p> <p>Develop long-term contracts with suppliers for hypertension medicines, ensuring predictable orders and timely payments. Specify quality standards and delivery schedules, as recommended by WHO, for ensuring a steady supply of affordable, quality-assured medicines (47).</p>

Challenges	Potential strategies
	<p>4. Strengthen procurement and supply chain systems</p> <p>Use transparent, competitive bidding processes and digital procurement platforms to minimize delays and corruption. Regularly forecast needs and monitor stock levels to prevent stockouts and ensure on-time distribution to health facilities (48).</p> <p>5. Monitor and report funding and supply performance</p> <p>Implement regular monitoring of financing flows, procurement cycles, and medicine availability, using WHO-recommended indicators or internationally adopted key performance indicators to identify and address bottlenecks (49).</p>
<p><i>Hypertension medicines are frequently not covered under social security schemes or public health insurance.</i></p> <p>As a result, patients are forced to pay out-of-pocket for their hypertension medications. This lack of coverage disproportionately affects individuals with low incomes, who may find it financially prohibitive to continue long-term treatment (4, 50–54). Health insurance gaps hinder access to affordable hypertension medications (50, 55–57). In addition, there is a lack of pricing policy or policy implementation, such as on use of generic medicines.</p>	<p>1. Update health insurance and social security benefits</p> <p>Revise the benefits package of public health insurance and social security schemes to explicitly include all WHO-recommended antihypertensive medicines and their combinations (12).</p> <p>2. Align EML with WHO guidance</p> <p>Ensure that the EML includes all first-line and combination antihypertensive therapies recommended by WHO, making them eligible for reimbursement.</p> <p>3. Promote the use of quality-assured generic hypertension medicines</p> <p>Policies that encourage the increased use of quality-assured generic medicines would influence the price of these medicines not only because they are priced lower than the originator product prior to loss of market exclusivity but also through enhanced price competition.</p> <p>4. Secure sustainable financing</p> <p>Allocate sufficient, stable funding within national and insurance budgets to guarantee coverage for hypertension medicines, prioritizing populations at highest risk or with the greatest financial vulnerability.</p>

Challenges	Potential strategies
	<p>5. Implement government-managed reimbursement systems</p> <p>Implement government-managed reimbursement systems to ensure consistent and equitable access to hypertension medicines. These systems, often embedded within national health insurance or universal health coverage schemes, directly reimburse suppliers and health care providers for the cost of essential antihypertensive drugs, minimizing out-of-pocket expenses for patients and supporting regular supply. Such reimbursement frameworks are typically guided by evidence-based protocols and managed access agreements, which enhance the safe, effective, and cost-efficient use of medicines (45, 58).</p> <p>6. Monitor access and financial protection</p> <p>Regularly monitor out-of-pocket expenditures, medicine availability, and insurance claims to ensure that coverage is effective, and adjust policies as needed to close gaps.</p>

Challenges	Potential strategies
<p><i>Opaque pricing practices undermine efforts to ensure fair pricing of hypertension medicines.</i> In many cases, the true cost of medications is hidden from public view, making it difficult for governments and health systems to negotiate fair prices with suppliers. The lack of transparency in how prices are determined prevents competition and creates opportunities for suppliers to inflate prices without justification. This lack of transparency also complicates efforts to establish pricing regulations or to implement price controls (18, 27, 59). In some low- and middle-income countries, hypertension medicines cost up to 40 times more than the estimated cost-based generic price, highlighting the importance of strong pricing policies (27).</p>	<p>1. Develop and enforce transparent pricing policies Adopt national policies requiring the disclosure of medicine prices at all points in the supply chain, including net transaction prices, mark-ups, and acquisition costs, as recommended by WHO (63).</p> <p>2. Use value-based pricing for medicines WHO suggests the use of value-based pricing for medicines to support price-setting, and reimbursement decision-making where appropriate, used in conjunction with other pricing policies, such as price negotiation, internal and external reference pricing, and policies to promote the use of quality-assured generic medicines (63). Internal reference pricing is important since single-pill combinations are “preferred”, i.e. ensuring that price of combination is not more than its components.</p> <p>3. Develop and implement mark-up regulations Establish government policies to regulate or cap allowable mark-ups at each stage of the supply chain, following WHO’s recommendation for transparent and fair pricing structures (63).</p> <p>4. Mandate public reporting and data-sharing Require suppliers and procurement agencies to publicly report prices and pricing methodologies. Use digital platforms or government gazettes to make this information accessible to all stakeholders.</p> <p>5. Use WHO tools for price monitoring Implement standardized tools, such as the WHO/Health Action International methodology and the WHO EMP MedMon mobile application where possible, to regularly collect, analyse, and publish data on medicine prices and availability (13, 14).</p>

Challenges	Potential strategies
<p>In addition, <i>mark-ups at different stages, such as manufacturing, distribution, and retail, increase the cost of medicines.</i> Mark-ups are often driven by intermediaries across the supply chain who seek to profit at the expense of patients; the lack of regulation in some markets exacerbates this issue (60–63).</p>	<p>6. Build capacity and raise awareness Train procurement officials, policy-makers, and civil society on the importance of price transparency and how to use price data to negotiate fairer prices and detect overpricing.</p> <p>7. Participate in regional and global price-sharing initiatives Join international efforts and platforms to share and compare medicine prices across countries, supporting better negotiation and benchmarking.</p> <p>8. Use transparent data to inform regulation and negotiation Leverage transparent price data to implement or revise price controls, reference pricing, or tendering policies, ensuring fair pricing and competition.</p>

IV) Challenges and potential strategies to improve *procurement and supply chain management* for hypertension medicines

Challenges	Potential strategies
<p>Poor forecasting of the demand for hypertension medicines. Inaccurate or incomplete data on the prevalence of hypertension, and the actual need for medications, often lead to poor demand estimation. Often, the absence of standardized protocols complicates forecasting and supply planning, as health systems cannot predict with certainty which medicines will be needed in specific quantities, resulting in either overstocking or understocking of medicines. Overstocking leads to waste and ties up scarce resources, while understocking causes gaps in treatment availability, particularly during peak demand periods (64–66).</p>	<p>1. Strengthen data collection systems and forecasting processes</p> <p>Start by improving health information systems to collect accurate, up-to-date data on hypertension prevalence, diagnosis, medicine consumption at all levels and forecasting processes.</p> <p>2. Use a validated forecasting tool</p> <p>Apply a validated forecasting tool that uses epidemiological data, consumption patterns, and service delivery statistics to estimate medicine needs.</p> <p>3. Adopt standardized treatment protocols and integrate them into forecasting and supply planning</p> <p>Convene national experts and stakeholders to create or update standardized treatment protocols for hypertension, specifying recommended medicines, dosages, and treatment regimens, aligned with the WHO HEARTS recommendations (45). Use the standardized protocols as the foundation for morbidity-based forecasting, linking the number of patients to the specific medicines and quantities required. Put in place mechanisms to control prescribing practices and adherence of medical doctors to adopted standard treatment protocols.</p> <p>4. Build capacity of supply chain staff</p> <p>Train staff at national and facility levels on how to collect, analyse, and use data for forecasting and supply planning.</p>

Challenges	Potential strategies
	<p>5. Monitor and review forecasts</p> <p>Schedule periodic (e.g. quarterly or biannual) reviews of forecasts using the latest data to adjust procurement plans and respond to changes in demand. Monitor stock levels through systematic recordkeeping, such as stock cards, to track inventory, usage rates, and reorder needs. Ensuring traceability of all medicines and equipment is essential to prevent loss and maintain supply chain integrity (67).</p> <p>6. Integrate forecasting with national procurement and distribution</p> <p>Link forecasting directly with procurement and distribution planning to ensure that orders and deliveries match actual needs, minimizing waste and shortages.</p>
<p>Inefficient procurement processes, including negotiating, tendering and pooled procurement, increase the costs of medicines and reduce both the scale and bargaining power of procurement systems (46, 68–73).</p>	<p>1. Assess the procurement landscape</p> <p>Map existing procurement processes at all levels to identify fragmentation, inefficiencies, regulatory policies and price variations.</p> <p>2. Ensure collective negotiation and tendering:</p> <p>Collective negotiation and tendering policies at national level are essential for managing pharmaceutical prices through encouraging competitive mechanisms. It is important to promote the development and use of electronic e-tendering platform that increases efficiency and transparency of processes.</p> <p>3. Conduct competitive, transparent tendering</p> <p>Use open, competitive bidding processes to select suppliers, ensuring transparency and value for money (74).</p> <p>4. Aggregate demand and standardize product specifications</p> <p>Collect and consolidate medicine requirements from all regions and standardize product specifications based on national treatment protocols.</p>

Challenges	Potential strategies
	<p>5. Establish pooled procurement mechanisms, where feasible</p> <p>Pooled procurement mechanisms should be used in conjunction with other pricing policies, such as tendering and negotiation. Both centralized or decentralized procurement of hypertension medicines can be effective depending on a country's context and capacity. Centralized procurement, often coordinated at the national or regional level, is a common strategy for achieving economies of scale, reducing transaction costs, and securing lower prices through bulk purchasing. Decentralized models of procurement that benefit from central negotiation, can also improve medicine availability and quality if adequate capacity and oversight are in place. The choice between centralized and decentralized procurement should be guided by local needs, technical capacity, and the ability to maintain quality, efficiency, and affordability in the supply chain. Pooled procurement mechanisms should be considered in most of the cases as an alternative or complementary strategy to existing national procurement mechanisms.</p> <p>6. Monitor performance and ensure accountability</p> <p>Regularly monitor procurement outcomes (prices, delivery times, quality) and hold suppliers and procurement officials accountable.</p>

Challenges	Potential strategies
<p><i>Delayed government payments to suppliers.</i></p> <p>These delays often result in supplier debt, which can disrupt the regular supply of hypertension medicines. Suppliers may hesitate to provide medicines when there is uncertainty as to when payments will be received, leading to stockouts or interruptions in treatment (75–79).</p>	<p>1. Establish clear and binding payment schedules</p> <p>Set legal timelines for payments to suppliers in all procurement contracts.</p> <p>2. Ringfence and prioritize budgets for medicine payments</p> <p>Allocate and protect dedicated budget lines for medicine procurement, ensuring funds are available and prioritized for prompt payment to suppliers (63).</p> <p>3. Implement electronic payment and tracking systems</p> <p>Where possible, use digital platforms to automate invoice processing, track payment status, and flag overdue payments, increasing transparency and reducing administrative bottlenecks.</p> <p>4. Engage suppliers and address grievances rapidly</p> <p>Establish mechanisms for suppliers to report delayed payments and resolve disputes swiftly, maintaining open communication to avoid supply disruptions (80).</p>

Challenges	Potential strategies
<i>Pharmaceutical stockouts due to unreliable drug supply</i> including limited storage of medicines at pharmacies.	<p>To address pharmaceutical stockouts, relevant actors can follow the steps outlined above for better forecasting of the demand for hypertension medicines. Some additional concrete steps can be included:</p> <ol style="list-style-type: none"> 1. Improve storage capacity and practices at pharmacies Invest in adequate storage infrastructure and train pharmacy staff in good storage practices to maintain medicine quality and availability (81). 2. Strengthen inventory management Effective inventory management of hypertension medicines is essential to ensure uninterrupted treatment, prevent stockouts, and support consistent blood pressure control at both facility and programme levels, ensuring a better quality of health products along the storage and distribution stages. 3. Strengthen public-private partnerships Leverage public-private partnerships to expand access to affordable, quality-assured NCD medicines and technologies, emphasizing collaboration with the private sector to strengthen provision, supply chains, and market reforms (82). 4. Establish early warning and monitoring systems Set up electronic systems to detect and report low stock levels or impending shortages, enabling rapid response and redistribution of medicines where needed (83). 5. Develop and regularly review stockout prevention and management plans Create formal plans at both national and facility levels to prevent, respond to, and mitigate stockouts, including contingency supply arrangements (84).

Challenges	Potential strategies
Inaccessible packaging is a barrier that affects many patients, such as those with disabilities, including vision impairment or limited dexterity (85).	<p>1. Promote the use of accessible and user-friendly packaging</p> <p>Develop and enforce guidelines for accessible packaging, such as easy-to-open containers, large-print labels, and tactile features for people with disabilities and other marginalized populations.</p> <p>2. Engage users in packaging design</p> <p>Involve patient groups, pharmacists, and disability advocates in the development and review of packaging standards to ensure practical usability.</p>
Weak distribution system and infrastructure (poor roads, lack of transportation, inadequate storage facilities) challenge effective distribution and the ability to reach people who are most in need of medicines (86).	<p>1. Assess and map distribution needs and infrastructure</p> <p>Conduct a thorough assessment of existing roads, storage facilities, and transportation resources to identify gaps, and prioritize areas for improvement.</p> <p>2. Upgrade storage facilities to align with good storage practices</p> <p>Renovate or construct storage facilities to meet WHO standards of good storage practice (87).</p> <p>3. Optimize distribution routes and delivery schedules</p> <p>Plan efficient delivery routes and schedules based on geographical and population needs, using centralized or regional warehouses where appropriate to minimize transport challenges.</p> <p>4. Implement a warehouse management and inventory system</p> <p>Use standardized operating procedures and, where feasible, digital inventory systems to manage stock, track shipments, and monitor performance.</p> <p>5. Train supply chain personnel</p> <p>Provide regular training for staff in logistics, storage management, and distribution best practices to maintain quality and efficiency.</p> <p>6. Monitor distribution performance and address bottlenecks</p> <p>Establish regular monitoring and evaluation to identify delays, losses, or inefficiencies, and use findings to improve the system.</p>

V) Challenges and potential strategies to improve *prescribing* for hypertension medicines

Challenges	Potential strategies
<p>Limited access to a comprehensive formulary of antihypertensive drugs in public health settings</p> <p>forces healthcare providers to prescribe suboptimal options or to rely on patients seeking treatment from private markets, where medicines may be prohibitively expensive (5, 78, 88, 89). Also, high pill burden for patients due to the number of antihypertensive agents needed is often an obstacle for patient adherence.</p>	<p>The strategy for addressing limited access to a broad formulary of antihypertensive drugs includes many of the steps across the previous stages of the pharmaceutical chain outlined above. This may involve the following actions:</p> <ol style="list-style-type: none"> <p>1. Align the National Essential Medicines List with the WHO essential medicines list</p> <p>Review and update the national formulary to include all WHO-recommended first-line antihypertensive medicines classes and preferred combination therapies (12). Ensure regular review and update of the formulary.</p> <p>2. Include fixed-dose combination drugs in the national essential medicines list</p> <p>Ensure that commonly-used fixed-dose combination antihypertensive drugs are listed on the national EML and are prioritized for procurement and supply in public health facilities to reduce high pill burden (11).</p> <p>3. Engage stakeholders in formulary and procurement decisions</p> <p>Involve clinicians, pharmacists, patients, and procurement agencies in formulary development and procurement planning to ensure the formulary meets population health needs.</p> <p>4. Pooled procurement of essential antihypertensive medicines where feasible</p> <p>Aggregate demand and conduct pooled procurement to secure a reliable supply of all formulary-listed antihypertensives at lower prices (see sections above for more on pooled procurement).</p> <p>5. Monitor medicine availability and address gaps</p> <p>Implement regular monitoring of medicine stocks at all public health facilities and establish rapid response mechanisms to address shortages or gaps in the supply chain.</p>

Challenges	Potential strategies
<p><i>Affordability of branded drugs limits prescribing.</i> At times, providers may be forced to prescribe alternatives that are more affordable but less effective (5, 90).</p>	<p>1. Promote generic prescribing and use Update national policies and clinical guidelines to require or strongly encourage the prescription of quality-assured generic antihypertensive medicines instead of branded versions, as per WHO recommendations (63).</p> <p>2. Educate health care providers and patients Conduct training and awareness campaigns for prescribers and the public on the safety, efficacy, and cost-effectiveness of generics (91). WHO encourages education to address misconceptions about generics and support rational prescribing.</p> <p>3. Implement price regulation and reimbursement policies Introduce price controls, reference pricing, or reimbursement schemes that favour generics and limit the reimbursement of high-cost branded drugs (63).</p> <p>4. Monitor prescribing patterns and medicine prices Regularly track prescribing trends and medicine prices to ensure compliance with generic prescribing policies and to identify areas for improvement (14).</p>

Challenges	Potential strategies
<p><i>Lack of training on updated hypertension guidelines</i> limits rational prescribing (54). As a result, providers may rely on outdated practices or recommend suboptimal treatment regimens (71, 92).</p>	<p>1. Educate health care providers</p> <p>Ensure continuous education to ensure health care providers stay updated on the latest hypertension guidelines and emerging therapies, which is essential for high-quality care and optimal prescribing. Implement regular training sessions, workshops, and access to updated clinical resources to help health care providers adopt evidence-based practices and adapt to new treatment protocols, ultimately improving patient outcomes (93, 94).</p> <p>2. Integrate clinical decision support systems into electronic medical records</p> <p>Integrating clinical decision support systems into electronic medical records with real-time alerts and guideline-based recommendations prompts clinicians to prescribe the most appropriate antihypertensive therapies (95, 96).</p> <p>3. Implement regular audit and feedback mechanisms</p> <p>This can be achieved using prescribing data to identify under-prescription or inappropriate prescribing trends and provide constructive, data-driven feedback to clinicians.</p>

Challenges	Potential strategies
Clinical inertia challenges initiating or intensifying medication treatment (97–100).	<p>1. Implement standardized treatment protocols</p> <p>Develop and disseminate clear, evidence-based hypertension treatment protocols that specify when to initiate and intensify therapy, including use of single-pill combinations. Protocols reduce clinician uncertainty and provide clear decision points to overcome inertia (12, 45).</p> <p>2. Use team-based care and task-sharing</p> <p>Engage non-physician health workers (nurses, pharmacists, community health workers) in patient follow-up, blood pressure monitoring, and medication adjustment under protocol guidance. Team-based care improves follow-up and treatment intensification rates (45).</p> <p>3. Enhance clinician awareness and education</p> <p>Provide ongoing training on hypertension guidelines, the importance of timely treatment intensification, and interpretation of blood pressure measurements (including ambulatory blood pressure monitoring).</p> <p>4. Improve patient follow-up and monitoring systems</p> <p>Establish systems to ensure timely follow-up visits and blood pressure monitoring, including reminders and outreach for patients with uncontrolled hypertension (45). Regular follow-up reduces missed opportunities for treatment intensification. Providing clear guidance on monitoring, and managing common antihypertensive side effects, helps reduce treatment discontinuation and supports long-term adherence.</p> <p>5. Use fixed-dose combination medicines</p> <p>Promote the prescribing of fixed-dose combination antihypertensive medicines to simplify regimens and facilitate treatment intensification.</p>

VI) Challenges and potential strategies to improve *dispensing* for hypertensive medicines

Challenges	Potential strategies
<p>Limited access to pharmacies restricts the ability of patients in rural or underserved areas to access hypertension medicines. Even if pharmacies are available, they may be poorly stocked or lack essential medicines due to local distribution challenges (101, 102).</p>	<p>1. Invest in pharmacy infrastructure and workforce Support the establishment of new pharmacies in underserved areas and provide ongoing training for staff in stock management, patient counselling, and hypertension care, following the recommendations of WHO and the International Pharmaceutical Federation (103). Where this is not feasible, invest in training nurses or other health care officials to prescribe and dispense.</p> <p>2. Integrate community pharmacies into primary care networks Expand the role of community pharmacies at primary care, ensuring they are recognized as essential access points for hypertension medicines and care (104).</p> <p>3. Engage community health workers and mobile outreach Where fixed pharmacies are not feasible, deploy community health workers or mobile pharmacy units to dispense medicines and support adherence in remote communities.</p>
<p>Weak regulatory enforcement contributes to the dispensing of substandard or counterfeit drugs (105–107).</p>	<p>For guidance, see section I above: “Challenges and potential strategies to improve the regulatory landscape for hypertension medicines”.</p>

Challenges	Potential strategies
<p><i>Inadequate pharmacy infrastructure</i> (limited space or lack of privacy) affects the ability to properly store and dispense hypertension medicines or counsel patients, thus complicating the dispensing process (5, 108, 109).</p>	<p>1. Assess pharmacy infrastructure and identify gaps Conduct a nationwide or regional assessment of pharmacy premises to identify limitations in storage space, privacy for counselling, and workflow design, to ensure compliance with WHO's good distribution practices (110).</p> <p>2. Upgrade storage facilities to meet standards for good storage practice Renovate or equip pharmacies with adequate shelving, climate control, and secure storage to protect medicine quality and safety.</p> <p>3. Train pharmacy staff on best practices Provide training on proper storage, inventory management, and patient counselling, emphasizing the importance of privacy and medicine safety.</p> <p>4. Monitor and enforce compliance with infrastructure standards Establish regular inspections and audits to ensure pharmacies maintain adequate infrastructure and adhere to national and WHO standards.</p>

Challenges	Potential strategies
<p><i>Lack of training of pharmacists and miscoordination between pharmacists, prescribers, and patients:</i></p> <ul style="list-style-type: none"> • Inadequate training of pharmacists (lack of knowledge on up-to-date guidelines and potential drug interactions) can result in errors in the dispensing process, such as recommending incorrect dosages, failing to identify possible drug interactions, or not providing the proper counselling regarding side effects (111–113). • The lack of fluent communication between pharmacists and prescribers leads to errors and missed opportunities for medication adjustments (114–116). • Communication gaps between pharmacists and patients can lead to misunderstanding of medication instructions and premature discontinuing of patient's treatment (117–120). 	<p>1. Implement continuing professional education for pharmacists</p> <p>Establish regular training programmes to update pharmacists on the latest hypertension guidelines, drug interactions, correct dosing, and patient counselling techniques (121).</p> <p>2. Foster multidisciplinary team-based care</p> <p>Encourage regular meetings and shared care plans between pharmacists, prescribers, and other health care providers to ensure alignment with treatment goals and medication management (45).</p> <p>3. Strengthen patient counselling and engagement</p> <p>Train pharmacists to provide clear, tailored counselling on medication use, side effects, and the importance of adherence, using language and materials suited to the patient's literacy level.</p> <p>4. Dispense longer durations</p> <p>Dispensing longer durations (30–90 days) can promote adherence and convenience for the patient.</p>

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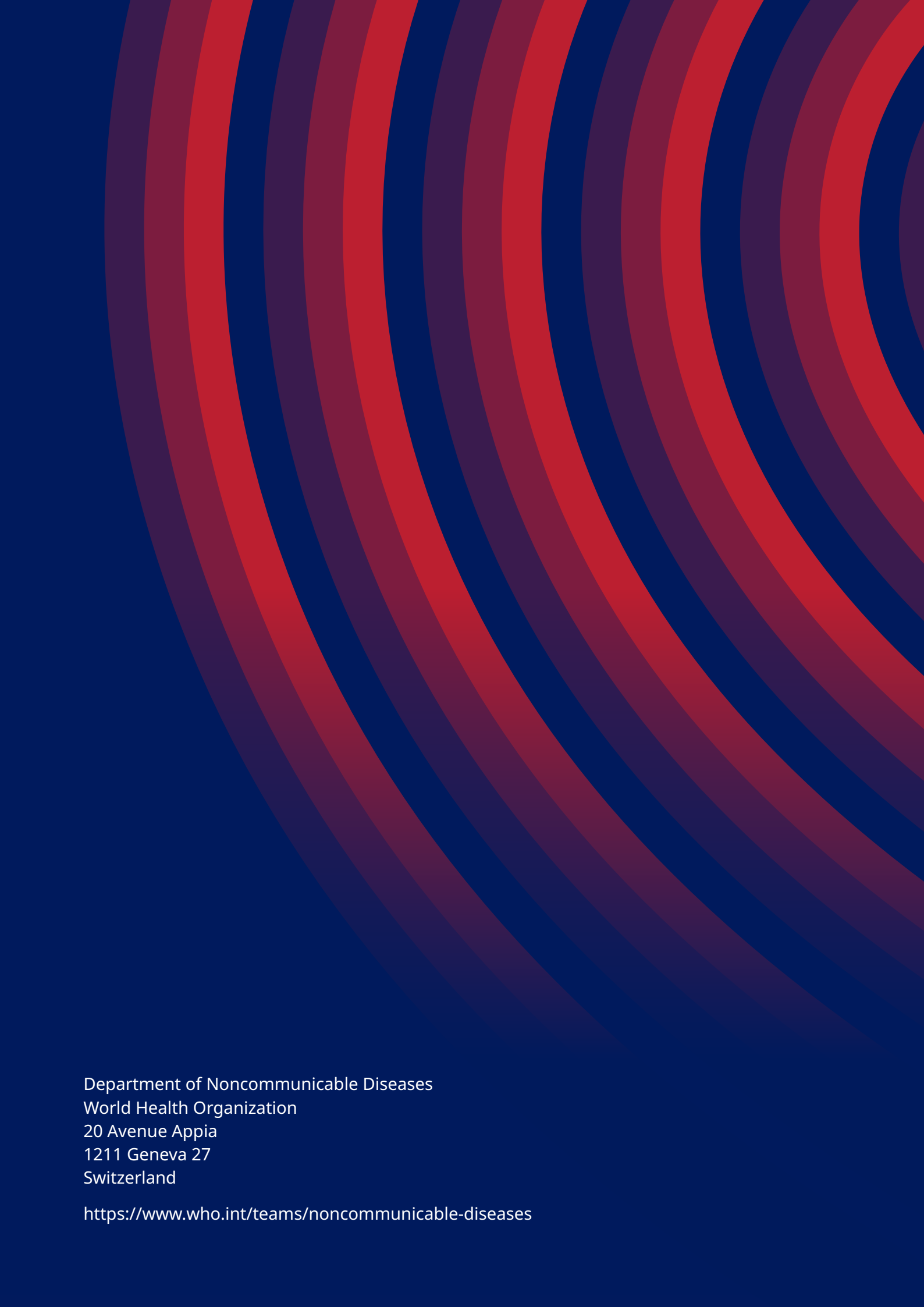
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