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Prevalence, awareness, treatment, and control of hypertension in Nigeria in 1995 and 2020: A systematic analysis of current evidence

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None.

Abstract

Improved understanding of the current burden of hypertension, including awareness, treatment, and control, is needed to guide relevant preventative measures in Nigeria. A systematic search of studies on the epidemiology of hypertension in Nigeria, published on or after January 1990, was conducted. The authors employed random-effects meta-analysis on extracted crude hypertension prevalence, and awareness, treatment, and control rates. Using a meta-regression model, overall hypertension cases in Nigeria in 1995 and 2020 were estimated. Fifty-three studies (n = 78 949) met our selection criteria. Estimated crude prevalence of pre-hypertension (120-139/80-89 mmHg) in Nigeria was 30.9% (95% confidence interval [CI]: 22.0%-39.7%), and the crude prevalence of hypertension (\geq 140/90 mmHg) was 30.6% (95% CI: 27.3%-34.0%). When adjusted for age, study period, and sample, absolute cases of hypertension increased by 540% among individuals aged \geq 20 years from approximately 4.3 million individuals in 1995 (age-adjusted prevalence 8.6%, 95% CI: 6.5-10.7) to 27.5 million individuals with hypertension in 2020 (age-adjusted prevalence 32.5%, 95% CI: 29.8-35.3). The age-adjusted prevalence was only significantly higher among men in 1995, with the gap between both sexes considerably narrowed in 2020. Only 29.0% of cases (95% CI: 19.7-38.3) were aware of their hypertension, 12.0% (95% CI: 2.7-21.2) were on treatment, and 2.8% (95% CI: 0.1-5.7) had at-goal blood pressure in 2020. Our study suggests that hypertension prevalence has substantially increased in Nigeria over the last two decades. Although more persons are aware of their hypertension status, clinical treatment and control rates, however, remain low. These estimates are relevant for clinical care, population, and policy response in Nigeria and across Africa.

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1 | INTRODUCTION

Hypertension (HTN) is a leading risk factor for cardiovascular disease (CVD) worldwide.^{1,2} Low- and middle-income countries (LMICs), including Nigeria, appear to be worst hit, with relatively higher number of cases and limited awareness, treatment, and control rates, against the trend observed in developed countries.^{3,4}

In Nigeria, HTN is the most frequently diagnosed CVD risk equivalent, with HTN-related complications accounting for approximately a quarter of emergency admissions in urban hospitals.^{5,6} The Nigerian population's mean blood pressure is higher than that of populations in Europe and the United States.⁷ In prior work,⁸ we reported that one in four adult Nigerians is hypertensive and that HTN unawareness is a likely contributor to deaths from CVD in the country.^{8,9}

Though numerous prior studies have provided estimates on the prevalence of HTN in Nigeria,^{7,9-11} few studies have examined HTN trends over time. These data may be particularly informative in light of the substantial and more recent demographic shifts occurring in the Nigerian population.³

The goal of this systematic review was to estimate both the prevalence of pre-HTN and HTN in Nigeria, and the level of awareness, treatment, and control of HTN. Further, we sought to examine for evidence of geographic, urban/rural, and sex-based differences in these estimates. These data are required to understand the likely trajectory of HTN in the country (useful for regional and global comparisons) and guide relevant country-wide strategies to address the burden of HTN-related disease.

2 | METHODS

2.1 | Search strategy

We conducted a systematic search of four databases—MEDLINE, EMBASE, Global Health, and Africa Journals Online (AJOL)—for studies on the prevalence of HTN in Nigeria. We also searched for studies on cardio-metabolic risk as we identified from an initial scoping exercise that a high proportion of such studies report on the prevalence of HTN (search terms are shown in Table 1). Unpublished (gray) documents were mainly sourced from Google Scholar and Google searches. Titles and abstracts of studies were reviewed, and full texts of relevant studies were accessed for further screening. The reference lists of accessed full texts were hand-searched for additional studies. Authors of selected papers were contacted for any missing information.

2.2 | Selection criteria

Studies were selected if they were (i) original population (or community)-based studies reporting on the prevalence of HTN in Nigeria, (ii) published on or after January 1, 1990, (iii) conducted among individuals aged at least 15 years, and (iv) providing estimates

on the prevalence, awareness, control, or treatment of HTN in Nigeria. We excluded hospital-based reports, studies on Nigerians in diaspora, reviews, viewpoints, and commentaries.

2.3 | Case definitions

The main outcome measures in this study were (i) prevalence of pre-HTN, (ii) prevalence of HTN, (iii) awareness of HTN (expressed as percent of HTN cases aware of their status), (iv) treatment of HTN (expressed as percent of HTN cases on antihypertensive medication), and (v) control of HTN (expressed as percent of HTN cases with blood pressure controlled). The American College of Cardiology (ACC) and American Heart Association (AHA) recently published an updated report on the prevention, detection, evaluation, and management of HTN in adults.¹² In this report, stage 1 HTN was defined as a systolic blood pressure (SBP) of 130-139 mmHg or a diastolic blood pressure (DBP) of 80-89 mmHg, and stage 2 as SBP of 140 mmHg or more or a DBP of 90 mmHg or more. However, as this classification has not been employed by several epidemiologic studies in Nigeria, we maintained the definition of HTN by the Joint National Committee on prevention, detection, evaluation, and treatment of high blood pressure.^{13,14} Therefore, we defined HTN as SBP of 140 mmHg or more, a DBP of 90 mmHg or more, taking antihypertensive medication, or having been diagnosed as hypertensive by a physician (corresponding to stage 2 HTN in the 2017 ACC/AHA classification). When available, we also extracted the prevalence of pre-HTN (defined as SBP of 120-139 mmHg or a DBP of 80-89 mmHg). For the awareness of HTN, we defined this as self-reported prior diagnosis of HTN by a doctor or a certified health worker, excluding women who were diagnosed with HTN during pregnancy.¹⁵ We defined treatment of

TABLE 1 Search terms on hypertension in Nigeria

No.	Searches
1	africa/ or africa, sub-sahara/ or africa, western/ or nigeria/
2	exp vital statistics/
3	(incidence* or prevalence* or morbidity or mortality).tw.
4	(disease adj3 burden).tw.
5	exp "cost of illness"/
6	case fatality rate.tw
7	hospital admissions.tw
8	Disability adjusted life years.mp.
9	(initial adj2 burden).tw.
10	exp risk factors/
11	2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10
12	exp hypertension/ or high blood pressure/ or hypertensive heart disease/ or cardiovascular risks/ or cardio-metabolic risks
13	1 and 11 and 12
14	Limit 13 to "1990-current"

HTN as self-reported medication use to lower blood pressure at the time of interview.¹⁵ Control of HTN was defined as SBP below 140 mmHg and DBP below 90 mmHg while currently on antihypertensive medication.¹⁵

2.4 | Data extraction

Literature searches and assessment of eligible studies were conducted independently by three reviewers (DA, EOO, and AA), according to the selection criteria to ensure consistency in final selection of studies. Disagreements in study selection were resolved by consensus. Data on the study site, period, design, setting (urban or rural), sample size, and mean age of the population were extracted. These were matched with corresponding data on the number of HTN cases and prevalence of HTN in each study.

2.5 | Quality assessment

We adapted a previously used quality assessment criteria for studies on chronic diseases¹⁶ to provide insights on the quality of selected studies. We screened for explicit description of methods, protocols, case ascertainment, and sampling and representativeness of reported estimates within the larger geopolitical zone. We graded studies as *high* (4-5), *moderate* (2-3), or *low quality* (0-1) (see Supplemental Material for details of quality grading).

2.6 | Data analysis

We conducted a random-effects meta-analysis, using the DerSimonian and Laird Method,¹⁷ on the individual study estimates to generate national and subnational pooled crude estimates of the respective study outcomes in Nigeria. Standard errors were determined from the reported crude estimates and population denominators, assuming a binomial (or Poisson) distribution. We assessed heterogeneity between studies using I-squared (I^2) statistics. Subgroup analysis was conducted to detect causes of heterogeneity. We investigated publication bias using the Funnel plot and Egger's test. As described in previous studies,^{8,16} we constructed a meta-regression epidemiologic model accounting for study sample, year, and mean age to determine age-adjusted prevalence distribution of HTN by age of the Nigerian population. Model expressed as:

$$Prev_{HTN(\%)_i} = \alpha + \beta_1 * Mean\ age + \beta_2 * Study\ year + u_i$$

where $Prev_{HTN(\%)_i}$ is the prevalence of hypertension in percentage, α is the constant, β_1 and β_2 are regression coefficients for mean age and study year, and u_i represents study-level variance.

From this model and the age-adjusted prevalence rates, we estimated the absolute number of adult individuals with HTN in

Nigeria at midpoints of the United Nation (UN) population 5-year age groups for Nigeria for the years 1995 and 2020.¹⁸ All statistical analyses were conducted on STATA (Stata Corp V.14, Texas, USA). The study was conducted in line with the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines.¹⁹ The complete dataset employed in this review is available in the Supplemental Material. Further details on searches, data extraction, and analysis are available on reasonable request from corresponding author.

3 | RESULTS

3.1 | Search results

Our searches returned 4154 studies—4132 from the four databases (MEDLINE, 1691; EMBASE, 2123; Global Health, 246; and AJOL, 72), and an additional 22 studies identified from Google Scholar, Google searches, and reference lists of relevant studies. After duplicates were removed, 1897 titles were screened for relevance (ie, for evidence of a population-based study on HTN in Nigeria). On applying the selection criteria, 1709 studies were excluded. We assessed 188 full texts, which were screened explicitly using the selection and quality criteria. Fifty-three studies were finally selected for both qualitative and quantitative syntheses (Figure 1).

3.2 | Study characteristics

The 53 studies were selected across the six geopolitical zones of Nigeria and covering a total population of 78 949 individuals (Table 2). The South-west and South-east were represented by 15 studies each, followed by the South-south with 14 studies. North-central had three studies, North-west, three; and North-east, two. One study was conducted across multiple sites in the country. Twenty-one studies each were conducted in urban and rural settings, with 13 in mixed urban-rural settings. We rated 32 studies as high quality, and the remaining 21 rated as moderate quality. Study periods ranged from 1995 to 2017, with most studies (90%) were conducted within a one-year period. Sample mean age ranged from 23.0 to 71.1 years. Heterogeneity was high across studies, with I-squared (I^2) estimated at 99.1% ($P < .001$). The Funnel plot suggests no publication bias, with the Egger's test ($P = .309$) further confirming no small study effects (Supplemental Material).

3.3 | Prevalence of pre-HTN in Nigeria

The prevalence of pre-HTN (SBP 120-139 mmHg or DBP 80-89 mmHg) reported in studies ranged from 17.2% estimated from two cities in the South-south in 2012,²⁰ to 42.5% recorded in Anambra State, South-east Nigeria, in 2016.²¹ The estimated pooled

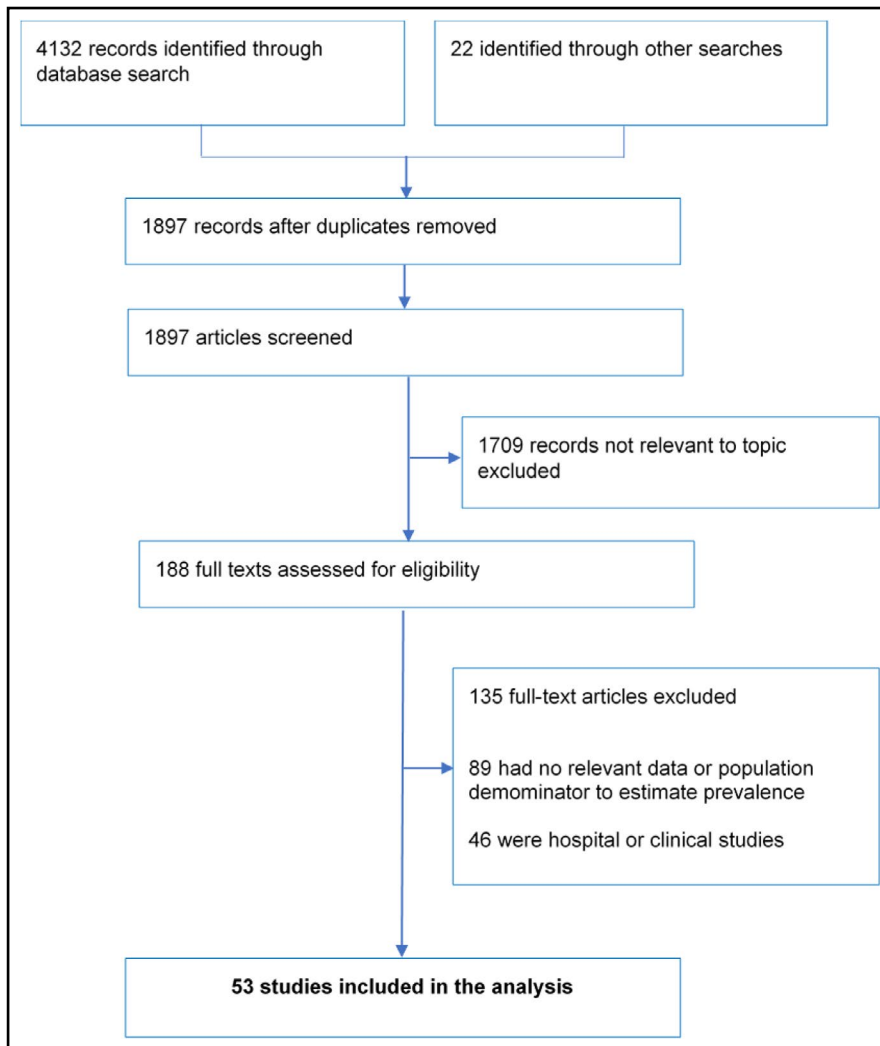


FIGURE 1 Flowchart of selection of studies

crude prevalence of pre-HTN in Nigeria was 30.9% (95% CI: 22.0-39.7) (Figure 2). No sex-specific estimates were reported.

3.4 | Crude prevalence of HTN in Nigeria

From individual study estimates, the highest prevalence of HTN (SBP \geq 140 mmHg or DBP \geq 90 mmHg) was recorded in an urban community in Kaduna State, North-west Nigeria, at 55.9% in 2018,²² with the lowest prevalence estimated in Ibadan Oyo State, South-west Nigeria, at 9.3% in 1999.²³ When pooled crude prevalence of HTN across the geopolitical zones was considered, pooled estimates in the four zones were relatively similar and above 30%. The highest prevalence was in the South-east at 33.3% (95% CI: 27.3-39.4), closely followed by the North-central with a prevalence of 32.2% (95% CI: 13.5-34.0); while the North-west had 31.9% (95% CI: 14.9-48.9), and the South-west had 30.2% (95% CI: 23.6-36.8) (Figure 3). The North-east and the South-south had a pooled HTN prevalence of 24.7% (95% CI: 22.4-27.1) and 27.6% (95% CI: 21.4-33.9), respectively. The overall pooled crude prevalence of HTN in Nigeria was 30.6% (95%

CI: 27.3-34.0) (Figure 3). Although no significant difference, the prevalence was slightly higher among women (30.4%, 95% CI: 25.2-35.6) than among men (29.5%, 95% CI: 25.4-33.6) (Table 3 and Supplemental Material). Across both sexes, the pooled prevalence was consistently higher among urban dwellers (33.5%, 95% CI: 25.1-42.0) than among rural dwellers (25.5%, 95% CI: 21.1-29.9) (Table 3).

3.5 | Pooled mean SBP and DBP in Nigeria

The pooled mean population SBP in Nigeria was 130.9 mmHg (128.4-133.4) and the pooled mean DBP was 81 mmHg (79.5-82.8) (Table 3 and Supplemental Material).

3.6 | Awareness, treatment, and control of HTN in Nigeria

The pooled HTN awareness rate (expressed as a percentage of all HTN cases) was 29.0% (95% CI: 19.7-38.3), while 12.0% (95% CI:

TABLE 2 Characteristics of studies on prevalence of hypertension in Nigeria

Author	Study period	Location	Geopolitical zone	Study design	Study setting	HTN prevalence %
Abegunde and Owoaje ⁴⁷	2011	Oyo State	South-west	Descriptive cross-sectional study	Mixed	34.8
Adedoyin et al ⁴⁸	2008	Ile-Ife, Osun State	South-west	Descriptive cross-sectional study	Semi-urban	36.6
Adedoyin et al ⁴⁹	2012	Maiduguri, Borno State	North-east	Population-based cross-sectional study	Semi-urban	25.2
Ahaneku et al ⁵⁰	2011	Enugu, Enugu State	South-east	Population-based cross-sectional study	Rural	44.5
Alikor et al ⁵¹	2013	Port-Harcourt, River State	South-south	Descriptive cross-sectional study	Rural	20.2
Amira et al ⁵²	2010	Lagos State	South-west	Descriptive cross-sectional study	Urban	33.0
Amole et al ⁵³	2008	Ogbomoso, Oyo State	South-west	Descriptive cross-sectional study	Mixed	50.5
Asekun-Olarinmoye et al ⁵⁴	2011	Osogbo, Osun State	South-west	Population-based cross-sectional study	Rural	13.2
Cooper et al ⁵⁵	1995	Ibadan, Oyo State	South-west	Descriptive cross-sectional study	Mixed	14.5
Ejimi et al ⁵⁶	2006	Enugu, Enugu State	South-east	Population-based cross-sectional study	Rural	46.4
Ekanem et al ⁵⁷	2012	Abak, Akwa Ibom State	South-south	Descriptive cross-sectional study	Semi-urban	47.0
Ekwuonife et al ⁵⁸	2009	Nsukka, Enugu State	South-east	Population-based cross-sectional study	Mixed	21.1
Erhun et al ⁵⁹	2003	Ile-Ife, Osun State	South-west	Descriptive cross-sectional study	Semi-urban	21.0
Hendriks et al ⁶⁰	2011	Ilorin, Kwara State	North-central	Population-based cross-sectional study	Rural	21.0
Isezuo et al ⁶¹	2010	Sokoto, Sokoto State	North-west	Population-based cross-sectional study	Mixed	24.8
Kadiri et al ⁶²	1998	Ibadan, Oyo State	South-west	Descriptive cross-sectional study	Urban	9.3
Mbah et al ⁶²	2012	Nsukka, Enugu State	South-east	Population-based cross-sectional study	Semi-urban	32.5
Odugbemi et al ⁶³	2010	Tejuosho, Lagos	South-west	Descriptive cross-sectional study	Urban	34.8
Ogah et al ⁶⁴	2012	Umuahia, Abia State	South-east	Population-based cross-sectional study	Mixed	31.4
Oghagbon et al ⁶⁵	2007	Ilorin, Kwara State	North-central	Population-based cross-sectional study	Urban	27.1
Oladapo et al ⁶⁶	2005	Egbeda, Oyo State	South-west	Descriptive cross-sectional study	Rural	20.8
Omorogiuwa et al ⁶⁷	2008	Ekpoma, Edo State	South-south	Descriptive cross-sectional study	Urban	33.0
Omuemu et al ⁶⁸	2004	Edo State	South-south	Population-based cross-sectional study	Rural	20.2
Suleiman et al ⁶⁹	2011	Amassoma, Bayelsa State	South-south	Descriptive cross-sectional study	Semi-urban	15.0
Uiasi et al ⁷⁰	2008	Enugu State	South-east	Population-based cross-sectional study	Mixed	32.8
Uiasi et al ⁷¹	2010	Enugu State	South-east	Population-based cross-sectional study	Mixed	42.2
Agaba et al ⁷²	2014	Jos, Plateau State	North-central	Descriptive cross-sectional study	Urban	48.5
Akinbodewa et al ⁷³	2014	Akure & Ondo, Ondo State	South-west	Descriptive cross-sectional study	Mixed	43.4
Emerole et al ⁷⁴	2007	Owerri, Imo State	South-east	Descriptive cross-sectional study	Urban	29.1
Ibekwe ⁷⁵	2012	Oghara, Delta State	South-south	Descriptive cross-sectional study	Rural	21.0
Ige et al ⁷⁶	2013	Ibadan, Oyo State	South-west	Descriptive cross-sectional study	Urban	21.5
Okaka and Eiya ⁷⁷	2013	Ovia, Edo state	South-south	Population-based cross-sectional study	Rural	19.3

(Continues)

TABLE 2 (Continued)

Author	Study period	Location	Geopolitical zone	Study design	Study setting	HTN prevalence %
Oyeyemi and Adeyemi ⁷⁸	2013	Maiduguri, Borno State	North-east	Population-based cross-sectional study	Semi-urban	23.1
Oguoma et al ⁷⁹	2015	Kwale, Delta State	South-south	Population-based cross-sectional study	Mixed	35.5
Ezejimofor et al ⁸⁰	2014	Niger Delta, Rivers State	South-south	Community-based cross-sectional study	Rural	51.1
Adebayo et al ⁸¹	2013	Ife North, Osun State	South-west	Population-based cross-sectional study	Rural	26.4
Andy et al ²⁰	2012	Cross River & Akwa Ibom States	South-south	Population-based cross-sectional study	Rural	23.6
Akpan et al ⁸²	2015	Akwa Ibom State	South-south	Population-based cross-sectional study	Urban	28.6
Egbi et al ⁸³	2013	Yenagoa, Bayelsa State	South-south	Population-based cross-sectional study	Rural	21.3
Bello-Ovosi et al ²²	2017	Kawo, Kaduna State	North-west	Population-based cross-sectional study	Urban	55.9
Chukwuonye et al ⁸⁴	2013	Abia State	South-east	Population-based house-to-house survey	Mixed	40.2
Ekpe et al ⁸⁵	2015	Adim, Cross River State	South-south	Population-based cross-sectional study	Rural	19.9
Ezeala-Adikaibe et al ⁸⁶	2016	Enugu State	South-east	Population-based cross-sectional study	Urban	52.5
Ezekwesili et al ²¹	2016	Anambra State	South-east	Population-based cross-sectional study	Mixed	22.8
Iloh et al ⁸⁷	2009	Imo State	South-east	Descriptive cross-sectional study	Rural	16.3
Iloh et al ⁸⁸	2008	Imo State	South-east	Descriptive cross-sectional study	Rural	18.4
Murthy et al ⁸²	2013	National	National	Population-based cross-sectional study	Mixed	44.9
Ofuya ⁸⁹	2007	Niger Delta, Rivers State	South-south	Population-based cross-sectional study	Rural	13.8
Okafor et al ⁹⁰	2014	Enugu, Enugu State	South-east	Population-based cross-sectional study	Urban	47.7
Olamoyegun et al ⁹¹	2016	Ekiti State	South-west	Population-based cross-sectional study	Semi-urban	55.5
Shittu et al ⁹²	2016	Oke-Ogun, Oyo State	South-west	Population-based cross-sectional study	Semi-urban	38.5
Ugwuuja et al ⁹³	2015	Igbeagu, Ebonyi State	South-east	Population-based cross-sectional study	Rural	23.2
Wahab et al ⁹⁴	2006	Katsina, Katsina State	North-west	Population-based cross-sectional study	Urban	16.0

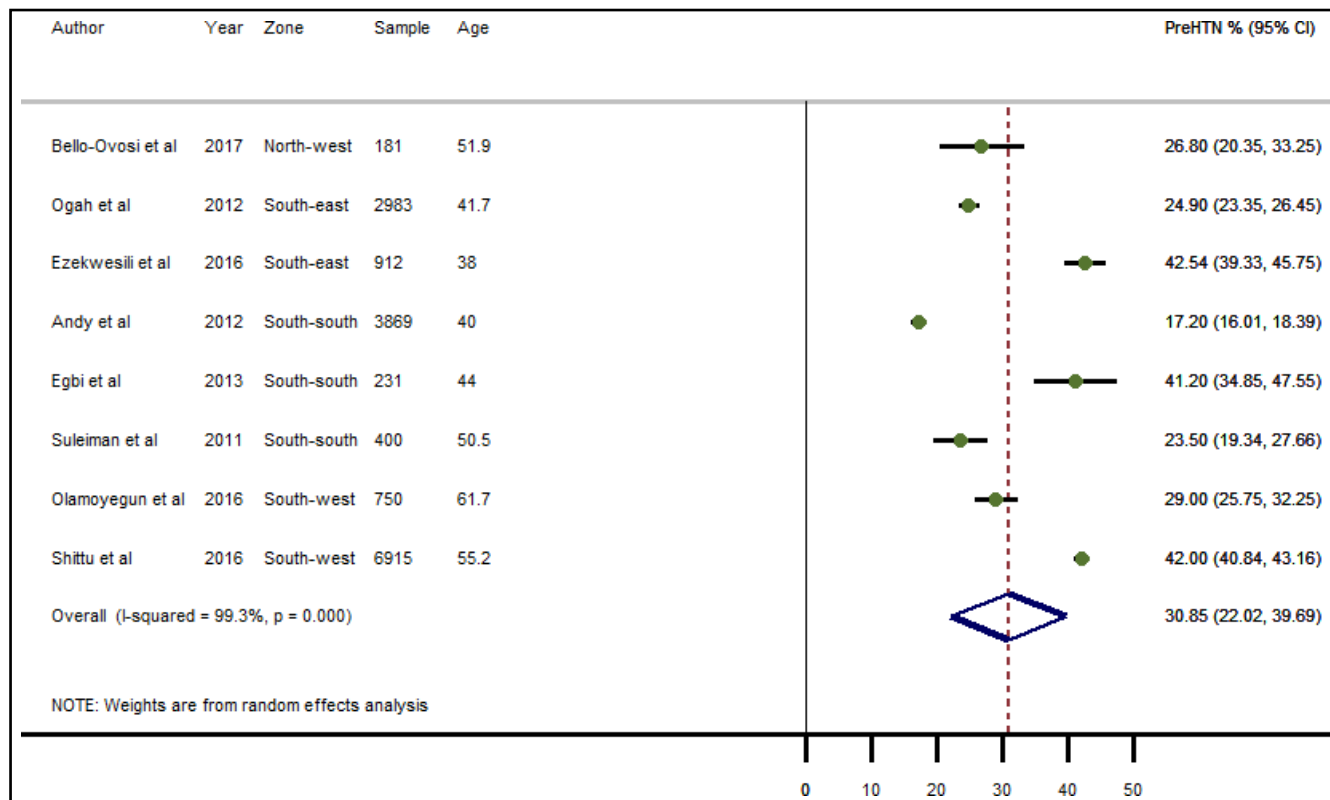


FIGURE 2 Crude prevalence of pre-hypertension in Nigeria

2.7-21.2) were on antihypertensive medications, and 2.8% (95% CI: 0.1-5.7) of these had at-goal blood pressure (Figure 4).

3.7 | Estimated number of individuals with HTN in Nigeria

The meta-regression epidemiologic modeling showed that age and study period were statistically significant determinants of HTN prevalence in Nigeria, $P < .001$ (Supplemental Material). The prevalence of HTN increased significantly with advancing age and year of study. For example, in 1995, the prevalence of HTN at ages 20-24 and 50-59 years was 1.0% and 15.6%, respectively, and by 2020, the prevalence rates at these age brackets had increased to 23.5% and 40.0%, respectively (Table 4). Using the United Nations demographic projections for Nigeria, we estimated that approximately 4.3 million individuals over the age of 19 had HTN in Nigeria in 1995 (age-adjusted prevalence of 8.6%, 95% CI: 6.5-10.7). This figure increased by 540% to 27.5 million individuals over the age of 19 with HTN in 2020 (age-adjusted prevalence of 32.5%, 95% CI: 29.8-35.3) (Table 4). When the sexes were considered, cases increased significantly from 3 million (12.0%, 95% CI: 9.3-14.8) to 14.2 million (33.5%, 95% CI: 29.3-37.7) among men, and 1.3 million (5.2%, 95% CI: 2.5-7.9) to 13.2 million (31.5%, 95% CI: 27.0-35.9) among women between 1995 and 2020, respectively. The age-adjusted prevalence was only significantly higher in men in

1995, with the gap in prevalence between both sexes considerably narrowed in 2020.

4 | DISCUSSION

In this systematic review of 53 studies on the prevalence of HTN in Nigeria, we found strong evidence that HTN has become far more common among Nigerian adults in recent years and that awareness of the condition remains alarmingly low. We also provide the first country-specific estimates of pre-HTN for Nigeria, and present strong evidence of geographic heterogeneity in this condition. These results have strong implications for future preventative and educational campaigns.

Our results suggest that between 1995 and 2020, HTN cases in Nigeria increased by over 540% from four million individuals to 28 million individuals. We estimated that the age-adjusted HTN prevalence in 2020 was 32.5%, a substantially higher number than the 28.0% prevalence we estimated in 2010 in a prior study.⁸ Likely contributors to this high and steady increase in HTN include population aging, increased urbanization, unhealthy lifestyles, and the absence of effective nation-wide preventative measures. Our results lend credence to concerns that HTN and related complications may soon represent the most significant public health and economic threat in many African countries, overshadowing epidemics such as malaria and other infectious diseases.^{7,24,25}

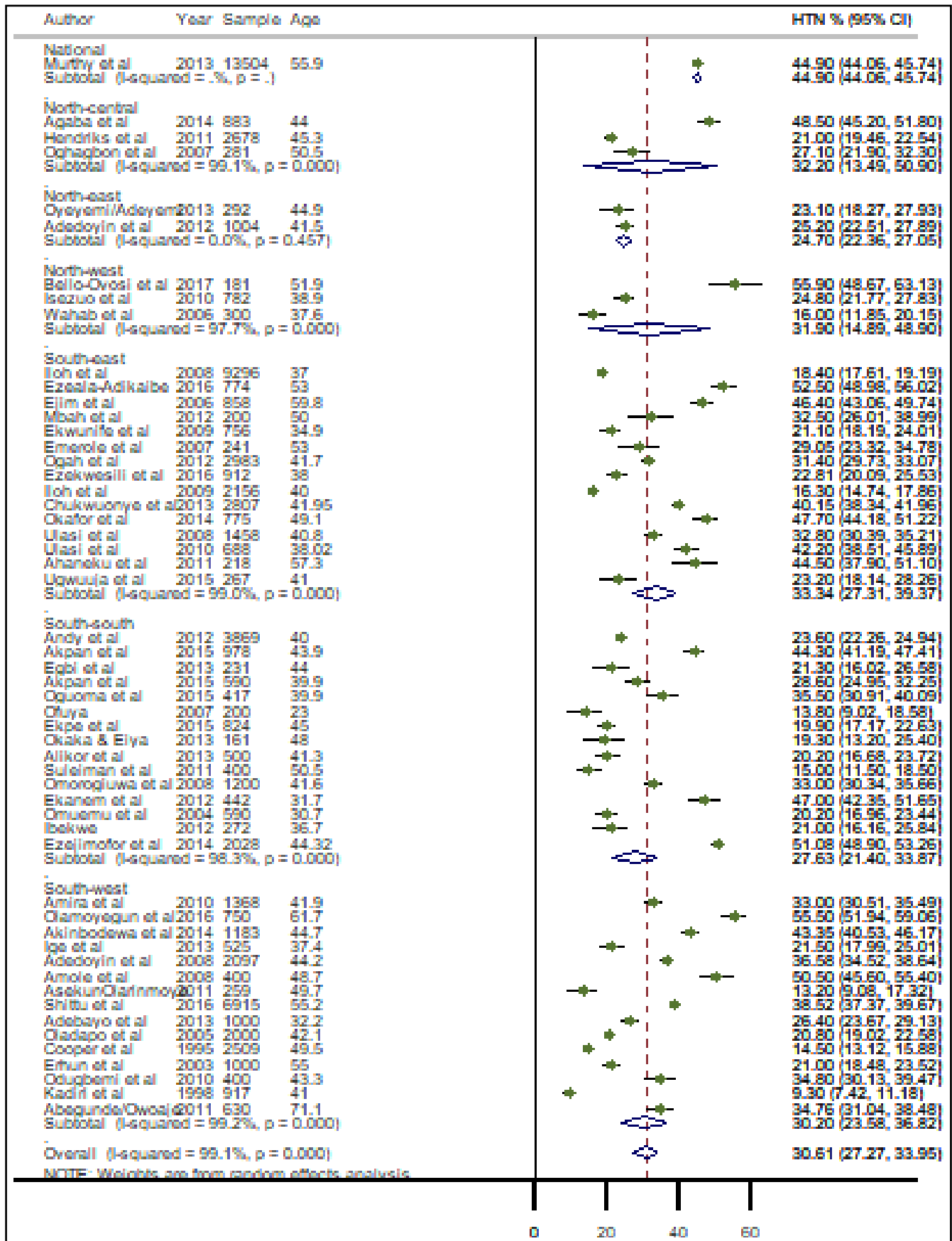


FIGURE 3 Crude prevalence of hypertension in Nigeria

TABLE 3 Pooled crude estimates of prevalence of hypertension in Nigeria

Region	Both sexes		Men		Women	
	Prevalence % (95% CI)	I ² , P-value	Prevalence % (95% CI)	I ² , P-value	Prevalence % (95% CI)	I ² , P-value
Nation-wide						
Hypertension	30.6 (27.3-34.0)	99.1, <.001	29.5 (25.4-33.6)	98.2, <.001	30.4 (25.2-35.6)	99.2, <.001
Pre-hypertension	30.9 (22.0-39.6)	99.3, <.001	-	-	-	-
Awareness ^a	29.0 (19.7-38.3)	98.9, <.001	-	-	-	-
Treatment ^a	12.0 (2.7-21.2)	97.9, <.001	-	-	-	-
Control ^a	2.8 (0.0-5.7)	83.1, .015	-	-	-	-
SBP (mmHg)	130.9 (128.4-133.4)	90.7, <.001	-	-	-	-
DBP (mmHg)	81.1 (79.5-82.8)	95.0, <.001	-	-	-	-
Geopolitical zone						
North-central	32.2 (13.5-34.0)	99.1, <.001	35.9 (21.6-50.2)	93.3, <.001	24.8 (21.3-28.4)	97.1, <.001
North-east	24.7(22.4-27.1)	0.0, .457	23.3 (19.5-27.1)	28.7, .236	24.8 (21.3-28.4)	0.0, .867
North-west	31.9 (14.9-48.9)	97.7, <.001	20.1 (7.2-33.1)	90.9, <.001	34.0 (13.9-54.1)	97.2, <.001
South-east	33.3 (27.3-39.4)	99.0, <.001	40.8 (33.7-48.0)	95.1, <.001	35.8 (29.0-42.6)	96.1, <.001
South-south	27.6 (21.4-33.9)	98.3, <.001	24.4 (18.9-29.8)	92.2, <.001	20.9 (15.6-26.3)	94.6, <.001
South-west	30.2 (23.6-36.8)	99.2, <.001	27.3 (17.3-37.2)	98.0, <.001	30.9 (20.0-41.8)	99.4, <.001
Settings						
Urban	33.6 (25.1-42.0)	98.8, <.001	27.2 (17.3-37.2)	97.9, <.001	34.5 (23.2-45.8)	98.3, <.001
Rural	25.5 (21.1-29.9)	98.6, <.001	26.4 (20.6-32.2)	94.5, <.001	22.9 (17.8-28.1)	95.5, <.001
Mixed	33.7 (26.7-40.7)	99.3, <.001	35.8 (27.8-43.7)	98.6, <.001	34.1 (25.0-43.1)	99.1, <.001

^aAwareness, treatment, and control rates expressed as percent of HTN cases.

Given our pooled mean SBP and DBP estimates of 131 mmHg and 81 mmHg, respectively, our study findings may indicate that many Nigerians are also in the pre-hypertensive stage. Though pre-HTN does not connote inevitable progression to HTN, studies had long shown that the presence of pre-HTN increases the risk for HTN, cardiovascular complications, and target organ damage by 30% in the absence of lifestyle modifications or treatment.²⁶⁻²⁸ We estimated that nearly one in three Nigerians is pre-hypertensive. Our estimate is in the range of pre-HTN prevalence estimates from Ghana (30.7%) and South Africa (29.4%), but higher than the pooled estimate in four sub-Saharan African countries that included Nigeria (21.0%).^{29,30} In contrast, Chow et al³¹ estimated that pre-HTN prevalence was 36.8% from a multicountry study, although this does not include Nigeria. Comparison between prior studies and ours may be challenging due to the differences in the methodology between studies. However, several studies²⁹⁻³¹ including the current have pointed to a high prevalence of pre-HTN and HTN in Nigeria and neighboring countries, calling for more awareness and education.

We found evidence of substantial regional variation in the prevalence of HTN in Nigeria, which ranged from 25% to 33% across the geopolitical zones. The highest prevalence was in the South-east and North-central at 33.3% and 32.2%, respectively. Although the regional pattern of distribution may be subject to further studies, Murthy et al³² reported high prevalence of HTN in 2013 among the

Nupe and Igbo communities in the North-central and South-east at 50.5% and 40.4%, respectively. Dietary differences in these regions, particularly in the amount of oil and salt used in food, may be the contributing factor. The significant variations in socio-economic conditions also have important implications on dietary choices, particularly in urban settings characterized by high consumption of processed foods, without population-wide strategies promoting healthy diets.^{33,34} Moreover, varying weather and climatic conditions in Nigeria considerably affect farming and the type of food crops produced, possibly another important factor for the dietary differences. Our findings of a higher prevalence of HTN among urban dwellers and those of advanced age are consistent with findings from numerous previous studies.^{25,35-37}

Our estimates clearly indicate a narrowing prevalence gap between men and women, with a difference of 7% in 1995 and 2% in 2020. In prior work,⁸ we reported a 5% difference between the two sexes (30% men vs 25% women) in 2010. Although the current crude prevalence difference in both sexes was not statistically significant, this was slightly higher among women (30.4%) compared with men (29.5%). These findings are consistent with those from a 2013 study of 13 504 Nigerians, in which the prevalence of HTN was higher among women (46.8%) than among men (42.6%). The rising prevalence of HTN among women could be linked to increasing obesity, decreasing physical inactivity and unhealthy diets.³⁸⁻⁴¹ Moreover, women appear to suffer worse

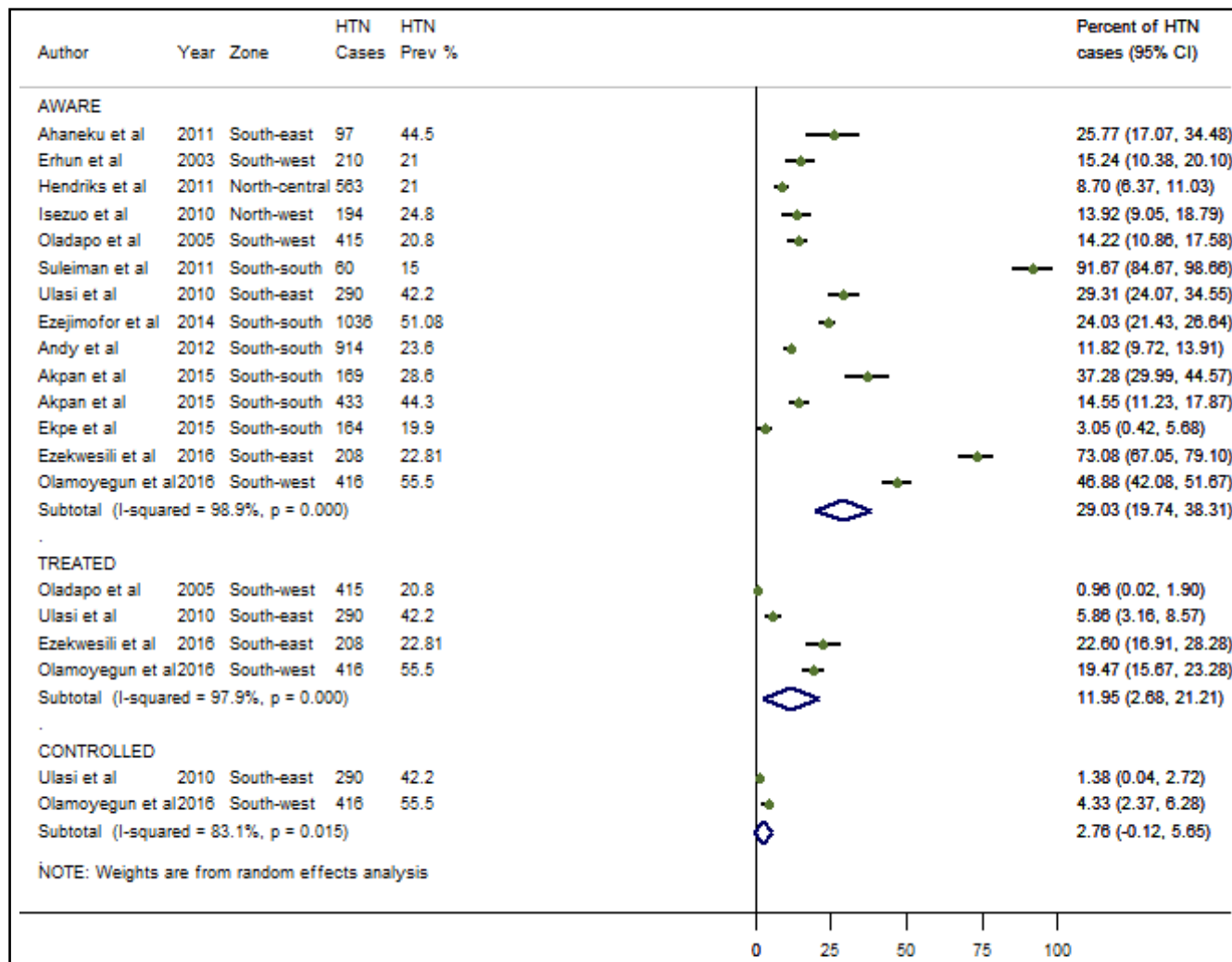


FIGURE 4 Awareness, treatment, and control of hypertension in Nigeria

mental, psychological, and emotional consequences from increasing security challenges in Nigeria, with repeated anxiety and panic attacks likely having adverse effects on the overall cardiovascular health of many. In addition, it is worth noting that women are more likely to participate in community medical outreach efforts, possibly leading to selection bias and relatively higher prevalence reported for females.^{8,9}

Compared with our previous pooled awareness rate (17.4%),⁸ HTN status awareness (expressed as a percentage of HTN cases in the country) increased to 29%. This rate is higher than recorded in some African countries (Gabon, Uganda, and Kenya), which ranged from 9% to 12%.^{7,42} Despite the improvement in awareness of HTN in the country, the treatment and control rates of HTN (also expressed as percentage of HTN cases) were relatively low at 12% and 3%, respectively. These rates are very low compared with treatment and control rates in other African countries such as Zimbabwe and South Africa, which are above 30%.^{40,41,43} Addressing the relatively low awareness, treatment, and control rates of HTN in Nigeria is key to reducing cardiovascular health burden. However, an important consideration are the challenges relating to acquiring and adhering

to antihypertensive medications.^{9,44} Although cardiology training program for medical doctors has relatively improved over the years, and there are ongoing studies and trials on medications, several doctors particularly in primary and secondary health facilities lack the requisite knowledge of the standard management for hypertension. Prescriptions are often too complex, and there is a lack of follow-up of cases, resulting in both poor adherence and suboptimal control of HTN.^{33,45}

Targeted community-wide programs, commonly organized by non-governmental organizations and research groups, are an important avenue for blood pressure screening in Nigeria.^{7,9-11} The government, ministry of health and other stakeholders can collaborate with these organizations and groups in observing the annual May Measurement Month (MMM) across primary care levels in the country to raise awareness and facilitate blood pressure screening in catchment communities. According to Beaney et al,⁴⁶ the MMM is an inexpensive intervention that can be employed to address a shortfall in screening of blood pressures across world regions, with over 35 000 (28%) newly diagnosed cases reported in sub-Saharan Africa alone in 2017. In addition to initiatives and

TABLE 4 Absolute number of hypertensive individuals in Nigeria (age ≥ 20 years), during 1995 and 2020

Age (years)	Both sexes						Men			Women		
	1995			2020			1995			2020		
	Prevalence % (SE)	Cases (000)	Prevalence % (SE)	Cases (000)	Prevalence % (SE)	Cases (000)	Prevalence % (SE)	Cases (000)	Prevalence % (SE)	Cases (000)	Prevalence % (SE)	Cases (000)
20-24	1.0 (0.09)	95.6	23.5 (0.34)	3752.2	1.3 (0.16)	66.1	29.6 (0.51)	2409.6	0.6 (0.11)	29.4	17.1 (0.43)	1342.6
25-29	1.8 (0.15)	139.0	26.2 (0.37)	3686.8	2.6 (0.25)	102.1	30.9 (0.55)	2207.9	1.0 (0.16)	36.9	21.4 (0.49)	1479.0
30-34	4.5 (0.26)	299.0	29.0 (0.41)	3509.6	7.8 (0.47)	258.8	32.2 (0.60)	1981.5	1.2 (0.19)	40.2	25.7 (0.57)	1528.1
35-39	7.3 (0.35)	404.0	31.8 (0.47)	3170.5	12.9 (0.64)	355.7	33.5 (0.66)	1704.6	1.7 (0.25)	48.2	30.0 (0.66)	1465.8
40-44	10.1 (0.44)	463.9	34.5 (0.54)	2681.4	15.8 (0.76)	359.1	34.7 (0.75)	1383.7	4.5 (0.43)	104.9	34.3 (0.77)	1297.7
45-49	12.8 (0.54)	499.3	37.3 (0.62)	2240.1	18.6 (0.88)	361.6	36.0 (0.89)	1094.6	7.1 (0.58)	137.7	38.6 (0.89)	1145.5
50-54	15.6 (0.63)	519.0	40.0 (0.69)	1999.6	21.5 (1.01)	354.7	37.1 (1.01)	914.3	9.8 (0.73)	164.2	42.9 (0.98)	1085.2
55-59	18.3 (0.75)	493.6	42.8 (0.77)	1774.6	24.3 (1.18)	319.5	38.1 (1.18)	760.2	12.6 (0.89)	174.0	47.2 (1.07)	1014.4
60-64	21.1 (0.89)	441.2	45.6 (0.86)	1515.3	27.2 (1.40)	273.4	38.9 (1.40)	611.8	15.5 (1.09)	167.8	51.5 (1.19)	903.5
65-69	23.9 (1.08)	368.5	48.3 (0.99)	1234.3	30.0 (1.69)	219.8	40.1 (1.69)	486.2	18.3 (1.36)	148.8	55.8 (1.36)	748.1
70-74	26.6 (1.37)	274.7	51.1 (1.17)	930.5	32.9 (2.15)	157.4	41.0 (2.14)	351.2	21.2 (1.74)	117.3	60.1 (1.58)	579.3
75-79	29.4 (1.89)	170.9	53.8 (1.52)	580.2	35.7 (2.97)	93.2	41.4 (2.97)	203.9	24.2 (2.39)	77.7	64.4 (1.98)	376.4
80+	32.4 (2.49)	114.5	56.9 (1.84)	410.5	38.9 (4.04)	56.6	40.7 (4.04)	126.4	27.9 (3.11)	58.0	69.1 (2.3)	284.1
All (20+)	8.6	4283.2	32.5	27 485.6	12.0	2978.1	33.5	14 235.8	5.2	1305.1	31.5	13 249.8
Lower CI	6.5	3224.6	29.8	25 154.2	9.3	2295.9	29.3	12 449.5	2.5	638.8	27.0	11 369.8
Upper CI	10.7	5341.8	35.3	29 816.9	14.8	3660.4	37.7	16 022.0	7.9	1971.3	35.9	15 129.8

Abbreviations: CI, 95% confidence interval; SE, standard error.

campaigns such as the MMM, primary health workers who are in regular contact with patients can play active roles in promoting screening and regular assessment of blood pressure for early identification of individuals at risk and timely provision of treatments where necessary.

Our study should be considered with respect to its limitations. Heterogeneity across studies was high, reflecting variations in population structures, blood pressure measurement protocols, and overall study designs. Of the 53 studies retained, only eight were conducted in the Northern regions, and data on age- and sex-specific prevalence, and specific geographic settings, were not always provided. It is not so clear why studies are predominantly lower in the North, but this has been observed in previous studies,^{8,16} possibly a reflection of the overall research capacity in the region. These factors resulted in some discrepancies in the crude sex estimates, although this was accounted for in the final model. Moreover, our estimates were based on JNC classifications, as there were no available studies based on the 2017 ACC/AHA guidelines. Moreover, we reported relatively high age-adjusted estimates in the younger age groups in 2020; this should be cautiously interpreted due to sparse overall data for persons under 30 years. Largely, these limitations are balanced by the strengths of our study, including its large sample size, rigorous methodology, and its provision of the first nation-wide estimates of the treatment and control of HTN in Nigeria.

5 | CONCLUSIONS

In summary, the burden of HTN is increasing in Nigeria and our data suggest that many Nigerians are pre-hypertensive. HTN prevalence appears to be increasing at a faster rate among Nigerian women than among men. Further, though the awareness of HTN has improved over time, more than half of hypertensive individuals in Nigeria are untreated and/or have poorly controlled blood pressure. Our results strongly support a need for improved and comprehensive nation-wide population preventive strategies to mitigate the effects of HTN in Nigeria.

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DISCLOSURE

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AUTHOR CONTRIBUTIONS

DA conceived and designed the study. DA, EOO, and AA conducted the literature searches and data extraction. DA, EOO, and MOH

wrote the first draft. DA and MOH conducted the analysis. DA, AA, DBO, MTD, TOO, OSO, CO, NE, RGM, EA, MG, WA, AOA, MOH, and other authors contributed to the final draft and checked for important intellectual content. All authors approved the manuscript as submitted.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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