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PREVALENCE OF ARTERIAL HYPERTENSION AND ITS MAIN CLINICAL-DEMOGRAPHIC INDICATORS

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ABSTRACT

Arterial hypertension is one of the leading risk factors for cardiovascular disease and premature death in women. Recent studies have shown that this condition is prevalent not only among older women but also among women of reproductive age. In women, the development of arterial hypertension, in addition to traditional risk factors, is closely associated with pregnancy-related hypertensive disorders, gynecological and hormonal changes, psychosocial stress, socioeconomic inequalities, and gender differences in the use of health care services.

The aim of this review is to summarize the available scientific evidence on the prevalence, risk factors, clinical consequences, and gender-specific aspects of the management of arterial hypertension in women. Epidemiological studies conducted across different regions indicate significant regional and social disparities in hypertension prevalence, as well as inadequate detection, treatment, and control of the disease, particularly in low- and middle-income countries.

Furthermore, cardiovascular complications in women have been shown to develop at lower blood pressure levels than in men. In conclusion, effective prevention and control of hypertension in women require a life-course–oriented, gender-specific, and comprehensive approach. Early screening, promotion of healthy lifestyles, management of body weight and mental health, and integration

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of women-specific risk factors into clinical practice are essential for reducing the burden of cardiovascular disease.

Keywords: Arterial hypertension, women of reproductive age, cardiovascular disease, gender-specific risk factors, body mass index (BMI), obesity, overweight, lifestyle.

Introduction

Arterial hypertension remains a serious public health concern for women across the life course—from adolescence through pregnancy, menopause, and old age. The prevalence of hypertension exhibits racial, ethnic, and socio-economic disparities that are apparent not only in the general population but also between sexes. Blood pressure thresholds during pregnancy have not yet been updated to align with the 2017 ACC/AHA guidelines due to insufficient data. Moreover, the mechanisms underlying the development of hypertension during menopause, including the roles of sex hormones and genetic factors, are not yet fully understood. The prevalence of hypertension among women continues to rise due to decreased physical activity, increasing obesity, and population aging. Consequently, further research is required to implement lifelong screening and monitoring of women for hypertension, as well as to investigate gender-specific mechanisms. These measures are critical for reducing the burden of cardiovascular disease [10].

Arterial hypertension is a leading risk factor for cardiovascular disease and premature death in women worldwide. However, basic knowledge about the gender-specific pathophysiology of this condition is lacking. In addition, risk factors for hypertension and cardiovascular disease that are specific to women or the female gender are not adequately recognized in clinical practice guidelines. This review summarizes the available evidence on risk factors specific to women and the female gender, as well as the clinical management of hypertension, and

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aims to identify gaps in knowledge that are important for research, clinical practice, and awareness of women's heart health.Risk factors specific to women do not only relate to aspects of reproduction, such as gynecological diseases, adverse pregnancy outcomes, or the relationship of menopause to arterial hypertension, but also to the specific roles of women in society and science. In particular, gender differences in the provision of health care and the underrepresentation of women as scientists and research participants contribute to limitations in evidence-based, sex- or gender-specific recommendations.

One important aspect is that the development of arterial hypertension often begins in young, premenopausal women, in connection with disorders in the functioning of the reproductive organs. Therefore, in order to prevent cardiovascular diseases in the future, it is necessary to monitor and manage arterial hypertension from the early stages of life. Given that cardiovascular diseases develop at relatively lower blood pressure levels in women, the established cut-off values for the diagnosis and treatment of arterial hypertension may need to be lower for women [5].

In the United States, hypertension is one of the most important modifiable risk factors for cardiovascular disease and poses a significant risk to maternal and child health when it occurs during pregnancy. There is currently no consistent and uniform national or state-level monitoring system for hypertension among women of reproductive age (WRA). Therefore, there is a lack of sufficient information to determine the prevalence of hypertension, its mechanisms of development, and preventive measures. The study analyzed health surveys such as BRFSS, NHANES, NHIS, PRAMS, and administrative databases such as the National Inpatient Sample, State Inpatient Databases, and Nationwide Emergency Department Sample. These data allow us to distinguish between non-pregnant and pregnant WRA women, while PRAMS studies hypertension status before and during pregnancy only in women with a live birth. However, detailed and systematic data on hypertension in the postpartum period are lacking. As a

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result, expanding and improving data will allow for effective monitoring of hypertension among RYA women, planning health strategies during pregnancy and the postpartum period, and targeted implementation of physical activity, weight control, nutrition and preventive measures. At the same time, these measures are important in reducing the burden of cardiovascular diseases and improving maternal and child health [18].

A review of recent evidence on sex differences in the prevalence, consequences, and management of hypertension indicates that, although hypertension is more common in men, women experience a more pronounced increase in blood pressure from the third decade of life onwards, resulting in a relatively faster rise in prevalence with age. Mechanisms contributing to this pattern may include the long-term vascular effects of hypertensive disorders during pregnancy, interactions between the renin–angiotensin–aldosterone system and sex hormones, as well as psychosocial and gender-specific factors such as socioeconomic disadvantage. Furthermore, the impact of hypertension is not uniform: women are at higher risk of developing various adverse cardiovascular outcomes at lower blood pressure thresholds. Although blood pressure is a sex-specific characteristic and significant differences exist between men and women in the prevalence, pathophysiology, and consequences of hypertension, there is currently insufficient evidence to establish gender-specific blood pressure targets [8].

Arterial hypertension is a serious public health problem in Rwanda and represents a major risk factor for cardiovascular disease. This analysis, based on data from the 2022 WHO STEPS Survey in Rwanda, aimed to determine the prevalence of hypertension and its key predictors. The results indicated that the overall prevalence of hypertension in the country was 16.8%. Hypertension was more common among older adults and individuals with obesity. Adults aged 60–69 years had a 5.7-fold higher risk of hypertension compared with younger adults. Overweight and obese individuals had a 1.6-fold higher risk, while those who

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consumed alcohol in the past 12 months had a 1.4-fold higher risk. Regional differences were also observed: residents of the Northern, Western, and Southern provinces had a significantly higher risk than those residing in the Eastern province. These findings underscore the need for targeted public health interventions to control hypertension in Rwanda, including hypertension screening, weight management programs, promotion of healthy lifestyle changes, and strengthening community-based preventive strategies to improve cardiovascular health [12].

Hypertension is also a major public health challenge among women of reproductive age in sub-Saharan Africa. This study assessed and analyzed socioeconomic inequalities in hypertension using data from five countries (Benin, Cameroon, Ghana, Kenya, and Lesotho). A total of 52,076 women of reproductive age were included. The overall Erreygers Normalized Concentration Index (ECI) was 0.06, indicating a pro-rich inequality in hypertension prevalence. The factors contributing most to these socioeconomic inequalities were wealth status (12.6%), media exposure (19%), education level (2.3%), marital status (-34.3%), and place of residence (-31.7%). Hypertension was more prevalent among women of reproductive age in sub-Saharan Africa in wealthier populations. Wealth index, marital status, media exposure, and place of residence were the main drivers of this inequality. Targeted interventions aimed at reducing socioeconomic disparities could substantially decrease the prevalence of hypertension [14].

In India, hypertension is a major public health concern and is closely associated with age, sex, place of residence, socioeconomic status, and lifestyle. According to NFHS-5 data, the prevalence of hypertension among individuals aged 15 years and older is 22.6%, higher in men (24.1%) than in women (21.2%). The risk of hypertension increases sharply with age, particularly among those over 60 years, where prevalence approaches half of the population. Urban residents exhibit higher hypertension prevalence compared to rural populations, reflecting the

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negative impacts of urbanization, lifestyle changes, and environmental factors on blood pressure. Significant regional differences were also observed, with the highest prevalence in Sikkim (37.9%) and the lowest in Rajasthan (16.5%). Key risk factors for hypertension include age, body mass index (BMI), waist circumference, diabetes, alcohol consumption, and low educational attainment. Gender differences are notable: older women, especially those with obesity, are at higher risk than men. While overweight or obesity increases hypertension risk in men, the effect of obesity is more pronounced in women. These findings underscore that hypertension control in India requires a comprehensive approach beyond medical treatment, including promoting healthy lifestyles, strengthening preventive programs, improving health literacy, and increasing access to healthcare services. Such measures are essential to reduce long-term cardiovascular complications and improve overall population health [17].

The high morbidity and mortality from cardiovascular diseases (CVD) among the working-age population in Russia necessitates the development of new screening targets and evidence-based prevention models. An 8-year prospective study showed that the prognostic factors for the development of arterial hypertension depend on gender. In women, the main factors were marital status (widowhood), diastolic blood pressure, and physical activity outside work. In men, in addition to the usual clinical and behavioral factors, anxiety as a personal trait was also an independent predictor. The results confirm the need for a polyprofessional approach (physician-internist, psychiatrist, medical psychologist) and highlight the importance of developing gender-specific prevention strategies. This approach allows for increased effectiveness in the prevention of CVD [3].

Hypertension is a widespread and serious health problem worldwide, and its detection, treatment and control are inadequate in many countries. This study aimed to identify factors associated with hypertension care in a black population aged 21 years and older living in Cape Town, South Africa. Results showed that 62.4% of detected hypertension patients were on treatment, 75.6% of detected

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patients were on treatment, and 57.1% of treated patients had blood pressure controlled. Women have higher rates of detection, treatment, and control than men, and gender differences have been found to be significant. The main sociodemographic and clinical factors associated with the diagnosis of hypertension include age >45 years, female gender, family history of hypertension, low education, long-term urban residence, diabetes, and chronic kidney disease. However, individuals with the lowest socioeconomic status are less likely to be diagnosed with hypertension. Hypertension care strategies should be equitable and targeted in terms of gender, socioeconomic status, and access to health resources. In addition, it is important to implement an individualized approach based on age, sex, and disease characteristics, as well as to strengthen prevention and monitoring programs in the poor and less urbanized populations [19].

The 2017 American College of Cardiology/American Heart Association (ACC/AHA) classification of arterial hypertension significantly increases the detection of this condition among women of reproductive age. Specifically, a study based on NHANES data from 2005–2014 found that the prevalence of arterial hypertension among non-pregnant women aged 20–44 years was 112% higher under the ACC/AHA 2017 guidelines compared with the JNC7 guidelines. Although the number of women diagnosed with hypertension increased substantially, there was minimal change in the proportion recommended for antihypertensive drug treatment. This indicates that the main focus of the new guidelines is on strengthening early preventive measures through lifestyle modification rather than drug therapy. According to the study, older women (35–44 years), obese women, and women with diabetes were more likely to be newly classified as hypertensive, indicating that these groups are at higher risk for future cardiovascular disease. In contrast, the relatively low probability of being newly classified as hypertensive among Hispanic women highlights the significance of ethnic and socio-demographic factors. Overall, the implementation of the 2017

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ACC/AHA guidelines allows for early detection of arterial hypertension in women of reproductive age and has important clinical and preventive implications for long-term cardiovascular disease prevention. However, the application of these guidelines in clinical practice requires an individualized approach that considers women-specific risk factors [6].

Hypertension is prevalent among women of reproductive age in Lesotho, representing a leading cause of severe pregnancy complications and a significant burden on healthcare costs. This study utilized data from the 2014 Lesotho Demographic and Health Survey, analyzing 3,353 women aged 15–49. Findings indicated that one in five women had hypertension, while 23% were classified as prehypertensive. The risk of hypertension was particularly elevated among women aged 45–49, with a 9.78-fold increase. Additional risk factors included cohabitation with a partner, orphanhood, and residence in the Maseru district. Overall, the risk of hypertension among women of reproductive age in Lesotho increased with age. Accordingly, primary prevention strategies should prioritize high-risk groups, including older women, married women, and women with prehypertension [15].

The association between traditional (modifiable and non-modifiable) risk factors for arterial hypertension has long been well-documented in the literature. However, additional potential risk factors specific to women may also contribute to the development of arterial hypertension, including early menarche, age at first childbirth, women's social activity and independence (empowerment), number of children, hysterectomy, and others. This study represents the first to investigate the potential association between both traditional and gender-specific risk factors and arterial hypertension using a nationally representative sample.

The study was based on a secondary analysis of data from the National Family Health Survey (NFHS-4) conducted in India, which included 699,686 women of reproductive age. The interview questionnaire collected information on general background characteristics, marital and reproductive history, hysterectomy,

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knowledge of and access to family planning services, maternal and child care, women's social independence, non-communicable diseases, and domestic violence. Blood pressure was measured directly by trained investigators using a digital sphygmomanometer. Weighted statistical analyses were applied to account for sampling bias and nonresponse. Logistic regression analysis was conducted to assess the strength of associations between risk factors and arterial hypertension.The prevalence of arterial hypertension among women was 11.8%. Among traditional risk factors, increasing age, elevated body mass index (BMI), tobacco use, and alcohol consumption were associated with a higher likelihood of arterial hypertension. Conversely, higher educational attainment, higher socioeconomic status, and urban residence were associated with a lower likelihood of hypertension [7].

A study conducted in three Nigerian states (Abia, Oyo, and Kano) revealed gender differences in the prevalence of hypertension, awareness of high blood pressure, and utilization of health services among young adults. The study included 924 respondents aged 18–40 years. The overall prevalence of hypertension was 18.2%, with higher prevalence in women than in men (19.2% vs. 16.7%). Awareness of elevated blood pressure among women was 59.7%, compared with 52.5% among men, a difference that was statistically significant ($p = 0.03$). Women were also more likely than men to seek medical care. Factors associated with high blood pressure in women included age, marital status, ethnicity, education level, and occupation, whereas age, marital status, and ethnicity were significant predictors in men. These findings indicate that gender-specific differences exist in the burden of hypertension, awareness, and healthcare utilization among young adults in Nigeria. Consequently, gender-sensitive preventive and therapeutic interventions are essential to reduce and control the burden of hypertension [13].

A study in Nepal aimed to examine the relationship between hypertension, anemia, and body mass index (BMI) in women of reproductive age. The results

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showed that the incidence of hypertension was significantly higher in non-anemic women, and increases in BMI and hemoglobin levels increased the risk of hypertension. Additionally, weight gain, overweight, obesity, smoking, and mid-upper arm circumference were identified as factors that significantly increase the risk of hypertension. Conversely, anemia was associated with a reduced risk of hypertension, highlighting hemoglobin levels as an independent risk factor. These findings indicate the need for regular monitoring of hemoglobin and BMI, as well as dietary and lifestyle interventions, to reduce the risk of hypertension among women of reproductive age. The study findings are important for the development of health policies and preventive programs, especially for the formulation of strategies to improve women's health [2].

A study conducted in North Dakota identified several key factors influencing the development of arterial hypertension among women of reproductive age. In particular, frequent psychological stress (psychological distress), obesity, the 35–44 age group, and residence in areas with limited access to primary care professionals were found to significantly increase the risk of arterial hypertension. Inequalities in access to healthcare services also play an important role in the development of hypertension. These findings underscore the importance of prioritizing mental health support, obesity reduction, and expanded access to healthcare when designing prevention and control programs for arterial hypertension in women of reproductive age [9].

Hypertension in women of reproductive age is a serious health problem requiring special attention due to pregnancy-related hypertension and socio-cultural vulnerability. Data from the National Family Health Survey (2015–2016), which included 687,230 women aged 15–49 years in India, were analyzed. The results showed that 11.3% of women had hypertension. The prevalence of hypertension increased with age and weight gain and was higher among urban residents, alcohol users, and tobacco users. Using a logistic regression model, the main predictors of hypertension development were identified as older age, urban

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residence, tobacco and alcohol consumption, meat consumption, and overweight. Based on these factors, a risk score was developed, providing an important tool for early detection and planning preventive measures. In conclusion, a gender-specific and individual risk factor-based approach is required for the prevention and monitoring of hypertension in women of reproductive age [4].

This study also represents the first attempt to estimate the prevalence of hypertension in India at the national, state, and district levels, providing an essential foundation for the development of effective preventive strategies. In addition, it aimed to identify key risk factors for hypertension. According to the National Family Health Survey (NFHS-4) conducted in 2015–2016, the age-adjusted prevalence of hypertension among individuals aged 15–49 years was 11.3%, with 13.8% in men and 10.9% in women. The prevalence of hypertension was slightly higher in urban areas compared to rural areas, and varied substantially across states, ranging from 8.2% in Kerala to 20.3% in Sikkim. The primary predictors of hypertension development included increasing age, obesity/overweight, male sex, socio-economic status, and alcohol consumption. The study's findings indicate that hypertension is increasingly prevalent among lower-income populations. Accordingly, policy interventions are needed to reduce lifestyle-related risk factors and to mitigate occupational and social pressures that contribute to increased consumption of high-calorie foods and alcohol [11].

In Tanzania, data from the 2022 Demographic and Health Survey and the Malaria Indicators Survey were analyzed to assess the prevalence of arterial hypertension and its predictors among adults aged 15–49. The study included 13,385 participants. Results revealed that the prevalence of hypertension among adults of reproductive age was 11%. Hypertension prevalence increased with age and body weight, reaching 22.11% in those aged 40–49 years and 23.69% among individuals with obesity. Geographically, hypertension was more common in the southern, eastern, western, southern highlands, northwestern, and northeastern

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regions, which also have higher proportions of older adults and elevated BMI. Age and obesity emerged as the strongest determinants of hypertension, with individuals aged 40–49 exhibiting an almost six-fold higher risk compared to those aged 15–19, and obese individuals showing higher risk than overweight individuals. These findings indicate that hypertension prevalence among adults of reproductive age in Tanzania varies according to risk factors, with age and body mass index being the most significant predictors [16].

Hypertension (HTN) is a serious public health problem that has reached epidemic proportions globally. This study assessed the prevalence of hypertension in rural and urban India through a systematic review and meta-analysis to identify regional differences. The results of the study included 112 eligible studies conducted between 2011 and 2022. According to the pooled results, the prevalence of hypertension in the adult population in India was 27.2%. The highest prevalence was observed in the northern regions, where it was 33.0%. One in four adults in India suffers from hypertension, which is a serious public health problem. This systematic review and meta-analysis enriches the existing knowledge and provides important guidance to health policymakers and professionals in developing effective control and treatment interventions, especially in implementing regional approaches [20].

Conclusion

Arterial hypertension is a major public health problem among women across their lifespan, significantly increasing the risk of cardiovascular disease and premature death. Evidence indicates that hypertension in women is influenced not only by traditional risk factors but also by sex-specific biological, reproductive, and hormonal factors, as well as psychosocial and socioeconomic conditions. Hypertensive disorders during pregnancy, hormonal changes associated with menopause, and psychological stress can lead to earlier and more rapid increases in blood pressure in women. Furthermore, women may develop cardiovascular

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complications at relatively lower blood pressure levels, highlighting the need for early detection and management of hypertension. Therefore, implementing gender-specific approaches in the development of screening, prevention, and treatment strategies, strengthening early lifestyle interventions, and developing comprehensive, women-centered preventive programs are essential for reducing the burden of cardiovascular disease.

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