

## Editorial

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# Hypertension in Bangladesh: Race Against a Silent Killer

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Hypertension has become the leading modifiable risk factor for global deaths. Unlike many sudden illnesses, its progression is usually silent, with vascular damage building up over years before leading to stroke, heart attack, heart failure, or chronic kidney disease, earning it the nickname “silent killer.” Even blood pressure higher than normal, without reaching hypertension levels or requiring treatment, raises the risk of death from cardiovascular and other diseases. In 2021, global data show that 53% of all cardiovascular deaths, including 58% of stroke deaths and 31% of chronic kidney disease deaths, were linked to high systolic blood pressure. Overall, high blood pressure contributed to 11 million deaths, or 16% of all deaths worldwide, more than any other risk factor. By 2024, about 1.4 billion adults aged 30–79 globally suffer from hypertension. This accounts for 33% of people in this age group and has remained nearly unchanged since 1990, when it was 32%. However, due to population growth and ageing, the number of affected individuals has more than doubled since 1990, from 650 million. Death rates vary greatly among regions: while 8% of all deaths in the African Region are due to high blood pressure, the rate in the Western Pacific Region is much higher at 22%. Slight differences are also seen between sexes, with high blood pressure causing 15% of deaths in men and 18% in women. Regarding age, 11% of all deaths related to high blood pressure occur in people under 70, and 21% among those 70 and older. In 2018, nearly 20 million adults in Bangladesh had hypertension, but only 38% were receiving treatment, and a mere 15% had their blood pressure controlled. In recent decades, Bangladesh has faced many structural and systemic barriers, such as limited access to essential medicines in rural areas, long waits at primary care clinics, high transportation costs, weak patient follow-up systems, and a lack of awareness about hypertension’s risks. Environmental factors like widespread use of solid fuels have also contributed to a significant rise in hypertension, especially among women.<sup>1</sup>

Bangladesh took some steps to address its challenges in hypertension control: integrating hypertension management into UHC level with strengthened governance mechanisms

and policies. 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 alongside sustainable financing. Continued investment in digital tools, free medication provision, workforce training, and community engagement has laid the foundation for long-term sustainability. Daily treatment with affordable, evidence-based antihypertensive medicines is cost-effective and delivers substantial returns on investment.<sup>2</sup> Every investment 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. When a national regulatory system is independent, efficient, science-based, transparent, and well-managed, it supports robust and effective regulation of medical products, 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 manufactured, stored, distributed, and dispensed appropriately. It ensures that health professionals and patients can use medicines and other medical products rationally because they have the information they need to do so, and ensures that promotion and advertising are 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 better prepared for emergencies. Several challenges in the regulatory landscape can hinder access to safe, high-quality essential hypertension medicines. The recommended steps that policymakers can take to address these challenges are presented.<sup>3 4</sup>

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A comprehensive analysis of the existing regulatory system can help identify gaps in regulatory capacity, processes, and outputs. Countries without regulatory systems can start by establishing a legal and institutional framework to create a national medicines regulatory authority or an equivalent body. Strengthen and streamline regulatory processes: Build capacity of regulatory staff: Invest in training and technical support for regulatory staff to improve expertise in the evaluation of hypertension medicines, inspections, and post-marketing surveillance. Internationally recognized guidelines for medicine quality, safety, and efficacy are the foundation for national regulations. Develop clear rules for good manufacturing, distribution, and storage practices, and require compliance from all stakeholders. Implement market surveillance. Collaborate with regional regulatory harmonization initiatives and leverage pooled procurement mechanisms to improve access to quality-assured hypertension medicines and share regulatory resources.

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.<sup>5</sup>

This shift involves transitioning from informal consultation to more sustained, institutionalized participatory approaches to leadership, in which 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.

Thus, not only is effective hypertension control in Bangladesh about following a set of protocols but also about incorporating structured community participation and lived experience in health care delivery. While the national strategy in Bangladesh aligns with World Health Organization recommendations on hypertension control, which emphasize standardized treatment approaches, task sharing, digital registries, and affordable medication options, experience sharing plays a vital role in ensuring the overall process is effective. When people living with hypertension become active partners in the process, through patient councils and patient education groups, and when they are also part of the overall process through community outreach programs, it not only becomes easier to ensure that they are more committed to the process but also that the overall process becomes more culturally responsive. Thus, not only is the process about ensuring that hypertension control becomes a provider-driven intervention but also about

mobilizing the people to become active partners in ensuring that the process becomes a public health movement to achieve cardiovascular health outcomes in the country. The below reflection by **Elena Shelestova** captures a core principle of behavioral medicine: “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.”

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