Determinants of Hypertension in West Africa: Contribution of Anthropometric and Dietary Factors to Urban-Rural and Socioeconomic Gradients

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The determinants of hypertension in West Africa have not been well defined. The authors sampled 598 participants aged 45 years or more from a recent population-based survey in southwest Nigeria (190 rural men and women, 205 urban poor men and women, and 203 retired railway workmen). The estimated mean age was 61 (10) years. Mean pressures were low relative to westernized societies: systolic blood pressure = 124 (24) mmHg, diastolic blood pressure = 72 (13) mmHg. Both men and women were remarkably lean: body mass index = 21.3 (3.6) and 23.0 (5.2) kg/m², respectively. Hypertension prevalence increased across the gradient from rural farmers to urban poor to railway workers: 14, 25, and 29 percent, respectively, had a blood pressure of 140/90 mmHg or greater, and 3, 11, and 14 percent, respectively, had a blood pressure of 160/95 mmHg or greater (p for trend < 0.01 for both outpoints). On the basis of a 24-hour urine sample, daily electrolyte excretion was 110 (57) mEq of sodium and 46 (24) mEq of potassium. Mean sodium:potassium ratio was 2.6 (1.0) and was higher among the urban residents (p < 0.01) and correlated with systolic and diastolic pressures (r = 0.16–0.18, p < 0.01). These findings provide quantitative estimates of the impact of known hypertension risk factors in West Africa and demonstrate the basis for increased prevalence with urbanization and associated economic and dietary change. These results also provide support for recommendations for prevention in West Africa and provide a benchmark against which to compare populations in the African diaspora. Am J Epidemiol 1996;143:1203-18.

Cardiovascular diseases, particularly stroke, renal failure, and heart failure, account for a considerable proportion of the chronic disease burden among adults in sub-Saharan Africa (1–3), even though the prevalence of hypertension remains substantially lower than in industrialized societies (4–7). Previous studies have observed lower blood pressures and prevalence of hypertension in rural compared with urban populations in Africa (8–11), and positive gradients in blood pressure have been identified as a function of education, occupational rank, or other measures of socioeconomic position (12–14). This pattern contrasts with findings in the United States, however, where the highest prevalence of hypertension has been observed among blacks in the rural South (15–17). Furthermore, in industrialized societies, the relation between socioeconomic position and blood pressure is usually inverse (18–22). International comparisons have suggested that this inverse association is the more common pattern within societies (23), although a positive association between blood pressure and level of industrialization appears to hold across societies (24, 25).

The socioeconomic gradient must therefore be understood as antecedent to a set of more proximate risk factors, as its relation to blood pressure varies from positive to negative in different settings depending on the specific distribution of these factors across the gradient. Because there is likely to be a smaller set of such factors operating in the West African setting, it may be an environment that is well suited to studies designed to identify these proximate factors. Risk factors associated with blood pressure change that may potentially play a role in West Africa include dietary sodium (26–28), potassium (29, 30), sodium:potassium ratio (31, 32), obesity (33–38), ambient temperature (39, 40), pulse rate (12, 41), alcohol in-
take (42, 43), and migration status (44–48). Sex differentials in blood pressure levels have also been examined in West Africa, but with conflicting results (13, 14, 49–51). Psychosocial stress, another important determinant of hypertension, has been studied little in Africa.

Given the difficulty of long-term drug treatment in low-income countries, primary prevention assumes a greater public health importance (52, 53). The basis for a prevention strategy lies in precise estimates of the impact of causal risk factors. Although some evidence exists that the pattern of risk in Africa is similar to that found in other regions, few studies are available from West Africa that include population samples representative of the major social strata.

In this research, we examined the influence of the known social and environmental risk factors for hypertension in three population subgroups drawn from among the Yoruba-speaking people of southwestern Nigeria. The objective was to estimate the quantitative impact of the risk factors within the population and their potential contribution to urban versus rural and social class differences in hypertension prevalence. More than 90 percent of the Nigerian population, including those in rural areas as well as the urban poor, are relatively homogeneous with respect to socioeconomic position (54). The remainder of the population includes ethnic minorities characterized by a persistently high degree of isolation (55) and a very small elite whose lifestyle has become almost fully westernized (56). Our strategy was to avoid the extremes of this distribution and to attempt to depict the circumstances for the 90 percent in the middle.

The data collected in this survey were also intended to serve as a baseline against which prevalence of hypertension and the impact of risk factors may be assessed in populations of the African diaspora. The prevalence of hypertension among blacks in the United States is among the highest in the world (17), and this increased risk has led to widespread speculation about unique, presumably genetic, characteristics of this population (57–61). This perspective has been associated with a tendency, apparent for many years, to conclude that hypertension is surprisingly common in West Africa (13, 62, 63). In addition, it has been proposed that the impact of dietary sodium is atypical in these populations (58, 64–66). This investigation therefore represents one component of our attempt to examine these issues within the context of an international collaborative study designed to estimate the gradient in hypertension prevalence and the impact of known risk factors in Africa, the Caribbean, and the United States (67, 68).

MATERIALS AND METHODS

Study setting

Three sites were chosen to represent the basic socioeconomic groupings within the Nigerian population. Residents of the village of Idere, located in the Ibarapa District of Western Oyo State, comprised the rural sample. The 6,000 inhabitants of this village cultivate individual allotments of communal land apportioned on the basis of family lineage (69). These subjects will be referred to as “Rural Farmers.”

The other two study sites were located within Ibadan, an indigenous Yoruba city of approximately three million people. The community of Idikan, a high-density section of the old city, includes about 7,000 inhabitants who are engaged primarily in trade or craftsmanship. Although the community is urban, very few in this community have access to regular wage labor and are characterized most accurately as informal sector workers, designated here as the “Urban Poor.”

Pensioners of the Nigerian Railway Corporation in Ibadan were selected as the third subgroup. The majority of these subjects spent their entire adult lives as salaried employees of the colonial and federal governments. Because very few women were employed in this manner, recruitment was limited to men. Participants in all sites were aged 45 years or older to ensure sufficient disease risk.

Sampling scheme

The Rural Farmer and Urban Poor were selected as random subsets of participants who had been examined in 1992–1993 for the International Collaborative Study on Hypertension in Blacks (67, 68). The Study sampling strategy was based on probability proportionate to size cluster sampling (70), as described in detail elsewhere (68). This method involved random selection of clusters from an enumeration of all possible clusters in the geographic area of interest. From the age-eligible subjects, 300 names (150 men and 150 women) in each of the two sites were randomly generated for this substudy, with the goal of recontacting 100 men and 100 women in each site.

For the sample of Railway Workers, we attempted to enroll all age-eligible members of the Nigerian Railway Pensioners’ Union resident in Ibadan by contacting members during union meetings. Participants were asked about other pensioners who did not attend meetings, and an interviewer contacted these individuals and encouraged them to come to a meeting to be enrolled. Lindsay (71) investigated a random sample of employee records of the same group at the archive maintained by the Nigerian Railway Corporation.
Mean values for demographic characteristics, including age, number of children, years of education, number of wives, religion, and state of origin, did not differ between the sample of employee records and our participants.

**Blood pressure measurement**

Blood pressure was measured with the procedures developed for the International Collaborative Study on Hypertension in Blacks (68). Briefly, after emptying their bladder, participants were seated for 5–10 minutes and during this period were queried about consumption of food, alcohol, coffee, or cigarettes within the previous 30 minutes. The ambient temperature was recorded, the arm circumference at the midpoint was measured, and an appropriate cuff was selected. The radial pulse was located, the pulse obliteration pressure was estimated, and 30 mmHg was added to this value to serve as the maximum inflation point. Systolic and diastolic blood pressures were measured with a standard mercury manometer three times as the first and fifth-phase Korotkoff sounds. Examiners were trained to deflate the mercury at a rate of 2-mm per second and record values to the closest even integer. Thirty-second pulse was counted before each of the three readings. Virtually all previously diagnosed hypertensives were found to be either unmedicated or, if taking medication, were doing so with great irregularity or in doses insufficient to reduce blood pressure. For this reason, medication status was not included in the case definition. Participants with readings of 160/95 mmHg or greater were referred for care and provided a 1-year supply of medication.

**Anthropometric measurements**

Weight was recorded to the nearest 0.1 kg by using an electronic digital scale after participants removed shoes and any heavy clothing. Height was determined in meters with a rigid measure against a vertical wall. Two measurements of waist and hip circumference were made for each participant. For measurement of waist circumference, participants stood erect with their abdomen relaxed, arms at their side, and heels of their feet together. The tape was positioned at the level of the natural waist, which was considered to be the narrowest part of the torso as seen from the front. For a subject who had a large amount of abdominal fat, the tape was positioned at the point midway between the bottom of the rib cage and the top of the iliac crest (approximately 2 cm above the iliac crest). For the measurement of hip circumference, the measurer squatted at the right side of the subject so that the point of maximum extension of the buttocks could be seen, and the recorder checked to be certain that the tape was horizontal by standing on the opposite side of the participant’s body. Measurement were recorded to the nearest 0.1 cm. If there was a difference of 0.5 cm or more between the two readings, measurements were repeated, and all three readings were recorded. The mean of two or all three readings was used as the value for analysis.

**Certification procedures**

Six field workers were recruited and trained; all were young adults native to Ibadan, and two were residents of Idikan. Field staff were at least bilingual (Yoruba and English), and one was also conversant in Pidgin, a dialect of English spoken as a second language in many parts of West Africa.

Since a primary objective of this study was cross-site comparison, careful attention was devoted to training and quality control. All field staff first passed a videotaped examination (Shared Care, Inc., Torrance, California). Training involved taking readings using a double-headed (i.e., “Y” terminal) stethoscope, and formal certification included a series of three consecutive blood pressure readings on two practice subjects. If the trainer’s mean readings differed by more than 3 mmHg from those of the trainee for either systolic or diastolic pressure, a third practice subject was measured.

A Dinamap Portable Vital Signs Monitor (Model 8100, Critikon Inc., Tampa, Florida) was also used for certification. On each practice subject, Dinamap readings were taken after the second and third manual blood pressure readings. The examiners had to match the trainer’s mean readings within 3 mmHg; given the well-described difference between oscillometric devices and human readings (72, 73), the trainee had to match the mean Dinamap reading within only 8 mmHg for both systolic and diastolic pressures.

The accuracy of blood pressure measurement was high, as assessed by three outcome measures. First, digit preference was limited. For readings ending in zero, two, four, six, and eight, the following distribution was observed for systolic pressure: 18.3, 21.2, 19.3, 19.6, and 21.6 percent. The corresponding distribution of terminal digits for diastolic pressure was 21.5, 20.4, 20.4, 16.5, and 21.2 percent. The highest use of zero for any single observer was 26.3 percent. Second, the correlation of the examiner’s values and the Dinamap readings was 0.96 for systolic pressure and 0.90 for diastolic pressure, based on a subsample of 67 subjects who had Dinamap readings taken after both the second and third manual readings. When modeled in regression equations, the slopes of the relation between manual and automated readings did
not differ from 1.0, and the intercepts did not differ significantly from zero. Third, repeat measures on a set of 23 individuals taken on separate days by the same observers yielded a correlation of 0.84 and a within-person standard deviation of 7 mmHg.

Two field workers gathered data only in Idikan, while the other four collected data in all sites. Analysis of variance showed that observer means for blood pressure do not differ independently of site effects ($p > 0.20$) and thus do not contribute to cross-site variation.

Subjects chose their language of response; 95.5 percent answered in Yoruba, 4.1 percent chose English, and two subjects opted for Pidgin English. The interview instrument was translated from English into Yoruba and back-translated for purposes of verification (74). Interviewers collected questionnaire information on marital and family status, alcohol and cigarette consumption, occupation, religion, migration status, educational level, age, previous diagnosis of hypertension, and other variables. Ages were estimated or missing in many cases, however, especially in the Rural Farmers and Urban Poor, where the majority of participants did not know their exact date of birth. A technique for estimating age in the rural area (based on a list of historical events) was applied; however, since ages as reported are considered to be less than completely accurate, subjects were stratified into two age categories, 45–54 and 55 or more years.

**Collection of 24-hour urine samples**

Because of refrigeration and transportation constraints, 24-hour urine samples were collected for 100 percent of the Urban Poor, for random subsets of 50 percent of the Rural Farmers, and for 10 percent of the Railway Workers. After careful instruction, participants chosen for urine collection were given jars containing boric acid as a preservative. Subjects returned to the clinic the following morning or were met in their home. When the samples were collected on the following day, the times that the collection began and ended were recorded, and participants were asked about completeness of the collection.

Two aliquots of urine were stored for each subject. One aliquot was analyzed at the Department of Chemical Pathology of the University College Hospital, Ibadan, Nigeria, using a flame photometer. Samples were reanalyzed for sodium and potassium at Loyola Medical School, Maywood, Illinois; the correlations for sodium, potassium, and sodium:potassium ratio between the analysis values of the two laboratories were all greater than 0.92, and the values obtained in Nigeria were used in the analysis.

**Statistical methods**

Data were entered into Epi-Info Version 5 (75), and analysis was carried out with statistical programs available on the Statistical Analysis System (SAS) Version 6 (76). Group differences were assessed with $t$ tests; the conservative Cochran and Cox approximation for the $p$ value was used in the case of unequal variances (77). Site differences among the men were assessed by using analysis of variance, $x^2$ tests, and Mantel-Haenszel trend tests, and bivariate relations of continuous variables were examined with correlation analysis. Hierarchic modeling was used to determine the best predictors of mean blood pressure. Given the uncertainty about body mass index (BMI) as a predictor at the low levels of obesity observed here (78), different models were evaluated, including height and weight separately. Overall BMI appeared to capture explanatory information equal to, but not greater than, weight and was included in the final models to facilitate comparisons with other studies.

The effect of the “regression-dilution” effect on the relation between urinary electrolytes was estimated with repeat 24-hour collection in a subsample of participants (79). Although a correction factor was estimated, the primary emphasis for these analyses remained on the raw values.

**RESULTS**

**Descriptive findings**

Demographic characteristics of the sample are shown in table 1, stratified by sex, and further separated by socioeconomic group for men. Women are not stratified by socioeconomic group because few significant differences were observed between the two sites in which they were sampled. Statistics comparing group means appear at the right side of data stratified by site for men. The site $p$ value corresponds to tests for differences by socioeconomic group among men only, since women were not included in the Railway Workers subgroup. The last column provides $p$ values from $t$ tests for the difference between means for men and women.

On the basis of reported age, Railway Workers were significantly younger than other men, and women were younger than men. As noted above, however, ages were estimated in many cases, especially in the Rural Farmer and Urban Poor groups, and subjects were therefore classified into two age categories, 45–54 and 55 or more years. There were no differences in the proportions of subjects in these two age strata. Dramatic differences in level of education existed between men and women and for men between socioeconomic groups (table 1). Use of alcohol was
most common for males in the Rural Farmers group, a result of the availability of palm wine and other non-commercials.

Diastolic pressure was higher in men than in women, and a gradient was apparent from Rural Farmers to Railway Workers, with Urban Poor intermediate between the two (table 2). This pattern was also significant for prevalence of hypertension, as measured by either of the two common criteria, but not for systolic pressure. Significant differences in the levels of several established risk factors for blood pressure elevation were observed, including waist circumference and hip circumference, with the Rural Farmers having the lowest values. While height did not vary for men, weight increased along the expected gradient, leading to a significant trend in mean BMI. Women had a higher BMI, a lower waist-to-hip ratio, and a higher pulse.

On the basis of 24-hour urine collection, sodium and potassium excretion did not differ significantly between men and women or between socioeconomic groups among the men (table 3). Sodium:potassium ratio, however, showed a significant trend across the socioeconomic groups, mirroring the pattern for hypertension prevalence (figure 1).

For men, both 24-hour sodium and sodium:potassium ratio were positively and significantly correlated with both systolic and diastolic pressures (table 4). For women, only the correlation between sodium:potassium ratio and diastolic pressure was significantly different from zero. The strongest correlations were observed for male Rural Farmers ($r = 0.3$–$0.5$).

Urinary electrolytes were not significantly correlated with reported age for all men combined, although women did demonstrate an inverse correlation between age and 24-hour sodium excretion ($r = -0.18$, 95 percent confidence interval (CI) $-0.33$ to $-0.03$). Men, on the other hand, showed strong positive correlations between BMI and sodium excretion ($r = 0.20$, 95 percent CI $0.04$ to $0.35$) and also between waist-to-hip ratio and sodium excretion ($r = 0.23$, 95 percent CI $0.07$ to $0.38$). These correlations were particularly strong for men in the Urban Poor group ($r_{\text{sodium}\cdot\text{BMI}} = 0.30$, 95 percent CI $0.08$ to $0.52$ and $r_{\text{sodium}\cdot\text{waist-to-hip}} = 0.25$, 95 percent CI $0.03$ to $0.48$).

**Univariate comparison of hypertensives and normotensives**

Hypertensives as a group excreted significantly more sodium and had significantly higher sodium:potassium ratios than did normotensives (table 5). They were also older and had higher pulse rates, BMI values, and waist-to-hip ratios. Alcohol consumption showed no relation to hypertension (data not shown).
TABLE 2. Cardiovascular characteristics of the sample, stratified by site and sex, age >45 years, Nigeria, 1994

<table>
<thead>
<tr>
<th></th>
<th>Rural farmers (n = 108)</th>
<th>Urban poor (n = 75)</th>
<th>Railway workers (n = 203)</th>
<th>Site (p value)*</th>
<th>Total men (n = 386)</th>
<th>Total women (n = 212)</th>
<th>Total sample (n = 598)</th>
<th>Sex test p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic blood pressure (mmHg)</td>
<td>121.1 (17.9)</td>
<td>125.6 (27.3)</td>
<td>127.0 (24.2)</td>
<td>0.10</td>
<td>125.1 (23.4)</td>
<td>122.6 (24.5)</td>
<td>124.2 (23.8)</td>
<td>0.23</td>
</tr>
<tr>
<td>Diastolic blood pressure (mmHg)</td>
<td>70.6 (10.9)</td>
<td>72.4 (14.0)</td>
<td>76.1 (13.5)</td>
<td>0.00</td>
<td>73.8 (13.2)</td>
<td>69.8 (12.1)</td>
<td>72.4 (12.9)</td>
<td>0.00</td>
</tr>
<tr>
<td>Body mass index (kg/m²)</td>
<td>20.4 (2.8)</td>
<td>21.4 (4.5)</td>
<td>21.8 (3.6)</td>
<td>0.00</td>
<td>21.3 (3.6)</td>
<td>23.0 (5.2)</td>
<td>21.9 (4.3)</td>
<td>0.00</td>
</tr>
<tr>
<td>Waist-to-hip ratio</td>
<td>0.92 (0.05)</td>
<td>0.92 (0.05)</td>
<td>0.91 (0.05)</td>
<td>0.10</td>
<td>0.91 (0.06)</td>
<td>0.88 (0.07)</td>
<td>0.90 (0.06)</td>
<td>0.00</td>
</tr>
<tr>
<td>Weight (kg)</td>
<td>57.6 (8.6)</td>
<td>61.0 (12.7)</td>
<td>61.9 (11.4)</td>
<td>0.01</td>
<td>60.5 (11.1)</td>
<td>56.8 (13.9)</td>
<td>59.2 (12.3)</td>
<td>0.00</td>
</tr>
<tr>
<td>Height (cm)</td>
<td>168.1 (6.0)</td>
<td>168.7 (6.2)</td>
<td>168.3 (6.9)</td>
<td>0.82</td>
<td>168.4 (6.5)</td>
<td>157.2 (5.9)</td>
<td>164.4 (8.2)</td>
<td>0.00</td>
</tr>
<tr>
<td>Waist circumference (cm)</td>
<td>79.4 (7.6)</td>
<td>83.1 (11.4)</td>
<td>82.4 (10.3)</td>
<td>0.01</td>
<td>81.7 (9.9)</td>
<td>83.8 (11.6)</td>
<td>82.4 (10.6)</td>
<td>0.02</td>
</tr>
<tr>
<td>Hip circumference (cm)</td>
<td>86.2 (6.4)</td>
<td>90.3 (8.2)</td>
<td>90.6 (7.8)</td>
<td>0.00</td>
<td>89.3 (7.7)</td>
<td>95.9 (11.4)</td>
<td>91.7 (9.7)</td>
<td>0.00</td>
</tr>
<tr>
<td>Pulse rate (beats/minute)</td>
<td>75.1 (10.2)</td>
<td>75.0 (13.5)</td>
<td>75.8 (10.6)</td>
<td>0.82</td>
<td>75.5 (11.1)</td>
<td>77.9 (10.8)</td>
<td>76.3 (11.1)</td>
<td>0.01</td>
</tr>
<tr>
<td>Proportion with mean blood pressure ≥140/90 mmHg</td>
<td>0.14</td>
<td>0.25</td>
<td>0.29</td>
<td>0.01</td>
<td>0.24</td>
<td>0.23</td>
<td>0.24</td>
<td>0.79</td>
</tr>
<tr>
<td>Proportion with mean blood pressure ≥160/95 mmHg‡</td>
<td>0.03</td>
<td>0.11</td>
<td>0.14</td>
<td>0.01</td>
<td>0.10</td>
<td>0.09</td>
<td>0.10</td>
<td>0.45</td>
</tr>
</tbody>
</table>

* Site group means compared with $F_{(3, n-3)}$ statistics, proportions compared with $χ^2(2)$ statistics.
† SD, standard deviation.
‡ World Health Organization Criteria.
Multivariate relations

Results of modeling blood pressure of the men as a linear function of selected covariates are shown in tables 6 and 7. Separate models were considered for each of the three socioeconomic groups, although Railway Workers were omitted from table 7 because of insufficient urinary electrolyte data. Models that excluded sodium:potassium ratio accounted for 8–26 percent of the variation in blood pressure. The effect of temperature was uniformly negative and significant in all three sites. BMI was a predictor of blood pressure for both the Rural Farmers and Railway Workers, although men in the Urban Poor group did not show this relation and instead had a consistent effect of waist circumference on blood pressure.

In models that included sodium:potassium ratio, 13–48 percent of the variance in blood pressure was accounted for by the selected covariates (table 7). The adjusted effect of sodium:potassium ratio was uniformly positive for both systolic (range $\beta_{\text{ratio}}$: 4.19–6.58) and diastolic (range $\beta_{\text{ratio}}$: 2.11–2.46) blood pressures.

Similar models based on a larger set of predictors for all men and all women are shown in table 8. Age category was positively associated with systolic pressure for both men and women. Anthropometric measures were significant predictors of systolic and diastolic pressures for men, but not for women. Women, however, showed an effect of the number of children, with more offspring being associated with lower systolic pressure.

After sodium:potassium was added to the set of predictors in these models, the percentage of variance accounted for by the models ranged from 7 to 23 percent. The pattern of effects remained similar, although the reduced sample size resulted in a loss of some precision for the coefficient estimates. Only the number of children remained a strong predictor of systolic pressure for women ($\beta = -3.55$), while pulse rate and sodium:potassium ratio showed modest effects for diastolic pressure ($\beta_{\text{pulse}} = 0.31$, $\beta_{\text{ratio}} = 1.55$). Sodium:potassium ratio showed a strong positive relation to both systolic ($\beta = 6.35$) and diastolic ($\beta = 2.93$) pressures for men, however.

Assessment of attenuation of the relation between blood pressure and sodium:potassium ratio

A subset of participants was asked to collect 24-hour urine samples on multiple days to estimate the within-person variability of electrolyte excretion. Data were available for two to three 24-hour collections in
FIGURE 1. Socioeconomic gradient (mean, 95 percent confidence interval) in the prevalence of hypertension, body mass index (BMI), and sodium:potassium ratio, Nigeria, men, 1994. BMI site effect, \( p < 0.01 \); sodium:potassium ratio site effect, \( p < 0.05 \); hypertension, 160/95 mmHg; test of trend, \( p < 0.01 \).

The findings of this study demonstrate that while hypertension exists in West Africa, the prevalence is considerably lower than that typically observed in industrialized societies (81). Approximately one in four individuals over age 45 years was found to have a blood pressure greater than 140/90 mmHg, while about one in 10 had values greater than 160/95 mmHg. The associated disease burden may be substantial, however; given the virtual absence of effective pharmacologic treatment in the current social and economic environment (82), persons with severe hypertension are clearly at significant risk of cardiovascular complications (1). Approximately 15 percent of the deaths among adults in sub-Saharan Africa are attributable to cardiovascular causes, half of which are secondary to hypertension (2, 83).

The forces apparently driving the emergence of hypertension as a mass disease through the lifestyle changes associated with urbanization and economic transition are portrayed in the findings of this study. The gradient from Rural Farmers to Urban Poor to Railway Workers is seen both in the important risk factors and in the outcomes (figure 1). For both hypertension criteria, the test of linear trend across so-
Hypertension in West Africa

We propose that the gradient in risk factors between sites is the consequence of their differing socioeconomic foundations: subsistence agriculture for the Rural Farmers, trade and craftwork for the Urban Poor, and wage labor for the Railway Workers. When these three groups are considered, it is important to recognize the relatively elite status of the Railway Workers as wage laborers in an economy not yet truly capitalist, but merely "articulated" by capitalism (84). More than 70 percent of the Nigerian population are still engaged in subsistence agriculture (54), and wage earners make up less than 4 percent of the adult population (85). In large, urban areas such as Ibadan, up to one fifth of the adult population may be wage earners, while in the remainder of the country less than 2 percent receive regular wages. Of those working for wages, 67 percent are in the public sector (e.g., civil servants, teachers, Railway Workers, etc.) (86).

While wage laborers may not be "richer" than farmers or traders in terms of value of goods or currency acquired during a given year, their involvement in a wage-labor economy has a significant impact on social organization and lifestyle factors, and their access to regular cash payments, however small, sets them apart as a distinct social group. The changes in lifestyle and behavior, as well as social and family structure, afforded by this involvement with wage economy, however, appear to be associated with greater opportunity for cardiovascular risk, including increased weight, increased sodium-potassium ratio, and decreased social integration (51). This trend is analogous to published findings of increased blood pressure or hypertension prevalence as a function of occupational grade, educational level, or status within given study populations (12–14).

While the vast majority of Nigerians are not integrated into a wage economy, few previous studies in the region provide a basis for comparison with the Rural Farmer and Urban Poor groups presented here. Several studies have investigated blood pressure among urban (12–14, 63, 87) and rural (50, 88) wage-earning populations, as well as among children (89, 90) and university students (91, 92), but few have addressed the majority population of urban and rural adults engaged in non-wage-earning labor and in sub-
Johnson (93) completed a population survey of Lagos, Nigeria, residents, including blood pressure measurements on 1,392 subjects aged 10–102 years. Only 24 percent of male subjects had no schooling, and fully 43 percent were engaged in "skilled or professional" work, suggesting a population more thoroughly integrated into a wage economy than the Urban Poor group in our study. Not surprisingly, therefore, mean blood pressures and prevalence of hypertension were considerably higher than among the Urban Poor group described here; 23 percent of men in the comparable age-sex group had a systolic pressure of 160 mmHg or more (93). Pobee et al. (94) conducted studies of hypertension prevalence among villagers in rural Ghana and found prevalences of 2–5 percent (diastolic pressure ≥ 95 mmHg), roughly comparable with the Rural Farmer group described here.
TABLE 8. Regression coefficients from linear models predicting mean blood pressure in men and women as a function of a set of covariates, age ≥45 years, Nigeria, 1994

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Temperature (°C)</th>
<th>BMI (kg/m²)</th>
<th>Waist (cm)</th>
<th>Hb (g/dL)</th>
<th>Pulse (minutes)</th>
<th>Non-migrant §</th>
<th>No. of children</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic blood pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men (n = 364)</td>
<td>108.00**</td>
<td>6.08*</td>
<td>-1.01**</td>
<td>0.90*</td>
<td>-0.14</td>
<td>0.88**</td>
<td>-6.95**</td>
<td>-0.20</td>
<td>5.74**</td>
</tr>
<tr>
<td>Women (n = 207)</td>
<td>108.74**</td>
<td>9.04</td>
<td>0.50</td>
<td>-0.56</td>
<td>0.13</td>
<td>0.23</td>
<td>-0.17</td>
<td>5.46</td>
<td>-3.46**</td>
</tr>
<tr>
<td>Diastolic blood pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men (n = 364)</td>
<td>60.91**</td>
<td>-0.28</td>
<td>0.69**</td>
<td>0.16*</td>
<td>-0.25*</td>
<td>0.41**</td>
<td>-5.14**</td>
<td>0.11</td>
<td>6.17**</td>
</tr>
<tr>
<td>Women (n = 207)</td>
<td>61.28**</td>
<td>-0.18</td>
<td>0.30</td>
<td>-0.04</td>
<td>0.31</td>
<td>1.33</td>
<td>-0.66</td>
<td>1.20</td>
<td>0.05</td>
</tr>
</tbody>
</table>

* p < 0.05 [for H₀: βₚ = 0]; ** p < 0.01 [for H₀: βₚ = 0].
† Mean pressure = β₀ + β₁ × AGE + β₂ × TEMP + ... + β₇ × RATIO + e.
‡ BMI, body mass index.
§ Nonmigrant = participant born in the same community in which he or she now lives.

While overall hypertension prevalence among the Railway Workers was found to be lower than in several previous studies of wage-earning populations in West Africa (13, 14, 63), differences in the characteristics of samples appear to account for the lower overall prevalence observed here (table 9). Bunker et al. (13), for example, studied civil servants in Benin City, a group that might at first seem comparable with the Railway Workers group, since both groups are made up of public sector wage laborers. For men between ages 45 and 64 years in the study by Bunker et al., however, mean BMI was 24.4, significantly higher (p < 0.01) than the value of 21.8 observed for men in the Railway Workers group (13). Furthermore, 65 percent of the male subjects in that study reported drinking alcohol, while the comparable percentage among Railway Workers in the current study was 22 percent. In addition, fewer than 1 percent of the subjects in the study by Bunker et al. had zero years of education, compared with 14 percent of surveyed Railway Workers (13).

Two studies in West Africa in which the subjects may be roughly comparable with the Railway Workers group in the current study are those by Ogunlesi et al. (12) and Giles et al. (50). Ogunlesi et al. measured 404 male Nigerian factory workers aged 18-54 years and found a mean BMI of 21.6. Blood pressures and prevalence of hypertension were also roughly equivalent between these factory workers and the Railway Workers in the current study. Giles et al. surveyed 3,588 Liberian rubber plantation workers (age 20 years or more). Blood pressures in men of the same age range


<table>
<thead>
<tr>
<th>Study (reference)</th>
<th>Subjects</th>
<th>No.</th>
<th>Age range (years)</th>
<th>% ≥140/90 mmHg</th>
<th>% ≥160/85 mmHg</th>
<th>Mean systolic pressure (mmHg)</th>
<th>Mean diastolic pressure (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaufman et al.*</td>
<td>Male railway workers</td>
<td>203</td>
<td>≥45</td>
<td>29.0</td>
<td>14.2</td>
<td>127</td>
<td>76</td>
</tr>
<tr>
<td>Idahosa (63)†</td>
<td>Male civil servants</td>
<td>521</td>
<td>20-62</td>
<td>33.6</td>
<td>8.8</td>
<td>134</td>
<td>75</td>
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<tr>
<td></td>
<td></td>
<td>45</td>
<td>45-62</td>
<td>68.9</td>
<td>33.3</td>
<td>141</td>
<td>89</td>
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<td></td>
<td></td>
<td>34</td>
<td>20-63</td>
<td>24.4</td>
<td>8.2</td>
<td>130</td>
<td>76</td>
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<tr>
<td>Police men</td>
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<td>594</td>
<td>45-63</td>
<td>58.8</td>
<td>41.2</td>
<td>144</td>
<td>69</td>
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<tr>
<td>Bunker et al. (13)*</td>
<td>Male civil servants</td>
<td>438</td>
<td>25-54</td>
<td>34.0</td>
<td>18.0</td>
<td>128</td>
<td>82</td>
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<tr>
<td></td>
<td></td>
<td>102</td>
<td>45-54</td>
<td>52.0</td>
<td>26.0</td>
<td>136</td>
<td>67</td>
</tr>
<tr>
<td>Ekpo et al. (14)‡</td>
<td>Urban workers§</td>
<td>5,200</td>
<td>≥216</td>
<td>II</td>
<td>8.1</td>
<td>II</td>
<td>II</td>
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<tr>
<td></td>
<td></td>
<td>141</td>
<td>35-54</td>
<td>27.0</td>
<td>11.0</td>
<td>128</td>
<td>73</td>
</tr>
</tbody>
</table>

* Blood pressure values = mean of second and third readings from standard mercury manometer and variously sized cuffs.
† Blood pressure values = second of two readings from an automated device and single cuff.
‡ Blood pressure values = second of two readings from standard mercury manometer and variously sized cuffs.
§ Subjects were predominantly (84.2%) male.
II Statistic not provided in published source.
†† Blood pressure values = mean of three readings from automated device and variously sized cuffs.

Am J Epidemiol  Vol. 143, No. 12, 1996
as the Railway Workers in this study were roughly equivalent, while prevalence of hypertension in the similarly aged Liberian workers was slightly lower.

Although weight was a predictor of elevated blood pressure in our study, the effect was relatively small and was restricted to men, in contrast to some previous studies in Africa. Bunker et al. (13), for example, found correlations of BMI with systolic and diastolic pressures to be 0.33 and 0.32, respectively, for men, and 0.44 and 0.44, respectively, for women. Hypotheses to explain this disparity include the possibility that participants in our study were sufficiently lean to be near a threshold value for the effect of overweight or that BMI is not an accurate reflection of percent body fat in lean populations (78). Among Railway Workers, the group of men with the highest mean BMI, correlation with mean systolic pressure was 0.19 (95 percent CI 0.05 to 0.32), and that with mean diastolic pressure was 0.15 (95 percent CI 0.02 to 0.29). With an obesity cutpoint of BMI of 25.0 or greater, the adjusted odds ratio for hypertension (160/95 mmHg) among men was 2.34 (95 percent CI 1.05 to 5.22), yielding population attributable risk percents of 8.0, 17.7, and 18.7 among Rural Farmers, Urban Poor, and Railway Workers, respectively.

While the absence of a relation between BMI and blood pressure for women (whose mean BMI was significantly greater than that of men) is not consistent with most previous findings, it is commonly observed that the relation between BMI and blood pressure has a lower magnitude in women than in men (95). Furthermore, Walker et al. studied obese women (BMI ≥ 29.5) in South Africa and found that "in [a] low socioeconomic and low fat dietary context" (96, p. 101), obesity apparently conferred no additional risk of hypertension. The INTERSALT investigators observed significant positive correlations between BMI and blood pressure for women in only 27 of 52 sites (33). Finally, it is also possible that the sample size of 212 women in the our study simply did not provide sufficient power to identify a modest relation between BMI and blood pressure.

Sodium and potassium were found to be related to blood pressure, with hypertensives excreting approximately 10 percent more sodium than normotensives and both men and women showing positive correlations between sodium:potassium ratio and blood pressure. The absolute quantity of sodium excreted in 24 hours in this sample was moderate, i.e., higher than in the four INTERSALT low-blood pressure sites characterized by extremely low sodium excretion (<60 mEq/24 hours) (97), but lower than in all but one of the other 48 INTERSALT sites (81). Adjusted coefficients for the relation between sodium:potassium ratio and blood pressure in our study were generally greater in magnitude than the INTERSALT values (31).

Relative to Western populations, the study population is characterized by low mean BMI, low levels of alcohol and cigarette consumption, high levels of physical activity, and moderate levels of sodium intake. Of the factors considered in this study, the relation between sodium and potassium appears to be the single most important predictor of hypertension from a public health standpoint (98). If the sodium:potassium ratio were to be modified, either by reduction of sodium or augmentation of potassium, from its observed mean value of 2.6 to a plausible target of 1.0, the data presented here predict that a 30–40 percent reduction in the prevalence of hypertension would be realized (figure 2). This recommendation is consistent with current public health guidelines in other countries (99) and may be more readily achievable in Nigeria, where discretionary use of sodium accounts for a greater percentage of intake than in westernized diets (100) and where natural sources of dietary potassium are abundant.

Of the variables considered here, only the number of children was a strong, consistent, and independent predictor of blood pressure for women. This is consistent with some previously published studies (14) and suggests that in this relatively low-risk environment, the important contributions of psychosocial and socioeconomic variables might come to the foreground, unobscured by the anthropometric and behavioral effects that capture most investigators' attention in studies of westernized populations. While socioeconomic status was examined here for men, no women in our study were wage laborers, but instead were primarily occupied as agricultural workers, tradesmen, and craft workers. While Bunker et al. (13) observed that women in their sample of relatively elite urban workers took on the social status commensurate with their husbands' occupational grade, women in our study demonstrated a high degree of economic independence from their spouses and generally achieved status through active rather than passive means. Women achieved their status, for example, through successful small-business ventures and activity in community organizations, as well as through the number of children raised (69, 101). Further research should concentrate, however, on measures of social status, social and economic stress, and social integration that are relevant to women living in these social contexts, since established physiologic risk factors are apparently not highly predictive of disease status for this group.

The majority of existing studies of blood pressure in West Africa have been conducted in clinical settings or among other nonrepresentative populations such as
Hypertension in West Africa

20
12
6
3
4
5
Na:K


wage workers or urban elites (4). An important strength of this study is therefore its potential to characterize accurately the population of West Africans. While the communities sampled are representative of the general population, however, a weakness of our study rests in the degree to which participants who were examined are representative of those who were sampled. The failure to recontact a significant portion of the previously sampled subjects in both the Rural Farmer and Urban Poor groups raises important concerns about the potential for nonresponse bias in this study. A comparison of demographic characteristics shows no significant differences between those who were recontacted and those who were not, but this does not rule out the possibility of differential follow-up.

The data presented here support the hypothesis that there is a continuous distribution of hypertension prevalence from lean, low-salt, high-physical-activity societies in which wage labor is uncommon or absent to high-BMI, high-salt, low-physical-activity populations in which wage labor is the norm (e.g., the United States and Europe) (24, 97). Social and economic transformations occurring in some segments of the contemporary West African population are apparently bringing hypertension prevalence values closer to those seen in Western societies (13, 63), but these data suggest that hypertension prevalence in the general population in West Africa, while significant from a public health standpoint, is still considerably less than that seen industrialized societies.

Contrary to some previous speculation (64–66), there appears to be no evidence that unique processes are operating in the etiology of hypertension in this population. Rather, the same risk factors that are important in industrialized societies can be identified in West Africa. Where those risk factors are largely absent, the prevalence of the disease remains low, and where those risk factors become more common, prevalence rises pari passu. This is consistent with previous findings that different racial or ethnic groups, when observed under conditions of relatively equal social position and equal prevalence of common risk factors, demonstrate similar patterns of disease (102). This study is therefore consistent with the general hypothesis that human populations are essentially uniform in their mean susceptibility to hypertension and that observed differences in disease distributions result from differential exposure to established risk factors (103).

ACKNOWLEDGMENTS

Supported by National Institutes of Health grant HL 45508.
The authors acknowledge the assistance of Dr. William Briefer, Michael Oladokun, Dr. Babatunde Osotimehin, and Dr. Oyenike Oyejide. The field workers who gathered the data presented here were Funmilayo Abadebi, Yemisi Apatu, Henry Obuene, Bimpe Owolude, Abiona Yisa, and Taofik Yusuff. Technical support was provided by Abidun Oyelami in Ibadan, Nigeria, and Carlos Reyes in Chicago, Illinois. Drs. Lanre Johnson, Ayodele Olusanya, and Modupe Ladipo oversaw the treatment of hypertensive cases discovered during the course of this study. The authors thank Drs. Tony Schork, Alan Weder, and MaryFran Sowers for their helpful comments on the manuscript.

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