**Prevalence and Risk Factors for** **Hypertension, Diabetes, and Hypercholesterolemia Across the Six Southeast Asian Regions**

**Summary**

**Background**

Non-communicable diseases (NCDs) are the primary cause of morbidity and mortality globally, posing an increasingly significant health burden. This study examined the prevalence of hypertension, diabetes, and hypercholesterolemia across the Southeast Asian Regions (SEARs) and their associated behavioral and biological risk factors.

**Methods**

We analyzed the most recent WHO STEP wise approach to NCD risk factor surveillance (STEPS) survey data from the six SEARs using a cross-sectional study approach. The outcome variables were hypertension, diabetes, and hypercholesterolemia. We employed bivariable analyses and adjusted multivariable logistic regression models to evaluate the status of these NCDs and their associated risk factors, which included socio-economic background, dietary intake, and physical activity, both across different countries and within the pooled dataset for this region.

**Findings**

This study found that the prevalence of hypertension was highest in Timor-Leste (39.70%), diabetes was most prevalent in Bangladesh (8.71%), and hypercholesterolemia was most common in Myanmar (34.40%). Conversely, the lowest rates of these conditions were observed in the Maldives for hypertension (18.01%), Timor-Leste for diabetes (1.15%), and Nepal for hypercholesterolemia (11.13%). The pooled analysis conducted in this region revealed prevalence rates of 27.39% for hypertension, 5.69% for hyperglycemia, and 31.21% for hypercholesterolemia.

Age has been identified as a significant risk factor for hypertension and hypercholesterolemia, with adjusted odds ratios (AORs) indicating that participants aged 60 years and above, 45-59 years, and 30-44 years have 5.54, 4.49-, and 2.41 times higher odds, respectively, of developing hypertension compared to those aged 18-29 years. For hypercholesterolemia, participants aged 60 years and above, 45-59 years, and 30-44 years have 4.17, 3.79-, and 2.11 times higher odds, respectively, of developing the condition compared to those aged 18-29 years. Gender also influences the risk, with females having 1.39 times higher odds of developing hypercholesterolemia compared to males. Educational attainment is another factor, with individuals having no formal schooling to basic literacy showing 30% times lower odds, and those with secondary to high school education showing 1.38 times higher odds of developing hypercholesterolemia compared to those with college or higher education. Marital status significantly influences the risk of developing hypertension, with married individuals having 1.14 times higher odds compared to unmarried individuals. Not engaging in vigorous work activities is associated with 1.63 times higher odds of developing hypercholesterolemia, a lack of moderate activities with a 4.94-fold increase in hyperglycemia odds, and not participating in active transportation with 1.18 times higher odds of hypertension compared to their counterparts. Obesity stands out as a significant risk factor, with obese individuals having 3.01, 3.96, and 1.18 times higher odds of developing hypertension, hyperglycemia, and hypercholesterolemia, respectively, compared to their non-obese counterparts.

**Interpretation**

The study highlighted an increase in the prevalence of NCDs and identified several associated risk factors. Higher age, female populations, lower educational levels, lack of engagement in vigorous or moderate work activities, active transportation, and obesity were found to significantly increase the risk of developing various NCDs within certain SEARs. It underscores the imperative for concerted efforts to develop comprehensive national action plans aimed at addressing the burden of NCDs.

**Funding** None.

**Research in context**

**Evidence before this study**

According to WHO (2020), noncommunicable diseases (NCDs) are a major and increasing burden in the South-East Asia Regions (SEARs), causing 62% of all deaths, or 9 million people. Premature mortality from NCDs, occurring before age 70, is particularly concerning. In 2021, NCDs accounted for approximately two-thirds of all deaths in WHO SEARs, with half of these fatalities occurring among individuals aged 30–69 years. By 2021, ten countries in the region had developed comprehensive national action plans for NCDs, aligning with Sustainable Development Goal (SDG) 3.4, which targets a 33.3% reduction in premature NCD mortality by 2030.

A PubMed search on December 31, 2023, using terms related to NCDs and Southeast Asia, found studies limited to specific areas and NCDs among the adult population in South and Southeast Asia. However, no study provided both a country-wise comparison and a pooled analysis to represent the regional scenario and associated risk factors. This study aims to examine the epidemiological patterns and determinants of behavioral and biological risk factors for several NCDs, using both country-wise and pooled data in SEAR.

**Added value of this study**

This study is the first in Southeast Asia to use nationwide survey data to estimate differences in NCD prevalence and the related risk factors. Timor-Leste (39.30%), Bangladesh (8.30%), and Myanmar (36.70%) showed higher rates of hypertension, diabetes, and hypercholesterolemia, respectively, while Maldives (19.07%), Timor-Leste (1.50%), and Nepal (11.19%) had lower rates. A combined analysis of these countries indicated prevalence rates of 28.76% for hypertension, 5.76% for hyperglycemia, and 32.15% for hypercholesterolemia. These rates were particularly elevated among individuals aged 60 years or older. Engaging in strenuous activities at work was linked to decreased NCD rates, whereas obesity was identified as a significant risk factor for increased NCD rates. Other factors like gender, level of education, marital status, employment status, dietary patterns, physical exercise, and commuting behaviors also displayed notable connections to NCD prevalence.

**Implications of all the available evidence**

Since the adoption of the 2011 UN High-level Political Declaration, Southeast Asian countries have prioritized strengthening primary healthcare systems to tackle NCDs. Regional commitments such as the 2013 Delhi Declaration on high blood pressure, 2015 Dili Declaration on tobacco, and 2016 Colombo Declaration on NCDs at the primary healthcare level guide national actions for risk prevention and management. Common risk factors in the region include poor diet, tobacco use, physical inactivity, and abdominal obesity. The study recommends individual and collective interventions, focusing on the elderly, female, and urban populations, to inform comprehensive national action plans. Population-based primary healthcare approaches are crucial for risk reduction, detection, and treatment. Hospital-based strategies should also address diagnosed cases of hypertension and diabetes. Non-health sectors should participate in preventive efforts, targeting specific demographics and considering urban-rural disparities and socioeconomic status.

**Introduction**

Non-communicable diseases (NCDs), such as cardiovascular diseases, cancer, respiratory conditions, and diabetes mellitus, persist over time due to a complex interplay of genetic, physiological, environmental, and behavioral risk factors1. Furthermore, these diseases are progressively emerging as prominent factors contributing to morbidity and mortality in low- and middle-income countries (LMICs)2,3. As per the World Health Organization (WHO) assessments, NCDs account for 71% of total global fatalities. Approximately 85% of premature deaths in LMICs, and within this demographic, 62% of the deaths, or 9 million people affect individuals below the age of 70 4. In 2012, NCDs led to a total of 277,500 fatalities, equating to a mortality rate of 564.1 per 100,000 in males and 531.9 per 100,000 in females 5. Numerous conducted studies have determined that socio-demographic characteristics play a role in the variation of NCD risk factors. In addition, according to WHO’s Global Health Risks Report, the primary global risk factor for NCDs in terms of attributable deaths is hypertension, responsible for 13% of global fatalities 1. Other significant risk factors include tobacco use (9%), physical inactivity (6%), elevated blood glucose levels (6%), and being overweight or obese (5%) 6.

The risk factors associated with these significant NCDs are extensively documented and commonly shared by WHO 1. In LMICs, a notable increase in NCD risk factors is attributed to behavioral (smoking, alcohol, unhealthy diet, physical inactivity) and biological factors (elevated BP, blood glucose, cholesterol, overweight)7. Furthermore, the likelihood of NCDs advancing is noted to escalate when multiple risk factors coexist in an individual, a phenomenon termed clustering 8. The World Health Report 2002 emphasized the importance of concentrating on risks and risk factors for assessment and intervention. In the adult population of the South Asian Regions (SARs), there is a clustering of risk factors for NCDs, and this clustering becomes more apparent as individuals age. In the SARs, cardiovascular diseases (CVDs), cancer, diabetes, and chronic respiratory diseases, primarily, pose a significant and escalating challenge to health and development 9. In Bangladesh, Bhutan, Myanmar, Nepal, and Cambodia, hypertension and central obesity are predominant risk factors. For the urban population of Southeast Asia, the overall pooled prevalence of hypertension was 33.82%. Specifically, hypertension prevalence was 33.98% in community settings and 32.45% among adolescents in schools 10. The most recent studies report the prevalence of hypertension as follows: Bangladesh at 17.9%, Bhutan at 23.9%, India at 31.4%, Maldives at 31.5%, Nepal at 33.8%, Pakistan at 25%, and Sri Lanka at 20.9% 11. Vietnam and Pakistan face hypertension and total cholesterol as predominant risks, while Timor-Leste sees hypertension and diabetes as prevalent. In the Lao People's Democratic Republic, total cholesterol and overweight/obesity are prominent risk factors. Sri Lanka reports hypertension and diabetes as top risk factors 12. In this region, 32.00% of individuals had one metabolic risk factor, 22.10% had two, and 12.38% had three or more. For behavioral risk factors, 24.00% of individuals had one, 49.00% had two, and 22.00% had three or more. The likelihood of having three or more metabolic risk factors was higher among women, older individuals, and those with higher education levels 13.

The SEARs have witnessed a concerning proliferation of NCDs, marked by a pronounced surge in NCD-related fatalities between 2000 and 2012, surpassing other global regions. Currently, the region contends with an annual toll exceeding 8.5 million deaths attributable to NCDs. In 2021, NCDs accounted for nearly two-thirds of all deaths within countries comprising the WHO SEAR, with half of these fatalities occurring among individuals aged 30–69 years 12. Predominantly, NCD-related mortality is attributed to (CVDs), followed by cancers, chronic respiratory diseases, and diabetes. Particularly susceptible are the region's impoverished populations, predisposed to bearing the brunt of NCDs, thereby exacerbating health and socioeconomic disparities. This escalating trend is chiefly propelled by factors including urbanization, economic advancement, and globalization, precipitating the adoption of unhealthy lifestyle practices among the populace. These practices include consumption of nutritionally deficient diets, sedentary behaviors, and tobacco use, culminating in heightened susceptibility to NCDs 14.

The confluence of communicable diseases and NCDs presents a formidable obstacle for the already fragile healthcare systems and constrained health budgets prevalent in Southeast Asia15. Compounded by the region's historical focus on infectious diseases and acute care, healthcare infrastructures are inadequately equipped to address the escalating demand for chronic care services 15,16. Midst of the persisting challenges in maternal and child health, coupled with the resurgence of communicable diseases, SEARs have increasingly prioritized NCDs on their public health agendas. This shift is underscored by substantial political advocacy efforts, bolstered by support from the World Health Organization (WHO) through guidance and tools like the NCD surveillance dashboard, fostering momentum and enhancing accountability in NCD management. By 2021, ten countries within the region had formulated integrated national action plans for NCDs, aligning with the Sustainable Development Goal (SDG) 3.4 target of a 33.3% reduction in premature NCD mortality by 2030, alongside the establishment of time-bound objectives addressing NCD risk factors and management 17. The NCD implementation roadmap for Southeast Asia (2022–2030) endeavors to streamline and expedite the deployment of impactful interventions, with a particular emphasis on leveraging digital solutions 18.

In response, the WHO STEP wise approach to NCD risk factor surveillance (STEPS) in 2000. This methodology is centered on acquiring fundamental data related to established risk factors that play a pivotal role in determining the major disease burden 19. The member states of the WHO have reached a consensus on 25 indicators categorized into three areas. These areas concentrate on crucial outcomes, risk factors, and the necessary national system responses for preventing and managing NCDs. This includes one target related to mortality, six targets about risk factors, and two targets associated with national systems 20. The WHO STEPS survey comprises three steps: behavioral assessment through questionnaires (STEP 1), identification of anthropometric risk factors through physical measurements (STEP 2), and identification of biochemical risk factors through measurements (STEP 3) 19.

Assessing the prevalence of NCDs and identifying high-risk populations is crucial for developing community-based interventions aimed at reducing risk factors. Currently, there is inadequate information for a comprehensive nationwide comparison of NCD prevalence and associated risk factors in the SEAR. Previous community-based studies in this area have been constrained to specific regions, providing a limited and potentially skewed representation of the overall NCD scenario 2,3,7,8,13,21–24. This study aimed to assess epidemiological patterns and determinants of behavioral and biological risk factors associated with specific NCDs in SEARs. Moreover, it will help policymakers and planners SEAR take convenient and efficient steps regarding this crucial matter.

**Methods**

**Data source & study design**

We utilized data from the latest cross-sectional studies of the STEPS survey, following the standardized approach developed by the WHO for monitoring NCD risk factors in the SEARs. The STEPS survey is a global initiative conducted every three to five years in SEARs, employing a consistent protocol. The survey's scope encompasses all males and females aged 18 years or older **(Figure 1)**. It is noteworthy that the study considered individuals living in that country, irrespective of their citizenship status, and excluded only those temporarily visiting (e.g., tourists), residing in military bases or group quarters (e.g., dormitories), or institutionalized (e.g., hospitals, prisons, nursing homes).

Essentially, the study aimed to encompass individuals residing across all geographic areas of the country. Samples were collected using a geographically stratified probability-based method with standardized protocols across countries. STEPS surveys follow ethical and technical review processes, seeking approval from national ethics committees. Participants provide oral and written consent, ensuring the survey respects rights and safeguards ethical considerations. Informed consent is obtained from each participant before interviews, adhering to WHO guidelines 19. The characteristics of participants in the sample varied across the six countries. After the exclusion of less than 18 years participants, participants had not measured blood pressure, blood glucose, or blood cholesterol, and missing information, the weighted sample size for hypertension ranged from Maldives 1627 to 8182 in Bangladesh. For diabetes, the weighted sample size ranged from Maldives 1635 to 8185 in Bangladesh, and for hypercholesterolemia 2489 in Timor-Leste and 8185 in Bangladesh.

**Data collection**

We sourced the latest STEPS survey data for six SEARs—Bangladesh, Maldives, Myanmar, Nepal, Sri Lanka, and Timor-Lest 25. Out of 12 potential countries, we focused on these six for our study. These countries were selected based on meeting our inclusion criteria and having current standard STEPS data. Some countries were excluded either because WHO did not conduct a STEPS survey in those areas, or their data was not available in the public domain, lacked sufficient data, and relevant variables, and had unreported non-response rates.

**Selected NCD outcome variables**

We examined three categories of outcome variables: raised blood pressure (hypertension), raised blood glucose (hyperglycemia or diabetes), and raised total blood cholesterol (hypercholesterolemia). Each of these outcome variables is binary, designated as "YES = 1/NO = 0 **(Table 1)**.

Hypertension, a significant health risk factor, often shows no symptoms and is known as a "silent killer." Diagnosis requires consecutive systolic blood pressure readings≥140 mm Hg and diastolic readings≥90 mm Hg. Contributing factors include an unhealthy diet, lack of physical activity, tobacco/alcohol use, and being overweight 26. Blood pressure measurements utilized a digital monitor, with participants resting for 15 minutes. Three readings were taken, and the mean of the three readings was calculated. Observations outside the valid range were excluded 19. Diabetes, characterized by raised blood glucose, results from insufficient insulin production (Type 1) or ineffective use (Type 2), causing damage to vital organs. Type 2 diabetes, prevalent in those aged 35+, is linked to obesity, inactivity, and smoking, with fasting blood glucose≥126 mg/dL or 7 mmol/L indicating diabetes 27. Lifestyle changes, including regular physical activity, maintaining a healthy weight, nutritious diet, and avoiding tobacco, can prevent or delay Type 2 diabetes onset. Blood glucose levels were assessed with observations falling outside the range of fasting blood glucose <18 mg/dL or >630 mg/dL excluded 19. Raised total blood cholesterol, defined as a lipid profile ≥190 mg/dL or currently on medication, poses heart disease and stroke risks. Approximately one-third of global ischemic heart disease cases are attributed to high cholesterol28. Early detection through regular screening is a key public health strategy. Observations outside the total cholesterol range of <75 mg/dL or >470 mg/dL were excluded, with none falling within this range 19  **(Table 1)**.

In addition, due to insufficient measured data on blood glucose in the Maldives, this study employed self-reported blood glucose levels to assess prevalence. Participants were asked, 'Have you ever been informed by a healthcare professional that you have raised blood glucose or diabetes?' Those who responded affirmatively were categorized as diabetic patients or ‘Yes’; otherwise, responses were classified as 'No'. Furthermore, the Maldives STEP survey of 2011 did not include reporting on total blood cholesterol levels. So, we excluded that from the country-wise analysis and also in the pooled analysis.

**Selected explanatory variables**

Sociodemographic details and health measures (tobacco use, diet, physical activity) were collected. Physical assessments included height, weight, and hip/waist circumference using validated instruments, with barefoot participants in light clothing. Physical activity data was transformed into MET minutes per week. Measurements were conducted by trained enumerators and medical technologists with post-graduate qualifications. Staff underwent comprehensive training, including interactive sessions and pilot testing 19 **(Table 2)**.

**Statistical Analysis**

When analyzing survey datasets, addressing issues like uneven unit selection probabilities is crucial. Sample weights are essential to mitigate bias resulting from disproportionate sampling and non-response, significantly influencing standard error calculations. Excluding weights may lead to biased estimates. Categorical variables were appropriately defined for interpretation. After extracting variables from each country dataset, we analyzed them in two ways. Firstly, we performed a comprehensive analysis using descriptive statistics (percentages) to assess NCD prevalence among participants from different countries and socio-economic backgrounds and health measures. This stage helped us to cross-check the prevalence of each country's reports. Next, we pooled all six countries' data into a single dataset. In STATA, a singleton was introduced to handle a single primary sampling unit (PSU) within a stratum. We chose the singleton (scaled) approach for analysis. We used this method because each country has a different PSU in each study, using singleton (scaled) will provide a single PSU for all countries or combined datasets. In addition, a single PSU in the stratum can occur for various reasons such as missing data. This leads to numerous problems in analyzing the data such as not being able to calculate standard errors 29. Singleton PSUs also handle those issues and provide standard errors. Cross-tabulation and Chi-square tests evaluated the association, with significance set at p < 0.05 and 95% confidence intervals. Informed consent and adherence to ethical guidelines, including the revised declarations of Helsinki, were ensured. This study utilized secondary and publicly available data; thus, ethical approval was not required.

Multivariable (adjusted) logistic regression analyses were then conducted to identify associated risk factors for pooled data. Results were reported as adjusted odds ratios (AOR) with their respective 95% confidence intervals and 5% level of significance. Initially, bivariable analysis (chi-square test) was performed individually for each independent variable. A significance threshold of p-value ≤ 0.20 was applied arbitrarily to determine the inclusion of covariates in the multivariable models 30. Additionally, we assessed multicollinearity in the final model using a cut-off value of 4.00 for the variance inflation factor (VIF) analysis 31. At this stage, all variables were incorporated into the model since the VIF values for each variable were below 4.00.

We utilized the Area under the Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC), and Receiver Operating Characteristic (AUROC) curve, sensitivity, and specificity to assess the accuracy of the best model. Higher AUROC values indicated superior model performance. In the ROC curve, a lower p-value suggests that the model effectively discriminates between two categories, with an area under the curve exceeding 0.50 32. Weighted estimates were used for national accuracy, and the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement guided study reporting **[Supplementary Table S1]**. All analysis was conducted using STATA 16.

**Results**

All findings presented herein are based on weighted estimates to represent the population accurately. The prevalence of NCDs across different countries and cohorts remains high, underscoring the importance of preventive measures to attain the SDG 3.4 target of reducing premature NCD mortality by 33.3% by 2030.

**Country-wise description**

Summary statistics of selected parameters

The mean systolic blood pressure exhibited the highest value in the Timor-Leste at 129.85 mmHg (95% CI: 124.68-135.02) and the lowest in Maldives at 121.38 mmHg (95% CI: 120.48-122.28). Conversely, the mean systolic blood pressure for the SEAR as a whole was calculated at 126.82 mmHg (95% CI: 124.81-128.82). Similarly, the mean diastolic blood pressure was recorded as highest in the Sri Lanka and lowest in Maldives, with values of 84.46 mmHg (95% CI: 81.51-87.42) and 76.64 mmHg (95% CI: 76.00-77.27), respectively. The mean diastolic blood pressure for the SEAR was determined as 82.04 mmHg (95% CI: 80.84-83.23). Moreover, the mean blood glucose and mean total blood cholesterol levels both were observed to be highest in Bangladesh (97.32 mg/dL) and (167.64 mg/dL), respectively, while lowest in Timor-Leste (77.59 mg/dL and 139.69 mg/dL) for both parameters. Conversely, the pooled mean values for blood glucose and total blood cholesterol for the SEAR were calculated at 90.42 mg/dL and 171.66 mg/dL, respectively **(Table 3)**.

Hypertension and risk factors

As **Figure 2** shows, the percentage of participants who have hypertension was highest in Timor-Leste (39.70%) and lowest in Maldives (18.01%). **Table 7** illustrates a clear association between age and the prevalence of hypertension, with an overall increase observed as age advances. Notably, Timor-Leste and Nepal deviate from this trend. Examining the 18-29 age group, we find varying percentages of hypertension across different countries: Maldives (7.95%), Sri Lanka (9.06%), Myanmar (10.13%), Timor-Leste (46.26%), Bangladesh (8.84%), and Nepal (15.74%). In contrast, the 60 years or above age group shows higher percentages in the same countries: Maldives (60.88%), Sri Lanka (50.63%), Myanmar (45.66%), Timor-Leste (38.37%), Bangladesh (37.66%), and Nepal (44.56%). Sri Lankan (23.30%), Myanmar (27.14%) and Bangladeshi (16.82%) male exhibit the lowest percentage of hypertension, while females have the lowest percentage in Maldives (15.69%), Timor-Leste (28.03%) and Nepal (20.66%). The prevalence of hypertension is highest among individuals with no formal education to basic literacy and the lowest among people of college, university, or postgraduate completion.

Diabetes and risk factors

The percentage of participants who have diabetes was highest in Bangladesh, at 8.71%, and lowest in Timor-Leste, at 1.15% **(Figure 2)**. Analyzing the 18-29 age group, varying percentages of diabetes are observed lowest across different countries: Maldives (1.87%), Sri Lanka (1.89%), Myanmar (1.12%), Timor-Leste (0.66%), Bangladesh (4.48%), and Nepal (2.40%). In contrast, the 60 years or above age group exhibits higher percentages in the same countries: Maldives (20.49%), Sri Lanka (11.77%), Myanmar (11.49%), Timor-Leste (1.37%), Bangladesh (14.38%), and Nepal (8.00%). Accept Bangladesh and Nepal, males display the lowest percentage of diabetes, while females have the highest percentage. The other four countries exhibit the prevalence of diabetes is highest among males and lowest in females. The raised blood sugar is highest among individuals with no formal education to basic literacy in the Maldives (8.41%) and Nepal (15.97%), lowest in Sri Lanka (4.52%), Myanmar (6.03%), Timor-Leste (0.98%) and Bangladesh (8.40%) **(Table 8)**.

Hypercholesterolemia and risk factors

As of **Figure 2** the percentage of participants who hypercholesterolemia was highest in Myanmar, at 34.40%, and lowest in Nepal, at 11.13%. Analyzing the 18-29 age group, varying percentages of raised total blood cholesterol are noted across different countries: Sri Lanka (13.03%), Myanmar (18.45%), Timor-Leste (7.50%), Bangladesh (19.42%), and Nepal (6.05%). In contrast, the 60-year-old or above age group displays higher percentages in the same countries: Sri Lanka (27.21%), Myanmar (48.91%), Timor-Leste (17.46%), Bangladesh (35.73%), and Nepal (21.63%). All countries exhibit the highest percentage of raised hypercholesterolemia in females than males. Notably, except for Sri Lanka and Timor-Leste, the prevalence of hypercholesterolemia is highest among individuals with no formal education to basic literacy in other countries (**Table 9)**.

**Hypertension, Diabetes, and Hyperglycemia in SEARs**

**Table 10** presents the association between selected risk factors and major NCDs within pooled data from SEARs. In these nations, hypertension, hyperglycemia, and hypercholesterolemia have prevalence rates of 27.39%, 5.69%, and 31.21%, respectively. Among younger individuals (aged 18-29), these rates are notably lower at 10.97%, 1.35%, and 16.17%, respectively, while in the older age group (60 years and above), they peak at 46.75%, 11.35%, and 42.41%, respectively.

Females exhibit higher prevalence rates of hypertension (27.96%), hyperglycemia (6.61%), and hypercholesterolemia (35.65%) compared to males (26.84%, 4.78%, and 26.81%, respectively). Currently, married individuals display higher rates of NCDs compared to unmarried individuals. For instance, hypertension, hyperglycemia, and hypercholesterolemia rates are 29.23%, 5.86%, and 34.14% among married participants, whereas among unmarried individuals, they are lower at 24.88%, 4.30%, and 33.61%, respectively. Regarding employment status, hypertension is more prevalent among unemployed participants (27.42%) than among employed individuals, homemakers, or voluntary workers (28.47%). Similarly, hyperglycemia is more common among the unemployed, homemakers, or voluntary workers (5.84%) compared to the employed (4.86%) and unemployed (5.81%). Additionally, hypercholesterolemia rates are higher among homemakers or voluntary workers (32.36%) compared to the employed (27.90%) or unemployed (28.12%) (**Table 10)**.

The prevalence of NCDs is lowest among daily or regular smokers and highest among non-smokers or irregular smokers, although this difference is not statistically significant. Similarly, the frequency of fruit consumption per week shows no statistical significance. However, hypertension and hyperglycemia rates are highest among those who do not consume fruits weekly, while hypercholesterolemia rates are highest among weekly fruit consumers. Conversely, with vegetable consumption, the highest rates of hypertension and hyperglycemia occur among weekly consumers, while hypercholesterolemia rates are lowest among this group (**Table 10)**.

Regarding salt intake, hypertension prevalence is highest (43.41%) among those who sometimes or rarely add salt to their meals. Conversely, hyperglycemia and hypercholesterolemia rates are lowest at 2.97% and 17.32%, respectively, among those who always add salt. Similarly, the prevalence of hypertension and hyperglycemia is highest among those using coconut, groundnut, sunflower, or mustard oil, while hypercholesterolemia rates are lowest among this group and highest among those using olive, corn, or unspecified oils. In terms of physical activity, those engaged in vigorous or moderate activity show the lowest prevalence of NCDs, with rates of 20.42%, 2.53%, and 20.70%, respectively. Obese individuals demonstrate higher NCD prevalence compared to non-obese individuals, with rates of 56.39%, 11.65%, and 40.45% compared to 25.96%, 5.33%, and 30.38%, respectively (**Table 10)**.

In the adjusted model (Model 1), age, marital status, active transport, and obesity were significantly associated with hypertension at the 5% significance level (p < 0.05). Specifically, participants aged 60 years and above, 45-59 years, and 30-44 years had a higher risk of hypertension compared to those aged 18-29 years, with adjusted odds ratios (AORs) of 5.54 (95% CI: 3.92-7.85, p < 0.001), 4.49 (95% CI: 3.11-6.48, p < 0.001), and 2.41 (95% CI: 1.77-3.27, p < 0.001), respectively. Married individuals had 1.14 times higher odds of developing hypertension, compared to unmarried individuals. Participants not engaged in active transport had 1.18 times higher odds of hypertension (AOR: 1.18, 95% CI: 1.04-1.35, p = 0.011) compared to those who were actively commuting. High-obesity participants had a 3.01 times higher risk of hypertension (AOR: 3.01, 95% CI: 2.06-4.40, p < 0.001) than non-obese participants **(Table 11).**

In Model 2, moderate activity at work and obesity were significantly associated with hyperglycemia. Participants not participating in moderate activity had a 4.94 times higher risk of hyperglycemia (AOR: 4.94, 95% CI: 1.52-5.99, p = 0.008) compared to those who did. High-obesity participants had a 3.89 times higher risk of hyperglycemia (AOR: 3.96, 95% CI: 1.17-5.39, p = 0.027) than those who were not obese **(Table 11).**

In Model 3, age, sex, education level, and vigorous activity at work were significantly associated with hypercholesterolemia. Participants aged 60 years and above, 45-59 years, and 30-44 had a higher risk of hypercholesterolemia compared to those aged 18-29 years, with AORs of 4.17 (95% CI: 3.28-5.30, p < 0.001), 3.79 (95% CI: 2.99-4.82, p < 0.001), and 2.11 (95% CI: 1.67-2.67, p < 0.001), respectively. Female participants had 1.39 times higher odds of hypercholesterolemia (AOR: 1.39, 95% CI: 1.19-1.62, p < 0.001) compared to males. Individuals having no formal schooling to basic literacy showed 30% times (AOR: 0.70, 95% CI: 0.50-0.97, p = 0.035) lower odds, and those with secondary to high school education showed 1.38 times (AOR: 1.38, 95% CI: 1.06-1.79, p = 0.017) higher odds of developing hypercholesterolemia compared to those with college or higher education. Additionally, participants not engaged in vigorous activity had 1.63 times higher odds of hypercholesterolemia (AOR: 1.63, 95% CI: 1.26-2.10, p < 0.001) compared to those who were vigorously active **(Table 11).** The adjusted models demonstrated a good fit with acceptable classification accuracy, reflected in AUC values of 68.01%, 71.70%, and 65.45%, respectively for model 1, model 2, and model 3 **(Tables 12 and Figure 3).**

**Discussion**

National surveys across the SEAR have provided insights into the prevalence of hypertension and its associated risk factors. This paper synthesizes key findings from these initiatives and surveys, highlighting significant risk factors for major NCDs among Southeast Asians and emphasizing the importance of addressing behavioral factors to prevent and control this widespread health condition. Recent national surveys across the region have revealed varying rates of hypertension prevalence; for instance, 18.01% in Maldives (2011) 33, 23.77% in Sri Lanka (2014) 34, 27.93% in Myanmar (2014) 35, 39.70% in Timor-Leste (2014) 36, 20.41% in Bangladesh (2018) 37, and 26.60% in Nepal (2019) 38 and pooled prevalence is 27.39%.

In this study, significant risk factors for hypertension among Southeast Asians include age, marital status, dietary habits (such as the type of oil used and frequency of meals eaten outside), levels of physical activity (including vigorous exercise and active transport), obesity, and medication use. Additionally, some studies have highlighted statistically significant associations between hypertension and factors like sex, education level, and employment status 10,11,39,40. Consistent with our findings, previous research has indicated significant correlations between hypertension and marital status and frequency of meals eaten outside 41,42. Besides age, behavioral factors emerge as the most crucial and modifiable risk determinants for hypertension. For instance, unhealthy dietary patterns and insufficient physical activity contribute to overweight or obesity, hypertension, and adverse lipid profiles. Addressing behavioral risk factors, particularly promoting healthy diets and physical activity, holds promise for hypertension prevention. Initiatives aimed at reducing salt intake can significantly contribute to hypertension prevention and control 43–46. Notably, high body mass index (BMI) stands out as a well-established risk factor for hypertension, with several studies highlighting its strong association with the condition 47. In 2018, India and Thailand initiated efforts to intensify their programs aimed at managing hypertension. By 2022, the India Hypertension Control Initiative had enrolled over 6 million individuals for treatment, resulting in notable enhancements in quarterly cohort blood pressure control rates 48. Thailand's initiative similarly led to the monthly diagnosis of approximately 50,000–70,000 hypertension cases, accompanied by improved blood pressure management at the clinic level 49.

The rise in NCDs across the SAR is attributed to a shift in disease patterns from communicable to noncommunicable ailments 50. Factors contributing to this transition include heightened life expectancy, rapid population expansion, unplanned urbanization, low levels of literacy, and increased external debt leading to reductions in national healthcare expenditure 51. These collective issues have led to the emergence of significant regional health challenges, notably the prevalence of NCDs such as diabetes. Recent national surveys in the region have revealed varying rates of diabetes prevalence, 3.73% in Maldives (2011) 33, 6.41% in Sri Lanka (2014) 34, 5.58% in Myanmar (2014) 35, 1.15% in Timor-Leste (2014) 36, 8.71% in Bangladesh (2018) 37, 5.76% in Nepal (2019) 38 and pooled rates is 5.69%.

Within this study, several factors including age, sex, education level, marital status, dietary habits (such as extra salt intake and choice of cooking oil), levels of physical activity (including vigorous and moderate activities as well as active transport and leisure activities), obesity, wealth or income and medication usage were identified as significant risk factors for diabetes among South East Asians 50,52–57. Consistent with existing research, our findings corroborate associations between diabetes and variables including age and sex 58,59, education level 55, adding extra salt and types of oil 57. 50,53,60The recent diabetes epidemic in the region is largely attributed to environmental factors such as dietary habits and levels of physical activity, compounded by genetic predisposition 50,53,60. Moreover, increasing body weight play significant roles in diabetes susceptibility, with associations observed between diabetes and indices such as body mass index (BMI), waist-hip ratio, and abdominal obesity 61.56

Hypercholesterolemia, characterized by raised levels of total cholesterol in the blood, is linked to an augmented risk of cardiovascular disease 62. Its prevalence is escalating in developing nations, contributing to a global upsurge in coronary heart disease 63. Individuals with familial hypercholesterolemia (FH) face a substantially heightened risk of coronary artery disease, estimated to be ten times greater than that of healthy counterparts 64. Timely diagnosis and management of FH play a pivotal role in reducing the burden of low-density lipoprotein cholesterol (LDL-C), thereby mitigating the progression of atherosclerosis and improving coronary outcomes. Consequently, screening initiatives employing cascade testing or universal screening methods are recommended to identify FH early and mitigate cardiovascular risk in a considerable portion of the population 65. Recent national surveys in the region have revealed varying prevalence rates of hypercholesterolemia, 19.94% in Sri Lanka (2014) 34, 34.40% in Myanmar (2014) 35, 17.39% in Timor-Leste (2014) 36, 26.59% in Bangladesh (2018) 37, 11.13% in Nepal (2019) 38 and the pooled percentage is 31.21%.

This study identified age, sex, education level, work status, levels of physical activity (both vigorous and leisure), obesity, and medication usage as significant risk factors for hypercholesterolemia among Southeast Asians, which is consistent with other findings 65–71. However, associations observed with marital status, dietary habits, and modes of physical activity did not attain statistical significance. The positive correlation observed between age and hypercholesterolemia aligns with findings from prior studies 67,68. Similarly, the modestly increased risk of hypercholesterolemia associated with lower educational attainment is consistent with existing literature 66,68. Lifestyle and behavioral factors among the Southeast Asian population exhibit a notable influence in this study. In Thailand, transitioning towards Westernized lifestyles and behaviors poses challenges in preventing and managing coronary heart disease, along with other conditions prevalent among more sedentary and obese populations 71. In the Malaysian context, hypercholesterolemia prevalence is reported to be notably high among individuals who are overweight or obese, regardless of gender 69,70.

The studies identified several limitations, including the lack of differentiation between various categories within NCDs in Southeast Asian prevalence studies. For instance, while exploring the association with hypertension, distinctions such as primary or secondary, stage 1, or stage 2 were not considered. Similarly, diabetes data were examined in a generalized manner without distinguishing between type 1 and type 2 diabetes. Moreover, the classification of hypercholesterolemia into genetic or acquired forms was not specified. Another limitation was that all studies included in the analysis were community-based surveys, potentially underestimating the true regional burden as hospital admissions and care center data were not accounted for. Additionally, some studies relied solely on self-reported NCDs, and changes in definitions and diagnostic criteria over time may have influenced prevalence rates. However, to present prevalence data for individual countries, only the most recent studies were included, minimizing variations in diagnostic criteria as older studies were excluded.

Despite these methodological limitations, promoting public awareness through health education emerges as a crucial strategy for altering mass dietary habits and tobacco consumption behaviors in the region. Implementing initiatives such as healthy urban community design to encourage walkability and promoting healthy food options in schools and cafeterias could help mitigate the growing obesogenic environment. Tailored intervention programs targeting high-risk groups based on identified risk factors are essential for early detection and treatment of major NCDs.

In conclusion, this study highlighted the prevalence of major NCDs and identified high-risk groups in the SEAR region. The regional pooled analysis revealed prevalence rates of 27.39% for hypertension, 5.69% for hyperglycemia, and 31.21% for hypercholesterolemia. NCDs were significantly associated with common health risk factors such as age, sex, education level, marital status, work-related physical activity, active transportation, and obesity. Older participants showed higher odds of developing hypertension and hypercholesterolemia compared to younger age groups. Females were more likely to develop hypercholesterolemia than males. Education levels influenced risk, with those having no formal schooling or basic literacy at a lower risk, while secondary to high school education increased the risk of hypercholesterolemia compared to higher educational participants. Married individuals had higher odds of hypertension than those unmarried. Lack of vigorous work activity raised the likelihood of hypercholesterolemia, absence of moderate activities heightened hyperglycemia risk, and not participating in active transportation increased odds of hypertension. Additionally, obese participants significantly elevated the risk of developing hypertension, hyperglycemia, and hypercholesterolemia compared to non-obese.

The study outcomes advocate for both individual and collective program interventions, with a particular focus on elderly individuals, and female populations. Moreover, the findings are poised to contribute significantly to the development of comprehensive national action plans aimed at mitigating the escalating burden of NCDs. Hence, a population-based approach utilizing the primary healthcare system is warranted for risk reduction, early detection, and treatment. Furthermore, non-health sectors should actively participate in preventive efforts targeting specific demographic groups, considering variations in risk factor distribution across regions, as well as by gender and socioeconomic status. However, addressing modifiable risk factors necessitates collaborative endeavors from multiple sectors to foster an environment conducive to behavior change. The current federal structure, wherein municipalities are responsible for various sectors including health, education, infrastructure, and environment, presents an opportunity for coordinated interventions across sectors, ultimately contributing to the reduction of NCD risk factors in Southeast Asian countries.

**Data sharing statement**

The data are available on request to the corresponding author.

**Declaration of interests**

There is no conflict of interest.

**Acknowledgments**

We gratefully acknowledge the WHO STEPwise approach to NCD risk factor surveillance (STEPS) survey for granting access to the SEARs datasets.

**References**

1 WHO. Noncommunicable diseases. 2023. https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases (accessed Dec 2, 2023).

2 Boutayeb A. The double burden of communicable and non-communicable diseases in developing countries. *Trans R Soc Trop Med Hyg* 2006; **100**: 191–9.

3 Alwan A, MacLean DR, Riley LM, *et al.* Monitoring and surveillance of chronic non-communicable diseases: progress and capacity in high-burden countries. *Lancet* 2010; **376**: 1861–8.

4 WHO. Chronic Diseases-Core package. 2006.

5 WHO. Global status report on noncommunicable diseases 2014. 2014. https://www.who.int/publications/i/item/9789241564854 (accessed Nov 22, 2023).

6 Atuahene M, Ganle JK, Adjuik M, Atuahene NF, Kampitib GB. Overweight and obesity prevalence among public servants in Nadowli district, Ghana, and associated risk factors: a cross-sectional study. *BMC Obes* 2017; **4**. DOI:10.1186/S40608-017-0153-5.

7 Aboobakur M, Latheef A, Mohamed AJ, *et al.* Surveillance for non-communicable disease risk factors in Maldives: results from the first STEPS survey in Male. *Int J Public Health* 2010; **55**: 489–96.

8 Ahmed SM, Hadi A, Razzaque A, *et al.* Clustering of chronic non-communicable disease risk factors among selected Asian populations: levels and determinants. *Glob Health Action* 2009; **2**: 68–75.

9 WHO. Noncommunicable diseases - SEARO. 2023. https://www.who.int/southeastasia/health-topics/noncommunicable-diseases (accessed Dec 3, 2023).

10 Mohammed Nawi A, Mohammad Z, Jetly K, *et al.* The Prevalence and Risk Factors of Hypertension among the Urban Population in Southeast Asian Countries: A Systematic Review and Meta-Analysis. *Int J Hypertens* 2021; **2021**. DOI:10.1155/2021/6657003.

11 Neupane D, McLachlan CS, Sharma R, *et al.* Prevalence of Hypertension in Member Countries of South Asian Association for Regional Cooperation (SAARC): Systematic Review and Meta-Analysis. *Medicine* 2014; **93**. DOI:10.1097/MD.0000000000000074.

12 Noncommunicable diseases - SEARO. https://www.who.int/southeastasia/health-topics/noncommunicable-diseases (accessed Feb 23, 2024).

13 Biswas T, Townsend N, Gupta R Das, *et al.* Clustering of metabolic and behavioural risk factors for cardiovascular diseases among the adult population in South and Southeast Asia: findings from WHO STEPS data. *The Lancet Regional Health - Southeast Asia* 2023; **12**: 100164.

14 Fritz M, Fromell H. How to dampen the surge of non-communicable diseases in Southeast Asia: insights from a systematic review and meta-analysis. *Health Policy Plan* 2022; **37**: 152–67.

15 Dans A, Ng N, Varghese C, Tai ES, Firestone R, Bonita R. The rise of chronic non-communicable diseases in southeast Asia: Time for action. *The Lancet* 2011; **377**: 680–9.

16 Meiqari L, Nguyen TPL, Essink D, Wright P, Scheele F. Strengthening human and physical infrastructure of primary healthcare settings to deliver hypertension care in Vietnam: a mixed-methods comparison of two provinces. *Health Policy Plan* 2020; **35**: 918–30.

17 SEARO NCD Dashboard. https://searncddashboard.searo.who.int/NCDMortality (accessed Feb 22, 2024).

18 de Silva A, Varghese C, Amin MR, *et al.* Non-communicable diseases in South-East Asia: journeying towards the SDG target. *The Lancet Regional Health - Southeast Asia* 2023; **18**. DOI:10.1016/J.LANSEA.2023.100305.

19 WHO. Noncommunicable Disease Surveillance, Monitoring and Reporting. 2008. https://www.who.int/teams/noncommunicable-diseases/surveillance/systems-tools/steps (accessed Dec 2, 2023).

20 About the 66th World Health Assembly. https://www3.paho.org/hq/index.php?option=com\_content&view=article&id=8659:2013-66th-world-health-assembly&Itemid=0&lang=fr#gsc.tab=0 (accessed Dec 2, 2023).

21 Riaz BK, Islam MZ, Islam ANMS, *et al.* Risk factors for non-communicable diseases in Bangladesh: findings of the population-based cross-sectional national survey 2018. *BMJ Open* 2020; **10**: 41334.

22 Zaman MM, Bhuiyan MR, Karim MN, *et al.* Clustering of non-communicable diseases risk factors in Bangladeshi adults: An analysis of STEPS survey 2013. *BMC Public Health* 2015; **15**: 1–9.

23 Msyamboza KP, Ngwira B, Dzowela T, *et al.* The Burden of Selected Chronic Non-Communicable Diseases and Their Risk Factors in Malawi: Nationwide STEPS Survey. *PLoS One* 2011; **6**: e20316.

24 Bista B, Dhimal M, Bhattarai S, *et al.* Prevalence of non-communicable diseases risk factors and their determinants: Results from STEPS survey 2019, Nepal. *PLoS One* 2021; **16**: e0253605.

25 Data Catalog. https://extranet.who.int/ncdsmicrodata/index.php/catalog/?page=1&ps=15 (accessed June 30, 2024).

26 WHO. Hypertension. 2023. https://www.who.int/news-room/fact-sheets/detail/hypertension (accessed Dec 4, 2023).

27 WHO. Diabetes. 2023. https://www.who.int/news-room/fact-sheets/detail/diabetes (accessed Dec 4, 2023).

28 Raised cholesterol. https://www.who.int/data/gho/indicator-metadata-registry/imr-details/3236 (accessed Sept 2, 2024).

29 Tan TY, Lunke S, Chong B, *et al.* A head-to-head evaluation of the diagnostic efficacy and costs of trio versus singleton exome sequencing analysis. *European Journal of Human Genetics 2019 27:12* 2019; **27**: 1791–9.

30 Hasan MN, Abdul Baker Chowdhury M, Jahan J, Jahan S, Ahmed NU, Uddin MJ. Cesarean delivery and early childhood diseases in Bangladesh: An analysis of Demographic and Health Survey (BDHS) and Multiple Indicator Cluster Survey (MICS). *PLoS One* 2020; **15**: e0242864.

31 Hasan MN, Babu MR, Chowdhury MAB, *et al.* Early childhood developmental status and its associated factors in Bangladesh: a comparison of two consecutive nationally representative surveys. *BMC Public Health* 2023; **23**: 1–13.

32 Hasan MN, Tambuly S, Trisha KF, Haque MA, Chowdhury MAB, Uddin MJ. Knowledge of HIV/AIDS among married women in Bangladesh: analysis of three consecutive multiple indicator cluster surveys (MICS). *AIDS Res Ther* 2022; **19**: 1–10.

33 SEA-NCD-91 Distribution: General WHO STEPS survey on risk factors for noncommunicable diseases Maldives, 2011. 2014.

34 2015 STEPS Country Report Sri Lanka. https://www.who.int/publications/m/item/2015-steps-country-report-sri-lanka (accessed Feb 16, 2024).

35 2014 STEPS Country Report Myanmar. https://www.who.int/publications/m/item/2014-steps-country-report-myanmar (accessed Feb 16, 2024).

36 Timor-Leste - STEPS 2014. https://extranet.who.int/ncdsmicrodata/index.php/catalog/687 (accessed Feb 16, 2024).

37 2018 STEPS Fact Sheet Bangladesh. https://www.who.int/bangladesh/about-us/publications-1/m/item/2018-steps-fact-sheet-bangladesh (accessed Feb 16, 2024).

38 Nepal - STEPS 2019. https://extranet.who.int/ncdsmicrodata/index.php/catalog/771 (accessed Feb 16, 2024).

39 Gupta R Das, Chakraborty PA, Hossain MB. Association of household wealth and education level with hypertension and diabetes among adults in Bangladesh: a propensity score-based analysis. *Tropical Medicine & International Health* 2021; **26**: 1047–56.

40 Yokobori Y, Fukunaga A, Okawa S, *et al.* Sex differences in the association between socioeconomic status and untreated hypertension among residents with hypertension in rural Khánh Hòa, Vietnam: a post-hoc analysis. *BMC Cardiovasc Disord* 2024; **24**: 1–9.

41 Segawa HK, Uematsu H, Dorji N, *et al.* Gender with marital status, cultural differences, and vulnerability to hypertension: Findings from the national survey for noncommunicable disease risk factors and mental health using WHO STEPS in Bhutan. *PLoS One* 2021; **16**: e0256811.

42 Alfaqeeh M, Alfian SD, Abdulah R. Factors Associated with Hypertension Among Adults: A Cross-Sectional Analysis of the Indonesian Family Life Survey. *Vasc Health Risk Manag* 2023; **19**: 827.

43 Kokubo Y, Padmanabhan S, Iwashima Y, Yamagishi K, Goto A. Gene and environmental interactions according to the components of lifestyle modifications in hypertension guidelines. *Environ Health Prev Med* 2019; **24**: 1–11.

44 Rios FJ, Montezano AC, Camargo LL, Touyz RM. Impact of Environmental Factors on Hypertension and Associated Cardiovascular Disease. *Canadian Journal of Cardiology* 2023; **39**: 1229–43.

45 Zambrano AK, Cadena-Ullauri S, Guevara-Ramírez P, *et al.* Genetic diet interactions of ACE: the increased hypertension predisposition in the Latin American population. *Front Nutr* 2023; **10**: 1241017.

46 Ojangba T, Boamah S, Miao Y, *et al.* Comprehensive effects of lifestyle reform, adherence, and related factors on hypertension control: A review. *The Journal of Clinical Hypertension* 2023; **25**: 509.

47 Ibrahim MM, Damasceno A. Hypertension in developing countries. *Lancet* 2012; **380**: 611–9.

48 India Hypertension Control Initiative (IHCI), 2021. https://www.who.int/southeastasia/internal-publications-detail/india-hypertension-control-initiative-(ihci)-2021 (accessed Feb 22, 2024).

49 HYPERTENSION CARE IN THAILAND. .

50 Jayawardena R, Ranasinghe P, Byrne NM, Soares MJ, Katulanda P, Hills AP. Prevalence and trends of the diabetes epidemic in South Asia: A systematic review and meta-analysis. *BMC Public Health* 2012; **12**: 1–11.

51 Islam A, Zaffar Tahir M. Health sector reform in South Asia: New challenges and constraints. *Health Policy (New York)* 2002; **60**: 151–69.

52 Ramachandran A, Snehalatha C, Kapur A, *et al.* High prevalence of diabetes and impaired glucose tolerance in India: National Urban Diabetes Survey. *Diabetologia* 2001; **44**: 1094–101.

53 Das U, Kar N. Prevalence and risk factor of diabetes among the elderly people in West Bengal: evidence-based LASI 1st wave. *BMC Endocr Disord* 2023; **23**. DOI:10.1186/s12902-023-01421-3.

54 Rannan-Eliya RP, Wijemunige N, Perera P, *et al.* Prevalence of diabetes and pre-diabetes in Sri Lanka: a new global hotspot-estimates from the Sri Lanka Health and Ageing Survey 2018/2019. *BMJ Open Diabetes Res Care* 2023; **11**. DOI:10.1136/BMJDRC-2022-003160.

55 Ramachandran A, Mary S, Yamuna A, Murugesan N, Snehalatha C. High prevalence of diabetes and cardiovascular risk factors associated with urbanization in India. *Diabetes Care* 2008; **31**: 893–8.

56 Barnett AH, Dixon AN, Bellary S, *et al.* Type 2 diabetes and cardiovascular risk in the UK south Asian community. *Diabetologia* 2006; **49**: 2234–46.

57 Morrison J, Akter K, Jennings HM, *et al.* Participatory learning and action to address type 2 diabetes in rural Bangladesh: a qualitative process evaluation. *BMC Endocr Disord* 2019; **19**. DOI:10.1186/S12902-019-0447-3.

58 Kautzky-Willer A, Leutner M, Harreiter J. Sex differences in type 2 diabetes. *Diabetologia* 2023; **66**: 986–1002.

59 Ramke J, Lee L, Brian G. Prevalence of diabetes among adults aged ≥40years in Timor-Leste. *J Diabetes* 2012; **4**: 392–4.

60 Akhtar S, Ali A, Asghar M, Hussain I, Sarwar A. Original research: Prevalence of type 2 diabetes and pre-diabetes in Sri Lanka: a systematic review and meta-analysis. *BMJ Open* 2023; **13**: 68445.

61 Majeed NA, Shiruhana SA, Maniam J, Eigenmann CA, Siyan A, Ogle GD. Incidence, prevalence and mortality of diabetes in children and adolescents aged under 20 years in the Republic of Maldives. *J Paediatr Child Health* 2020; **56**: 746–50.

62 Cimminiello C, Zambon A, Polo Friz H. [Hypercholesterolemia and cardiovascular risk: advantages and limitations of current treatment options]. *G Ital Cardiol (Rome)* 2016; **17**: 6S – 13.

63 Gaziano TA, Bitton A, Anand S, Abrahams-Gessel S, Murphy A. Growing Epidemic of Coronary Heart Disease in Low- and Middle-Income Countries. *Curr Probl Cardiol* 2010; **35**: 72.

64 Groselj U, Wiegman A, Gidding SS. Screening in children for familial hypercholesterolaemia: start now. *Eur Heart J* 2022; **43**: 3209–12.

65 Sadiq F, Shafi S, Sikonja J, *et al.* Mapping of familial hypercholesterolemia and dyslipidemias basic management infrastructure in Pakistan: a cross-sectional study. *The Lancet Regional Health - Southeast Asia* 2023; **12**. DOI:10.1016/j.lansea.2023.100163.

66 Jackson CL, Zordok M, Kullo IJ. Familial hypercholesterolemia in Southeast and East Asia. *Am J Prev Cardiol* 2021; **6**: 100157.

67 Lee MY, Nam GE, Han K, *et al.* Association between height and hypercholesterolemia in adults: a nationwide population-based study in Korea. *Lipids Health Dis* 2019; **18**. DOI:10.1186/S12944-019-1148-7.

68 Al-Zahrani J, Shubair MM, Al-Ghamdi S, *et al.* The prevalence of hypercholesterolemia and associated risk factors in Al-Kharj population, Saudi Arabia: a cross-sectional survey. *BMC Cardiovasc Disord* 2021; **21**. DOI:10.1186/S12872-020-01825-2.

69 Chan YY, Lim KK, Lim KH, *et al.* Physical activity and overweight/obesity among Malaysian adults: findings from the 2015 National Health and morbidity survey (NHMS). *BMC Public Health* 2017; **17**. DOI:10.1186/S12889-017-4772-Z.

70 Abdul Murad NA, Mohammad Noor Y, Zam ZZ, *et al.* Hypercholesterolemia in the Malaysian Cohort Participants: Genetic and Non-Genetic Risk Factors. *Genes (Basel)* 2023; **14**. DOI:10.3390/GENES14030721/S1.

71 Lohsoonthorn V, Dhanamun B, Williams MA. Prevalence of metabolic syndrome and its relationship to white blood cell count in a population of Thai men and women receiving routine health examinations. *Am J Hypertens* 2006; **19**: 339–45.