Author's response to reviews

Title: Epidemiology and awareness of hypertension in a rural Ugandan community: a cross-sectional study

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Author's response to reviews: see over
Dear Editor,

We are pleased to submit a revised version of our manuscript entitled, “Epidemiology and awareness of hypertension in a rural Ugandan community: a cross-sectional study,” for consideration for publication in *BMC Public Health*. We thank the reviewers for their helpful suggestions and requests for clarification. The revised manuscript has been strengthened with their inclusion.

The following changes have been made in response to the points raised by the reviewers:

Dr. Hiremath’s review:

1. Adult population of Kakyarere parish (3485 persons) has now been clearly stated in the results section of the manuscript.
2. Difference in prevalence of hypertension between our previous pilot study in 2011 and current study has now been examined in the discussion section - relating the use of a more rigorous hypertension definition in this study as the likely source of the difference.
3. The reason for a relatively modest frequency of self-reported hypertension in our study despite prior screening in 2011 is likely multifactorial. Many of the 645 persons reported to be hypertensive in 2011 were subsequently found not to be hypertensive on repeat screening at local health facilities. These persons did not identify themselves as hypertensive in 2012; consequently, the frequency of self-reported hypertension decreased in our study. This over-reporting from our pilot study led us to develop a more rigorous definition of hypertension, which has now been clarified in the discussion section. In addition, sampling differences between the two studies could also contribute to lower self-reported hypertension.
4. Dr. Hiremath’s inference about self-reported hypertension from Table 2 is correct: of the 224 with self-reported hypertension, 135 were confirmed to be hypertensive (high BP on screening or taking antihypertensive medications), while 89 were not truly hypertensive on screening. These 89 persons likely represent those who were misclassified as being hypertensive at some point previously, possibly due to unreliable BP measurement or white coat hypertension.
5. HIV infected men were less likely to be hypertensive in our study, a finding that is consistent with prior reports. However, hypertension prevalence estimates in our study were not adjusted for HIV prevalence. Age-standardized and raw estimates of hypertension prevalence are reported.

Dr. Fodor’s review:

1. Due to space limitations, implementation of the community health campaign is not discussed in detail in this manuscript; however, major aspects of the campaign relevant to this work are now presented in the methods section. Previous work describing the detailed implementation strategy of a
community health campaign in Kakyerere parish in 2011 has been cited for those interested (PMID 22916256).

2. We have now provided additional information about the Ugandan health care system in the methods section under “Hypertension treatment referral.”

3. The community health campaign is not required for securing continuing medical care or subsidy for drugs, as is now clarified in the “Hypertension treatment referral” sub-section. Rather, once hypertensive persons are identified at community health campaigns they are referred to the existing Ugandan health care infrastructure that guarantees free medical care (including drugs).

Thank you for considering this revised manuscript. We look forward to your favorable response.

Sincerely,
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