



SDI Review Form 1.6

Journal Name:	International Journal of TROPICAL DISEASE & Health
Manuscript Number:	2013_IJTDH_6240
Title of the Manuscript:	HYPERTENSION IN THE ADULT POPULATION OF KAYA HEALTH AND DEMOGRAPHIC SURVEILLANCE SYSTEM IN BURKINA FASO: PREVALENCE AND ASSOCIATED FACTORS
Type of the Article	Research Paper

General guideline for Peer Review process:

This journal's peer review policy states that **NO** manuscript should be rejected only on the basis of '**lack of Novelty**', provided the manuscript is scientifically robust and technically sound.

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(<http://www.sciencedomain.org/page.php?id=sdi-general-editorial-policy#Peer-Review-Guideline>)



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PART 1: Review Comments

	Reviewer's comment	Author's comment (if agreed with reviewer, correct the manuscript and highlight that part in the manuscript. It is mandatory that authors should write his/her feedback here)
Compulsory REVISION comments	Line 69, define rural and semi-urban. Consider using the term peri-urban instead of semi-urban. 100% participation rate suggests that study subjects were coerced into participation. Was there a payment to participants? What about ill or mentally ill subjects? How were participants chosen at the household? At random or simply the person that answered the door if >18 years? How was informed consent administered? Were participants told they had the right to say no?	Kaya is a full-fledged city, ranked among the 10 cities of Burkina Faso. It is therefore not a peripheral area of one city. It has 53000 inhabitants and it is less developed than the capital Ouagadougou (with $\approx 2\,000\,000$ inhabitants). This is why this area covered by Kaya is called "semi-urban areas" by comparison with Ouagadougou. "Rural areas" includes only hamlets and very small villages. Response rates in BurkinaFaso are very high. The population perceives no harm from the interviewers and they are willing to participate and get a medical check –up such as a blood pressure reading. In addition, they are prone to collaborate when approached with politeness and good explanations of what will be done and why. During data collection, informed consent form was given to the participant when he was literate or translated to the participant when he could not read. All participants were informed that participation was voluntary, and he/she was free to respond. No payment was given to the participant. Households were randomly selected from a list of households from Kaya surveillance system. Then, the participant was randomly drawn from the list of members of each household before going to the household. We spent 3 or 4 days in each village and carry out several visits if a participant was absent in the first time. Cases of patients were referred to a physician (from KaDeSSTeam) when he



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	Authors should aim to integrate two recent publications on hypertension in subSaharan Africa (SSA) in PLOS One in their discussion (Muzinguzi et al., Malaza et al.). It would actually be useful to have an additional table with all cited studies on hypertension in SSA, including their country, year, size, risk factors identified. This would help to increase the citation scope of the paper. Use a consistent order of risk factor variables in all of the tables. It would make more sense to replace figure 2 with proportions who are hypertensive as a function of age and location. The mean of SBP and DBP are not the focus of the regression analysis. Line 209 Need to mention in results section of text that age is linearly associated with hypertension. High levels of hypertension >15% only observed in semi-urban persons 45 years and older. In final multivariate model, check interaction terms of residence with physical activity, as non-vigorous activity only prevalent in semi-urban area or consider stratifying multivariate model by residence.	did not already have a support. The consent form is sent to the editor. The 2 publications are now integrated into the discussion. The table 5 concerning risk factors identified by previous studies is now in the text. The order of risk factor variables has been revised. The figure with means of SBP and DBP is replaced by a figure with hypertension prevalence by age and residence. These statements have been added in the text just before figure 2. The interaction terms of residence with physical activity was tested but they did not reach statistical significance ($P = .103$ and 95% CI: 0.84-7.12). Given that the confidence interval provides evidence of an association and a lack of precision due to limited sample size we have now included this information in the paper.
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Minor REVISION comments	Line 62, Replace “aboriginals” with “natives” Line 79 Provide more detail on laptop data collection, what OS, what software, data package? Line 92, describe whether participants were given any feed-back on BP results, what to do? Line 98, replace “overweight” by “pre-obese”, overweight usually refers to ≥ 25 and includes the obese Line 100, replace “inquired” by “recorded” Line 110, please specify whether walking was coded as vigorous activity Line 127, justify why a threshold of 5 was chosen, give a reference Line 135, AIDS or AIDS/HIV? Table 1, provide median age rather than categories Indicate in results table 1 or main text, how many were participants were taking hypertensive medication; Line 164, how does the study population compare with the general population (age structure, literacy) Tables, give sample sizes in title Line 267, replace “transportation” by “personal transport”	Done The software used for data collection was William software version 1.5 of MultiSpectra. This is now included in the text. Any participant with newly screened hypertension was referred to a clinic for a confirmatory diagnosis and possible treatment. Done Done Brisk walking was considered as vigorous activity. Participant was considered as a probable psychiatric case when his total scores exceeded the threshold of four. The reference (Mashele, 2010) is now cited. It is AIDS/HIV. Median age is now shown in table 1. There were 25 people taking medication for hypertension. Our study population was comparable to the general population that is constituted by 51.7% of women, 57.0% of people under 20 years old and 70% of people without any instruction. Done Done
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<u>Optional/General</u> comments	100% participation rate suggests that study subjects were coerced into participation. What about ill or mentally ill subjects? How were participants chosen at the household, at random? Or simply persons that answered the door? How was informed consent administered? Were participants told they had the right to say no?	Response rates in Burkina Faso are very high. The population perceives no harm from the interviewers and they are willing to participate and get a medical check –up such as a blood pressure reading. In addition, they are prone to collaborate when approached with politeness and good explanations of what will be done and why. During data collection, informed consent form was given to the participant when he was literate or translated to the participant when he could not read. All participants were informed that participation was voluntary, and he/she was free to respond. No payment was given to the participant. Households were randomly selected from a list of households from Kaya surveillance system. Then, the participant was randomly drawn from the list of members of each household before going to the household. We spent 3 or 4 days in each village and carry out several visits if a participant was absent in the first time. Cases of patients were referred to a physician (from KaDeSS Team) when he did not already have a support. The consent form is sent to the editor.
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