PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Exploring barriers to living donor kidney transplant for African, Caribbean, and Black communities in the Greater Toronto Area, Ontario: a qualitative study protocol
AUTHORS	Edwards, Beth; Marshall, Lydia-Joi; Ahmadzadeh, Ghazaleh; Ahmed, Ranie; Angarso, Lydia; Balaji, Shilpa; Okoh, Princess; Rogers, Emma; Neves, Paula; Boakye, Priscilla; Gill, Jagbir; James, Carl Everton; Mucsi, Istvan

VERSION 1 – REVIEW

REVIEWER	Park, Meyeon University of California, San Francisco
REVIEW RETURNED	16-May-2023

GENERAL COMMENTS	This looks like an impressively comprehensive study and I wish the authors luck with the project.

REVIEWER	McElroy, Lisa M Duke University, Surgery
REVIEW RETURNED	23-May-2023

GENERAL COMMENTS	This is a thoroughly described study protocol targeting a longstanding problem of inequity in access to LDKT. The strengths and limitations are clearly identified and the theoretical framework is a particularly valuable contribution to the literature. I have a couple minor questions/suggestions. 1-barriers to care are multifaceted and multilevel. Although this is community based participatory research aimed at patient report, you will still likely identify system and center-based barriers. How will they be incorporated? (page 3 line 33) System center and provider driven barriers are nicely included in the theoretical framework but there is no mention in your analysis plan. 2-page 6 line 5: by "medical" do you mean from the perspective of the medical profession? 3-page 8 line 40: the 3 groups don't seem to be mutually exclusive. is the kidney failure group patients declining dialysis? or is the kidney replacement therapy group meant to only include recipients of kidney transplantation?

VERSION 1 – AUTHOR RESPONSE

Responses to comments by Reviewer 1

Comment 1: This looks like an impressively comprehensive study and I wish the authors luck with the project.

Response 1: Thank you very much for your kind comment and good wishes.

Responses to comments by Reviewer 2

Comment 1: 1-barriers to care are multifaceted and multilevel. Although this is community based participatory research aimed at patient report, you will still likely identify system and center-based barriers. How will they be incorporated? (page 3 line 33) System center and provider driven barriers are nicely included in the theoretical framework but there is no mention in your analysis plan.

Response 1: Thank you for this question. Yes, barriers to care are indeed multifaceted and multilevel. System and center-based barriers will likely arise during patient interviews and will be identified during the analytical process. We will use both inductive and deductive coding strategies, meaning that some of our codes will be pre-determined and others will be generated directly from the data. Since our analysis will be grounded by our theoretical framework, which incorporates broader, systemic barriers (as you have correctly identified) we will ensure that we include codes related to system and center-based barriers in our coding guide, which we will then apply to all of the data generated during interviews. This will ensure that we do not overlook the multifaceted nature of barriers to care. As indicated in the “Data Analysis” section of the manuscript, “Data analysis will begin in conjunction with data collection and will be informed by the tenets of CRT.” Please see the “Data Analysis” section on page 19 of the revised manuscript.

The process of RTA consists of six phases: (1) familiarization, (2) generation of initial *deductive and inductive* codes, (3) construction of themes, (4) review of potential themes, (5) naming and defining themes, and (6) production of the final report. *In order to identify patient and institutional level barriers, including the impact of various forms of racism on those considering kidney transplant and LDKT, we will generate a coding framework which will include both deductive and inductive codes, in that some of our codes will be pre-determined based on the literature and our theoretical framework, and others will be generated directly from the data. This coding framework will be revised as our analysis progresses and final codes will be applied to all of the data.*

Comment 2: page 6 line 5: by "medical" do you mean from the perspective of the medical profession?

Response 2: Thank you for this question. Yes, we have specifically written the sentence (“Living donor kidney transplant (LDKT) is considered the best treatment *from a medical perspective* for many patients with kidney failure who require kidney replacement therapies (dialysis or kidney transplant [KT]”) in this particular way upon the advice of our community engagement specialist who indicated that a statement like “LDKT is the best treatment” may include a bias of the medical profession that often goes unrecognized. Our colleague challenged this assumption and suggested that we should be open to the possibility that not everyone sees that living donor kidney transplant is necessarily the best treatment for kidney failure and that one of our objectives during data generation will be to understand the reasons for this. This thinking is also in line with one of the main tenets of Critical Race Theory outlined in the manuscript (please see the “Theoretical Framework” section on page 14) which posits that counternarratives should be counted as valid data. In our study, this means that “the research team will acknowledge, respect, and validate the experiences of ACB communities shared during interviews and focus groups as valid sources of data that serve to disrupt existing institutional perspectives,” such as LDKT being the best treatment for many patients with kidney failure. Based on our theoretical framework and discussion with our community engagement specialist, we felt it was important to acknowledge our potential biases and assumptions and challenge our “taken for granted” understandings as we approach our research. This is also further supported by Arriola et al, 2014, which we have now added as an additional reference in the “Introduction” section on page 5 of the revised manuscript.

From a medical perspective, living donor kidney transplant (LDKT) is considered the best treatment for many patients with kidney failure who require kidney replacement therapies (dialysis or kidney transplant [KT]). [1] LDKT is associated with better quality of life, graft survival, and life expectancy compared to dialysis [1-7]. LDKT is also associated with shorter wait times compared to deceased donor KT (DDKT). [1] *Importantly, along with medical considerations, major treatment decisions (such as LDKT) can also include financial, social, emotional, and cultural considerations.[8]*

VERSION 2 – REVIEW

REVIEWER	McElroy, Lisa M Duke University, Surgery
REVIEW RETURNED	16-Jul-2023

GENERAL COMMENTS	best of luck with the study.