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Title	Co-designing care improvements for women living with HIV: a patient-oriented deliberative dialogue workshop in Montréal, Québec
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Reviewer 1:	Ms. Pamela Jessen, British Columbia (patient reviewer)
Reviewer comments and author response	<p>What an important topic of discussion! I love how patients are shown to be just as crucial as providers and that their voices were allowed to be heard in this manner. Excellent analysis and recording of information in a clear and easy to read manner.</p> <p>RESPONSE: We thank the reviewer for their kind words and applaud CMAJ Open for their involvement of patient reviewers.</p>
Reviewer 2	Dr. Jennifer A. Boyko
Institution	McMaster University Hamilton, Ontario
Reviewer comments and author response	<p>This is an interesting paper with value to the developing methodology for deliberative dialogues, as well as co-design with patients/community. My feedback largely relates to including additional salient details that will strengthen the overall paper.</p> <p>RESPONSE: Thank you for your detailed review of our paper.</p> <p>Introduction:</p> <p>1. Clarify who the recommendations of the DD are for</p> <p>RESPONSE: The intended audience for our deliberation was quite broad, although primarily for those engaged in designing, implementing and/or evaluating quality improvements for this population, but includes policy-makers, AIDS Service Organization, or patients and providers themselves, depending on the recommendations put forth. In the methods section we also clarified that the intended audience of DD is often policy-makers.</p> <p>Revisions: Page 4-5</p> <p>Methods:</p> <p>2. Design:</p> <p>a. A challenge of writing up a paper using a methodology such as DD is providing sufficient context for the issue being addressed and rationale for use of the methodology. The reader would benefit from knowing more about the main study and why DD was chosen as the final phase. A description of DD is provided, but the reasons for choosing this approach are not clearly justified. For example, why was DD more appropriate than a focus group in this context?</p> <p>RESPONSE: Yes, we agree with the reviewer comments. We have now explicitly named why this approach was privileged as opposed to focus groups. In being mindful of the word limit, we have included the main study's website for further information.</p>

Revisions: Page 5

3. Recruitment:

a. Were "all participants" provided an honorarium or just patients?

RESPONSE: Yes, all participants (patients and providers) were offered an honorarium. As care providers (nurses, pharmacist) may have had to take time off work and/or cancel a clinic day. Of note, some clinicians preferred not to accept the honorarium, we then donated these honorariums to an organization dedicated to people living with HIV.

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b. What does "recruitment was facilitated by our existing CHIWOS" networks mean? Was a broad call out made or were specific people chosen based on those you knew?

RESPONSE: Care providers and patients who accepted our invitation were often people who had worked with the CHIWOS project in the past. We presume that this helped to motivate attendance for busy clinicians, and a sense of safety for women living with HIV. We have now noted in the methods that the patient recruitment was also facilitated by a list of CHIWOS participants who had indicated that they would be interested in participating in future research for women living with HIV. We acknowledge that our research is facilitated by our existing network as this is a feasibility consideration for others who may be interested in adopting a DD strategy.

Revisions: Page 6

4. Data Collection:

a. Clarify what evidence was provided to participants as pre-reading. Was this from the parent study? Why were the particular papers chosen? What other preparatory materials were provided?

RESPONSE: We suggest that the pre-reading pamphlet sent to participants be available to readers in a supplementary file. We also specified in the methods that the evidence presented was from the parent study and a systematic review, and we chose these 3 papers as they pertained to women's overall comprehensive care (vs. only violence or post-partum etc.). Table 1 also provides information about the evidence presented.

Revisions: Page 6

b. Were the small and large group discussions all recorded and transcribed?

RESPONSE: Yes, all small and large group discussions were recorded and transcribed. We have added this clarification in the methods.

Revisions: Page 7

c. The approach used led to a "vote" in order to generate recommendations. The value of DD is in the differences between participants that emerge. This seems to go against the definition of DD

provided.

RESPONSE: We have revised the methods section to clarify that the voting was a final 10 minutes of a 5-hour workshop. The focus of our DD was in co-designing care recommendations, so we were interested in both the distinct and overlapping recommendations amongst patients and providers, which are presented in Table 4. The voting on top 3 recommendations ranked the recommendations that emerged in the deliberation, without forcing any consensus, but helped to add clarity to the ideas that emerged during the day. Please also see our response to the editor in Method #1.

Revisions: Page 7

Results

5. Care priorities:

-a. How were these identified? Were these the result of the "post-its" that were used or the analysis of discussion? or both?

RESPONSE: We have revised the opening sentence to emphasized that care priorities were identified in the small and large group deliberation, previous to any ranking. This is also specified in the methods section under "data collection", and in Table 2.

Revisions: Page 6,8

6. Care improvements:

-a. Same as above - How were the four rapid care improvements identified?

RESPONSE: We have clarified this process, same as above.

Revisions: Page 6,8

b. What is the time frame around rapid vs. longer term?

RESPONSE: No set time frame was provided. The rational was to allow participants to name smaller solutions, as well as seemingly harder to accomplish strategies. This is indicated in Table 2 where the questions are described.

c. Similar to a previous comment, the idea of "ranking" seems to go against the positioning of DD at the start of the methods section.

RESPONSE: Please see our response to the editor in Method #1.

Revisions: Page 7

Interpretation

7. Is this section based on the researchers' perspective or is it grounded in the data collected from the DD? This reads more like a discussion section, yet new findings are introduced.

RESPONSE: Thank you, we have revised this interpretation section to ensure that no new findings are introduced. The lesson's learned are from the researchers' perspective and aim to elucidate key feasibility

considerations for others interesting in adopting a DD approach.
Revisions: Page 10

Limitations

8. The recommendations and priorities are also limited in that they do not reflect all stakeholder groups e.g., policymakers, administrators.

RESPONSE: Thank you, we agree and have added this limitation in this section of the manuscript.

Revisions: Page 10

Lessons Learned

9. A focus of the paper is co-design, therefore, this should be incorporated in the lesson learned more explicitly.

RESPONSE: We agree and have made revisions to clarify the key elements required for "co-design" to occur.

Revisions: Page 10-11

10. Based on the results provided, it is not clear how "mutual understanding" was achieved. One could argue that "mutual agreement" was achieved instead.

RESPONSE: We agree with the reviewer and have changed the text to read "mutual agreement"

Revisions: Page 11

Conclusion

11. The idea of "validating research findings" should be introduced at outset of the paper as an objective. Given the focus of the paper, the conclusion should synthesize the paper in relation to codesign and DD within the context of the current study (i.e., care improvement for women living with HIV).

RESPONSE: Thank you, we have revised the conclusion to be consistent with our paper's specific objectives.

Revisions: Page 11

General

12. The paper would also benefit from a thorough review for grammar and use of punctuation. There are several sentences that could be reworded or shortened.

RESPONSE: We have revised the paper for grammar and punctuation errors.

13. There are instances throughout the paper that use the term "current" or "recent". My preference is to avoid these terms as they can be subjective (i.e., what is recent).

	RESPONSE: Thank you, we have deleted terms such as current or recent.
Reviewer 3	Dr. Hazar Haidar
Institution	McGill University and Université de Montréal, Institute for Health and Social Policy and Centre de recherche en éthique
Reviewer comments and author response	<p>This is an interesting paper addressing a gap in the literature relatively to the care provided to women living with HIV through a patient-oriented deliberative dialogue. I've provided some comments and suggestions to improve the overall clarity and content.</p> <p>1. My only major comment is related to the interpretation section (p.10) where there is a total lack of an interpretation of data findings. When one reads it, it looks like a brief summary of the findings rather than an explanation of these findings.</p> <p>RESPONSE: In the interpretation section we have linked the findings more closely to external literature and relevant interventions to provide additional context and comparison for the deliberative findings presented in the results section. Revisions: Page 9-10</p> <p>a. For instance, how these results might be of benefit and for whom? Some practical considerations of these findings would enrich this section by making it clear and explicit.</p> <p>RESPONSE: Thank you for this suggestion, we have made links to our intended audience to strengthen the interpretation section.</p> <p>b. Also, maybe provide one or two examples of the way that the implementation of a specific care improvement (whether on a short or long term) might have a positive impact on women living with HIV and providers' way of care as well.</p> <p>RESPONSE: The short 2500-word count does not allow for further delving into the mechanisms and impact of the stakeholder recommendations beyond the rich explanations provided by patient and provider in the quotes of Table 3 and 4.</p> <p>Minor comments: 2. p.6 lines 12-13: the author mentions that the deliberative dialogue workshop was the final phase of a mixed methods study. It would be interesting to mention that the results for the mixed methods study were published.</p> <p>RESPONSE: We have specified in the text that readers can refer to Table 1 for the mixed methods study results. The references to the published articles are in the works cited list.</p> <p>3. p.8 (results) line 34: It's interesting to see that the number of African-Caribbean-Black and white women participants were equal (n=4). Was it a random selection?</p>

Or a purposeful one? And if so, why? Please clarify.

RESPONSE: Thank you for this question. The recruitment was purposeful. The HIV epidemic disproportionately affects women who are marginalized, for instance African-Caribbean-Black women in Ontario and Quebec, and Indigenous women in BC and prairie provinces.

Revisions: Page 6

4. Also in this section (or in another place the author might find is a good fit), it is crucial to

mention that because your participants were French speaking, you had to resort to translation. More specifically, did you translate all the deliberation workshop discussion? Or only the quotes for the sake of manuscript writing and preparation? Which author(s) did validate the translation? Please specify.

RESPONSE: We have specified in the methods section that we transcribed and translated the entirety of the deliberation, including the small and large group discussions in order to render our work accessible to an English audience. Author's initials are provided as requested in the methods section.

5. p.8 lines 48-49: the author keeps mentioning throughout the paper that "based on evidence

presented" without any further discussion of the type of this evidence.

Providing some examples

about the type and nature of the evidence discussed would be helpful to the reader by offering a context of the deliberation.

RESPONSE: We agree with the reviewer that the evidence from the pamphlet and the presentation is important information to the reader. This information is referred to in Table 1. Table 1, provides information regarding the research design (cohort, focus groups, systematic review), the participants, and the main results, as well as the references to the three manuscripts so authors may consult the original evidence to which we refer. We also suggest that the pamphlet be included online in a supplementary file.

6. p.11 limitations: it would be interesting to report on limitations found, if any, during the

workshop. For instance, did you notice or track if there was any changes in participants' views

throughout the deliberative discussion?

RESPONSE: We have added a sentence in our limitation section regarding the lack of decision-makers and policy representatives in our deliberation, as well as the need for future research focused on the process itself of patient engagement initiatives.

7. Was there any inter-group differences? For instance, ethnicity is still a source of bias in

receiving treatment and care in medicine. Did African-Caribbean-Black women bring up for instance more lack of care than white women during the discussion? etc.

RESPONSE: Given this small group (8 participants and 8 providers), and our study aim to co-design recommendation with patients and providers we did not analyze inter-group differences between women of different ethnicities, age, or years living with HIV, or between providers (e.g. nurses vs. doctors or male vs female). We agree that this type of analysis would be very interesting to conduct and suggest doing so with a larger group of participants.