NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

*The corresponding author has opted to make this information publicly available.

Personal or nonessential information may be redacted at the editor’s discretion.

Questions about these materials may be directed to the Obstetrics & Gynecology editorial office: obgyn@greenjournal.org.
RE: Manuscript Number ONG-23-284

"It’s about time!": Exploring Patient, Community Provider, and Health System Perspectives on Implementing Interventions for Optimizing Black Maternal Heart Health

Dear Dr. Wycoff:

Thank you for sending us your work for consideration for publication in Obstetrics & Gynecology. Your manuscript has been reviewed by the Editorial Board and by special expert referees. The Editors would like to invite you to submit a revised version for further consideration.

If you wish to revise your manuscript, please read the following comments submitted by the reviewers and Editors. Each point raised requires a response, by either revising your manuscript or making a clear argument as to why no revision is needed in the cover letter.

To facilitate our review, we prefer that the cover letter you submit with your revised manuscript include each reviewer and Editor comment below, followed by your response. That is, a point-by-point response is required to each of the EDITOR COMMENTS (if applicable), REVIEWER COMMENTS, and STATISTICAL EDITOR COMMENTS (if applicable) below. The revised manuscript should indicate the position of all changes made. Please use the "track changes" feature in your document (do not use strikethrough or underline formatting). Upload the tracked-changes version when you submit your revised manuscript.

Your submission will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by 04/24/2023, we will assume you wish to withdraw the manuscript from further consideration.

EDITOR COMMENTS:

Please note the following:

* Please edit the title to easily reflect that the paper's focus is "community engagement."

* Help us reduce the number of queries we add to your manuscript after it is revised by reading the Revision Checklist at https://journals.lww.com/greenjournal/Documents/RevisionChecklist_Authors.pdf and making the applicable edits to your manuscript.

* Figure 1: Is this figure original to the manuscript? If this has been previously published in another source, you will need to obtain written permission from the copyright holder for print and electronic use. Alternatively, you could link to the figure if it is available online.

REVIEWER COMMENTS:

Reviewer #1: The authors’ objective was to explore how patients, community providers, and health system clinicians and staff perceived facilitators and barriers to implementation of Change of HEART (Here for Equity, Advocacy, Reflection and Transformation), a randomized clinical trial designed to optimize Black maternal heart health. Phase 1 of Change of HEART was a qualitative, descriptive study. The authors utilized a community-based, participatory approach, which allowed their team to intentionally focus on avoiding harm and equalizing power dynamics throughout the research process. They found that participants articulated a number of key sentiments regarding facilitators and barriers to implementing Change of HEART.

The following are my questions and comments:
1. It may be helpful for the reader to provide a brief summary of the randomized trial in the introduction.
2. Is this study specific to obstetrics or does it involve medical care more broadly outside of pregnancy?

3. Can the authors elaborate on how participants were selected?

4. Can the authors provide the reader with data regarding the total number of attendings, OB nurses and midwives in the health system?

5. Do the participants in this phase 1 study reflect the overall population?

6. How did the authors decide on the number of participants?

7. Can the authors elaborate on how the key sentiments were identified and articulated by the participants?

8. What do the authors believe to be the most informative and impactful regarding these phase 1 results as it relates to the objectives and methodology of the planned randomized trial.

Reviewer #2:

Introduction

Lines 38 to 39 explain the well documented maternal mortality of 1 to 3 for white versus black women. I think it's important that this statistic is reported as white versus black women so that the mortality of black woman is not erased or rendered invisible to uplift gender diversity. I understand, value, and appreciate the interest of being more gender neutral and acknowledging gender identities- specially, because I myself consider myself "queer" experiences- - -but uplifting voices should not come at the cost of erasing others, but specially the experienced by black women.

Lines 48 and 49 note the interest to investigate individual and interpersonal factors it may be important to make the distinction of what is an individual factor versus an interpersonal factor- how do the author’s see these as distinct. Similarly, it may be relevant to explain what an institutional level factor is.

On a related note, I do not think these distinctions are clear in the results or discussion of the paper either. That is, I do not think the authors talked about the differences or the different individual and institutional factors.

In line 52 the authors state "different perspectives" - - -is this because the authors had evidence to suggest that the different groups in the study would have different perspectives? OR because this is what they think will occur. If the later, than perhaps it would just be important to delete the word different and save this type of interpretation of results for the discussion. Moreover, avoiding a hypothesis or claim of a direction of results in qualitative work may be more appropriate specially one that admittedly is "exploratory."

In lines 54 and 55 the authors mention positionality and power. However, these two words are not defined in context of the research or more broadly in context of the literature in which these concepts/terms are relevant. Definitions may be needed for the readership and are important to adopt a common ground and a common language.

In lines 61 through 63 the authors mentioned the objective of the research and although I get the idea of the objective- - -I do not think the objective is completely clear as written. Moreover the objective appears elsewhere and is not conveying the same objective.

Methods

The authors stated that CBPR is useful in exploring "complex health and social issues that have racial and power dynamics involved" - however, they have not made a case for the complexity of cardiovascular health or explained the racial and power dynamic that surround cardiovascular health in the introduction. That is, the introduction could be centered on these two topics that call for the use of CBPR. In the results the authors may consider a deeper discussion of race, racial consciousness, power, privilege that only peripherally creep up in some of the writing.

Among all the qualitative interview approaches- why use a focus groups?

In the setting section of the manuscript, the authors note that "Like other similar hospitals, XXXX needs scalable programs to decrease rates of maternal morbidity and mortality"- I think this is an opportunity to acknowledge that structural racisms create "ethnic ghettos" with under resourced hospitals that directly impact patient outcomes. The goal of health equity and justice is not to develop "scalable programs" within an existing structure and healthcare system, but to disrupt and dismantle the status quo and address the core issue- - -racism. Although maybe I am wrong and "scalable programs" means something else to the authors.

How did participants consent to participate?

Data saturation was reached during data collection? Saturation, to my knowledge is something that is assessed during analyses and not data collection.
Line 130- authors used "phenomena of interest" - it may be more appropriate at this stage of the study to just say what the phenomena is.

Results
I do not think the objectives of the study are addressed or discussed here in relation to the results being presented (see my feedback on the introduction) are not clear in the results or discussion.

Lines 150 - 176 Is the trauma in the community caused by the healthcare system? It is unclear if these traumas are related and if there is a sense from the participants of who is responsible for the trauma felt in the community.

Lines 179- 198 These lines were difficult for me to read. I think the authors oscillate from victim blaming to institutional blaming, but never really take a stand on racism as the cause of mistrust. I think this is a missed opportunity to highlight the damage of structural racism to communities and the healthcare system. But most importantly, Black people.

Line 230- probably better to name the themes instead of providing numbers.

Line 236 "attendings" is this in reference to the Physicians? Also, should there be an apostrophe?

Lines 254- 255, the authors are suggesting that both the patient and system are traumatized. Who is then responsible for the trauma? Later in lines 277- 283, the authors clarify that these traumas co-exist, but there are no solutions presented to the problem(s). I wonder if they can "unpack" the "delicate and nuanced balance" in details. We know what the problem is- but what are the solutions? What and how does one mitigate trauma and racism.

Lines 296 to 299, It seems like the authors are trying to say that they moved fast on this aspect of the project because the "overarching" project was the priority. I challenge the authors to take responsibility for participating in the reproduction of knowledge that is well intended and may harm communities, when the time spent in one aspect of the project is seen/treated as "less than" other aspects of the project. It does not have to be this way, funding agencies should also be held accountable for their participation in the reproduction of these institutionalized practices that contribute to health inequities and sustain a hegemonic, capitalist and racism society and science.

Reviewer #3: This is a very well written and well-designed qualitative research project with the goal of identifying barriers and facilitators around instituting a randomized control trial focused on optimizing Black maternal heart health. I have the following comments:

Introduction
1. The reader is left wondering about the specific interventions intended by the Change of HEART RCT, perhaps explain why those details are not relevant or share that level of detail.

2. Consider shortening the title

Methods
1. While the research team is described as diverse, there is no gender diversity within the research team, an explanation regarding that decision would be helpful.

2. Including the positionality statements is commendable.

3. Describing how positionality statements can help to avoid bias, might help the reader less familiar with qualitative research techniques understand the rationale behind including them.

4. The participants self-report as all female, since purposive sampling was used to recruit participants, it would be helpful to describe the rationale behind the decision to recruit all women.

5. As many readers of this journal are clinicians and may be less familiar with qualitative research techniques, it might be helpful to be more explicit regarding the validity of the methodology.

Results
1. The results are clearly described and well organized, the Tables are informative.

2. This qualitative study helps to raise the level of evidence regarding, trauma, issues of trust, and needing to be heard by the community studied, supporting that the stories individual women share are representing a more generalized experience.

Conclusions
1. Line 246, is "diverse" the correct term to describe the group of researchers?

2. Would consider expanding on how the results obtained lead to actionable interventions that could be developed, instituted and assessed.

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Sincerely,
Ebony B. Carter, MD, MPH
Associate Editor, Equity

The Editors of Obstetrics & Gynecology

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/ong/login.asp?a=r). Please contact the publication office if you have any questions.
Kirby L. Wycoff, Psy.D., Ed.M, MPH  
Department of Counseling and Behavioral Health  
College of Health Professions  
Thomas Jefferson University, Philadelphia, PA, USA  

May 1, 2023

Manuscript ID: ONG-23-284

Dear Drs. Ebony B. Carter and Jason Wright,

Thank you for giving us the opportunity to submit a revised draft of our manuscript titled “It’s about time!”: Engaging with Patient, Community Provider, and Health System Collaborators to Inform Implementation of Interventions for Optimizing Black Maternal Heart Health.

We appreciate the time and effort that the review team dedicated to providing valuable feedback on our manuscript. We believe it is a stronger piece as a result of the thoughtful peer review process.

Per the Revision Checklist for the revised manuscript, we have taken the following steps:

- The cover letter we are submitting with our revised manuscript includes each reviewer and Editor comment, followed by your response. That is, a point-by-point response is required to each of the editor and reviewer comments. Please see the chart below the signature line, which maps out our point by point response to every comment, followed by corresponding line numbers in the manuscript, where changes were made.
- We have used the “track changes” feature in our revised manuscript. We have uploaded the tracked-changes version when we submitted our revised manuscript. Due to the significant use of track changes, we have also uploaded a clean version for ease of reading. The line numbers in the clean version can be referenced in the point by point responses.
- We have added in all relevant funding information on the title page and at the end of the abstract.
- We have added the clinical trial registration number at the end of the abstract.
- We have named the IRB institution in the Methods section.
- We have added all information relevant to the specific location of the study throughout the manuscript.
- We have contacted one additional person who contributed to the work reported in the manuscript, but not sufficiently to be an author. We would like to acknowledge them in the piece and are awaiting their permission to do so.

Please note that we have diligently edited the manuscript to address the reviewers’ many excellent questions and insights and believe it is now a much stronger paper as a result. The nature of the qualitative work often necessitates expanded explanations and discussions. The original word count was very difficult to adhere to and is comparatively quite short for a qualitative piece when compared to other peer reviewed journals that more regularly publish
qualitative work. The reviewers comments and questions did in fact reveal, that we did not have enough room to fully explain the context or the findings of the study. In light of this being a qualitative piece, in which we received excellent and insightful feedback from the peer review process, we respectfully request that the editorial team consider a waiver of the original word count requirements.

Please note that while responding to this feedback, we revisited our original data from each of the participant groups. In doing so, we recognized that we incorrectly reported on the number of participants in both the nurses group (formerly we reported 8, but correct number is 6) and residents (formerly reported 7, but correct number is 4). The average number of participants per group was 6, which is consistent with the methodological literature and best practices for focus groups, suggesting a range of 2 to 21 participants per group. As a result, we have adjusted our approach to reporting on demographic data in the manuscript, to ensure we protect the anonymity of the participants. We removed the two tables on demographic characteristics of each group, and instead we report more broadly in narrative form on the demographic characteristics across all 38 participants at the beginning of the results section.

As we noted earlier, we believe that our research offers data that will inspire a rich interdisciplinary discussion as it has implications for obstetrics and gynecology clinicians, as well as others involved in the health system that are interested in structural racism, trauma and healthcare. We believe this work is critically important to your readership and offers meaningful contributions to the scientific literature. We welcome any additional feedback or dialogue related to the piece.

We confirm that this work is original and has not been published elsewhere nor is it currently under consideration for publication elsewhere. All authors have reviewed these comments and changes. Please address all correspondence concerning this manuscript to myself at kirby.wycoff@jefferson.edu. Thank you in advance for your consideration.

Sincerely,

Kirby L. Wycoff, Psy.D., Ed.M, MPH (Corresponding Author)
Jabina G. Coleman, MSW, IBCLC
Christine M. Santoro, MA, CPM
Leah L. Zullig, PhD, MPH
Niesha Darden, CRC, Postpartum Doula
Porsche M. Holland, MS
Jane F. Cruice, RN, MA
Shukriyyah Mitchell, BSN, RN
Michelle Smith, MAHS
Saleemah J. McNeil, CLC, MS, MFT
Sharon J. Herring, MD, MPH
<table>
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<tr>
<th>Comment #</th>
<th>Reviewer’s comment</th>
<th>Authors Response to Reviewers Comment</th>
<th>Corresponding Line Number</th>
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<tr>
<td><strong>EDITOR (E)</strong></td>
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<tr>
<td>#1-E</td>
<td>Please edit the title to easily reflect that the paper's focus is &quot;community engagement.&quot;</td>
<td>Thank you for this feedback. We have adjusted our title to more easily reflect community engagement, “It’s about time!”: Engaging with Patient, Community Provider, and Health System Collaborators to Inform Implementation of Interventions for Optimizing Black Maternal Heart Health.</td>
<td>Title Page</td>
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<tr>
<td>#2-E</td>
<td>Help us reduce the number of queries we add to your manuscript after it is revised by reading the Revision Checklist and making the applicable edits to your manuscript.</td>
<td>We followed the revision checklist during the editing process.</td>
<td>n/a</td>
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<td>#3-E</td>
<td>Figure 1: Is this figure original to the manuscript? If this has been previously published in another source, you will need to obtain written permission from the copyright holder for print and electronic use. Alternatively, you could link to the figure if it is available online.</td>
<td>Figure 1 is original to this manuscript and was developed by our research team.</td>
<td>n/a</td>
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<td><strong>Review #1 (A)</strong></td>
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<td>#4-A</td>
<td>It may be helpful for the reader to provide a brief summary of the randomized trial in the introduction</td>
<td>Thank you for this feedback. We have re-written the introduction section to more clearly describe the overarching randomized clinical trial, in which this smaller study is situated.</td>
<td>Lines 51-72</td>
</tr>
<tr>
<td>#5-A</td>
<td>Is this study specific to obstetrics or does it involve medical care more broadly outside of pregnancy?</td>
<td>We have provided additional language in the “Participants” section to make the study population clearer. For example, we now state, “Health system participants included clinicians and support staff who care for and/or interact with birthing people from pregnancy through the first year postpartum (e.g., obstetricians, family practice physicians and nurses, intensive care</td>
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<td>Lines 208 - 212</td>
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<td>#6-A</td>
<td>Can the authors elaborate on how participants were selected?</td>
<td>We appreciate this feedback. We have re-written the “Participants” section and provided more clarity and information related to how participants were selected. For example, we now state, “We recruited participants using purposive sampling, through the medical school and hospital, along with referrals from community partner organizations. Potential participants were identified during collaborative meetings between study investigative team members and faculty/nursing staff from Temple University’s School of Medicine, inpatient departments, outpatient clinics, and private physician practices. Potential participants were also drawn from community partner organizations who had previously worked with patients and had indicated interest in being contacted for studies.”</td>
<td>Lines 184 - 189</td>
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<tr>
<td>#7-A</td>
<td>Can the authors provide the reader with data regarding the total number of attendings, OB nurses and midwives in the health system? Do the participants in this phase 1 study reflect the overall population?</td>
<td>We have provided more information about the participants and our sampling procedures in the newly updated “Participants” section. For example, we now state, “Health system participants included clinicians and support staff who care for and/or interact with birthing people from pregnancy through the first year postpartum (e.g., obstetricians, family practice physicians and nurses, intensive care nursery staff) in order to fully represent the wide breadth of providers/staff that impact the experiences of birthing families. To the extent possible, we sought to have a balanced sample within each group. For example, inpatient and outpatient nurses, first through fourth year residents, attending physicians from Obstetrics, Internal Medicine and Family and Community Medicine, mix of community doulas, lactation...”</td>
<td>Lines 212 - 219, New Table 1</td>
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specialists and therapists, etc. For the nursing collaborator group, we intentionally avoided inclusion of nurse managers to minimize power dynamics among participants and to avoid direct supervisors being in the same group with their reporting employees.”

<p>| #8-A | How did the authors decide on the number of participants? | We put additional information in the data collection section to further clarify the number of participants per group (see 7A). In responding to this feedback, we revisited our original data from each of the participant groups. In doing so, we recognized that we incorrectly reported on the number of participants in both the nurses group (formerly we reported 8, but correct number is 6) and residents (formerly reported 7, but correct number is 4). The average number of participants per group was 6, which is consistent with the methodological literature and best practices for focus groups, suggesting a range of 2 to 21 participants per group. | Lines 226-228 |
| #9-A | Can the authors elaborate on how the key sentiments were identified and articulated by the participants? | We added information in the data analysis section to more fully explain how we identified key sentiments in the process. This was mapped out in the appendix in the original submission, but we have pulled some key information into the actual body of the manuscript in this revision, to make it more readily accessible to readers. We apologize for making this information difficult to find in the initial submission. We now state, “We used a five step analytic process to identify the key sentiments that were articulated by participants. The first step of our process involved convening our entire research team (all authors) to collaboratively design a data collection and analysis approach that captured and honored the knowledge of all team members. The second step involved the use of a templated summary table, where key observations and reflections were recorded and analyzed. The third step | Lines 247-256 |</p>
<table>
<thead>
<tr>
<th>#10-A</th>
<th>What do the authors believe to be the most informative and impactful regarding these phase 1 results as it relates to the objectives and methodology of the planned randomized trial.</th>
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<td>Thank you for this question. We believe that the single most informative and impactful finding from this study is related to Theme 1 - the pervasive trauma in the health care system and community. We have more clearly connected these results/conclusions to adaptations to the interventions in the updated discussion section.</td>
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**Reviewer #2 (B)**

<table>
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<tr>
<th>#11-B</th>
<th>Lines 38 to 39 explain the well documented maternal mortality of 1 to 3 for white versus black women. I think it’s important that this statistic is reported as white versus black women so that the mortality of black women is not erased or rendered invisible to uplift gender diversity. I understand, value, and appreciate the interest of being more gender neutral and acknowledging gender identities- specially, because I myself consider myself &quot;queer&quot; experiences- -but uplifting voices should not come at the cost of erasing others, but specially the experienced by black women.</th>
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<td>We very much appreciate this feedback and understand this is a delicate balance that requires much thought and consideration. We have added the following language as a footnote on page 1, “This research team recognizes that not all people who have the capacity for pregnancy identify as women. In this manuscript, we will use gender-inclusive language when possible (i.e. birthing people). If terms like women or mother are used, it is either in reference to research that was particularly focused on those who identify as women, or in a context where the intersectional and cultural identity of Black women warrants its use.”</td>
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<th>#12-B</th>
<th>Lines 48 and 49 note the interest to investigate individual and interpersonal factors it may be</th>
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<td>We apologize this was not clear. We have made modifications in the introduction that we believe address</td>
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</table>

**Lines 387-403** **Bottom of page 4**
important to make the distinction of what is an individual factor versus an interpersonal factor- how do the author's see these as distinct. Similarly, it may be relevant to explain what an institutional level factor is. This feedback. Specifically, we more clearly define individual, interpersonal and institutional levels of the interventions. For example, we now state, "For this RCT, utilizing a community-driven social ecological framework, we proposed to compare Change of HEART (COH), which incorporates two, evidence-based individual-level interventions (home blood pressure telemonitoring and nutrition/physical activity text messages with resources and tailored feedback) and an institutional-level intervention (anti-racism training of providers and staff and patient feedback to inform respectful care), with COH+, which includes COH plus interpersonal support for Black women by Black women (community doula care, mental health services, and lactation support)."

| #13-B | On a related note, I do not think these distinctions are clear in the results or discussion of the paper either. That is, I do not think the authors talked about the differences or the different individual and institutional factors. We believe that in addition to our response for the comment above, we have also more clearly tied this in in the discussion and results as well. | Lines 494 - 499 |
| #14-B | In line 52 the authors state "different perspectives" - - -is this because the authors had evidence to suggest that the different groups in the study would have different perspectives? OR because this is what they think will occur. If the later, than perhaps it would just be important to delete the word different and save this type of interpretation of results for the discussion. Moreover, avoiding a hypothesis or claim of a direction of results in qualitative work may be more appropriate specially one that admittedly is "exploratory." In lines 54 and 55 the authors mention positionality and power. However, these two words are not referred to in the results. We appreciate this feedback. The language “different perspectives” was intentionally used as we are operating from a fundamental position that all different people have different lived experiences and thus different perspectives. We have changed the word “different” to “various” to make this clearer. This is not an interpretation of data, rather a fundamental assumption. Relative to the comment in lines 54 and 55, in the re-written version, we better describe power and use the word positionality later in the manuscript, where it can be more fully described. | Line 79 | Lines 81-83 |
defined in context of the research or more broadly in context of the literature in which these concepts/terms are relevant. Definitions may be needed for the readership and are important to adopt a common ground and a common language.

#15-B
In lines 61 through 63 the authors mentioned the objective of the research and although I get the idea of the objective- - -I do not think the objective is completely clear as written. Moreover the objective appears elsewhere and is not conveying the same objective.

We have re-written the introduction to more clearly explain the objectives of the overarching RCT and the smaller, formative qualitative study, that is the focus of this manuscript. For example, we now state, “However, before moving forward with the RCT, we recognized the need to elicit and incorporate input from diverse patient, community, clinical and health system collaborators prior to implementation. This was prioritized to ensure our interventions were conducive to normal clinician workflows and satisfactory to Black birthing people, community providers and health system clinicians/staff. The current paper describes the formative work that we believed needed to occur before the commencement of the RCT.”

Lines 60 - 72
Lines 89-91

#16-B
The authors stated that CBPR is useful in exploring "complex health and social issues that have racial and power dynamics involved" - however, they have not made a case for the complexity of cardiovascular health or explained the racial and power dynamic that surround cardiovascular health in the introduction.

That is, the introduction could be centered on these two topics that call for the use of CBPR. In the results the authors may consider a deeper discussion of race, racial consciousness, power, privilege that only peripherally creep up in some of the writing. Among all the qualitative interview approaches-why use a focus groups?

Thank you for this feedback and we have now more clearly explained the complexity of CVD and the ways in which race and CVD intersect, in the re-written introduction section. We also believe we have also more clearly tied this to the rationale behind why CBPR was necessary and appropriate for this study.

Finally, we added additional writing in the methods section, to address why we specifically chose focus groups. We now state, “We specifically chose to conduct focus groups, rather than individual interviews, as these allowed us to better access group insights and the formation of perceptions related to the group identity within the system that would not be so readily accessible using individual interviews.”

Lines 43-50
Lines 106-117
intentionally organized the focus groups so that each group would be conducted with individuals identified as holding similar titles, roles or positions. For example, all patients were in a focus group with other patients and all residents were in a focus group with other residents. Our goal was to minimize power imbalances and capture a realistic understanding of participants' perceptions. We did this largely to address inherent power dynamics in various collaborator groups and ensure that all participants felt safe enough to authentically engage in the discussion.”

#17-B | In the setting section of the manuscript, the authors note that "Like other similar hospitals, XXXX needs scalable programs to decrease rates of maternal morbidity and mortality" - I think this is an opportunity to acknowledge that structural racisms create "ethnic ghettos" with under resourced hospitals that directly impact patient outcomes. The goal of health equity and justice is not to develop "scalable programs" within an existing structure and healthcare system, but to disrupt and dismantle the status quo and address the core issue- - racism. Although maybe I am wrong and "scalable programs" means something else to the authors.

We agree and have included additional information in the setting section that more clearly describes the location of the study and provides more contextual / background information to understand how this study is situated. This, in turn, provides a clearer backdrop for the discussions of structural racisms elsewhere (results and discussion). Relative to the comments regarding "scalable" programs - we firmly agree! Disruption and dismantling is absolutely the overarching goal. We have removed the word scalable programs and instead focused our language on more clearly mapping out the role of contemporary and historical racism.

Lines 172 - 180

#18-B | How did participants consent to participate?

We include additional details regarding the consenting process. We now state, “Temple University’s IRB waived the requirement to consent in writing. If the potential participant was interested, they were sent an IRB-approved informed consent and given the opportunity to read, review and have their questions answered before consenting or declining to participate. Additionally, at the

Lines 191-197
| #19-B | Data saturation was reached during data collection? Saturation, to my knowledge is something that is assessed during analyses and not data collection. | Member checking was intended to go into the data collection paragraph, as this was done in-vivo, during the groups. We have now adjusted our data collection paragraph to include this language. Saturation was assessed during analyses. This has now been addressed in the manuscript. Please note, we have included an additional section titled “Qualitative Rigor and Validity” to help address this question, as well as others related to qualitative work. | Lines 121 - 136  
Lines 232-235 |
| #20-B | Line 130- authors used "phenomena of interest" - it may be more appropriate at this stage of the study to just say what the phenomena is. | Thank you for this feedback. We have modified this language in two places to ensure more alignment and clarity throughout the piece. | Line 95  
Line 241 |
| #21-B | I do not think the objectives of the study are addressed or discussed here in relation to the results being presented (see my feedback on the introduction) are not clear in the results or discussion. | We apologize for a lack of clarity in the way the objectives were presented. We have re-written the introduction to address this point and earlier comments, and pulled this through to the discussion as well. | Lines 432 - 451 |
| #22-B | Lines 150 - 176 Is the trauma in the community caused by the healthcare system? It is unclear if these traumas are related and if there is a sense from the participants of who is responsible for the trauma felt in the community. | Yes, the trauma in the community is, in part, caused by the healthcare system. But not the health system alone. The traumas are absolutely related, but it is both complex and multifaceted. This fact has been expanded on in this revision to make the point clearer to readers. The trauma element was pervasive. | Lines 321-324  
Lines 397- 403  
Lines 494 - 499 |
| #23-B | Lines 179- 198 These lines were difficult for me to read. I think the authors oscillate from victim blaming to institutional blaming, but never really take a stand on racism as the cause of mistrust. I think this is a missed opportunity to highlight the damage of structural racism to communities and the healthcare system. But most importantly, Black people. | We really appreciate this feedback, and it has given us much to reflect on and consider. We have re-written various elements of the results and discussion sections to more clearly (and unapologetically) name the impact of racism. | Lines 311-317  
Lines 321-324  
Lines 460-464 |
<p>| #24-B | Line 230- probably better to name the themes instead of providing numbers. | We have made this revision. | Lines 363-364 |
| #25-B | Line 236 &quot;attendings&quot; is this in reference to the Physicians? Also, should there be an apostrophe? | The attendings’ group includes attending physicians and midwives. We have made this language more consistent throughout the manuscript. Regarding the apostrophe, our understanding is that if it is one attending it would be attending’s and if its multiple attendings, it would be attendings’. We have adjusted this throughout. | Lines 371-373 |
| #26-B | Lines 254- 255, the authors are suggesting that both the patient and system are traumatized. Who is then responsible for the trauma? Later in lines 277- 283, the authors clarify that these traumas co-exist, but there are no solutions presented to the problem(s). I wonder if they can &quot;unpack&quot; the &quot;delicate and nuanced balance&quot; in details. We know what the problem is- but what are the solutions? What and how does one mitigate trauma and racism. | We very much appreciate this question about the trauma and who is responsible for it. We have re-written various elements of the results and discussion to describe the root cause of the trauma more clearly (and unapologetically) and further unpack the delicate and nuanced balance. While broadly addressing solutions is beyond the scope of this manuscript, we have added some additional content addressing potential solutions. This work is ongoing and we expect future manuscripts to be able to address this more fully. | Lines 397-403 Lines 423-431 Lines 432 - 451 |
| #27-B | Lines 296 to 299, It seems like the authors are trying to say that they moved fast on this aspect of the project because the &quot;overarching&quot; project was the priority. I challenge the authors to take responsibility for participating in the reproduction of knowledge that is well intended and may harm communities, when the time spent in one aspect of the project is seen/treated as &quot;less than&quot; other aspects of the project. It does not have to be this way, funding agencies should also be held accountable for their participation in the reproduction of these institutionalized practices that | Thank you for this feedback and we agree that funding agencies must be held accountable. We continue to use our own position and power to advocate within the available funding systems and mechanisms. We have added additional information that we think further clarifies this for the reader in the discussion section. We added much more contextual information about the larger RCT in the introduction section, which more clearly situates this qualitative portion of the study. We also specifically added information to the methods section, that highlights why we chose this specific methodology and approach, which does employ a rapid | Lines 102-104 Lines 474-481 |</p>
<table>
<thead>
<tr>
<th>Reviewer #3 (C)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>#28-C</td>
<td>The reader is left wondering about the specific interventions intended by the Change of HEART RCT, perhaps explain why those details are not relevant or share that level of detail.</td>
</tr>
<tr>
<td>#29-C</td>
<td>Consider shortening the title</td>
</tr>
<tr>
<td>#30-C</td>
<td>While the research team is described as diverse, there is no gender diversity within the research team, an explanation regarding that decision would be helpful.</td>
</tr>
<tr>
<td></td>
<td>Thank you for this feedback and observation. We are aware that our research team lacks gender diversity (although we are very diverse in many other ways). Appendix C highlights our own self-authored positionality statements. The lack of gender diversity was not intentional but was coincidental and happened by chance. We will continue to seek ways that we can expand on the diversity in our research team.</td>
</tr>
<tr>
<td></td>
<td>Including the positionality statements is commendable.</td>
</tr>
<tr>
<td></td>
<td>Per a later comment below, we have included some additional content to the positionality statement section to better explain to readers why we included it and why it is important in research.</td>
</tr>
<tr>
<td>#31-C</td>
<td>Describing how positionality statements can help to avoid bias, might help the reader less familiar with qualitative research techniques understand the rationale behind including them.</td>
</tr>
<tr>
<td>#32-C</td>
<td>The participants self-report as all female, since purposive sampling was used to recruit participants, it would be helpful to describe the rationale behind the decision to recruit all women.</td>
</tr>
<tr>
<td></td>
<td>Per the inclusion criteria, we did not specify that participants had to be all women. This is, however, representative of the larger population of participants.</td>
</tr>
<tr>
<td>#33-C</td>
<td>As many readers of this journal are clinicians and may be less familiar with qualitative research techniques, it might be helpful to be more explicit regarding the validity of the methodology.</td>
</tr>
<tr>
<td>#34-C</td>
<td>The results are clearly described and well organized, the Tables are informative.</td>
</tr>
<tr>
<td>#35-C</td>
<td>This qualitative study helps to raise the level of evidence regarding, trauma, issues of trust, and needing to be heard by the community studied, supporting that the stories individual women share are representing a more generalized experience.</td>
</tr>
<tr>
<td>#36-C</td>
<td>Line 246, is &quot;diverse&quot; the correct term to describe the group of researchers?</td>
</tr>
<tr>
<td>#37-C</td>
<td>Would consider expanding on how the results obtained lead to actionable interventions that could be developed, instituted and assessed.</td>
</tr>
</tbody>
</table>