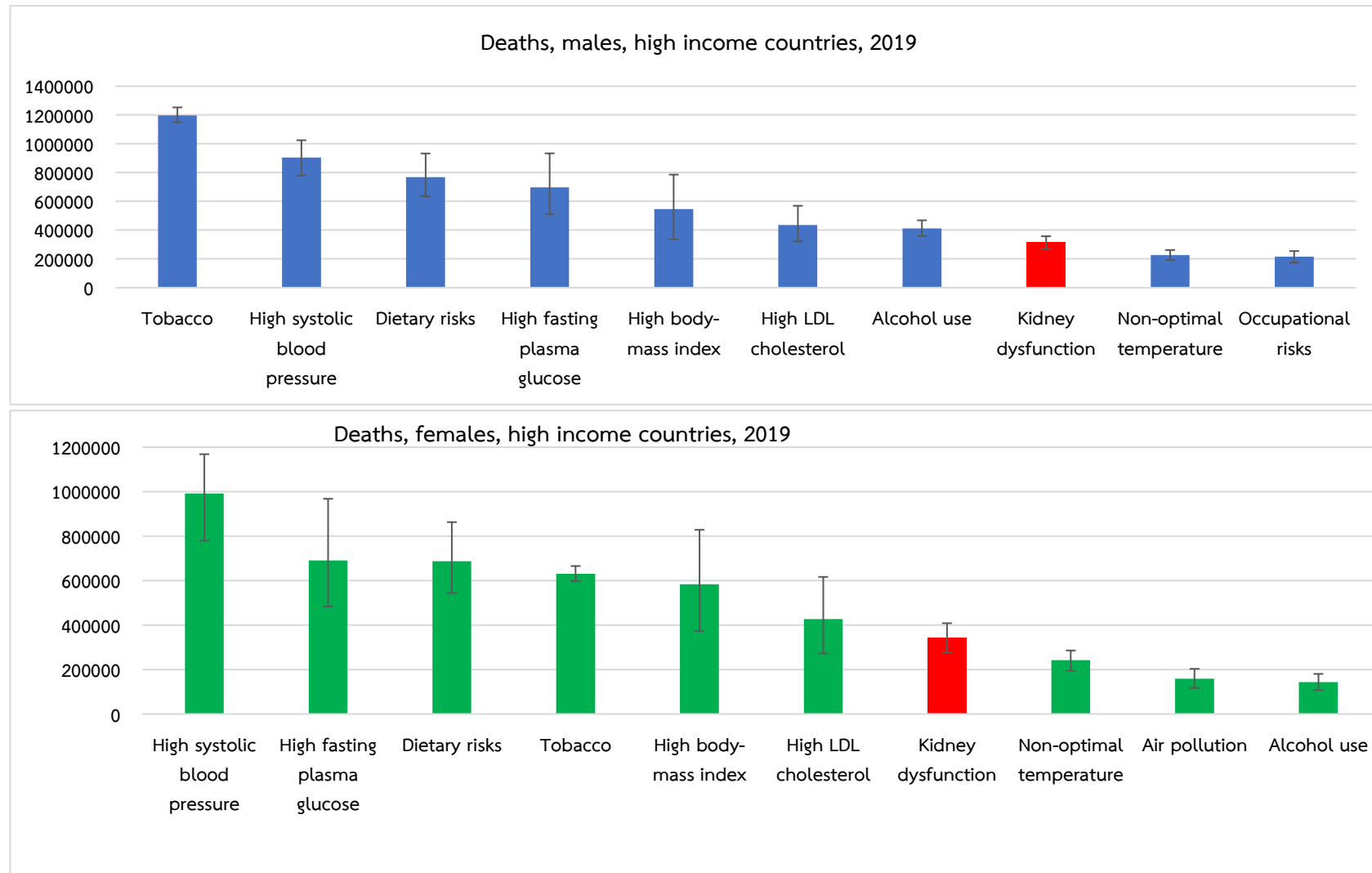
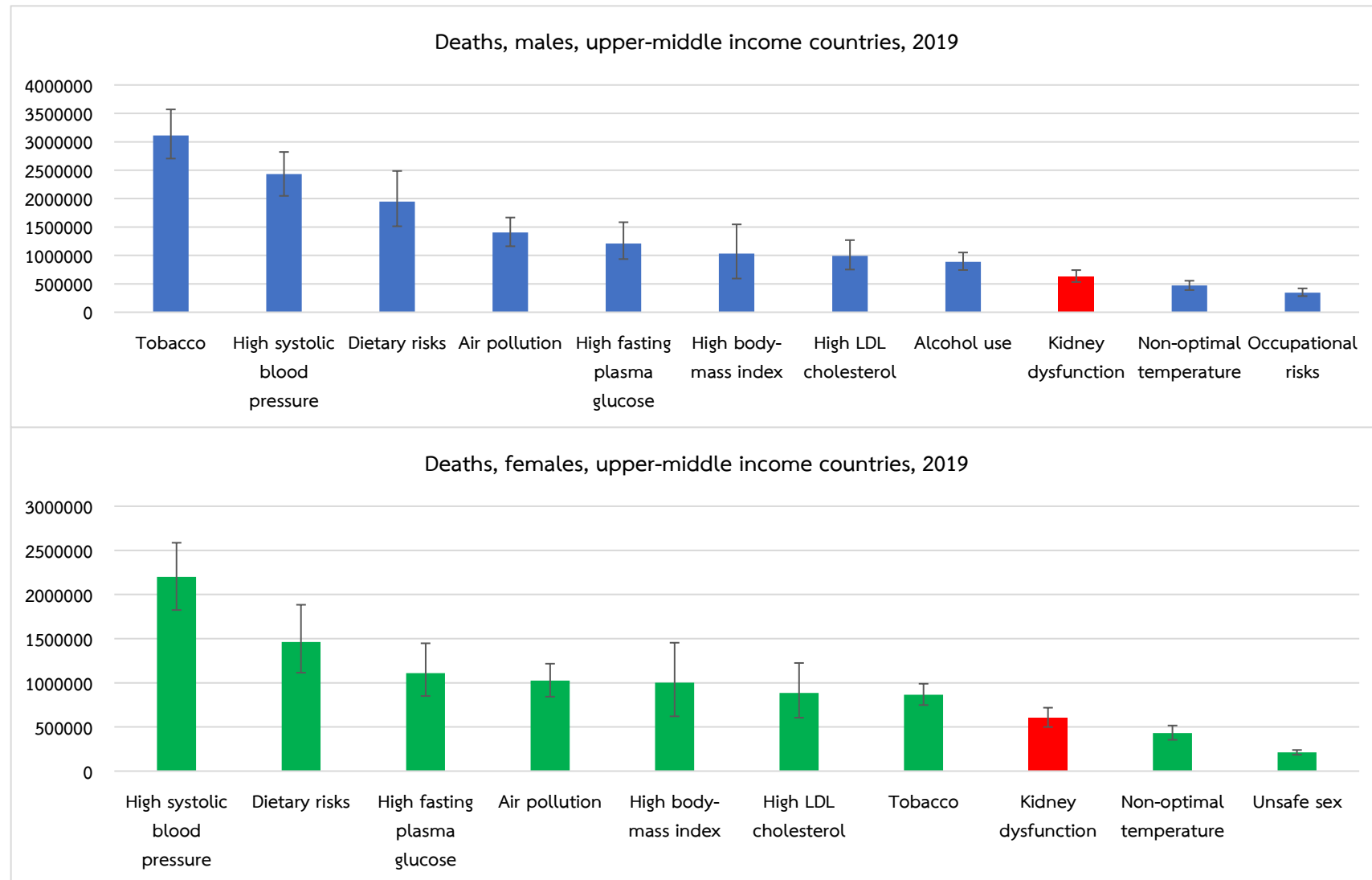


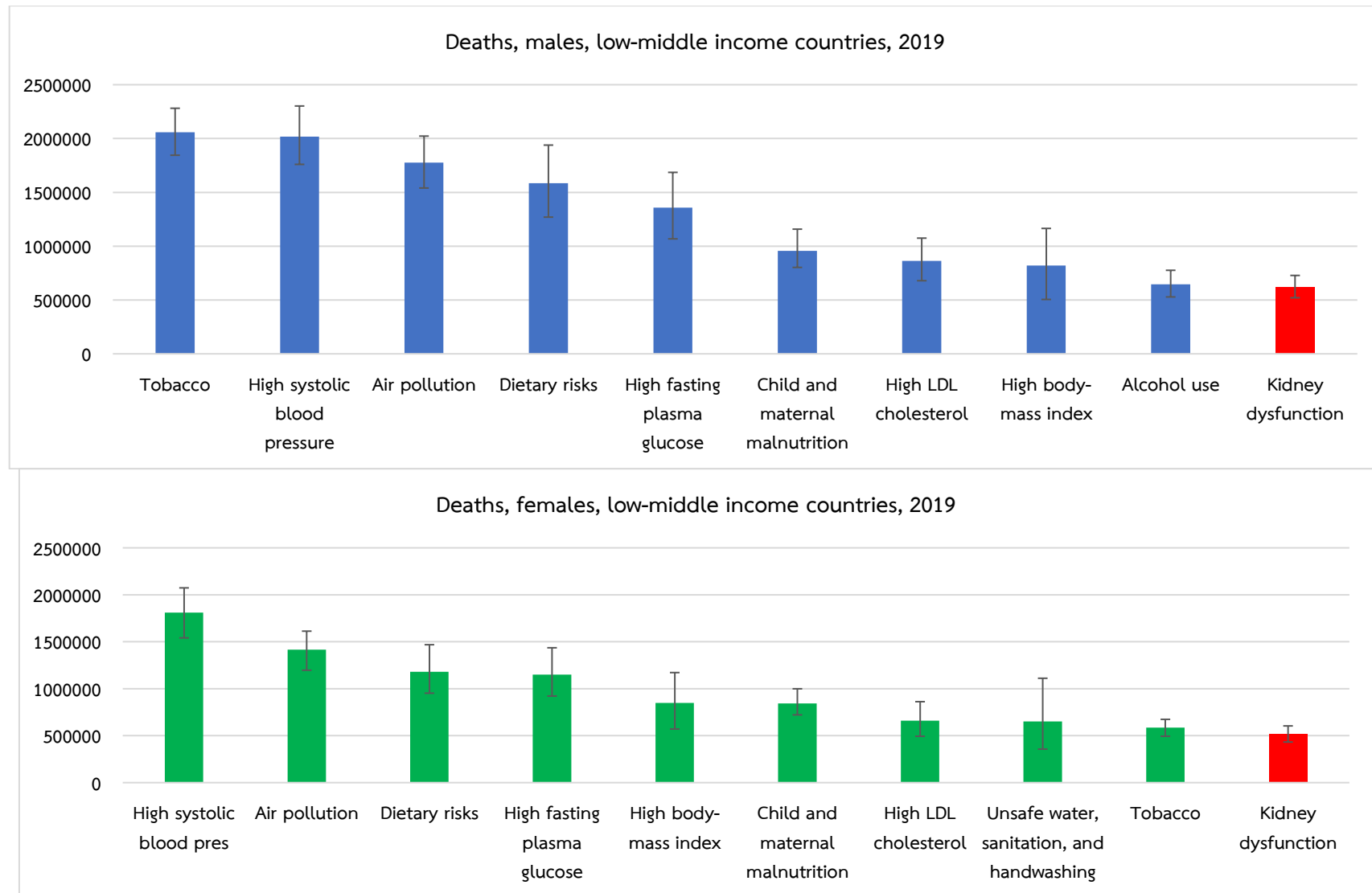
## Supplementary Materials



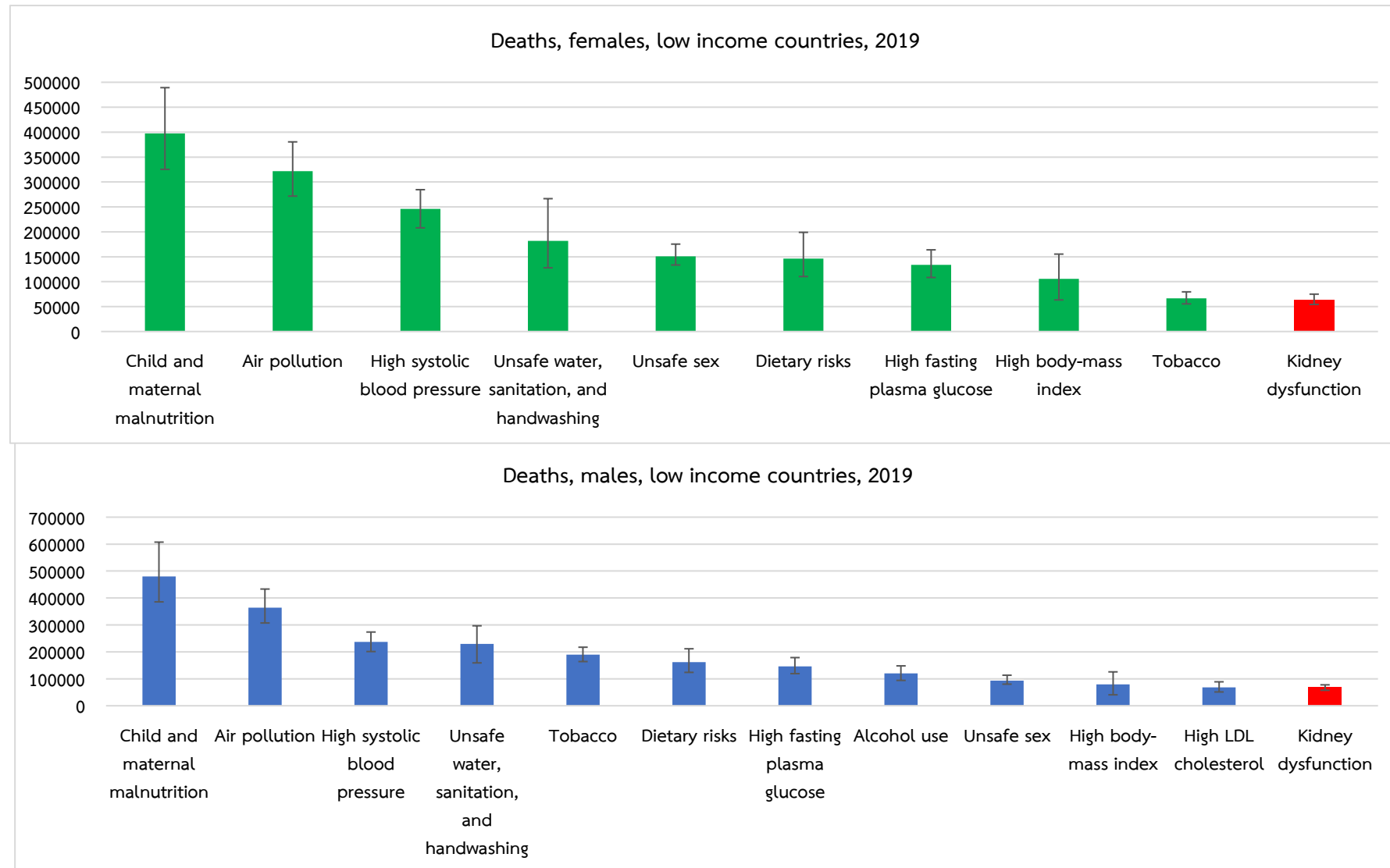
## Supplementary Materials



## Supplementary Materials



## Supplementary Materials



Supplementary Figure S1: Ranking of kidney dysfunction as a cause of death stratified by world-income category and gender by level 2 risk factors for death

Data from Global Burden of Diseases Study: <https://vizhub.healthdata.org/gbd-results/>

## Supplementary Materials

Supplementary Table S1. Approved and emerging novel therapeutic agents for various kidney diseases

| Medications (Class)   | Conditions              | Status   | Clinical Trials                                       |
|---|-------------------------|----------|---|
| Inaxaplin (APOL1 inhibitor)                                       | Two APOL1 variants FSGS | Emerging | NCT04340362   |
| Sparsentan (Endothelin A receptor antagonist)                     | FSGS                    | Emerging | DUPLEX (NCT03493685)                                  |
|   | IgAN                    | Approved | PROTECT (NCT03762850)                                 |
| Budesonide (Corticosteroid)                                       | IgAN                    | Approved | NEFIGARD (NCT03643965)                                |
| Atrasentan (Endothelin A receptor antagonist)                     | IgAN                    | Emerging | ALIGN (NCT04573478)                                   |
| Sibeprenlimab (APRIL inhibitor)                                   | IgAN                    | Emerging | VISIONARY (NCT05248646)                               |
| Narsoplimab (MASP-2 inhibitor)                                    | IgAN                    | Emerging | ARTEMIS-IgAN (NCT02682407)                            |
| Iptacopan (Factor B inhibitor)                                    | IgAN                    | Emerging | APPLAUSE-IgAN (NCT04578834)                           |
|   | aHUS                    | Emerging | APPELHUS (NCT04889430)                                |
| Ravulizumab (long acting anti-C5 monoclonal antibody)             | aHUS                    | Approved | ALXN1210-aHUS311 (NCT02949128)                        |
| Dapagliflozin/ Empagliflozin (SGLT2-i)                            | CKD/ DKD                | Approved | DAPA-CKD (NCT03036150)<br>EMPA-kidney (NCT03594110)   |
| Canagliflozin (SGLT2-i)   | DKD                     | Approved | CREDENCE (NCT02065791)                                |
| Finerenone (non-steroidal mineralocorticoid receptor antagonists) | DKD                     | Approved | FIGARO-DKD (NCT02545049)<br>FIDELIO-DKD (NCT02540993) |
|   | CKD                     | Emerging | FIND-CKD (NCT05047263)                                |

### Supplementary Materials

|  |                            |          |   |
|--|----------------------------|----------|---|
| Ziltivekimab (Antibody Mediated IL-6 Inhibition) | CKD                        | Emerging | RESCUE (NCT03926117)<br>RESCUE II (NCT04626505) |
|  | Atherosclerotic CVD in CKD |          | ZEUS (NCT05021835)                              |
| Semaglutide (GLP-1 receptor agonist)             | DKD                        | Emerging | FLOW (NCT03819153)                              |
| Voclosporin (Calcineurin inhibitor)              | Lupus nephritis            | Approved | AURORA1/2 (NCT03021499)                         |
| Belimumab (anti-BAFF monoclonal antibody)        | Lupus nephritis            | Approved | BLISS-LN (NCT01639339)                          |
| Anifrolumab (anti-interferon $\alpha$ antibody)  | Lupus nephritis            | Emerging | IRIS (NCT05138133)                              |
| Daratumumab (anti-CD38 monoclonal antibody)      | Lupus nephritis            | Emerging | NCT04868838                                     |
| Avacopan (C5a receptor antagonist)               | ANCA vasculitis            | Approved | ADVOCATE (NCT02994927)                          |

aHUS, atypical haemolytic uremic syndrome; CKD, chronic kidney disease; DKD, diabetic kidney disease; FSGS, focal segmental glomerulosclerosis; IgAN, IgA nephropathy

## Supplementary Materials

Supplementary Table S2: Patient comments on accessibility, affordability, knowledge, facilitators and barriers to optimal kidney care

[illegible]

## Supplementary Materials

| Patient comment/category |  | Cost | Side effects, interaction | Patient empowerment | Safety | Source of information | Comfort level to query | Delay new therapy | New hope | Policies/ prevention | Education | Fragmentation of care | Lack of specialists |
|--------------------------|--|------|---------------------------|---------------------|--------|-----------------------|------------------------|-------------------|----------|----------------------|-----------|-----------------------|---------------------|
| <b>HN</b>                | In the absence of solid programs/policies regarding the management of comprehensive kidney disease, as in Honduras, isolated programs exist for renal care, where the action is mostly geared to dialysis treatment only. Government responsibility for public assistance covers 85% of the renal population, 12-13% is covered by the social security system, and about 3% privately. Currently in Honduras, the law that does not cover the interests of kidney patients and it must be updated and revised in order to manage the comprehensive program of kidney disease.  | x    |                           |                     |        |                       |                        |                   |          | x                    |           |                       |                     |
| <b>HN</b>                | There is a significant diversity observed in the other countries of Latin America in health policies regarding Renal Health Programs promoted by SLANH, however many of them have shortcomings ranging from timely and early diagnosis, lack of coverage and accessibility to medicines. In Latin America, in recent years n most countries the focusing on the accessibility of medication has been on price rather than the benefit, effectiveness and quality of medicines.   | x    |                           |                     |        |                       |                        |                   |          | x                    |           |                       |                     |
| <b>HN</b>                | In Honduras, access to medicines is limited due to economic barriers and the type of health system that is managed. Many patients struggle to obtain the medications they need, but they cannot always be obtained and the costs of the low-income patient are inaccessible. Even though the Ministry of Health has a basic set of medicines, it does not meet the needs and does not adjust to the growth of the renal population, therefore they are insufficient.   | x    |                           |                     |        |                       |                        |                   |          |                      |           |                       |                     |
| <b>HN</b>                | In Honduras, the absence of programs defined in primary care for the early or opportune detection of chronic diseases such as kidney, and having a fairly collapsed health system, has led to the increases in kidney disease in the last decade, and this has been deepened with the lack of health budget. ItFor these reasons patients are unable to obtain appropriate treatments of quality and with the regulatory requirements that are required. On the other hand, the lack of specialized professional resources affects us directly since medical cares is given only in case of extreme urgency and this means that in many cases very advanced complications are already detected.  | x    |                           |                     |        |                       |                        |                   |          | x                    |           |                       |                     |
| <b>HN</b>                | In Latin America, some countries which have developed a national public health coverage such as Argentina and Uruguay do not have major deficits but the rest of the countries have many deficiencies within their public systems in terms of timely medical attention. There is lack of education regarding the disease for patients.   | x    |                           |                     |        |                       |                        |                   |          | x                    | x         |                       |                     |
| <b>HN</b>                | We have very few specialized health professionals in the renal area and most are concentrated in the main cities of the country in Honduras, little or none in the other areas where the number of patients affected by kidney disease is growing, and this directly affects the patient since they have to migrate to the cities to be able to be treated affecting their quality of life or they have to abandon treatment for not having the resources. Although in Honduras in recent years we have had an increase in renal specialists, these are concentrated in two areas of the country leaving uncovered the other 16 areas. Policies are needed to help improve this shortage, to improve care, especially in the hospitals of the network of the Secretary of Health. Care accessibility barriers need to be broken. |      |                           |                     |        |                       |                        |                   |          | x                    |           |                       | x                   |



## Supplementary Materials

| Patient comment/category |   | Cost | Side effects, interaction | Patient empowerment | Safety | Source of information | Comfort level to query | Delay new therapy | New hope | Policies/ prevention | Education | Fragmentation of care | Lack of specialists |
|--------------------------|---|------|---------------------------|---------------------|--------|-----------------------|------------------------|-------------------|----------|----------------------|-----------|-----------------------|---------------------|
| <b>HN</b>                | In Honduras in recent years we have managed to organize some groups or NGOs of patients who fight for improvements in accessibility to adequate and timely medication with the quality of the same under the necessary regulatory standards, but this is only small percentages of the affected population, that is why we fight in education for patient empowerment, However, we often find barriers and paradigms on the part of medical societies and health authorities, but we have achieved and made written approaches, as well as little by little the involvement with entities that have to do directly with the provision of services and management of medicines.  |      |                           | x                   |        |                       |                        |                   |          |                      |           |                       |                     |
| <b>HN</b>                | At the Latin American level, we work on empowerment on the different actions necessary to address renal health programs through scientific societies in different educational aspects from the perspective of the patient and health professionals, trying to make joint work alliances to raise awareness about the underlying diseases that may lead to kidney disease. All this work through participating in networks of associations at national and international level.  |      |                           | x                   |        |                       |                        |                   |          |                      | x         |                       |                     |
| <b>HN</b>                | In summary, access to medicines is essential for kidney patients in Honduras, as these medicines not only relieve pain and discomfort, but are also critical to preventing serious complications and maintaining an acceptable quality of life. Ensuring equitable access to care and medication is essential to addressing the kidney health needs of all patients in the country. And at the same time through the different actions and struggles that are executed, empower us to be able to participate in the different health policies necessary to have dignified and adequate medical care with accessibility to the best health practices by renal specialists and the appropriate effective and quality timely medication. | x    |                           |                     |        |                       |                        |                   |          |                      |           |                       |                     |
| <b>IN1</b>               | Patients are well advised on need for medications at all stages. When prescription changes more information on need for change for better outcome is needed.  |      |                           |                     |        |                       |                        |                   |          |                      | x         |                       |                     |
| <b>IN2</b>               | Co-relation between medications and the dietary requirements need to be established   |      | x                         |                     | x      |                       |                        |                   |          |                      |           |                       |                     |
| <b>IN3</b>               | Cost is a huge factor for the poor as well as middle -income patients   | x    |                           |                     |        |                       |                        |                   |          |                      |           |                       |                     |
| <b>IN4</b>               | Exceptional drugs for rare diseases like eculizumab must be made available at reasonable costs world-wide   | x    |                           |                     |        |                       |                        |                   |          | x                    |           |                       |                     |