

OBSTETRICS & GYNECOLOGY



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.

Date: Oct 08, 2019
To: "Lindsay M. Cannon" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1656

RE: Manuscript Number ONG-19-1656

Sexual and reproductive health characteristics of women in substance use treatment in Michigan

Dear Dr. Cannon:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Oct 29, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: In this manuscript, the authors present a survey study of sexual and reproductive health characteristics of women in substance abuse treatment in the state of Michigan. The results are not that surprising. There are a few actionable findings that could applied from the study. I have the following specific questions/comments:

- 1) It would be great if sexual and reproductive health services were better defined. This could be broadly defined and narrowing that down for the reader precisely what you're going for here would be helpful.
- 2) It is alarming that only 22% of substance abuse treatment facilities screen patients for STIs - why?
- 3) A challenge with the methods is that the women sampled were not randomly selected. This introduces a bias. That subjects had to speak English is also a bias that could influence the generalizability of these data. Given the subjects \$20 to participate in the study - was this given after survey was complete or was it an incentive to participate? If the later, then that too is an issue as to if these data can be generalizable to other populations.
- 4) How do the demographics - age, years of use, etc - compare to the general population of users not seeking treatment?
- 5) Predictably subjects reported fear of judgment as a barrier to care. If an individual participates in a behavior that negatively impacts their success in life - no matter what it is - there is often a corresponding guilt or blame assigned to the behavior. Having a bad temper, for example, can negatively impact life success. Having this behavior can be associated with guilt or judgment. This is natural because in society these adverse behaviors are to be discouraged. My point is, can the fear of judgment be eliminated? Likewise, while it is true some users have been mistreated by clinicians but I'm reminded of the book, "Thinking Fast and Slow" and the acronym, "WYSIATI (What you see is all there is). Kahneman is not the only one to express the idea that our brains look for what we expect to see, thus if a user expects to see judgment, they find it whether or not it is actually present. Some of your message does not appear to account for this reality.
- 6) STI and pregnancy testing should be done more often among these women. This seems to be strongest finding and correspondingly I'd move it up in your discussion.
- 7) When you say, "structural barriers have been reduced," doesn't fix the negative attitude matter but you've lumped them together. Is there no solution to the negative attitude concern despite finding this the strongest barrier?

Overall, interesting and predictable study - and to be clear often good studies are predictable!

Reviewer #2: This study is a cross-sectional study of female patients undergoing treatment for opioid use disorder (OUD) at 22 randomly selected treatment programs in a midwestern state from 12/15-5/17. The objective of the study is to evaluate sexual and reproductive health characteristics of these women. Although it has been acknowledged previously that women experiencing OUD have a high rate of unintended pregnancy and increased rates of sexually transmitted infections, there is less information on barriers to sexual and reproductive health from the patients' perspective. This study specifically examines this information.

The paper is well written and overall is clear and easy to read. The introduction addresses what is currently known about reproductive health access in women affected by opioid use disorder, and the knowledge gaps that this study intends to address.

Study type is appropriate to evaluate current barriers to reproductive health care to women enrolled in OUD treatment in varied programs across a single Midwestern state. There is a reasonable distribution across different types of treatment programs.

The method of self-interview is also appropriate as it preserves confidentiality and allows patients to answer questions without concern related to sharing of information within treatment program. The amount that patients were compensated is reasonable for this project.

The conclusions are consistent with the evidence as presented and acknowledge significant gaps in access to reproductive care. It is also nice to see that subjects were asked about distance to access specific services.

Overall this study adds important information to the area of substance use disorders and women's health, specifically treatment of opioid use disorders. It identifies that women are interested in coordination between substance use disorder treatment and access to reproductive health services if desired.

I recommend only minor revisions as noted below with recommendation for acceptance if revisions are addressed.

Specific recommendations

1. Overall this manuscript is very well written and easy to read. I would recommend using figures 2 - 4 to complement the Results section, as they currently replicate exactly the same data.. The Results text can be used to highlight most relevant information in the tables. Likewise, some information in the Figures that is not addressed at all in the manuscript might be considered to be removed from the Figure (i.e. questions addressing overdose history and naloxone training and use, and possible CPS involvement and child custody data)

2. Figure 1 is a map of surveyed substance use treatment programs. This could be made available in supplemental online materials, but does not need to be in the manuscript when published. I would suggest a line or two in the text identifying that treatment centers were overall distributed across the state, with only two urban counties having three treatment programs.

3. Under limitations, it might be interesting to address whether Michigan accepted the Medicaid expansion and what Medicaid typically covers for substance use treatment and for reproductive care in the state of Michigan. It is also important to acknowledge that barriers noted by these patients may be even less than those women who are unable to access OUD treatment due to lack of insurance or other barriers.

Reviewer #3: The manuscript is a review of characteristics of reproductive age women who were in substance abuse treatment programs in Michigan.

The sampling design is absent, just take all comers (sample of convenience); the participants are self-selected. Research question is absent.

The questions are sometimes from some validated, standardized instrument, sometimes not.

The "platform" was tested on study staff.

The manuscript is non-clinical and contains no clinical information.

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we

will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

- A. OPT-IN: Yes, please publish my point-by-point response letter.
- B. OPT-OUT: No, please do not publish my point-by-point response letter.

2. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

3. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

4. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at <https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize>. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

6. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

- * All financial support of the study must be acknowledged.
- * Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
- * All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
- * If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

7. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

8. Only standard abbreviations and acronyms are allowed. A selected list is available online at <http://edmgr.ovid.com/ong/accounts/abbreviations.pdf>. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

9. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

10. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%).

11. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

12. The Journal's Production Editor has the following to say about the figures in this manuscript:

"Figures 1–2: Please upload as high-res figure files to Editorial Manager. "

When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

13. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at <http://links.lww.com/LWW-ES/A48>. The cost for publishing an article as open access can be found at <http://edmgr.ovid.com/acd/accounts/ifaauth.htm>.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

If you choose to revise your manuscript, please submit your revision through Editorial Manager at <http://ong.editorialmanager.com>. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

- * A confirmation that you have read the Instructions for Authors (<http://edmgr.ovid.com/ong/accounts/authors.pdf>), and
- * A point-by-point response to each of the received comments in this letter.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors and that each author has given approval to the final form of the revision.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Oct 29, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2018 IMPACT FACTOR: 4.965

2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

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.



October 28, 2019

Dear *Obstetrics & Gynecology* Editors:

Thank you for the opportunity to resubmit our manuscript “Sexual and reproductive health characteristics of women in substance use treatment in Michigan,” to be considered for publication in *Obstetrics & Gynecology*. This paper provides a novel look at the sexual and reproductive health characteristics of women in treatment for opioid use disorder.

This study received Institutional Review Board approval from the University of Michigan Medical School IRB, as well as the Michigan Department of Health and Human Services IRB prior to study initiation. This research was supported by funding from by the Society of Family Planning Research Fund. Vanessa K. Dalton is a paid expert witness for Bayer. No other authors have any interests to disclose.

Our manuscript is not under consideration at another journal. The word counts are as follows:

Abstract: 269

Manuscript Text: 2,592

References: 28

Tables: 4

[REDACTED]

Sincerely,

Lindsay M. Cannon, MPH, MSW

[REDACTED]

[REDACTED]

**Response to Editor for
“Sexual and reproductive health characteristics of women in substance use treatment in
Michigan”**

Submitted to *Obstetrics & Gynecology*

We thank the editors and reviewers for their comments on our article. In response, we have made specific adjustments based on your feedback. All edits are noted with track changes throughout the body of the manuscript. We believe the revised manuscript is improved by these recommendations. We hope you agree. Thank you.

Reviewer 1

- 1) It would be great if sexual and reproductive health services were better defined. This could be broadly defined and narrowing that down for the reader precisely what you're going for here would be helpful.

Thank you for this recommendation. We have included the following definition of sexual and reproductive health (SRH) on page 4 lines 96-98: “Sexual and reproductive health services include services or referral related to family planning, pregnancy, abortion, infertility, reproductive tract infections, cervical cancer screening, and gender-based violence.”

- 2) It is alarming that only 22% of substance abuse treatment facilities screen patients for STIs - why?

We also find it alarming that only 22% of substance use treatment facilities screen patients for STIs. This data is from the National Survey of Substance Abuse Treatment Centers, which does not speculate as to the reason for this low rate of STI testing. However, prior work has suggested that lack of funding for SRH services and lack of knowledge related to SRH on the part of substance use treatment providers may account for some of the lack of SRH service provision in substance use treatment programs (MacAfee et al., 2019).

- 3) A challenge with the methods is that the women sampled were not randomly selected. This introduces a bias. That subjects had to speak English is also a bias that could influence the generalizability of these data. Given the subjects \$20 to participate in the study - was this given after survey was complete or was it an incentive to participate? If the later, then that too is an issue as to if these data can be generalizable to other populations.

Thank you for this comment. Although the women who were sampled were not randomly selected, the substance use treatment centers from which surveyed women were recruited were randomly selected. This has the potential to improve generalizability. We have added language about the random selection of clinics to the discussion on page 12 line 297. We acknowledge that the restriction of the sample to English speaking subjects is a limitation and have added this to the limitations paragraph on page 12 lines 303-304. Participants received \$20 after the survey was completed. We have included language to make this clearer on page 6 line 137.

- 4) How do the demographics - age, years of use, etc - compare to the general population of users not seeking treatment?

Using data from the National Survey on Drug Use and Health in 2017, we have constructed three tables displaying national receipt of treatment by age, race/ethnicity, and education. As you can see, our sample is consistent with the national age groups represented in treatment and is mostly consistent with the education status represented in treatment, although we have fewer college graduates in our sample. In terms of race/ethnicity, our sample is much Whiter than the national data, although this is consistent with the Michigan population, where 79.3% of the population is White. We specifically indicate throughout the manuscript that this study assesses the sexual and reproductive health characteristics of women in treatment for substance use disorders, and our sample appears to be representative of that population. Future studies should evaluate the sexual and reproductive health characteristics of women not in substance use treatment, who appear to be demographically different from those in treatment for substance use.

Receipt of Treatment by Age

	<i>Needed Treatment</i>	<i>Received Treatment</i>	<i>Did Not Receive Treatment</i>	<i>Our Sample</i>
<i>18-25 years</i>	34.6% (2,587,000)	19.7% (319,000)	38.7% (2,268,000)	15.4% (40)
<i>26 or older</i>	65.4% (4,886,000)	80.3% (1,299,000)	61.3% (3,588,000)	84.6% (220)

Receipt of Treatment by Race/Ethnicity

	<i>Needed Treatment</i>	<i>Received Treatment</i>	<i>Did Not Receive Treatment</i>	<i>Our Sample</i>
<i>White</i>	63.1% (5,199,000)	68.8% (1,151,000)	61.7% (4,048,000)	85.0% (221)
<i>Black</i>	14.7% (1,209,000)	12.4% (208,000)	15.2% (1,001,000)	2.7% (7)
<i>Multiple Races</i>	3.1% (259,000)	3.3% (56,000)	3.1% (203,000)	4.2% (11)
<i>Other</i>	3.7% (305,000)	2.9% (48,000)	3.9% (257,000)	5.4% (14)
<i>Hispanic</i>	15.4% (1,267,000)	12.6% (211,000)	16.1% (1,056,000)	1.9% (5)
<i>Unknown</i>	-	-	-	0.8% (2)

Receipt of Treatment by Education

	<i>Needed Treatment</i>	<i>Received Treatment</i>	<i>Did Not Receive Treatment</i>	<i>Our Sample</i>
<i>Less than High School</i>	18.1% (1,351,000)	23.9% (386,000)	16.5% (965,000)	17.3% (45)
<i>High School Graduate</i>	29.4% (2,203,000)	32.6% (527,000)	28.6% (1,676,000)	33.9% (88)
<i>Some College</i>	37.2% (2,776,000)	34.9% (565,000)	37.8% (2,211,000)	43.9% (114)
<i>College Graduate</i>	15.3% (1,142,000)	8.6% (140,000)	17.1% (1,002,000)	4.2% (11)
<i>Unknown</i>	-	-	-	0.8% (2)

- 5) Predictably subjects reported fear of judgment as a barrier to care. If an individual participates in a behavior that negatively impacts their success in life - no matter what it is - there is often a corresponding guilt or blame assigned to the behavior. Having a bad temper, for example, can negatively impact life success. Having this behavior can be

associated with guilt or judgment. This is natural because in society these adverse behaviors are to be discouraged. My point is, can the fear of judgment be eliminated? Likewise, while it is true some users have been mistreated by clinicians but I'm reminded of the book, "Thinking Fast and Slow" and the acronym, "WYSIATI (What you see is all there is)". Kahneman is not the only one to express the idea that our brains look for what we expect to see, thus if a user expects to see judgment, they find it whether or not it is actually present. Some of your message does not appear to account for this reality.

We wholeheartedly agree with the reviewer that this is not a surprising finding and is likely a complicated component of care for women with opioid use disorder. Certainly, stigma and judgment are common among women with substance use disorder and contribute to their difficulties in accessing substance use treatment, much less reproductive health treatment. While we may not be able to fully understand all of the individual contributions of why they feel that judgment as you describe above, we believe by at least acknowledging this barrier, providers will have a better understanding of why this population of women may have difficulty accessing care in the first place. Sexual and reproductive health providers can use this information to consider how they can best support and welcome these women using trauma-informed care and other approaches to enhance and encourage women to seek SRH.

- 6) STI and pregnancy testing should be done more often among these women. This seems to be strongest finding and correspondingly I'd move it up in your discussion.

Thank you for this feedback. We have moved the paragraph on the need for more frequent testing up to be the second paragraph in the Discussion (page 10 lines 244-249).

- 7) When you say, "structural barriers have been reduced," doesn't fix the negative attitude matter but you've lumped them together. Is there no solution to the negative attitude concern despite finding this the strongest barrier?

Thank you for this comment. We agree that this was an oversight and have added in a sentence about programs that have been shown to be effective at combatting substance use stigma among medical students. We have added this sentence to page 11 lines 274-276.

Reviewer 2

- 1) Overall this manuscript is very well written and easy to read. I would recommend using figures 2 - 4 to complement the Results section, as they currently replicate exactly the same data.. The Results text can be used to highlight most relevant information in the tables. Likewise, some information in the Figures that is not addressed at all in the manuscript might be considered to be removed from the Figure (i.e. questions addressing overdose history and naloxone training and use, and possible CPS involvement and child custody data)

Thank you for this recommendation. Although we do not address all the information presented in the Tables within the text (i.e., questions addressing overdose history and naloxone training/use, CPS involvement, etc.), we feel strongly about including this information in the Tables so the audience knows we asked about these experiences known to be significant barriers for this population. We hope that by including our findings on these topics in the Tables, it provides an

opportunity to facilitate discussion about these issues and how they may impact women's ability to access sexual and reproductive health care. However, as the reviewer suggested, we have chosen to use the text to highlight the most relevant information for the overall theme of the paper, thus why we do not address these points in the text.

- 2) Figure 1 is a map of surveyed substance use treatment programs. This could be made available in supplemental online materials, but does not need to be in the manuscript when published. I would suggest a line or two in the text identifying that treatment centers were overall distributed across the state, with only two urban counties having three treatment programs.

Thank you for this recommendation. We have now included Figure 1 as a Supplemental file and have added in two sentences describing the distribution of treatment centers throughout the state of Michigan on page 5 lines 112-115.

- 3) Under limitations, it might be interesting to address whether Michigan accepted the Medicaid expansion and what Medicaid typically covers for substance use treatment and for reproductive care in the state of Michigan. It is also important to acknowledge that barriers noted by these patients may be even less than those women who are unable to access OUD treatment due to lack of insurance or other barriers.

We agree that the Medicaid expansion in Michigan could affect the generalizability of the results, especially compared to states that did not accept the Medicaid expansion. We have included this information in the limitations paragraph on page 12 lines 305-309.

Reviewer 3

- 1) The sampling design is absent, just take all comers (sample of convenience); the participants are self-selected.

Our sampling design is discussed in the Materials and Methods section on pages 4-6 lines 109-142. We randomly selected treatment programs across the state to achieve a representative sample at the facility level and a convenience sample was used at each facility to survey as many women as were available. While this does introduce the possibility of selection bias, we believe that it provided us with a larger available sample so that we could gain a better understanding of the reproductive health needs of women in treatment.

- 2) Research question is absent.

This is a descriptive study, with a goal of describing the sexual and reproductive health characteristics of women in opioid use disorder treatment (page 4 lines 103-107). In our comprehensive literature review on this subject, we found that there was no recent assessment of the sexual and reproductive health needs of women in opioid use disorder treatment in the United States. Before we can embark on initiatives or programs to address or improve these outcomes, we need to have a current understanding of what those needs are and what barriers may be identified to help better understand next steps in addressing these concerns.

- 3) The questions are sometimes from some validated, standardized instrument, sometimes not.

We utilized validated, standardized instruments wherever possible, including when screening for post-traumatic stress disorder and alcohol use disorder. However, since our study sought to assess the sexual and reproductive health needs of women in opioid use disorder treatment, which has not been assessed systematically in recent studies, many of our measures were investigator created.

- 4) The "platform" was tested on study staff.

Thank you for this note. The language of "platform" was confusing, so we have changed the sentence to read "the self-interview was tested on study staff to ensure that branching logic was appropriate" (page 6 line 143).

- 5) The manuscript is non-clinical and contains no clinical information.

We certainly respect the reviewer's opinion, but believe that this article provides useful information to clinicians and researchers who are working with women with opioid use disorder. We believe that this highlights the reproductive health needs of women with opioid use disorder and provides some additional information about barriers to accessing such treatment which may be helpful to programs trying to integrate services or provide care to this population of women.

Editorial Office Comments

- 1) The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted.

OPT-IN: Yes, please publish my point-by-point response letter.

- 2) As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

Thank you for your feedback. We have confirmed this with our co-atuhors.

- 3) Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research

study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

We include the STROBE checklist at the end of this cover letter on pages 10-11.

- 4) Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at <https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize>. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

We have changed "Number of pregnancies" in Table 2 to "Gravidity." All other words used throughout the manuscript are in line with revitalize definitions.

- 5) Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

Our manuscript is 18 pages long (2,592 words).

- 6) Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:
 - * All financial support of the study must be acknowledged.
 - * Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
 - * All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all

individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.

* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

All of the above have been included on the title page of the manuscript.

- 7) The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

The abstract matches the body of the manuscript and follows the journal guidelines.

- 8) Only standard abbreviations and acronyms are allowed. A selected list is available online at <http://edmgr.ovid.com/ong/accounts/abbreviations.pdf>. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

Only standard abbreviations and acronyms are used throughout the manuscript.

- 9) The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

We have removed all used of the virgule symbol throughout the text and tables.

- 10) In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission.

For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%).

We are in line with this requirement.

- 11) Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here:
http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

We have reviewed this checklist and updated out tables accordingly.

- 12) The Journal's Production Editor has the following to say about the figures in this manuscript:

"Figures 1–2: Please upload as high-res figure files to Editorial Manager. "

When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

Figure 1 will now be a supplemental file, per Reviewer 2's recommendations. We have included a high resolution image and have removed the figure from the Word document containing the manuscript text.

STROBE Statement—checklist of items that should be included in reports of observational studies

	Item No	Recommendation	Page No
Title and abstract	1	(a) Indicate the study’s design with a commonly used term in the title or the abstract	3
		(b) Provide in the abstract an informative and balanced summary of what was done and what was found	3
Introduction			
Background/rationale	2	Explain the scientific background and rationale for the investigation being reported	4
Objectives	3	State specific objectives, including any prespecified hypotheses	4
Methods			
Study design	4	Present key elements of study design early in the paper	4-5
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection	4-5
Participants	6	(a) Cohort study—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up Case-control study—Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls Cross-sectional study—Give the eligibility criteria, and the sources and methods of selection of participants	4-5
		(b) Cohort study—For matched studies, give matching criteria and number of exposed and unexposed Case-control study—For matched studies, give matching criteria and the number of controls per case	N/A
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable	6
Data sources/measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group	6
Bias	9	Describe any efforts to address potential sources of bias	12
Study size	10	Explain how the study size was arrived at	4-5
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why	6
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding	6
		(b) Describe any methods used to examine subgroups and interactions	N/A
		(c) Explain how missing data were addressed	N/A
		(d) Cohort study—If applicable, explain how loss to follow-up was addressed Case-control study—If applicable, explain how matching of cases and controls was addressed Cross-sectional study—If applicable, describe analytical methods taking account of sampling strategy	6
		(e) Describe any sensitivity analyses	N/A

Continued on next page

Results			
Participants	13*	(a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed	6
		(b) Give reasons for non-participation at each stage	N/A
		(c) Consider use of a flow diagram	N/A
Descriptive data	14*	(a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders	6-7
		(b) Indicate number of participants with missing data for each variable of interest	17-22
		(c) <i>Cohort study</i> —Summarise follow-up time (eg, average and total amount)	N/A
Outcome data	15*	<i>Cohort study</i> —Report numbers of outcome events or summary measures over time	N/A
		<i>Case-control study</i> —Report numbers in each exposure category, or summary measures of exposure	N/A
		<i>Cross-sectional study</i> —Report numbers of outcome events or summary measures	6-10, 17-22
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included	N/A
		(b) Report category boundaries when continuous variables were categorized	17-22
		(c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period	N/A
Other analyses	17	Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses	N/A
Discussion			
Key results	18	Summarise key results with reference to study objectives	10-11
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias	12
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence	10-11
Generalisability	21	Discuss the generalisability (external validity) of the study results	12
Other information			
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based	1

*Give information separately for cases and controls in case-control studies and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

Note: An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at <http://www.plosmedicine.org/>, Annals of Internal Medicine at <http://www.annals.org/>, and Epidemiology at <http://www.epidem.com/>). Information on the STROBE Initiative is available at www.strobe-statement.org.