OBSTETRICS & GYNECOLOGY

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Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office: obgyn@greenjournal.org.

Date: Oct 25, 2019
To: "Julia R Steinberg" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1714

RE: Manuscript Number ONG-19-1714

Psychosocial Factors Associated with Postpartum Contraceptive Method Use Following an Unintended Birth

Dear Dr. Steinberg:

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 Nov 15, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Using a large postpartum survey database, the authors show that psychosocial factors are associated with the lack of postpartum contraceptive following births that were unintended. Furthermore, the authors suggest knowing this information may help counseling in the postpartum period for contraceptive use. I have several concerns about this study:

1. Although I commend you on your data crunching of this large database, the paper needs considerable work in making it understandable. Your paper needs to be more focused on your hypothesis. Please present data that is relevant to your point. Thus concentrate on the results of your adjusted odds ratio only. This would eliminate of information that is not an important to the final conclusion.

2. As pointed out in your paper stressors and IPV our inherently connected with depression. Most prenatal visit (as well as postpartum) these issues are constantly addressed. Therefore, I am unsure how the information presented in your paper would alter postpartum contraceptive use (counseling), since IPV and depression (in many clinics/offices)are assessed at each visit. I do not think anyone would be surprised that IPV and stressors would result in poor medical follow-up. Thus I am unsure of the clinical value of this finding.

3. The study also has inherent bias as it is a survey, and thus those that choose to answer may not be representative. However, the PRAMS database has additional bias, that you failed to mention. In most states, patient's at risk are targeted for the surveys (i.e. LBW, race, ethnicity, etc). This may add considerable bias to your study design.

4. In your introduction you noted that the unintended pregnancy rate is approximately 37%. However, in your study it is closer to 20%. In addition, Postpartum IUD use is 16% almost equal to the oral contraceptive use. This is not what is experienced in many practices. Please comment?

5. Do you think the same holds true for those pregnancies not categorized as unintended? Would this not be an appropriate comparisons? In addition, IPV affected 5% of your study population (2500)? Clinically concentrating resources on this contraceptive issue would not result in a dramatic decrease unintended pregnancies. Please comment?

In addition:

6. LN 47: The term weighted is confusing, please explain

7. Ln 48: Phase 7 is not needed; this is explained in the body of your paper

8. LN 58: Is important somewhere in the abstract to have the wrong numbers of total patients that experienced IPV etc.

9. Ln 104 I think you should include an additional reference that considered depression and PP contraception: PMID 28867443

10. LN 122 -131: I feel most of this information should be included in results and not in your material and methods. In addition you should have the total number of surveys that were considered (2million?)and the percentage that was used for your study. This is more appropriate (for clinical journal) than using weighted and on unweighted sample size expressions.

11. Ln 161: Since the presence or absence of stressor was an important part of your hypothesis, they should be clearly explained in your material and methods.

12. Ln204: Being aware of the bias for the selection (PRAMS). DO you think the population that was sample explains the high rate of depression?

13. Ln 212-217: The p (ps) values that appear in table 1 are confusing and best be left described in the text.

14. Ln 218: It may be helpful to limit this area (looking at individual effects), in fact whether table 2 is needed at all is questionable, since you are not eliminating any of these factors in your final adjusted OR. The result section should concentrate more on the adjusted risks, since that is what your hypothesis is based. The value of how each covariant effects postpartum contraception is not relevant, because clinically it is the interplay of all the psychosocial factors(i.e adjusted OR) that is important.

15. Ln 281: How to apply the results of the study clinically is difficult. Since we already asked many of these questions at each visit and at the postpartum visit, what can be done differently to increase the use of postpartum contraception in these individuals of risk? Please comment

Reviewer #2: This analysis of PRAMS data builds upon the existing literature that supports a link between psychosocial risk factors and medical decision-making. The study found that interpersonal violence (IPV) is associated with lowered use of all contraceptives, and logically increases the risk for recurrent unintended birth. The suggestion that providers should thus address psychosocial risk factors during the postpartum visit and/or contraceptive visit deserves more exploration, or at least a mention that national and institutional policies should support the time and effort required to have such a nuanced conversation about contraception during a 15 minute globally reimbursed postnatal visit.

Major Issues: none.

Specific comments:
1. Introduction: Please explain why these 3 specific psychosocial risk factors were explored for your study (LINES 107 - 109). Does this reflect the data available through PRAMS, or was this specifically chosen based on prior research on psychosocial factors and reproductive choice.

2. Method:
a. LINE 142 - "Fertility awareness" is a more accurate term than "rhythm" method under "less effective methods"
b. I would be interested to know whether insurance status was included within PRAMS data, as that could certainly influence women's access to contraception. If included, I would include that information among the covariates.

3. Results: Lines 226 - 248 is difficult to read, and would be better summarized as a succinct table (separate from the tables already existing).

4. Discussion:
a. LINES 283 - 284: Authors state that psychosocial factors relating to contraceptive use should be addressed in the same visit as the contraceptive visit. Need to address further the potential barriers to having such a nuanced and potentially lengthy discussion during the global postpartum visit, and advocate for change to payment and visit structure that would allow such as discussion.
b. LINES 295 - 297: The phrase "falling into it" may come across as paternalistic and undermines the previous statement that women may be choosing not to disclose their internal decision making. A more appropriate statement would be "Providers should make all efforts to remove barriers to contraceptive choice, while acknowledging that some women may still make the informed choice to decline contraception."

5. Tables and Figures: No revision needed.

Reviewer #3: Thank you for this submission. A need exists for more attention to the postpartum period and the topic of postpartum contraception is particularly timely. The research is enhanced by the sheer numbers of participants.

I have two comments:

Line 142 mentions "rhythm" which I believe is somewhat outdated and potentially biased. Would "natural family planning (NFP)" or "fertility awareness" be appropriate as a substitute?

In the section in lines from 280-297, the discussion centered on screening and "conversing" with a woman. I would suggest that the conclusion should at least mention how the provider should know of community resources and facilitate a woman's knowledge of and access to such help. Many of these women have profound social and economic needs that are beyond that of an average office, and they need long term solutions that require long term changes. A sentence or two could be added to note this.

STATISTICAL EDITOR'S COMMENTS:

1. Table 1: The columns by contraceptive methods and by row categories, in many cases, do not sum to 100%, despite citing individual entries to nearest 0.1% precision. Does this represent missing data? Need to clarify. Also, need to explain in Table legend what stats test the p column refers to. I presume Chi-square for the weighted %s applied to the unweighted N for all columns except "Total". Need units for age.

2. Table 2:For the number of stressors, should include SD, not SE. The large sample sizes make those numbers not useful to the reader. Also, given the number of comparisons in this Table, $p < .05$ will likely include some spurious associations. $P < .01$ would be more appropriate.

3. Table 3: There are a large number of statistical comparisons in this Table, using 2 models, 4 pairwise comparisons and > 25 row categories, ie, at least 100 comparisons, Therefore, to use p .10 or .05 as a threshold for inference testing will likely include many spurious associations. Should use a stricter threshold for p-values and for CI. At minimum, should be $p < .01$ with 99% CIs. Even then, should interpret cautiously all but the strongest associations.

4. General: As shown in Table 1, there were a number of baseline differences in the contraception cohorts, notably, race,age, education, marital status, insurance etc. In addition to the analysis using adjustment for those factors, the Authors should also use the large data set at hand to apply a matching algorithm to corroborate the independent association of IPV and number of stressors on PP contraception use.

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.
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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. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

4. Clinical trials submitted to the journal as of July 1, 2018, must include a data sharing statement. The statement should

indicate 1) whether individual deidentified participant data (including data dictionaries) will be shared; 2) what data in particular will be shared; 3) whether additional, related documents will be available (eg, study protocol, statistical analysis plan, etc.); 4) when the data will become available and for how long; and 5) by what access criteria data will be shared (including with whom, for what types of analyses, and by what mechanism). Responses to the five bullet points should be provided in a box at the end of the article (after the References section).

5. 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.

6. 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.

7. 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).

8. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.

9. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

10. 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.

11. 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.

12. 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.

13. 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%").

14. We discourage claims of first reports since they are often difficult to prove. How do you know this is the first report? If this is based on a systematic search of the literature, that search should be described in the text (search engine, search terms, date range of search, and languages encompassed by the search). If on the other hand, it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

15. 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.

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* 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 Nov 15, 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

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