

# OBSTETRICS & GYNECOLOGY



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- 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.

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**Date:** Apr 22, 2021  
**To:** "Carolyn Sufrin" [REDACTED]  
**From:** "The Green Journal" em@greenjournal.org  
**Subject:** Your Submission ONG-21-629

RE: Manuscript Number ONG-21-629

Abortion Access for Incarcerated People: Incidence of Abortion and Policies at U.S. Prisons and Jails

Dear Dr. Sufrin:

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 May 13, 2021, we will assume you wish to withdraw the manuscript from further consideration.

#### REVIEWER COMMENTS:

Reviewer #1:

##### Abstract:

As this will be the most (and in many cases the only) read portion of the paper, I would not use the word "carceral" in the Background section, as it is not a word commonly used by a medical audience.

##### Introduction:

Although you define jails and prisons starting on line 132 in the Methods section, I was looking for a definition in the Introduction. Given that this is for a generalist OBGYN audience, our knowledge of the carceral system is very limited. Even if you want to keep the explanation in the methods section so that you can be as thorough as you are, consider a sentence in the Introduction or indicate that the definition is coming, as I was looking for this as soon as I started reading the introduction.

##### Methods:

Line 155: remove the extra period.

##### General comments:

In this article, the authors survey abortion rates in a convenience sample of state and federal prisons and county jails. They found that although abortion is a federally protected legal right, abortion rates are low. Furthermore, restrictive policies within carceral institutions limit access to abortion, which appears to be more restrictive when those facilities are located in states that are generally more hostile towards abortion access. The authors exposed that many carceral institutions lack formal abortion policies, which likely makes the ability to receive abortions in those systems capricious and potentially vulnerable to systemic racism and other forms of unequal treatment among a highly vulnerable population. Not only did the authors use the data they were able to access to describe abortion rates within this sample, but the discussion offers a series of useful medical and policy goals and directions for future research, some of which appears to be very low hanging fruit (like pregnancy testing at intake for all reproductive age females at intake). In the paragraph beginning on line 299, the authors discuss several of the more nuanced considerations of the current state of abortion care in the carceral system. Notably, that the current practice of shackling patient in labor (which is common in various regions throughout the country) is inhumane. Additionally, in this era of reproductive justice, we have learned that honoring a pregnant person's autonomy requires that we offer a spectrum of non-judgmental options for everyone who is pregnant. For those women who are incarcerated, that means they should both have the option to receive an abortion as soon as a pregnancy is identified, but that same person should be offered comprehensive prenatal care, a dignified birth, and be allowed to bond with her infant postpartum if her desire is parenting. Reproductive coercion can work both ways, and it cannot be tolerated in the carceral system.

In summary, as the first study to document abortion incidence and policies in a large sample of thousands of women in the carceral system, this study captures an important and previously neglected area in academic medicine.

Reviewer #2:

This is an important paper shining a lens on inmates and potential barriers to access for abortion. I think this is an important topic that should be addressed as part of the larger societal conversation regarding prison reform. Article is important to demonstrate that access to abortion for incarcerated people has an arbitrary factor that needs to be addressed. Can you include in your discussion that there appears to be a need for a universally accepted or endorsed protocol for women who are jailed: to test all for pregnancy, and to offer options for that pregnancy.

I have a few suggestions:

Line 147: sites reported the number of women who requested an abortion. How do women request abortions? Would be interesting to have a glimpse of the process and understand whether that is a barrier

Line 151: You cite the abortion ration per the Guttmacher institute but Per the CDC definition the abortion ratio is: number of abortions per 1000 live births. Guttmacher: number abortions per 100 pregnancies ending in abortion or live birth. You need to define this in the paper because otherwise your allusion to miscarriages in the denominator is confusing.

Line 158 - not all readers will know what Hyde restrictions are, would be good to add short description.

Line 191: would be helpful to understand how a prison allows or doesn't allow an abortion. Under what governance - private or public does the facility allow or not allow?

Line 235/236: better to know the percentages or proportions here than raw numbers because hard to compare

Line 276: Seems like universal testing for pregnancy should be a protocol everywhere. Can you call for that in this paper? Is there an organization that is rallying for a universal policy of how to treat women at entry to incarceration? Seems like ACOG could develop a position statement if none exists. At a minimum please address this.

Reviewer #3:

The authors describe prison and jail policies and access to abortion on pregnancy outcomes over one year. They found that abortion policies varied, with some having no written policy at all, and most requiring the woman to pay for the service if she wanted an abortion. Abortion numbers were low overall, but significantly higher in settings that provided reasonable access. Key findings include that the abortion ratio of 1.4% in study prisons is 13 times lower than the US ratio of 18% and that both abortions and miscarriages were more common at prisons that performed pregnancy tests at intake. There were only 9 abortions in the study set, but the differences in the settings where they occurred and the rate compared to the US population is remarkable. Descriptive analyses were appropriate for the data available. The authors make a compelling argument that lack of access to abortion services denigrates reproductive autonomy and does not honor court decisions that have determined incarcerated people have the right to end a pregnancy. The manuscript is well-written, concise, and easy to follow.

Line 88 - The authors should briefly describe the Hyde Amendment, since not all readers will be familiar.

Line 191 - The ban on abortion in some prisons even in cases of rape or incest is astonishing, likely new information for readers.

Line 214 - In descriptions involving one or two states, is there a good reason not to just name the (abortion-hostile) state?

Line 310 - The connection to systemic racism and the need for health equity is important and relevant to this study.

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. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (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. Each of your coauthors received an email from the system, titled "Please verify your authorship for a submission to Obstetrics & Gynecology." Each author should complete the eCTA if they have not yet done so.

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), observational studies using ICD-10 data (ie, RECORD), 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, RECORD, 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 data definitions at <https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions> and the gynecology data definitions at <https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions>. 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).

\* If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."

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 limit for Original Research articles is 300 words; Reviews is 300 words; Case Reports is 125 words; Current Commentary articles is 250 words; Executive Summaries, Consensus Statements, and Guidelines are 250 words; Clinical Practice and Quality is 300 words; Procedures and Instruments is 200 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. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

11. 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%).

12. Your manuscript contains a priority claim. 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 it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

13. 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](http://edmgr.ovid.com/ong/accounts/table_checklist.pdf).

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in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

In addition, the American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found at the Clinical Guidance page at <https://www.acog.org/clinical> (click on "Clinical Guidance" at the top).

15. 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 <https://wkauthorservices.editage.com/open-access/hybrid.html>.

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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. Do not omit your responses to the Editorial Office or Editors' comments.

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 May 13, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,  
John O. Schorge, MD  
Associate Editor, Gynecology

2019 IMPACT FACTOR: 5.524  
2019 IMPACT FACTOR RANKING: 6th out of 82 ob/gyn journals

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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.



May 4, 2021

Dear Dr. Rouse and Dr. Schorge:

We are submitting for your consideration our revised, original research manuscript **Abortion Access for Incarcerated People: Incidence of Abortion and Policies at U.S. Prisons and Jails** for publication in *Obstetrics and Gynecology*.

Thank you and the reviewers for your thorough comments on our manuscript. We are grateful for the reviewers' and editors' detailed assessment of our manuscript and believe that our revised submission is stronger because of those comments. We have revised the manuscript using tracked changes based on these suggestions. This revision has been developed in consultation with all co-authors and they have given approval to the final form of the revision. Our point by point response to reviewers is below. In the comments, new text is identified by being underlined. In the revised manuscript, we have made changes using the tracked change feature, as instructed. In addition to revisions in response to reviewers, we have made several other minor edits to the manuscript to improve clarity. These are also reflected as tracked changes.

In response to the editors' efforts to increase transparency around its peer-review process, I confirm with: OPT-IN: Yes, please publish my point-by-point response letter. I have read the instructions for authors.

The lead author, Carolyn Sufrin, the manuscript's guarantor, 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.

We have followed the STROBE guidelines for reporting in observational studies. A checklist with reference to appropriate page numbers is at the end of this response to reviewers.

Portions of these data were presented at the 2017 North American Forum on Family Planning (and won the award that year for best oral abstract). There have been two publications of overall pregnancy outcomes that were collected in this study, including one in the Green Journal—Sufrin et. al. 2019, *AJPH* (doi: 10.2105/AJPH.2019.305006); and Sufrin et. al. 2020 *Obstet and Gynecol* (doi: 10.1097/AOG.0000000000003834). These publications focus on overall numbers of admissions of pregnant people, births, preterm births, C-sections and other outcomes, and do not focus on abortion. Some of those outcomes are also included in our reporting here in this manuscript in order to provide context for abortion outcomes, but those prior publications do not go into detail analyzing the abortions that occurred, such as trimester of abortions, whether they occurred in states that are hostile to abortion, that have Medicaid funding for non-incarcerated people seeking abortion, and whose prisons/jails are more than 10 miles from an abortion provider. Those two other publications also include no information about abortion policies at institutions in our study.

Thank you for your consideration of this revised manuscript on a timely and important topic of clinical, public health, and health equity significance.

Sincerely,



Carolyn Sufrin, MD, PhD, on behalf of co-authors  
 Assistant Professor  
 Department of Gynecology and Obstetrics  
 Johns Hopkins University School of Medicine  
 Department of Health, Behavior, and Society  
 Johns Hopkins Bloomberg School of Public Health

### **REVIEWER COMMENTS:**

#### **Reviewer #1:**

##### Abstract:

As this will be the most (and in many cases the only) read portion of the paper, I would not use the word "carceral" in the Background section, as it is not a word commonly used by a medical audience.

*Replaced "carceral" with "prisons' and jails"*

##### Introduction:

Although you define jails and prisons starting on line 132 in the Methods section, I was looking for a definition in the Introduction. Given that this is for a generalist OBGYN audience, our knowledge of the carceral system is very limited. Even if you want to keep the explanation in the methods section so that you can be as thorough as you are, consider a sentence in the Introduction or indicate that the definition is coming, as I was looking for this as soon as I started reading the introduction.

*Added the following text to the end of the first paragraph of the introduction:*

Prisons and jails, while both institutions intended to confine and punish people, have numerous differences that affect health care access, as described further below.

##### Methods:

Line 155: remove the extra period.

*Done*

##### General comments:

In this article, the authors survey abortion rates in a convenience sample of state and federal prisons and county jails. They found that although abortion is a federally protected legal right, abortion rates are low. Furthermore, restrictive policies within carceral institutions limit access to abortion, which appears to be more restrictive when those facilities are located in states that are generally more hostile towards abortion access. The authors exposed that many carceral institutions lack formal abortion policies, which likely makes the ability to receive abortions in those systems capricious and potentially vulnerable to systemic racism and other forms of unequal treatment among a highly vulnerable population.

Not only did the authors use the data they were able to access to describe abortion rates within this sample, but the discussion offers a series of useful medical and policy goals and directions for future research, some of which appears to be very low hanging fruit (like pregnancy testing at intake for all reproductive age females at intake).

In the paragraph beginning on line 299, the authors discuss several of the more nuanced considerations of the current state of abortion care in the carceral system. Notably, that the current practice of shackling patient in labor (which is common in various regions throughout the country) is inhumane. Additionally, in this era of reproductive justice, we



have learned that honoring a pregnant person's autonomy requires that we offer a spectrum of non-judgmental options for everyone who is pregnant. For those women who are incarcerated, that means they should both have the option to receive an abortion as soon as a pregnancy is identified, but that same person should be offered comprehensive prenatal care, a dignified birth, and be allowed to bond with her infant postpartum if her desire is parenting. Reproductive coercion can work both ways, and it cannot be tolerated in the carceral system.

In summary, as the first study to document abortion incidence and policies in a large sample of thousands of women in the carceral system, this study captures an important and previously neglected area in academic medicine.

*We thank the reviewer for this summary and assessment of the importance of this topic.*

## **Reviewer #2:**

This is an important paper shining a lens on inmates and potential barriers to access for abortion. I think this is an important topic that should be addressed as part of the larger societal conversation regarding prison reform. Article is important to demonstrate that access to abortion for incarcerated people has an arbitrary factor that needs to be addressed.

*Thank you for the recognition of the importance of this topic, especially in light of conversations of criminal legal system reform.*

Can you include in your discussion that there appears to be a need for a universally accepted or endorsed protocol for women who are jailed: to test all for pregnancy, and to offer options for that pregnancy.

*See below.*

I have a few suggestions:

Line 147: sites reported the number of women who requested an abortion. How do women request abortions? Would be interesting to have a glimpse of the process and understand whether that is a barrier

*This would certainly be interesting information to understand and report. Unfortunately, our study was not designed to be able to solicit this information. However, based on Dr. Sufrin's experiencing providing health care in a jail and working with clinicians at other prisons and jails, the processes are variable, but may primarily occur as it does through any health care service in prison or jail-- putting in writing a request to see a jail/prison health care professional and then the patient indicates their abortion request at a visit. We added the following text:*

; while we did not inquire about the process for women to request an abortion, requests for health care in general at many carceral facilities require the incarcerated person to submit a written form.

Line 151: You cite the abortion ration per the Guttmacher institute but Per the CDC definition the abortion ratio is: number of abortions per 1000 live births. Guttmacher: number abortions per 100 pregnancies ending in abortion or live birth. You need to define this in the paper because otherwise your allusion to miscarriages in the denominator is confusing.

*Revised this sentence to read:*

we adopted this strategy in order to make comparisons to the Guttmacher Institute's nationally reported abortion ratio, defined as the number of abortions per 100 pregnancies ending in abortion or live birth, and which does not include miscarriages in the denominator.<sup>16</sup>

Line 158 - not all readers will know what Hyde restrictions are, would be good to add short description.

*Added the following text:*

with payment according to Hyde Amendment restrictions, which prohibits the use of federal funds to pay for abortion except to save the life of the pregnant person or if the pregnancy resulted from rape or incest.<sup>8</sup>

Line 191: would be helpful to understand how a prison allows or doesn't allow an abortion. Under what governance - private or public does the facility allow or not allow?

*There is no formal governance structure under which they can dis-allow abortion. Each prison or jail will outline its health care policies based on its own leadership decisions—for a state prison, this likely comes under the department of corrections, but it may be under another state entity. For jails, it's even more variable. What allows facilities to not allow (or allow) abortion is the lack of standardization and accountability. The exception is federal BOP (the BOP exception is mentioned in the introduction). We have underscored the conditions that make this possible in the discussion:*

The health care services that an individual state prison or jail chooses to provide access to are not subject to any system of mandatory oversight ensuring that a certain standard set of services are provided; this lack of national governance or accountability system is what enables some facilities to permit abortion and others not to permit it.

Line 235/236: better to know the percentages or proportions here than raw numbers because hard to compare  
*We have added the proportions:*

(n=32, 8% vs. n=10, 3%, not shown).

Line 276: Seems like universal testing for pregnancy should be a protocol everywhere. Can you call for that in this paper? Is there an organization that is rallying for a universal policy of how to treat women at entry to incarceration? Seems like ACOG could develop a position statement if none exists. At a minimum please address this.

ACOG has recently revised its CO on Health Care for Pregnant Incarcerated Women, a publication of the Committee on Health Care for Underserved Women. The new CO, which was published electronically (epub ahead of print) on April 28, 2021, is significantly revised and includes updated policy and protocol recommendations, including pregnancy testing at intake. The National Commission on Correctional Health Care also makes this recommendation. We have added new text:

The lack of and inconsistent written policies demonstrates the need to implement standardized protocols for offering pregnancy testing at intake to all people with the capacity to become pregnant and providing access to abortion and continuing pregnancy care, as recommended by the American College of Obstetricians and Gynecologists and the National Commission on Correctional Health Care.

### **Reviewer #3:**

The authors describe prison and jail policies and access to abortion on pregnancy outcomes over one year. They found that abortion policies varied, with some having no written policy at all, and most requiring the woman to pay for the service if she wanted an abortion. Abortion numbers were low overall, but significantly higher in settings that provided reasonable access. Key findings include that the abortion ratio of 1.4% in study prisons is 13 times lower than the US ratio of 18% and that both abortions and miscarriages were more common at prisons that performed pregnancy tests at intake. There were only 9 abortions in the study set, but the differences in the settings where they occurred and the rate compared to the US population is remarkable. Descriptive analyses were appropriate for the data available. The authors make a compelling argument that lack of access to abortion services denigrates reproductive autonomy and does not honor court decisions that have determined incarcerated people have the right to end a pregnancy. The manuscript is well-written, concise, and easy to follow.

*We thank the reviewer for their recognition of the importance of the study and the positive comments on the writing.*

Line 88 - The authors should briefly describe the Hyde Amendment, since not all readers will be familiar.  
*See response to reviewer #2, above, for new text.*

Line 191 - The ban on abortion in some prisons even in cases of rape or incest is astonishing, likely new information for readers.

*It is indeed a striking and troubling finding.*

Line 214 - In descriptions involving one or two states, is there a good reason not to just name the (abortion-hostile) state?

*Since there was only one state in our study that had two jail sites, Texas, and since 2 jails in one state is apparent in Table 1, we have identified this in the results. However, at other points, especially when talking about prisons, we have chosen for brevity to emphasize the abortion-hostile characteristic rather than an individual state and have kept the text as is.*

Line 310 - The connection to systemic racism and the need for health equity is important and relevant to this study.  
*Thank you for acknowledging this.*

EDITORIAL OFFICE COMMENTS:

In addition, the abstract length should follow journal guidelines. The word limit for Original Research articles is 300 words. Please provide a word count.

*Abstract word count is: 283*

ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

*We have changed the language from "abortion provider" to "abortion caregiver" throughout.*

12. Your manuscript contains a priority claim. 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 it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

*We have removed this claim.*

STROBE Statement—checklist of items that should be included in reports of observational studies  
**PAGE NUMBERS ARE FOR THE REVISED MANUSCRIPT WITH TRACKED CHANGES**  
**ACCEPTED**

|                          | 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   | 4       |
|                          |         | (b) Provide in the abstract an informative and balanced summary of what was done and what was found  | 4       |
| Introduction             |         |  |         |
| Background/rationale     | 2       | Explain the scientific background and rationale for the investigation being reported   | 6       |
| Objectives               | 3       | State specific objectives, including any prespecified hypotheses   | 6       |
| Methods                  |         |  |         |
| Study design             | 4       | Present key elements of study design early in the paper  | 7       |
| Setting                  | 5       | Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection  | 7-8     |
| Participants             | 6       | (a) Cohort study—Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up  | 7       |
|                          |         | 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  |         |
|                          |         | (b) Cohort study—For matched studies, give matching criteria and number of exposed and unexposed   | n/a     |
|                          |         | Case-control study—For matched studies, give matching criteria and the number of controls per case   |         |
| Variables                | 7       | Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable   | 8-9     |
| 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 | 7-9     |
| Bias                     | 9       | Describe any efforts to address potential sources of bias  | 8       |
| Study size               | 10      | Explain how the study size was arrived at  | 7-8     |
| Quantitative variables   | 11      | Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why   | 9-10    |
| n/aStatistical methods   | 12      | (a) Describe all statistical methods, including those used to control for confounding  | 9-10    |
|                          |         | (b) Describe any methods used to examine subgroups and interactions  | 9-10    |
|                          |         | (c) Explain how missing data were addressed  | 9-10    |
|                          |         | (d) Cohort study—If applicable, explain how loss to follow-up was addressed  | 9-10    |
|                          |         | 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

(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            | 10        |
|                  |     | (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   | 10-11, 19 |
|                  |     | (b) Indicate number of participants with missing data for each variable of interest  | 13-14     |
|                  |     | (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   | 10-14     |
| 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  | n/a       |
|                  |     | (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   | 21-22     |

## Discussion

|                  |    |  |       |
|------------------|----|--|-------|
| Key results      | 18 | Summarise key results with reference to study objectives   | 13    |
| 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                 | 16-17 |
| Interpretation   | 20 | Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence | 13-16 |
| Generalisability | 21 | Discuss the generalisability (external validity) of the study results  | 16-17 |

## 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 | 1,7 |
|---------|----|---|-----|

\*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](http://www.strobe-statement.org).