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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.

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

Date: Aug 05, 2022
To: "Stephen Wagner" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-22-1061

RE: Manuscript Number ONG-22-1061

Temporal Changes in Counseling for and Use of Emergency Contraception From 2011-2019

Dear Dr. Wagner:

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

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

To facilitate our review, we prefer that the cover letter you submit with your revised manuscript include each reviewer and Editor comment below, followed by your response. That is, a point-by-point response is required to each of the EDITOR COMMENTS (if applicable), REVIEWER COMMENTS, STATISTICAL EDITOR COMMENTS (if applicable), and EDITORIAL OFFICE COMMENTS below. Your manuscript will be returned to you if a point-by-point response to each of these sections is not included.

The revised manuscript should indicate the position of all changes made. Please use the "track changes" feature in your document (do not use strikethrough or underline formatting).

Your submission will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Aug 26, 2022, we will assume you wish to withdraw the manuscript from further consideration.

DEPUTY EDITOR - GYN COMMENTS:

The Editors feel the submission would be best shortened as a Research Letter with some of the data in Supplemental Content. The guidelines for Research Letters is available at https://journals.lww.com/greenjournal/Pages /InformationforAuthors.aspx#II-C.

REVIEWER COMMENTS:

Reviewer #1:

Strengths:
* The survey data used, the NSFG, is very representative of the national population, and sampling is done mindfully, making these results very generalizable, and there is sufficient information in the demographics to appropriately describe the population and exclude folks who are not pregnancy-eligible.
* Primary outcome is clearly identified and meaningful, as the stated aims are to determine if counseling behaviors have changed in the medical field.
* Adjustment for confounders was performed appropriately, and the database has sufficient information to do appropriate correction.
* Sensitivity analysis is planned and performed, which increases the confidence of the reader in these results.

Limitations:
* As this is a negative study (no difference in counseling found) for the primary outcome, lack of power analysis means we don't know the true likelihood of a type II error. Even though this is a very large sample, so error around prevalence estimates is low, these are very low prevalences (3-5%), which makes it hard to see meaningful differences.
* The primary outcome is based on patient recall, which is, by nature, not known to be 100% for remembering options offered by physicians or medical providers, especially if the concept that was discussed is new/novel to the patient. There

is evidence that patients don't recall or integrate counseling about new things to them until the 2nd or 3rd time they hear it, so it is certainly possible that these patients were offered emergency contraception counseling on at least one occasion in the last year and did not recall it as such.
* As the survey is de-identified and the authors do not specifically address this in the manuscript, it is unclear if there is any possibility of overlap between these two populations. In other words, is there any chance that the same woman was asked the questions in both time windows? Or is that the protocol of the survey to exclude women who were queried previous. Double sampling affects what statistical tests are appropriate and how we think about results that are cumulative, such as "ever use" of emergency contraception.

Comments for authors by section

Introduction:
* Line 54-58: There is no clear hypothesis stated, which would make the thinking more clear.

Methods:
* Although this is a minor point, as this is a very large sample and likely has large power, it would have been nice to see some type of power analysis (post hoc) or a priori to determine if the sampling would be adequate from the years mentioned. This would help us have insight into the authors' thinking about how much of an increase in prevalence of counseling (the primary outcome) is clinically meaningful from a physician and/or patient perspective.
* It should be addressed somewhere in the Methods if double sampling was possible or probable in the two time windows. Did the survey methods exclude women that has been queried before specifically, and have methods to do that?

Discussion:
* Line 149-155: I would recommend discussing the limitations of patient recall in the limitations somewhere, as that is a large thing affecting your results, particularly the primary outcome. Women would recall using emergency contraception well, most likely, but recall of counseling about it is spotty at best.

Reviewer #2:

Overall: This manuscript addresses temporal changes in counseling for and use of EC from two cohorts starting in 2011 and ending in 2019. Policy changes occurred between the two groups that may have impacted both findings. While there was a rise in EC ever use overall, there was no change in structured counseling, even in participants that were not currently using another form of contraception. These are very interesting findings and are well described and easy to read. Minor edits are suggested.

Title: Accurately reflects the content of the manuscript

Précis: Accurately reflects the content of the manuscript

Abstract: Accurately reflects the content of the manuscript

Introduction:
Does a good job setting up the rest of the manuscript by introducing EC and counseling and why the topic is important to research

Methods:
No suggested edits, well described

Results:
Main results described; no edits suggested

Discussion:
How does ella play a role in these temporal changes? It would be important to include this in the discussion given that ella was first approved in the US in 2010 and still requires a prescription and therefore (generally speaking) structured counseling.

References:
Would omit or find another reference in lieu of 9, given link is no longer active and a wordpress site may lack the appropriate legitimacy

Tables/Figures:
Table 1 - Ensure percentages align with appropriate categories in first column; ensure Current health insurance and TOTAL pregnancies have categories tabbed over from headings above for consistency

Table 2 - No suggested edits

Table 3 - No suggested edits

STATISTICAL EDITOR COMMENTS:

Table 1: To further clarify that the mean total # pregnancies was < the mean # of live births, need to provide more information re: the parity, gravity of the cohorts, expressed in terms of median (range or IQR).

Tables 2, 3: Since the cohorts in the two time periods differed in age, education, insurance, income etc need to corroborate the multivariable logistic regression analysis with propensity score matching or some other matching algorithm to help convince the reader that the observed changes in rates of EC were not due to demographic differences.

Tables 2, 3: Should provide estimates for the counts in the subsets and justify that the counts provide sufficient sample size for the outcome of interest for all subsets.

EDITORIAL OFFICE COMMENTS:

1. If your article is accepted, the journal will publish a copy of this revision letter and your point-by-point responses as supplemental digital content to the published article online. You may opt out by writing separately to the Editorial Office at em@greenjournal.org, and only the revision letter will be posted.

2. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:
* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and at the end of the abstract. For industry-sponsored studies, describe on the title page how the funder was or was not involved in the study.
* Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
* Name the IRB or Ethics Committee institution in the Methods section (if applicable).
* Add any information about the specific location of the study (ie, city, state, or country), if necessary for context.

3. Obstetrics & Gynecology's Copyright Transfer Agreement (CTA) must be completed by all authors. When you uploaded your manuscript, each coauthor received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please ask your coauthor(s) to complete this form, and confirm the disclosures listed in their CTA are included on the manuscript's title page. If they did not receive the email, they should check their spam/junk folder. Requests to resend the CTA may be sent to em@greenjournal.org.

4. For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, describe the reasons that race and ethnicity were assessed in the Methods section and/or in table footnotes. Race and ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.

Use "Black" and "White" (capitalized) when used to refer to racial categories.

List racial and ethnic categories in tables in alphabetic order. Do not use "Other" as a category; use "None of the above" instead.

Please refer to "Reporting Race and Ethnicity in Obstetrics & Gynecology" at https://edmgr.ovid.com/ong/accounts/Race_and_Ethnicity.pdf.

5. ACOG uses person-first language. Please review your submission to make sure to center the person before anything else. Examples include: "People with disabilities" or "women with disabilities" instead of "disabled people" or "disabled women"; "patients with HIV" or "women with HIV" instead of "HIV-positive patients" or "HIV-positive women"; and "people who are blind" or "women who are blind" instead of "blind people" or "blind women."

6. The journal follows ACOG's Statement of Policy on Inclusive Language (https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language). When possible, please avoid using gendered descriptors in your manuscript. Instead of "women" and "females," consider using the following: "individuals;"

"patients;" "participants;" "people" (not "persons"); "women and transgender men;" "women and gender-expansive patients;" or "women and all those seeking gynecologic care."

7. 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:

STROBE: observational studies

Include the appropriate checklist for your manuscript type upon submission, if applicable, and indicate in your cover letter which guideline you have followed. 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 www.equator-network.org/.

8. 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.

9. Make sure your manuscript meets the following word limit. The word limit includes the manuscript body text only (for example, the Introduction through the Discussion in Original Research manuscripts), and excludes the title page, précis, abstract, tables, boxes, and figure legends, reference list, and supplemental digital content. Figures are not included in the word count.

Research Letters: 600 words (do not include more than two figures and/or tables [2 items total])

10. Specific rules govern the use of acknowledgments in the journal. Please review the following guidelines and edit your title page as needed:

* 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 or indicate whether the meeting was held virtually).
* 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]."
* Do not use only authors' initials in the acknowledgement or Financial Disclosure; spell out their names the way they appear in the byline.

11. Be sure that each statement and any data in the abstract are also stated in the body of your manuscript, tables, or figures. Statements and data that appear in the abstract must also appear in the body text for consistency. Make 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 manuscript.

In addition, the abstract length should follow journal guidelines. Please provide a word count.

Research Letter: 125 words

12. 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.

13. The journal does not use the virgule symbol (/) in sentences with words, except with ratios. 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.

14. ACOG avoids using "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.

15. 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.

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

Express all percentages to one decimal place (for example, 11.1%"). Do not use whole numbers for percentages.

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

17. Please review examples of our current reference style at https://edmgr.ovid.com/ong/accounts/ifa_suppl_refstyle.pdf. Include the digital object identifier (DOI) with any journal article references and an accessed date with website references.

Unpublished data, 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 formal reference list. Please cite them on the line in parentheses.

If you cite ACOG documents in your manuscript, be sure the references you are citing are still current and available. Check the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top). If the reference is still available on the site and isn't listed as "Withdrawn," it's still a current document. In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript.

Please make sure your references are numbered in order of appearance in the text.

18. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

19. 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.

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.

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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 as a Microsoft Word document. Your revision's cover letter should include a point-by-point response to each of the received comments in this letter. Do not omit your responses to the EDITOR COMMENTS (if applicable), the REVIEWER COMMENTS, the STATISTICAL EDITOR COMMENTS (if applicable), or the EDITORIAL OFFICE COMMENTS.

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

Again, your manuscript will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Aug 26, 2022, we will assume you wish to withdraw the manuscript from further consideration.

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

BROWN
Alpert Medical School

Department of Obstetrics, Gynecology &
Reproductive Sciences
Alpert Medical School

August 19, 2022

Jason Wright, MD
Editor-in-Chief
Obstetrics & Gynecology

RE: Temporal Changes in Counseling for and Use of Emergency Contraception From 2011-2019

Dear Dr Wright:

Thank you for the opportunity to revise our manuscript ONG-22-1061 "Temporal Changes in Counseling for and Use of Emergency Contraception From 2011-2019"

We have carefully reviewed your email dated August 5th, 2022, enclosing your comments and the reviewers' comments of our manuscript. Per the request of the editors, we have reformatted our submission into a research letter. We have revised the manuscript according to the reviewers' comments and we have provided our responses in a point-by-point manner. Some comments were acknowledged but not included secondary to the space limitations of the research letter format. Revisions in the manuscript are updated using Tracked Changes feature in Microsoft Word. Please note that the line numbers noted in our responses below refer to the clean copy. We hope the revised version is now suitable for publication in *Obstetrics & Gynecology* and we look forward to sharing this work with your readers.

Finally, I have read the Instructions for Authors and I affirm 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.

Sincerely yours,

Stephen M. Wagner, MD
Department of Obstetrics, Gynecology, and Reproductive Sciences
Warren Alpert Medical School of Brown University
[redacted]

DEPUTY EDITOR - GYN COMMENTS:

The Editors feel the submission would be best shortened as a Research Letter with some of the data in Supplemental Content.

Response: We appreciate this idea and have reformatted our manuscript as a Research Letter.

Reviewer #1:

Strengths:
* The survey data used, the NSFG, is very representative of the national population, and sampling is done mindfully, making these results very generalizable, and there is sufficient information in the demographics to appropriately describe the population and exclude folks who are not pregnancy-eligible.
* Primary outcome is clearly identified and meaningful, as the stated aims are to determine if counseling behaviors have changed in the medical field.
* Adjustment for confounders was performed appropriately, and the database has sufficient information to do appropriate correction.
* Sensitivity analysis is planned and performed, which increases the confidence of the reader in these results.

Limitations:
* As this is a negative study (no difference in counseling found) for the primary outcome, lack of power analysis means we don't know the true likelihood of a type II error. Even though this is a very large sample, so error around prevalence estimates is low, these are very low prevalences (3-5%), which makes it hard to see meaningful differences.
* The primary outcome is based on patient recall, which is, by nature, not known to be 100% for remembering options offered by physicians or medical providers, especially if the concept that was discussed is new/novel to the patient. There is evidence that patients don't recall or integrate counseling about new things to them until the 2nd or 3rd time they hear it, so it is certainly possible that these patients were offered emergency contraception counseling on at least one occasion in the last year and did not recall it as such.
* As the survey is de-identified and the authors do not specifically address this in the manuscript, it is unclear if there is any possibility of overlap between these two populations. In other words, is there any chance that the same woman was asked the questions in both time windows? Or is that the protocol of the survey to exclude women who were queried previous. Double sampling affects what statistical tests are appropriate and how we think about results that are cumulative, such as "ever use" of emergency contraception.

Response: We appreciate the reviewer's detailed comments about the manuscript.

Comments for authors by section

Introduction:

* Line 54-58: There is no clear hypothesis stated, which would make the thinking more clear.

Response: We thank the reviewer for this comment, we explicitly stated our hypothesis in line 25.

Methods:

* Although this is a minor point, as this is a very large sample and likely has large power, it would have been nice to see some type of power analysis (post hoc) or a priori to determine if the sampling would be adequate from the years mentioned. This would help us have insight into the authors' thinking about how much of an increase in prevalence of counseling (the primary outcome) is clinically meaningful from a physician and/or patient perspective.

Response: We appreciate the point that in a negative study such as this, it is possible that the result is either due to a true lack of relationship between the variables in question, or to a type II error. We did not perform an a priori power analysis in this case since with these secondary data, we were not, of course, in a position to recruit additional participants. We are eager to provide whatever additional background or information we can to contextualize our findings. However, we are hesitant to calculate a post hoc / observed power analysis, as we recognize this result would largely be driven by the observed p-value, and non-significant p-values consistently correspond to low observed powers. We believe, therefore, that a post hoc power analysis does not provide a great deal of further insight into the validity of our findings (see Hoenig and Heisey in The American Statistician. 2001;55(1):1-6. https://www.vims.edu/people/hoenig_jm/pubs/hoenig2.pdf).

However, to underscore the precision of our estimates, we would point out that the 95% confidence intervals around our prevalence estimates are consistently narrow (with upper and lower bounds of the CI largely within a 1-2% absolute difference of the point estimate). This does raise our confidence that our findings are valid, and not due to type II error. Likewise, our findings were consistent across our main unadjusted and adjusted analyses, our sensitivity analysis among those not using other forms of contraception, and our propensity score matched sensitivity analysis. This triangulation with multiple analytic approaches reinforces our conclusion that we have uncovered a true pattern in the data, rather than an effect that is the result of the specifications of a particular model.

* It should be addressed somewhere in the Methods if double sampling was possible or probable in the two time windows. Did the survey methods exclude women that has been queried before specifically, and have methods to do that?

Response: We thank the reviewer for this observation. In reviewing the NSFG sampling documentation (https://www.cdc.gov/nchs/data/nsfg/NSFG-2017-2019-Sample-Design-Documentation-508.pdf), we did not identify specific provisions for excluding any one household or respondent from re-sampling across survey windows. We have also posed this question to the biostatistics team in charge of NSFG at CDC, but as of the

time of this revision, we have not been able to explicitly clarify this point. However, as each survey window is nationally-representative in and of itself and our primary analysis compared national-level data across the 2011-2013 and 2017-2019 windows, and given both the large sampling frame for each survey window, and the large n for the study overall, we believe that any autocorrelation due to re-sampling is unlikely to have meaningfully biased our results. Due to the limited length of the Research Letter we did not add this comment into the main text, though if the editors feel this is a critical point, we are very happy to revisit this.

Discussion:

* Line 149-155: I would recommend discussing the limitations of patient recall in the limitations somewhere, as that is a large thing affecting your results, particularly the primary outcome. Women would recall using emergency contraception well, most likely, but recall of counseling about it is spotty at best.

Response: We thank the reviewer for this observation. We have acknowledged this limitation in lines 66-67.

Reviewer #2:

Overall: This manuscript addresses temporal changes in counseling for and use of EC from two cohorts starting in 2011 and ending in 2019. Policy changes occurred between the two groups that may have impacted both findings. While there was a rise in EC ever use overall, there was no change in structured counseling, even in participants that were not currently using another form of contraception. These are very interesting findings and are well described and easy to read. Minor edits are suggested.

Title: Accurately reflects the content of the manuscript

Précis: Accurately reflects the content of the manuscript

Abstract: Accurately reflects the content of the manuscript

Introduction:
Does a good job setting up the rest of the manuscript by introducing EC and counseling and why the topic is important to research

Methods:
No suggested edits, well described

Results:
Main results described; no edits suggested

Response: The authors thank the reviewer for the above comments.

Discussion:
How does ella play a role in these temporal changes? It would be important to include this in the discussion given that ella was first approved in the US in 2010 and still requires a prescription and therefore (generally speaking) structured counseling.

Response: We appreciate this comment. Unfortunately, the NSFG dataset does not distinguish between medications utilized as emergency contraception. As such we cannot comment on the temporal changes in the utilization of Ella. Due to the word limitations of the Research Letter format we were unable to address this in the text.

References:
Would omit or find another reference in lieu of 9, given link is no longer active and a wordpress site may lack the appropriate legitimacy

Response: We thank the reviewer for this observation. We now cite: Cleland K, Bass J, Doci F, Foster AM. Access to Emergency Contraception in the Over-the-Counter Era. Womens Health Issues. 2016;26(6):622-7.

Tables/Figures:
Table 1 - Ensure percentages align with appropriate categories in first column; ensure Current health insurance and TOTAL pregnancies have categories tabbed over from headings above for consistency

Response: The authors thank the reviewer for this observation and have attempted to adjust the table.

Table 2 - No suggested edits

Table 3 - No suggested edits

STATISTICAL EDITOR COMMENTS:

Table 1: To further clarify that the mean total # pregnancies was < the mean # of live births, need to provide more information re: the parity, gravity of the cohorts, expressed in terms of median (range or IQR).
Response: We thank the reviewer for this comment. We recognize how including both of these variables may introduce confusion. We are happy to rework this table to include just one, if that would be clearer. In the meantime, we have edited the table to attempt to clarify the coding definitions that account for this result: according to the NSFG coding, the total pregnancy number (variable name pregnum) is applicable to all

respondents. In contrast, number of live births (variable name lbpregs) is applicable only to those who have had a completed pregnancy. Therefore, the mean of the number of total pregnancies (pregnum) is consistently smaller than the mean of the number of live births (lbpregs), because respondents who have never had a completed pregnancy contribute a value of 0 for total pregnancy number (pregnum), but have missing data for total number of live births (lbpregs). At the same time, those with any completed pregnancy are much more likely to have had a live birth than those who have never had a completed pregnancy. This combination of factors accounts for the higher mean and median values of number of live births than total pregnancies.

For further distribution details, please see the unweighted median, IQR, and range information below:

Timeframe 1, Total pregnancies median (IQR, range): 1 (0-2, 0-16)
Timeframe 2, Total pregnancies median (IQR, range): 0 (0-2, 0-14)

Timeframe 1, Live-birth pregnancies median (IQR, range): 1 (1-2, 0-9)
Timeframe 2, Live-birth pregnancies median (IQR, range): 2 (1-2, 0-11)

Tables 2, 3: Since the cohorts in the two time periods differed in age, education, insurance, income etc need to corroborate the multivariable logistic regression analysis with propensity score matching or some other matching algorithm to help convince the reader that the observed changes in rates of EC were not due to demographic differences.

Response: We appreciate the point that demographic differences may have driven the observed difference in ever-use of EC. As requested, we performed a propensity score matched version of our analysis, the results of which are summarized below. With propensity score matching, we obtained globally well-balanced numbers in each demographic category, and found a Rubin's B of 15.1, and a Rubin's R of 0.93, both further suggesting appropriate covariate balance across our groups. Our findings from the propensity score matched analysis corroborated our findings from the multivariable logistic regression:

OR (95% CI) of EC counseling in the last 12 months for 2017-2019, compared with 2011-2013: 0.71 (0.49-1.03)
OR (95% CI) of EC use in the last 12 months for 2017-2019, compared with 2011-2013: 1.05 (0.79-1.40)
OR (95% CI) of ever use of EC for 2017-2019, compared with 2011-2013: 1.39 (1.17-1.66)

As these results corroborate our prior analysis, we have added text to describe this additional, confirmatory analysis in the supplement.

Tables 2, 3: Should provide estimates for the counts in the subsets and justify that the counts provide sufficient sample size for the outcome of interest for all subsets.

Response: We agree that an appropriate sample size and events per variable are important to the validity of the analysis. We have edited our tables to include the number of participants in each category, and maintained the weighted percentages and 95% CIs, as per our prior draft. We believe these ns are adequate for the assumptions of our models. Based on a requirement for 10 events per variable (Pedruzzi et al. A simulation study of the number of events per variable in logistic regression analysis. J Clinical Epidemiology. 1996;49:1373-1379.), a conservative sample size estimate for valid logistic regression based on 9 covariates (as in our multivariable adjusted analysis), and an event prevalence of 3.5% (our lowest raw event prevalence over two survey windows for this analysis) would be an n of 2,571 (or, (10*9)/0.035). We had 8,654 respondents in our overall study population, well exceeding this cutoff. Likewise, with 8 variables (as in our non-contracepting sensitivity analysis, since we no longer included contraceptive status as a covariate in this model), and an event prevalence of 2.2% (our lowest raw event prevalence over two survey windows in this analysis), a conservative sample size estimate for valid logistic regression would be 3,636 (or, (10*8)/0.022). We had 3,693 respondents in this sensitivity analysis population, again exceeding the cutoff for valid use of logistic regression. We therefore believe our sample size is adequate for this methodology.

1. If your article is accepted, the journal will publish a copy of this revision letter and your point-by-point responses as supplemental digital content to the published article online. You may opt out by writing separately to the Editorial Office at em@greenjournal.org, and only the revision letter will be posted.

Response: The authors acknowledge this statement.

2. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:

* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and at the end of the abstract. For industry-sponsored studies, describe on the title page how the funder was or was not involved in the study.
* Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
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