NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

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

Date: 11/22/2024
To: "Anna Fiastro" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-24-1873

11/22/2024

RE: ONG-24-1873: Telehealth medication abortion: A comparison of advance provision and pregnant patients in the United States

Dear Dr. Fiastro:

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, and STATISTICAL EDITOR COMMENTS (if applicable) below. 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). Upload the tracked-changes version when you submit your revised manuscript.

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 12/13/2024, we will assume you wish to withdraw the manuscript from further consideration.

EDITORIAL OFFICE COMMENTS:

Please note the following:

* Help us reduce the number of queries we add to your manuscript after it is revised by reading the Revision Checklist at https://journals.lww.com/greenjournal/Documents/RevisionChecklist_Authors.pdf and making the applicable edits to your manuscript.

* As of January 2024, only certain article types will appear in the print version of the journal. All accepted articles will continue to publish online. All articles will be indexed in PubMed as an official article of Obstetrics & Gynecology. Additional information is available in the Instructions for Authors (https://journals.lww.com/greenjournal/Pages/InformationforAuthors.aspx#II).

EDITOR COMMENTS:

Thank you for submitting this manuscript. This is an interesting topic- please respond to the comments in your revision. As the statistical editor indicates, having a denominator for the area in which the populations come from would be key to understanding more about the underlying rates of use.

STATISTICAL EDITOR COMMENTS:

Tables 1,2: Need units for age.

Figures 2, 3: The use of the scale "Number of People mailed pills" as applied to the county units in each State is somewhat misleading. The areas identified as having higher numbers were also predominantly "Large metro" areas as described in Tables 1 and 2. Should instead format as number of people mailed pills/total number of women of childbearing age in each county. That is, need to index it per the potential population of users in each county. Otherwise, the scale could simply be reflecting the counties with larger populations.

lines 128-130: Without context as to the populations of these States, one cannot interpret these proportions. Could simply reflect their corresponding populations.

REVIEWER COMMENTS:

Reviewer #1:

This study compares pregnant and non-pregnant patient demographics who requested advanced provision of abortion medications. I thank the authors for exploring this topic as it is interesting to learn about the differences between these two populations. The paper is clear and easy to follow.

Methods
I'm a little unclear about how patients know they could get advanced provision of abortion medications. Were patients informed of this option if they had already accessed care through Aid Access? Was public information posted online or through social media to make the general public aware?

I wonder if the authors have any insight into what patients did with their advanced provision medications? How often were they used (not disbursed but used)? Did any patients request more than one dose over the time period? Are any follow up studies, qualitative or quantitative, planned to better understand what happens after medication abortion medication disbursement?

Reviewer #2:

Overall, this piece is well constructed and will provider new insight into the shifting trends in abortion access in the United States. I have made some minor suggestions which may strengthen the readers' interpretation of the results and ability to consider future horizons. Thank you for this thoughtful piece.

Abstract:
No changes, description is succinct but comprehensive and gives readers a grounded basis of the research question, methodology, and results.

Introduction:
Overall, this section is well written and appropriate for the work. The authors allude to (lines 38-39, 42-43) advanced provision addressing barriers to care, but might also consider addressing explicitly this model's positionality with regard to personal empowerment and de-medicalization of the abortion process for those most subject to structural disadvantage.

Methods:
Line 59 - Could you comment on why those 27 states were included? I suspect it may be where Aid Access has operations, but a statement may allow us to better interpret who from these states feels comfortable asking for medications in advance.
Line 63 - For analysis purposes, how were participants who indicated they may be pregnant categorized?
Line 71 - Would be interesting consideration for your discussion section whether the difference in fee structure may have any relation to patient demographics noted here. > Appreciate this discussion in lines 169-171.
Tests of comparison are well described and appropriate.

Results: General comment (also would apply for data presented in the abstract): The authors (with guidance from the editorial team) could consider adding numerator/denominator when proportions are presented, which helps readers interpret data and understand when subgroups are being compared.
Overall, the results highlighted are appropriately chosen and clearly described.

Discussion:
Lines 183- 188 - I think these are the crux of the issue and most important to underscore. I would encourage the authors to call for more work understanding attitudes of people who experience more structural disadvantage in accessing sexual/ reproductive health care around advanced provision medication abortion and their values, concerns, and perceptions in

how this care is delivered.

Tables
While number of children is a reasonable metric to report, I would also consider including 'prior experience with medication abortion' as it may be interesting to note if this also differed between the groups (aka were people with a prior medication abortion experience more likely to consider advanced provision?)

Reviewer #3:

This is a cross-sectional study evaluating the number of advanced provision medication abortion pills prescribed during the time period of important U.S. judicial rulings that could impact abortion access and comparing the demographic characteristics of pregnant and advanced provision medication abortion patients from a single asynchronous telemedicine medication abortion provider (Aid Access) in 27 U.S. states and D.C.

Line 33 Introduction: clear and concise, but focusing on the comparison in demographic difference between advanced provision and pregnant patients, not on the changes in volume of advance provision medications during certain judicially significant time periods for abortion access.

Linge 54: (general comment on the methods) it looks like this was a convenience sample rather than a sample size determined from a power calculation, I would clearly state this somewhere in the methods if so.

Line 57 appropriate use and reporting of STROBE guidelines

Line 59: Why was this study performed in only 27 U.S. states? I was under the impression Aid Access provided medication abortion in all 50 states.

Line 64: Up to what gestational age is medication abortion provided for patients via Aid Access? Could have an impact on the demographic findings.

Line 71: the fact that the minimum cost for medication abortion pills was different for pregnant patients versus for advanced provision could have an important impact on the demographic differences in the two groups, and should be expounded beyond what is mentioned in the discussion (Line 169-173)

Line 73: It seems like the main takeaway from this study is not actually the primary outcome stated in methods, but rather the demographic differences between the two groups.

Line 96: The "primary outcome" here seems like somewhat of an afterthought, and if this is still included in the paper there needs to be more of an effort to tie in how these findings relate to the main story about the demographic differences. Are you trying to better describe the population of patients who request advanced provision? What do the temporal differences in requesting medications say about this population?

Line 109-111 Impressively large sample size is a strength of the study

Line 117: So interesting how many nulliparous patients are in both groups (although a larger proportion in the advanced provision group) which is different than the general demographics of patients seeking abortion care (majority having at least one child). Why do you think the pregnant patient population seeking medication abortion via Aid Access is different form the general abortion care population in this way? Demonstrates that findings may have limited generalizability.

Line 129: Interesting that most of the advanced provision patients live in states where abortion remained accessible and not restricted (although recognizing these states also have larger populations). I think this speaks to your argument that this group faces much fewer barriers to abortion.

Line 137-142: Again, your primary outcome here seems like an afterthought—does this significantly contribute to the paper or the important findings?

Line 161: I would expand on this conclusion—how could advanced provision be adjusted to better serve patient populations that experience greater barriers to abortion access? Decreasing the cost could be a major component, perhaps! Or is it somewhat like EC, where patients at highest risk of unwanted pregnancy seem not to opt for advanced provision for some reason?

Line 177: Is there a way you could follow up with advance provision patients to see if they ever actually used the medications?

Line 188: A qualitative study asking populations who experience greater barriers to access about their attitudes and beliefs regarding advanced provision of medication abortion could be particularly illuminating to answer some of these questions.

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Sincerely,
The Editors of Obstetrics & Gynecology

UW Medicine
UW SCHOOL OF MEDICINE

December 10, 2024

Jason D. Wright, MD
Editor in Chief, *Obstetrics & Gynecology*
409 12th Street SW
Washington, DC 20024

Dear Dr. Wright,

Please consider the revisions we have made to the manuscript, *Telehealth medication abortion: A comparison of advance provision and pregnant patients in the United States,* for publication in *Obstetrics & Gynecology* with point-by-point response to reviewer comments below.

We feel this paper continues to be timely and critical as access to medication abortion remains extremely limited in the U.S. Our research compares the patient population requesting medication abortion through telehealth for possible future use, a model known as advance provision, with pregnant patients using the same service. This study identified key differences in demographics, service utilization, and geographic distribution between these two groups. These findings build on recent work by Aiken et al. (JAMA, 2024), which focused solely on advance provision patients. By investigating differences in advance provision and pregnant patients, our findings provide additional insight into patient demographics, preferences, and the sustained demand for abortion services.

We confirm that the manuscript is original, has not been published elsewhere, and is not currently under consideration by another journal. We would welcome any opportunity to revise the manuscript in response to further feedback from reviewers. Preliminary findings were presented in poster format at the Society of Family Planning Annual Meeting in Baltimore, MD December 2022. Emily M. Godfrey receives honoraria as a trainer in the Nexplanon Clinical Training Program from Organon, outside the submitted work. None of the other authors has any conflicts of interest related to the submitted work.

The content is solely the responsibility of the authors and does not necessarily represent the official views of the University of Washington. The study was considered non-human subjects exempt by the University of Washington Institutional Review Board. Permission has been obtained from all authors and persons named in the acknowledgments.

Finally, we used the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guidelines to ensure the high quality of our work and have attached the requested documentation.

Thank you in advance for continuing to consider this manuscript for publication.

Sincerely,
Anna Fiastro, PhD MPH MEM
Research Scientist, University of Washington
Department of Family Medicine, Research Section
Address: Box 354982, 4311 11th Ave NE, Seattle, WA 98105
Telephone: 206-685-3276
Email: afiastro@uw.edu

EDITOR COMMENTS:

Thank you for submitting this manuscript. This is an interesting topic- please respond to the comments in your revision. As the statistical editor indicates, having a denominator for the area in which the populations come from would be key to understanding more about the underlying rates of use.

STATISTICAL EDITOR COMMENTS:

Tables 1,2: Need units for age.
Thank you for this comment. We have added '(in years)' to table 1 and 2.

Figures 2, 3: The use of the scale "Number of People mailed pills" as applied to the county units in each State is somewhat misleading. The areas identified as having higher numbers were also predominantly "Large metro" areas as described in Tables 1 and 2. Should instead format as number of people mailed pills/total number of women of childbearing age in each county. That is, need to index it per the potential population of users in each county. Otherwise, the scale could simply be reflecting the counties with larger populations.
We have changed the figures to report county-level number of people mailed pills per 100,000 reproductive age females.

lines 128-130: Without context as to the populations of these States, one cannot interpret these proportions. Could simply reflect their corresponding populations.
We appreciate the comment and agree the proportions reflect primarily the state's populations but also feel it is important to understand, nationally, where the demand for this service is coming from and compare demand for advance provision to pregnant patients, and so have opted to keep this sentence.

REVIEWER COMMENTS:

Reviewer #1:

This study compares pregnant and non-pregnant patient demographics who requested advanced provision of abortion medications. I thank the authors for exploring this topic as it is interesting to learn about the differences between these two populations. The paper is clear and easy to follow.
Thank you very much.

Methods
I'm a little unclear about how patients know they could get advanced provision of abortion medications. Were patients informed of this option if they had already

accessed care through Aid Access? Was public information posted online or through social media to make the general public aware?
Thank you for these questions. This is an evaluation of the Aid Access service. The provider advertises their services via Google, social media, and other abortion finder websites. The study did not make medication available, only evaluated the electronic health record data of patient/users of the Aid Access service during the study period. We have made edits to methods: setting and participants to further clarify this. Line 56-62

I wonder if the authors have any insight into what patients did with their advanced provision medications? How often were they used (not disbursed but used)? Did any patients request more than one dose over the time period? Are any follow up studies, qualitative or quantitative, planned to better understand what happens after medication abortion medication disbursement
As stated in line 59, this study does not include follow-up data. Contacting Aid Access users at varied intervals to understand use of the advanced provision abortion medications is time and resources intensive and outside the scope of this paper. Future research should examine actual use after orders and we have highlighted this in the discussion section (Line 175-176)

Reviewer #2:

Overall, this piece is well constructed and will provider new insight into the shifting trends in abortion access in the United States. I have made some minor suggestions which may strengthen the readers' interpretation of the results and ability to consider future horizons. Thank you for this thoughtful piece.

Abstract:
No changes, description is succinct but comprehensive and gives readers a grounded basis of the research question, methodology, and results.

Introduction:
Overall, this section is well written and appropriate for the work. The authors allude to (lines 38-39, 42-43) advanced provision addressing barriers to care, but might also consider addressing explicitly this model's positionality with regard to personal empowerment and de-medicalization of the abortion process for those most subject to structural disadvantage.
Thank you for this suggestion, we have included this sentiment in the introduction (line 44-45).

Methods:
Line 59 - Could you comment on why those 27 states were included? I suspect it may be where Aid Access has operations, but a statement may allow us to better interpret who from these states feels comfortable asking for medications in advance.
Yes, we included states where Aid Access was operating with U.S. licensed clinicians overseeing medication distribution. We have included this detail (line 60-61)

Line 63 - For analysis purposes, how were participants who indicated they may be pregnant categorized?
This is a helpful clarification; we have included more detail regarding our analysis design (line 62-64).

Line 71 - Would be interesting consideration for your discussion section whether the difference in fee structure may have any relation to patient demographics noted here. > Appreciate this discussion in lines 169-171.
We agree, it would be helpful to evaluate how cost and payment related to pregnant and non-pregnant patients. We hope to examine this in future analyses by including payment data.

Tests of comparison are well described and appropriate.

Results: General comment (also would apply for data presented in the abstract): The authors (with guidance from the editorial team) could consider adding numerator/denominator when proportions are presented, which helps readers interpret data and understand when subgroups are being compared.
Upon review, we feel we have accurately described the dominator throughout the results, either all advanced provision patients or all pregnant patients within the sample. The table also clearly states the n value for each column. We would appreciate more specific guidance if additional changes are needed.
Overall, the results highlighted are appropriately chosen and clearly described.

Discussion:
Lines 183- 188 - I think these are the crux of the issue and most important to underscore. I would encourage the authors to call for more work understanding attitudes of people who experience more structural disadvantage in accessing sexual/reproductive health care around advanced provision medication abortion and their values, concerns, and perceptions in how this care is delivered.
Thank you included more of this sentiment in the discussion (line 191-193)

Tables
While number of children is a reasonable metric to report, I would also consider including 'prior experience with medication abortion' as it may be interesting to note if this also differed between the groups (aka were people with a prior medication abortion experience more likely to consider advanced provision?)
While we agree this would be an important measure to assess, the electronic health record data we use is limited in this capacity. Future research should examine the relationship between prior abortion, prior medication abortion, and interested in and use of advance provision of abortion medications.

Reviewer #3:

This is a cross-sectional study evaluating the number of advanced provision medication abortion pills prescribed during the time period of important U.S. judicial rulings that could impact abortion access and comparing the demographic characteristics of pregnant and advanced provision medication abortion patients from a single asynchronous telemedicine medication abortion provider (Aid Access) in 27 U.S. states and D.C.

Line 33 Introduction: clear and concise, but focusing on the comparison in demographic difference between advanced provision and pregnant patients, not on the changes in volume of advance provision medications during certain judicially significant time periods for abortion access.

Thank you for this comment. It is not clear what the reviewer is referring to in line 33.

Linge 54: (general comment on the methods) it looks like this was a convenience sample rather than a sample size determined from a power calculation, I would clearly state this somewhere in the methods if so.

Thank you for this helpful comment. We have included a description of the sample as convenient in line 57.

Line 57 appropriate use and reporting of STROBE guidelines

Thank you

Line 59: Why was this study performed in only 27 U.S. states? I was under the impression Aid Access provided medication abortion in all 50 states.

Thank you for this comment, another reviewer also highlighted this point. We have updated this section to reflect that we focused on states that were served by U.S. licensed providers during the timeframe. Thought Aid Access has served all 50 states since 2018, at the time (prior to shield law provision of medication abortion), U.S. clinicians were serving only states with permissive abortion laws. We have added this detail in line 60-61.

Line 64: Up to what gestational age is medication abortion provided for patients via Aid Access? Could have an impact on the demographic findings.

Thank you, we have added <13 weeks gestation in line 67.

Line 71: the fact that the minimum cost for medication abortion pills was different for pregnant patients versus for advanced provision could have an important impact on the demographic differences in the two groups, and should be expounded beyond what is mentioned in the discussion (Line 169-173)

Unfortunately, we do not have more information about what patients paid for the two services and who and how they utilized the sliding scale payment option. We had added an additional sentence so the limitations in the discussion. Further research should explore this important factor in care seeking behavior.

Line 73: It seems like the main takeaway from this study is not actually the primary

outcome stated in methods, but rather the demographic differences between the two groups.
Thank you, we have updated the measures section to better reflect the goals of the study.

Line 96: The "primary outcome" here seems like somewhat of an afterthought, and if this is still included in the paper there needs to be more of an effort to tie in how these findings relate to the main story about the demographic differences. Are you trying to better describe the population of patients who request advanced provision? What do the temporal differences in requesting medications say about this population?
Thank you for this comment. We have incorporated clearer discussions of the comparison throughout the paper and per the other reviewers' comments as well. Line 153-154

Line 109-111 Impressively large sample size is a strength of the study
Thank you

Line 117: So interesting how many nulliparous patients are in both groups (although a larger proportion in the advanced provision group) which is different than the general demographics of patients seeking abortion care (majority having at least one child). Why do you think the pregnant patient population seeking medication abortion via Aid Access is different form the general abortion care population in this way? Demonstrates that findings may have limited generalizability.
Thank you for this thought. It is hard to say why Aid Access patients are less likely to have children than general abortion patients from these data, and it is certainly outside the scope of this manuscript. Prior research comparing telehealth to in-person medication abortion patients found no difference in the number of living children. Clearly, further research in this area is needed.

Line 129: Interesting that most of the advanced provision patients live in states where abortion remained accessible and not restricted (although recognizing these states also have larger populations). I think this speaks to your argument that this group faces much fewer barriers to abortion.
Agreed. Though our sample is limited to states with more supportive abortion policies.

Line 137-142: Again, your primary outcome here seems like an afterthought—does this significantly contribute to the paper or the important findings?
We see the comparison of advance provision patients during political events to patients from the rest of the study period as a sub-analysis as stated in line 98.

Line 161: I would expand on this conclusion—how could advanced provision be adjusted to better serve patient populations that experience greater barriers to abortion access? Decreasing the cost could be a major component, perhaps! Or is it somewhat like EC, where patients at highest risk of unwanted pregnancy seem not to opt for advanced provision for some reason?
We have added some additional contextualization to this paragraph.

Line 177: Is there a way you could follow up with advance provision patients to see if they ever actually used the medications?

This is an excellent idea for future research. Thank you.

Line 188: A qualitative study asking populations who experience greater barriers to access about their attitudes and beliefs regarding advanced provision of medication abortion could be particularly illuminating to answer some of these questions.

Agreed that additional research is needed. This qualitative study is a helpful starting place: *Fiastro, A. E., Young, E., Jacob-Files, E., Ruben, M. R., Coeytaux, F. M., Bennett, I. M., & Godfrey, E. M. (2023). Advance provision of medication for induced abortion: a qualitative study of patient perspectives. Contraception, 123, 110050.*