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.*

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

Date: Dec 21, 2021
To: "M. Antonia Biggs" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-21-2244

RE: Manuscript Number ONG-21-2244

Comprehension of an over-the-counter drug facts label prototype for a mifepristone and misoprostol medication abortion product

Dear Dr. Biggs:

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).

Please be sure to address the Editor comments (see "EDITOR COMMENTS" below) in your point-by-point response.

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 Jan 11, 2022, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

The authors present a study assessing comprehension of Drug Facts Label (DFL) for mifepristone/misoprostol medication abortion. They demonstrate that for nearly all of their primary and secondary communication objectives, subjects across a diverse range of age, race/ethnicity, and literacy have very high comprehension. The authors do a nice job presenting the importance of the study and introducing readers who may not be familiar with this type of work. The methods are easy to understand and appear appropriate. Recruitment met their sample size requirements. The results are succinctly presented and convincing that the DFL meets its purpose. The conclusions put the findings in perspective with comparison to other DFLs and make sound suggestions for improvements and the next phase of testing.

Line 38 - A brief mention of who considers prescription for MA medically unnecessary would be helpful.

Line 95 - Did subjects receive comprehension for participation?

Table 3 - This may be obvious, but was the proportion of subjects identifying as female at 96% intentional or just a product of the type of study? Presumably males could participate since the cohort wasn't 100% female?

Reviewer #2:

General Comments

The authors worked to design a drug label for medication abortion, a two drug regimen, to allow for over-the-counter use by people of reproductive age. They reached a wide audience of Americans with varied economic, geographic, and racial backgrounds. Through their iterative process, they were able to write a drug label that met FDA criteria for an OTC medication for almost all stated objectives. This is a great study which will help move a safe drug regimen to be available to more Americans.

Abstract - clear objectives, succinct. Good choice of keywords.

Introduction

1. Line 40 - I might say "lab testing" as opposed to Rh testing, as "routine" labwork up until the pandemic in many abortion facilities would include a hemoglobin and Rh testing; we have demonstrated in studies about telemedicine services that it is safe to avoid any routine lab testing for medication abortion.
2. Line 53-56: I'm not sure what the authors' are intending to state about the OTC MA DFL study from South Africa - is it that the authors' took the recommendations for DFL from this study into consideration? Was it a "proof of concept" that a DFL for OTC MA could be done?

Methods

3. Though perhaps outside of the scope of this study, was there any discussion about how feasible it is for patients to estimate their gestational age? While participants understood that MA should not be used if > 10 weeks gestation, do they understand how to calculate that for themselves/someone else to see if they would meet that inclusion criteria?
4. Was there any consideration for oversampling participants that identify as Black or Latina/o, as these racial/ethnic groups seek abortion care at higher rates than whites?
5. Line 103-104: The authors' list "female/born female" as inclusion criteria; however, gender non-conforming individuals who are capable of pregnancy may be screened out or choose not to participate with such a criterion. Perhaps stating "born with a uterus" or simply "capable of pregnancy" would better capture these individuals, who find many barriers to all types of healthcare, including abortion. They may seek OTC MA at higher rates than cisgender folks because of these barriers, and their understanding of an OTC DFL is crucial.

Results
6. Any insight into the 56% response rate? Whose opinions might we be missing?
7. I am grateful for the authors' inclusion of young people in this study - a group that again have many reasons to seek OTC MA.

Discussion

8. I absolutely agree with the point that because this study used a virtual format (as it was conducted during the COVID19 pandemic), it excludes rural and poor folks that lack internet access and likely have significantly more barriers to in-person abortion care. Thanks to the authors for highlighting this.

Reviewer #3:

This is a unique and timely study looking at developing a DFL prototype for OTC Medication Abortion. The researchers followed a robust process with an expert panel and interviews to develop the DFL prototype and then conducted interviews to assess DFL comprehension. The study includes people with low literacy and minors, important for OTC approval.

TITLE: Clear
ABSTRACT:
The focus of this paper isn't the "safety" of OTC MA but that label comprehension of a two dose pill regime is feasible, I would say that research on the feasibility of OTC use is warranted. I would include in methods what the target performance threshold range was so when "high levels of comprehension" is used later the reader understands what that means. I would add a line into the conclusion that when to contact a provider if little or no bleeding might mean for the future of the label.

PRECIS: appropriate
INTRODUCTION:
1. Sets up well why OTC MA is reasonable and the DFL process clearly for readers that are likely not familiar. The objective for the study is also clearly stated.

MATERIALS AND METHODS:
The methods are very clear including how and why the objectives were created and tested. In line 78, did the authors consider setting target performance threshold at 90% or higher given making MA OTC is likely controversial? In line 123, what minor changes were made, did you consider making changes to bleeding parameters at all?

RESULTS:
In line 138, what were the main reasons those screened found ineligible to participate? Did anything come out in the open ended questions about lack of bleeding and why that wasn't clearly understood by the user?

DISCUSSION: I would add to line 180 that the objective that wasn't met was around adequate bleeding. Do you have any additional suggestions to the label design to improve comprehension about bleeding or planned future studies to further evaluate this?

STATISTICAL EDITOR COMMENTS:

Table 1: Should embolden or otherwise designate those objectives that met vs not met the performance threshold, ie those whose LL of the CI were < the threshold. The CIs for "limited literacy" are wider, since their samples were smaller, so those "failures" may actually be due to limited stats power. On the other hand, the response from that category to the "Take pregnancy test 4 wks later" had both its point estimate and its UL CI < the 90% threshold.

lines 97-99: What is the expected PE used in this calculation? It seems that the lower limit of 95% CI was specified at 90%.

lines 138-139: How is the response rate = 56% not liable to selection bias?

EDITORIAL OFFICE COMMENTS:

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

A. OPT-IN: Yes, please publish my point-by-point response letter.
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* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
* 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.

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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, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/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. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

5. Figure 1: Are these images original to the manuscript/has permission been obtained to use them? Please upload higher resolution images as figure files on Editorial Manager.

Tables, figures, and supplemental digital content should be original. The use of borrowed material (eg, lengthy direct quotations, tables, figures, or videos) is discouraged. If the material is essential, written permission of the copyright holder must be obtained.

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6. 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.

7. 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.

8. 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 5,500 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

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* 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]."

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

11. 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. Please provide a word count.

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.

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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.

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%").

16. 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.

17. Please review examples of our current reference style at http://ong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources). 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 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 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.

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

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* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter. 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 Jan 11, 2022, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

John O. Schorge, MD
Deputy Editor, Gynecology

2020 IMPACT FACTOR: 7.661
2020 IMPACT FACTOR RANKING: 3rd out of 83 ob/gyn journals

University of California
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[redacted]

[redacted]

January 11, 2022

Dear Dr. Jason D. Wright and members of the Editorial Team,

We are pleased to resubmit a revision of our manuscript "Comprehension of an over-the-counter drug facts label prototype for a mifepristone and misoprostol medication abortion product" for your review.

We have addressed all the feedback from the editors and reviewers. On the next page we have included a response to each comment with a point-by-point response. We are grateful for the thoughtful feedback and hope you will find this revision acceptable for publication.

Thank you for the opportunity to resubmit our paper.

Sincerely,

M. Antonia Biggs, PhD

Corresponding author

RE: Manuscript Number ONG-21-2244

Comprehension of an over-the-counter drug facts label prototype for a mifepristone and misoprostol medication abortion product

- Our point-by-point responses to the comments from the editors and reviewers are below. We have included the editors' and reviewers' comments in plain font and our response in bulleted, blue font. The line numbers included in our response refer to the marked copy of the manuscript.

REVIEWER COMMENTS:

Reviewer #1:

The authors present a study assessing comprehension of Drug Facts Label (DFL) for mifepristone/misoprostol medication abortion. They demonstrate that for nearly all of their primary and secondary communication objectives, subjects across a diverse range of age, race/ethnicity, and literacy have very high comprehension. The authors do a nice job presenting the importance of the study and introducing readers who may not be familiar with this type of work. The methods are easy to understand and appear appropriate. Recruitment met their sample size requirements. The results are succinctly presented and convincing that the DFL meets its purpose. The conclusions put the findings in perspective with comparison to other DFLs and make sound suggestions for improvements and the next phase of testing.

Line 38 - A brief mention of who considers prescription for MA medically unnecessary would be helpful.

- Given FDA's recent change to the REMS on December 16, 2021, our original statement is no longer accurate. We have revised this sentence entirely to reflect this new change. "While the U.S. Food and Drug Administration (FDA) recently eliminated the in-person dispensing requirement for mifepristone, they still require it be prescribed by or under the supervision of a certified healthcare provider who meets certain qualifications.[1]" (lines 82-84)

Line 95 - Did subjects receive comprehension for participation?

- We have now specified that "We remunerated participants $50 for their participation in the study." (line 175)

Table 3 - This may be obvious, but was the proportion of subjects identifying as female at 96% intentional or just a product of the type of study? Presumably males could participate since the cohort wasn't 100% female?

- Participant eligibility criteria included being born with a uterus. Thus, while most participants identified as female, some (3%) described their gender identity as something other than female.

Reviewer #2:

General Comments

The authors worked to design a drug label for medication abortion, a two drug regimen, to allow for over-the-counter use by people of reproductive age. They reached a wide audience of Americans with

varied economic, geographic, and racial backgrounds. Through their iterative process, they were able to write a drug label that met FDA criteria for an OTC medication for almost all stated objectives. This is a great study which will help move a safe drug regimen to be available to more Americans.

- Thank you.

Abstract - clear objectives, succinct. Good choice of keywords.

- Thank you.

Introduction

1. Line 40 - I might say "lab testing" as opposed to Rh testing, as "routine" labwork up until the pandemic in many abortion facilities would include a hemoglobin and Rh testing; we have demonstrated in studies about telemedicine services that it is safe to avoid any routine lab testing for medication abortion.
   - We have revised as suggested and changed to "lab testing…" (line 86).

2. Line 53-56: I'm not sure what the authors' are intending to state about the OTC MA DFL study from South Africa - is it that the authors' took the recommendations for DFL from this study into consideration? Was it a "proof of concept" that a DFL for OTC MA could be done?
   - To clarify, we have added specificity and revised as follows "An exploratory pilot label comprehension study for an OTC MA product conducted in South Africa among 100 reproductive-age women demonstrated moderate understanding of key concepts and identified areas for modifying their label which informed the DFL design of the current study." (lines 102-103)

Methods

3. Though perhaps outside of the scope of this study, was there any discussion about how feasible it is for patients to estimate their gestational age? While participants understood that MA should not be used if > 10 weeks gestation, do they understand how to calculate that for themselves/someone else to see if they would meet that inclusion criteria?
   - We greatly appreciate this comment given the challenges for assessing pregnancy duration. We conducted a separate study designed to assess this question that was recently published (Ralph et al. 2021). We have added a new paragraph to the discussion summarizing its findings and implications to the label (lines 250-261).

     "While people across age and literacy groups demonstrated clear understanding that this product is not intended for people more than 10 weeks pregnant or people unsure of how far along they are in pregnancy, some people interested in using this product may have difficulty accurately assessing the duration of their pregnancies. Studies suggest that while most people can self-determine pregnancy duration based on the date of their last menstrual period (LMP), this exact date can be difficult for some to recall.[28] A recent study of patients seeking abortion across the U.S. found that a combination of three non-LMP questions achieved high accuracy in self-assessment of pregnancy duration; only 2.3% incorrectly self-screened as less than ten weeks' pregnant when using their responses to whether they were 1) more than 10 weeks pregnant; 2) more than 2 months pregnant or 3) had missed 2 or more periods. Integration of these three statements into the label instructions and as part of an

interactive online screening platform could help ensure that people have the best tools to self-screen for pregnancy duration with high accuracy and sensitivity.[29]"

Was there any consideration for oversampling participants that identify as Black or Latina/o, as these racial/ethnic groups seek abortion care at higher rates than whites?

- Our study design followed FDA guidance, which recommends that the study sample approximate the general population instead of the population of potential users. According to the FDA "*The [label comprehension] study should test label comprehension in a general population whether or not individuals express interest in using the drug product. Because nonprescription drug products are available for purchase without a learned intermediary, and since no drug product is administered in the study, exclusion factors should be minimal* (e.g., inability to read and understand English)"(U.S. Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research (CDER) 2020)."

4. Line 103-104: The authors' list "female/born female" as inclusion criteria; however, gender non-conforming individuals who are capable of pregnancy may be screened out or choose not to participate with such a criterion. Perhaps stating "born with a uterus" or simply "capable of pregnancy" would better capture these individuals, who find many barriers to all types of healthcare, including abortion. They may seek OTC MA at higher rates than cisgender folks because of these barriers, and their understanding of an OTC DFL is crucial.
   - Thank you for this suggestion. Our eligibility question screened for people with a uterus, so we have revised as suggested "Participant eligibility criteria included being born with a uterus…" (line 151)

Results

5. Any insight into the 56% response rate? Whose opinions might we be missing?
   - At the beginning of the results we have now added the reasons for ineligibility as well the demographic characteristics that differed between the responders and non-responders. "Among those who completed the screening process (n=1507), those participating were significantly more likely to self-identify as Black race than White race and did not differ significantly by age or Hispanic, Latina or Latinx ethnicity. Reasons for ineligibility included being a healthcare professional (n=147), not having video capability (n=171), having participated in research in past 3 months (n=123), or being a minor without an available parent (n=87), born without a uterus (n=24), not interested (n=22), outside eligible age range (n=7), or unable to speak and understand English (n=5)." (lines 189-195).
   - We have also added the potential for response bias as study limitation to the discussion. "While this study captured a diverse range of perspectives across age, income, race, ethnicity, literacy, and geography, our response rate of 56% raises the possibility that there are unobserved differences between our sample and the general population." (lines 278-280).

7. I am grateful for the authors' inclusion of young people in this study - a group that again have many reasons to seek OTC MA.
   - Thank you.

Discussion

8. I absolutely agree with the point that because this study used a virtual format (as it was conducted during the COVID19 pandemic), it excludes rural and poor folks that lack internet access and likely have significantly more barriers to in-person abortion care. Thanks to the authors for highlighting this.

- Thank you.

Reviewer #3:

This is a unique and timely study looking at developing a DFL prototype for OTC Medication Abortion. The researchers followed a robust process with an expert panel and interviews to develop the DFL prototype and then conducted interviews to assess DFL comprehension. The study includes people with low literacy and minors, important for OTC approval.

TITLE: Clear
ABSTRACT:
The focus of this paper isn't the "safety" of OTC MA but that label comprehension of a two dose pill regime is feasible, I would say that research on the feasibility of OTC use is warranted. I would include in methods what the target performance threshold range was so when "high levels of comprehension" is used later the reader understands what that means. I would add a line into the conclusion that when to contact a provider if little or no bleeding might mean for the future of the label.

- We have revised as suggested. "Given medication abortion's established safety record, research on the feasibility of moving it over the counter (OTC) is warranted." (lines 52-53)
- We have revised as suggested. "…with corresponding target performance thresholds (80%-90% accuracy)." (line 61)
- We included a new sentence to the abstract conclusion recommending the need to make changes in a future label. Due to word count limitations, we kept this statement vague without specifying all the recommended label changes. "..supervision and recommended minor modifications." (lines 73-75)

PRECIS: appropriate
INTRODUCTION:
Sets up well why OTC MA is reasonable and the DFL process clearly for readers that are likely not familiar. The objective for the study is also clearly stated.

- Thank you.

MATERIALS AND METHODS:
The methods are very clear including how and why the objectives were created and tested. In line 78, did the authors consider setting target performance threshold at 90% or higher given making MA OTC is likely controversial? In line 123, what minor changes were made, did you consider making changes to bleeding parameters at all?

- The one change to the DFL we made at this time was related to bleeding. We have now described this change "After 50 interviews, we paused the interview process to make minor modifications to the DFL and interview guide. In this iteration we changed the DFL language from 'Light or no bleeding' to 'No bleeding or only light bleeding'". (lines 172-173)

RESULTS:
In line 138, what were the main reasons those screened found ineligible to participate?

- At the beginning of the results we have now added the reasons for ineligibility as well the demographic characteristics that differed between the responders and non-responders. “Among those who completed the screening process (n=1507), those participating were significantly more likely to self-identify as Black race than White race and did not differ significantly by age or Hispanic, Latina or Latinx ethnicity. Reasons for ineligibility included being a healthcare professional (n=147), not having video capability (n=171), having participated in research in past 3 months (n=123), a minor without an available parent (n=87), born without a uterus (n=24), not interested (n=22), outside eligible age range (n=7), or unable to speak and understand English (n=5) .” (lines 189-195)

Did anything come out in the open ended questions about lack of bleeding and why that wasn't clearly understood by the user?

- We have summarized incorrect responses related to lack of bleeding “Most incorrect responses erroneously indicated that the label says nothing or that one should do nothing if no bleeding occurs soon after taking misoprostol (n=89). (lines 211-212).” Unfortunately, we do not have any additional open-ended data to explain why this concept was not clearly understood.

DISCUSSION: I would add to line 180 that the objective that wasn't met was around adequate bleeding. Do you have any additional suggestions to the label design to improve comprehension about bleeding or planned future studies to further evaluate this?

- We have now specified in the first sentence of the discussion that the objective related to lack of bleeding was not met. “Overall comprehension for this DFL prototype was excellent, meeting the pre-specified performance criteria for all but one primary communication objective, recognizing what to do if there is little or no bleeding.” (lines 237-238)
- In lines 241-246, we state that the objective related to lack of bleeding was not met “The one primary communication objective that did not meet its target threshold was related to understanding that lack of bleeding soon after taking misoprostol could indicate that the medication is not working and requires contacting a health professional. Lack of bleeding may be an indication that the pregnancy is continuing, or, in very rare cases, of an ectopic pregnancy. People may have had difficulty distinguishing among the many bleeding-related symptoms included on the DFL.”
- In lines 247-249, we give some suggestions for improving the label design “Changes to the label design, for example describing this concept in bold font or grouping the information on bleeding together, might improve understanding.”

STATISTICAL EDITOR COMMENTS:

Table 1: Should embolden or otherwise designate those objectives that met vs not met the performance threshold, ie those whose LL of the CI were < the threshold. The CIs for "limited literacy" are wider, since their samples were smaller, so those "failures" may actually be due to limited stats power. On the other hand, the response from that category to the "Take pregnancy test 4 wks later" had both its point estimate and its UL CI < the 90% threshold.

- We have revised Table 1 as suggested so that the PEs and confidence intervals of objectives that are met are in bold and include a symbol to indicate when the objective is not met.

- We agree that the wider CIs for the limited literacy group may be due to limited statistical power. We have added that point to the discussion ("While people with limited literacy did not meet performance criteria for three of the primary learning objectives (lower limit of the 95% CIs were below the threshold), only one point estimate was below the pre-specified performance threshold, suggesting that we may lack statistical power given the small sample size (n=157) of this group and that they may have more difficulty understanding label instructions. Further testing of these three label concepts among people with limited literacy is warranted." (lines 285-290)

lines 97-99: What is the expected PE used in this calculation? It seems that the lower limit of 95% CI was specified at 90%.

- We have clarified that the lower limit of the 95% CI was specified at 90% (line 145).

lines 138-139: How is the response rate = 56% not liable to selection bias?

- We agree that our response rate is liable to selection bias and have now noted this point in the discussion "…our response rate of 56% raises the possibility that there are unobserved differences between our sample and the general population." (lines 279-280)
- We have now examined how participants differed from those who did not participate. "Among those who completed the screening process (n=1507), those participating were significantly more likely to self-identify as Black race than White race and did not differ significantly by age or Hispanic, Latina or Latinx ethnicity. Reasons for ineligibility included being a healthcare professional (n=147), not having video capability (n=171), having participated in research in past 3 months (n=123), a minor without an available parent (n=87), born without a uterus (n=24), not interested (n=22), outside eligible age range (n=7), or unable to speak and understand English (n=5)." (lines 189-195)

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology have increased 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:

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* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
* 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.

- We have now added the title page and all the information stated above.

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- We have checked with all authors and included all disclosures in the title page.

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, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/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. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

- We have revised to adhere to these standards.

Figure 1: Are these images original to the manuscript/has permission been obtained to use them? Please upload higher resolution images as figure files on Editorial Manager.

- We created Figure 1 as part of the study and is entirely original. We revised the image to its original word format and removed any copyrighted information.

Tables, figures, and supplemental digital content should be original. The use of borrowed material (eg, lengthy direct quotations, tables, figures, or videos) is discouraged. If the material is essential, written permission of the copyright holder must be obtained.

- We believe Figure 1 is essential to be included in the publication of this study.

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- We have removed all copyrighted images from Figure 1.

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- We have removed all copyrighted images from Figure 1.

6. 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 https://urldefense.com/v3/__http://ong.editorialmanager.com__;!!LQC6Cpwp!8xUYEJ9OgZ0YV1If5wnQJcSsdjZ1Gklt6JM4lSVQgGMh5jW-x34HZZFy78w1L-MFhJpE$. 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.

- We followed STROBE reporting guidelines for observational studies.

7. 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 5,500 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

    - Manuscript word count: 3,790

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: 299.

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

- We have removed this symbol.

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.

- We have removed “provider” throughout the text with the exception to when it is referred to in quotes and included it as part of the DFL language.

18. Figure 1: Are these images original to the manuscript/has permission been obtained to use them? Please upload higher resolution images as figure files on Editorial Manager.

- Figure 1 is original. We have converted it to a word file so that it has better resolution.