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)*

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Date: Jul 08, 2022
To: "Hilary Brown" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-22-1020

RE: Manuscript Number ONG-22-1020

Interpersonal violence in the perinatal period among women with disabilities: Population-based study

Dear Dr. Brown:

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 Jul 29, 2022, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: The authors present a cohort study comparing the rates of perinatal interpersonal violence among patients with and without disabilities. They conclude that rates of IPV are higher among with with disabilities and further increased by a past history of IPV.

Abstract:
The objective is overall clear. The secondary objective may not be needed in the abstract, however it is the novel portion of the study. The results and methods appear clearly stated

Introduction: The introduction is succinct and provides relevant information. The authors should include a definition of interpersonal violence.

Methods:
Line 84- why was this time period selected?

Line 96- what was the database' inception?

Line 103- how did the authors ensure this was "interpersonal violence." The focus of the manuscript is IPV, however the codes used related to "abuse and violence" and while this is often interpersonal violence the authors do not appear to have a method to ensure this type of violence. They can consider simply stating "violence" in the manuscript and then listing this as a limitation.

Line 133- how was interpersonal violence history defined? Did the authors ensure this was pre-conception? Did they exclude prior pregnancies?

How were multiple pregnancies handled?

The results include a subset of "recent" history of interpersonal violence that is not included in the methods. Please include how this was obtained and defined in the methods section.

Results:
Line 159- how was stable and unstable defined?

Figure 1b-include how was recent history of interpersonal violence defined over any history? Did the authors evaluate the different subtypes of disabilities and history of violence? Also table 3 and figure 1 are repetitive and likely only one is needed.

Line 185- clarify this statement. The authors should simply state which disabilities did not cause elevated risk or refer to a table.

Discussion:
The authors clearly present the limitations of the study but as noted above the method of data collection does not appear to verify the violence as specifically interpersonal violence.

Reviewer #2: This article examines whether a history of interpersonal violence and disability increases the likelihood of violence during the perinatal period. The authors examined a large cohort of pregnancies in Ontario between 2004 and 2019. The disabilities examined included physical, sensory, or intellectual/developmental disability documented at two or more physician visits or at least one emergency department before conception. The analyses were appropriate and included underutilized measures of interaction and proportion of perinatal interpersonal violence attributable to disability and prior history of interpersonal violence.

There are only minor comments:
-The manuscript does not include validity information on the primary exposure (disability) or discuss the likelihood of potential misdiagnosis (particularly with respect to ED-related diagnoses).

-The manuscript does not describe how potential confounders were identified and the criteria for inclusion in the multivariable model.

-Page 10, line 207, the citation number provided is not correct.

Reviewer #3: Thank you for the opportunity to review this paper. This paper addresses the risk of interpersonal violence among currently or recently pregnant individuals with disabilities, including the risk among those with prior interpersonal violence. This is important because those affected by violence and those with disabilities are particularly vulnerable members of our communities who are underresearched and underrecognized in the medical field. The authors use a robust approach with a large data set to illustrate concerning risks among this particular population that translates to communities beyond Ontario. However, the impact of these data is limited and largely illustrative, such that a more compact piece may be a more appropriate venue for publication.

Title:
Is there a reason "interpersonal" was used rather than "intimate partner violence." I may be less familiar with standard Canadian terminology, but the CDC - and most resources I am familiar with - uses intimate partner.

Abstract:
It would be easier for me to follow if the methods explicitly stated the outcome measurement (ie "the outcome was …violence captured within an ED, hospitalization, death" - what do you mean captured? The number of unique encounters over the study period for those with and without disabilities?)

It is hard for me to be sure I'm understanding the first sentence of the results. It starts with a rate percent (do you mean a prevalence?) and then end with aRRs.

Conclusion: It may be more precise to say "relative high risk" (line 28) because, I believe later in the paper, the authors report that these events are "not common" (line 196, although I would argue by what metric are we arguing high risk or common events!)

Introduction:

Because the authors have made the choice to use the term interpersonal violence, which is not the standard term I am used to, it would be helpful to share a standardized definition. Source 1 is from the CDC and cites their intimate partner violence data from the NISVS, so the CDC definition may be best if it matches the methodology.

The idea that violence increases in pregnancy is intriguing and something I hear/read a lot, but I have never personally found compelling evidence to illustrate this - and sources 2 and 3, from my relatively brief review, do not seem to conclusively support this idea. Thus, the rationale of screening in pregnancy, to me, is because it's a time of high engagement with medical resources and thus potential support/intervention (and, children/potential children are a major motivating factor for IPV survivors to seek additional safety measures which I believe there are data for from social sciences/advocacy groups). Minor point, but a point of much curiosity for me in the past.

Line 39: I would delete "mothers." This term here (inadvertently) reduces the risks of violence in the perinatal period to a pregnant person's identity as a birthing person - these risks affect the person as a whole, not just as mothers or in their relation to recent pregnancy.

Line 46: A major contention I have with this article, which may be a byproduct of my naivete regarding the study of people with disabilities, is that this list of people who comprise "women with disabilities" must be remarkably diverse. The life experience of someone with a physical disability, I imagine, has very little likeness to someone with a severe intellectual disability. If it is commonplace to combine these categories of diagnoses, could the authors provide a justification? I presume it is because there are many shared experiences of having a disability in our society, including the shared vulnerability and risk of victimization (as this paper nicely illustrates later).

Methods:
This seems like nice collection of datasets, but perhaps the preceding text should reflect you are selectively measuring for more severe manifestations of IPV if you are only measuring ED visits, hospitalizations and deaths (as opposed to ambulatory encounters).

Can you help the non-Canadian reader a bit more with who is covered with these databases? It sounds like you identifying essentially all Ontario residents who had an ED/hospital visit or death, correct?

Cite the section 45 IRB exemption - that seems like a big deal given the sensitivity of data collected.

Line 83: why singletons only?

Outcomes: It sounds like IPV is identified by a list of specific codes. Did you include all encounters that included such codes, regardless of whether it was the primary diagnosis or primary cause of death? How was this list made? (eg "Counseling related to combined concerns regarding sexual attitude, behavior, and orientation" does not seem specific to sexual violence, but if this is a standardized set of codes to use for the study of SV, it would lend more legitimacy)

Line 110: I am not sure what health characteristics are indicative of disparities experienced by women with disabilities. May be worth putting in your otherwise comprehensive appendices.

Line 114: chronic unstable condition is not a term I am familiar with

Line 119: "Recent IPV" per the CDC, I believe, is 12 months not 24 months.

Line 133-144: I know this was one of the primary objectives, but I am trying to appreciate the significance, particularly clinically, of knowing not just the additive but the excess risk of history of IPV + disability diagnosis in understanding perinatal risk. Consider cutting or explaining in the intro/methods why the reader is invested in these calculations.

Discussion
196: again, "not common" is a tough term to use; compared to what? Does it matter if it's severe IPV?
198 : strikes me as odd to reiterate unadjusted figures here
202: state those implications; make the case these data have a meaningful impact
217-221 careful attention to word these proposed reasons as externally (eg societally) generated from the person with disabilities

A limitation that has been looming large over my interpretation of these data: in measuring IPV, particularly including sexual violence, pregnancy may be the direct result of that violence (eg sexual coercion, rape) rather than a risk factor, which for me, makes exposure (history of IPV among women with disabilities) and outcome (perinatal status with ongoing violence) seem like potential surrogates for one another

238: this comment about perpetrators reframed the entire manuscript for me. I realize that the coding used can include random attacks by strangers. Is this why "interpersonal" violence was used? This highlights how critical clear definitions will be at the start of the paper, particularly because the sources and screening tools mentioned, etc, are for intimate partner violence.

242: see duluth model power and control wheel for people with disabilities

Table 1: Why is >0.10 the cut off?
Figure 1: Unable to read bc of low resolution

STATISTICAL EDITOR COMMENTS:

Abstract: As space permits, need to include some actual rates of violence to contrast with the 0.5% rate against women without a disability.

lines 82-97: It appears that the unit of observation was a pregnancy from 2001-2019. How many women had more than 1 pregnancy during this time? Since multiple pregnancies would be expected to have some correlation of outcomes and were thus not independent events, what steps were taken to evaluate that influence on the estimates? Should either adjust for intraclass correlation, or randomly chose one pregnancy per woman for the calculation of risk of violence.

Table 1: Should provide the actual SMDs for comparing the control group vs the disability categories. Could be in another Table if needed.

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. 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."

5. 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."

6. All submissions that are considered for potential publication are run through CrossCheck for originality. The following lines of text match too closely to previously published works or need to be cited:

Lines 159-163 are from DOI:https://doi.org/10.1016/j.amepre.2021.05.037. Should be rephrased and cited.

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. 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.

Original Research: 3,000 words

9. For your title, please note the following style points and make edits as needed:
* Do not structure the title as a declarative statement or a question.
* Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles.
* Abbreviations, jargon, trade names, formulas, and obsolete terminology should not be used.
* Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," "A Systematic Review," or "A Cost-Effectiveness Analysis" as appropriate, in the subtitle. If your manuscript is not one of these four types, do not specify the type of manuscript in the title.

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.

Original Research: 300 words

The Editors request that you delete the last sentence of your Abstract-Conclusion.

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. Figure 1: Is this available at a higher resolution?

19. 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.

20. 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 Jul 29, 2022, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Jason D. Wright, MD
Editor-in-Chief

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

Department of Health & Society
UNIVERSITY OF TORONTO
SCARBOROUGH

July 22, 2022

Dr. Jason D. Wright, Editor-in-Chief
Obstetrics & Gynecology

Dear Dr. Wright:

Please find enclosed our revised submission to *Obstetrics & Gynecology*, entitled "Disability and interpersonal violence in the perinatal period". We thank the Editors and Reviewers for their thoughtful comments and suggestions on our manuscript. We have addressed each comment point-by-point in the pages that follow. Each response is accompanied by the excerpt of the revised text. The changes are indicated in our manuscript using "track changes".

We believe that our manuscript has been significantly strengthened as a result of the changes that were made in response to the reviews. We hope that our manuscript will now be acceptable for publication in *Obstetrics & Gynecology*.

Thank you for considering our manuscript, and we look forward to hearing from you.

Sincerely,

Hilary K. Brown, PhD
Canada Research Chair in Disability and Reproductive Health
Assistant Professor, University of Toronto Scarborough
[redacted]

RESPONSE TO REVIEWER 1

1. The authors present a cohort study comparing the rates of perinatal interpersonal violence among patients with and without disabilities. They conclude that rates of IPV are higher among with with disabilities and further increased by a past history of IPV.

   ➔ Thank you for your review of our manuscript. We respond to each comment point-by-point below.

2. The objective is overall clear. The secondary objective may not be needed in the abstract, however it is the novel portion of the study. The results and methods appear clearly stated.

   ➔ Thank you. We agree with the Reviewer that the second objective is novel, and therefore request to retain it in the abstract, since word count allows.

3. Introduction: The introduction is succinct and provides relevant information. The authors should include a definition of interpersonal violence.

   ➔ Thank you for this suggestion; Reviewer 3 made a similar comment. We have added a definition of interpersonal violence to the opening paragraph. We hope that this definition clarifies the focus of our paper and also addresses some of the questions from Reviewer 1 and Reviewer 3 that follow. See Page 6:

"The World Health Organization defines interpersonal violence as the intentional use of physical force or power against an individual by an intimate partner, family member, or other community member.[1]"

4. Methods: Line 84- why was this time period selected?

   ➔ Fifteen years of births gave us a sufficient sample size to study the rare outcome of acute health care and deaths related to interpersonal violence in the perinatal period. The cohort ended in 2019, as this was the maximum date for which data were available at the time that this project was initiated.

5. Line 96- what was the database' inception?

   ➔ We have added a supplementary table which provides information about ICES databases, including their dates of inception (Appendix 1). We also briefly clarify dates of inception in the text where the Reviewer has flagged the question, on Page 8 (note that the lookback period to database inception was necessary for measurement of disability because the disabilities we measured are permanent and may not be recorded in every health care encounter):

"Briefly, a disability was deemed present if a diagnostic code for a physical (i.e., a congenital

anomaly, musculoskeletal disorder, neurological disorder, or permanent injury), sensory (i.e., hearing or vision impairment), or intellectual or developmental disability (i.e., autism spectrum disorder, chromosomal anomalies associated with intellectual disability, fetal alcohol spectrum disorder, or intellectual disability), or multiple disabilities (i.e., ≥ 2 of the above), was recorded in ≥ 2 physician visits or ≥ 1 emergency department visits or hospitalizations from database inception (~1988-1991) to conception. Those without a pre-pregnancy disability in any of these categories were the comparison group."

6. Line 103- how did the authors ensure this was "interpersonal violence." The focus of the manuscript is IPV, however the codes used related to "abuse and violence" and while this is often interpersonal violence the authors do not appear to have a method to ensure this type of violence. They can consider simply stating "violence" in the manuscript and then listing this as a limitation.

   ➔ We hope that our definition in the Introduction helps to clarify. Interpersonal violence in our context refers to any violence perpetrated by another individual – e.g., intimate partner, family member, other community member. "Interpersonal violence" is therefore not used synonymously with "intimate partner violence", which we believe is what the Reviewer is referring to. Therefore, the codes we used for our outcome do reflect interpersonal violence broadly (but not necessarily intimate partner violence specifically). We have made some changes to the description of the outcome to be clearer. See Page 9:

"The primary outcome was any emergency department visit, hospital admission, or death related to physical, sexual, or psychological interpersonal violence between conception up to 365 days postpartum (Appendix 2).[23,24] External cause of injury codes have 85% accuracy compared to clinical records as a reference standard.[25,26] These data capture severe manifestations of interpersonal violence, i.e., those resulting in acute care use or death."

   ➔ We also comment on the inability to reliably identify the type of perpetrator (e.g., intimate partner or other) on Page 11:

"We also had no reliable information on perpetrators (e.g., intimate partners) since such data are not mandatory in administrative data.[24]"

7. Line 133- how was interpersonal violence history defined? Did the authors ensure this was pre-conception? Did they exclude prior pregnancies?

   ➔ We have clarified the definition of history of interpersonal violence. We did not exclude prior pregnancies from this definition, as this would have biased the cohort towards primiparous women. Rather, we defined a history of interpersonal violence as that occurring before the index pregnancy. See Page 9 and Appendix 3:

"Finally, we measured any (database inception to the index conception) and recent (< 2 years

before the index conception) history of interpersonal violence in ≥ 1 emergency department visits or hospital admissions for physical, sexual, or psychological violence.[23,24]"

8. How were multiple pregnancies handled?

   ➔ Twins and higher order multiples were excluded. This is described on Page 5:

"The cohort included all 15 to 49-year-olds with a singleton livebirth or stillbirth conceived between April 1, 2004 and March 31, 2019."

   ➔ We comment on this exclusion in the Limitations section on Page 15:

"Only singleton pregnancies resulting in a livebirth or stillbirth were included; thus, our findings may not be generalizable to individuals with twins or higher order multiples, or to pregnancies ending in a miscarriage or induced abortion."

   ➔ We handled multiple deliveries to the same mother during the study period using generalized estimating equations, which account for clustering in the analysis. See Page 10:

"To address the first objective, we used modified Poisson regression,[34] with generalized estimating equations to account for clustering of births to the same mother in the study period,[35] to calculate relative risks (RR) and 95% confidence intervals (CI) for any interpersonal violence between conception up to 365 days after delivery."

9. The results include a subset of "recent" history of interpersonal violence that is not included in the methods. Please include how this was obtained and defined in the methods section.

   ➔ We have clarified the definition of recent history of interpersonal violence (< 2 years before pregnancy) in the methods on Page 9 and Appendix 3.

"Finally, we measured any (database inception to the index conception) and recent (< 2 years before the index conception) history of interpersonal violence in ≥ 1 emergency department visits or hospital admissions for physical, sexual, or psychological violence.[23,24]"

10. Results: Line 159- how was stable and unstable defined?

   ➔ We have clarified the definition of stable and unstable chronic conditions on Page 9 and in Appendix 3, as follows:

"Chronic conditions were identified using collapsed ambulatory diagnostic groups for stable and unstable chronic conditions (excluding codes for disability to avoid overlap) from the Johns Hopkins Adjusted Clinical Groups (ACG)® System version 10 in the two years before conception,[31] where unstable conditions are those that are more likely to have complications

and require more ongoing resources such as specialty care."

11. Figure 1b-include how was recent history of interpersonal violence defined over any history? Did the authors evaluate the different subtypes of disabilities and history of violence? Also table 3 and figure 1 are repetitive and likely only one is needed.

    ➔ Recent history of interpersonal violence was defined as violence in the 2 years before the index pregnancy's conception date. See response to #9 above. We have also clarified the lookback period for recent history of violence in the title of Figure 1.

    ➔ We did not assess additive interaction of disability type and history of interpersonal violence, as a 5x2 interaction term is more difficult to interpret than a 2x2 interaction term. Given that all disability groups showed effects in the same direction, we do not believe that combining them for this secondary objective obscures any unique patterns.

    ➔ We appreciate the Reviewer's comment about Table 3 and Figure 1 being somewhat repetitive. However, we believe that Figure 1 is an important visual depiction of the additive interaction numerical values shown in Table 3. We therefore request to keep them both – though we would be happy to move Figure 1 to the Appendices if requested by the Editors.

12. Line 185- clarify this statement. The authors should simply state which disabilities did not cause elevated risk or refer to a table.

    ➔ We have re-phrased this paragraph to be clearer which disabilities did not have elevated risk. See Page 12:

"Compared to those without a disability, all disability groups experienced elevated risk of interpersonal violence during pregnancy, and those with physical, intellectual or developmental, and multiple disabilities, but not sensory disabilities, experienced elevated risk in the postpartum period (Appendix 5). Individuals with physical, intellectual or developmental, and multiple disabilities, but not sensory disabilities, experienced elevated risks of physical violence. All disability groups had a higher associated risk of sexual violence, and those with physical or multiple disabilities, but not intellectual or developmental or sensory disabilities, had a higher risk of psychological violence (Appendix 6). Individuals with physical, intellectual or developmental, and multiple disabilities, but not sensory disabilities, experienced the highest odds of having ≥ 2 health care encounters for violence perinatally (Appendix 7)."

13. Discussion: The authors clearly present the limitations of the study but as noted above the method of data collection does not appear to verify the violence as specifically interpersonal violence.

    ➔ Thank you for this comment. We hope that our definition of interpersonal violence now makes it clearer that we were able to measure interpersonal violence (as defined by the

World Health Organization), but not necessarily intimate partner violence, which we believe the Reviewer is referring to. We have clarified this in the Limitations section on Page 15:

"We also had no reliable information on perpetrators (e.g., intimate partners) since such data are not mandatory in administrative data.[24]"

RESPONSE TO REVIEWER 2

1. This article examines whether a history of interpersonal violence and disability increases the likelihood of violence during the perinatal period. The authors examined a large cohort of pregnancies in Ontario between 2004 and 2019. The disabilities examined included physical, sensory, or intellectual/developmental disability documented at two or more physician visits or at least one emergency department before conception. The analyses were appropriate and included underutilized measures of interaction and proportion of perinatal interpersonal violence attributable to disability and prior history of interpersonal violence.

   ➔ Thank you for your positive review of our manuscript.

2. There are only minor comments: The manuscript does not include validity information on the primary exposure (disability) or discuss the likelihood of potential misdiagnosis (particularly with respect to ED-related diagnoses).

   ➔ Thank you for this important comment. We have added further information to our methods section on prior work showing the validity of the disability algorithms that we used. See Page 8:

"Disability predating conception was identified using algorithms developed to identify a disability in health administrative data,[18,19] as reported previously.[20] These algorithms have been shown to identify disabilities associated with functional limitations.[21] and with need for accommodations when accessing health care.[22]"

   ➔ Nevertheless, we agree that there remains some potential for misclassification of exposure status. We have now expanded on this in our limitations section. See Page 15:

"Disability ascertainment was restricted to medical records, meaning that undiagnosed disabilities were missed.[19] This might bias estimates toward the null."

3. The manuscript does not describe how potential confounders were identified and the criteria for inclusion in the multivariable model.

   ➔ Thank you for this comment. We identified covariates based on a literature review of social and health disparities that impact women with disabilities, which are also known

risk factors for experiencing interpersonal violence in the perinatal period. We have clarified this on Page 9:

"Covariates were derived from the literature, and included age, parity, and social and health characteristics indicative of disparities experienced by individuals with disabilities[28,29] which are also associated with increased risk of interpersonal violence (Appendix 3).[2-4]"

➔ We included all of these covariates in the multivariable model because of their theoretical importance as factors associated both with disability status and with interpersonal violence. We have clarified this on Page 10:

"RRs were adjusted for covariates that are associated with disability status and are risk factors for interpersonal violence:[2-4,28,29] age, parity, neighborhood income quintile, rurality, stable and unstable chronic conditions, mental illness, and substance use disorder; pre-pregnancy history of interpersonal violence was added to the multivariable models in a separate step."

4. Page 10, line 207, the citation number provided is not correct.

➔ Thank you for catching this important typo. It has been corrected.

RESPONSE TO REVIEWER 3

1. Thank you for the opportunity to review this paper. This paper addresses the risk of interpersonal violence among currently or recently pregnant individuals with disabilities, including the risk among those with prior interpersonal violence. This is important because those affected by violence and those with disabilities are particularly vulnerable members of our communities who are underresearched and underrecognized in the medical field. The authors use a robust approach with a large data set to illustrate concerning risks among this particular population that translates to communities beyond Ontario. However, the impact of these data is limited and largely illustrative, such that a more compact piece may be a more appropriate venue for publication.

➔ Thank you for your positive review of our paper. We have responded to each of your concerns, point-by-point, in the pages that follow. We believe that a full-length article is necessary for this paper given the nuanced discussion required for this topic, and the lack of prior research on disability and experiences of interpersonal violence in the perinatal period. We therefore request to maintain the structure and length of our paper.

2. Is there a reason "interpersonal" was used rather than "intimate partner violence." I may be less familiar with standard Canadian terminology, but the CDC - and most resources I am familiar with - uses intimate partner.

➔ Thank you for this question. Reviewer 1 had similar questions. In our context, the World Health Organization definition of interpersonal violence is used, which defines interpersonal violence as that perpetrated by an intimate partner, family member, or community member. “Interpersonal violence” is therefore not used interchangeably with “intimate partner violence”, but rather, intimate partner violence is one type of interpersonal violence. We have added a definition of interpersonal violence to the first sentence of our paper, which we believe clarifies the focus of our paper. See Page 6:

“The World Health Organization defines interpersonal violence as the intentional use of physical force or power against an individual by an intimate partner, family member, or other community member.[1]”

➔ The reason we did not focus on intimate partner violence specifically, is that perpetrator information is not a required field in our health records, and as such any focus on intimate partner violence specifically would have a high level of missingness. We expand on this in our Limitations section on Page 15:

“We also had no reliable information on perpetrators (e.g., intimate partners) since such data are not mandatory in administrative data.[24]”

➔ Nevertheless, we believe that the focus on interpersonal violence broadly in this context is highly relevant for women with disabilities since, in addition to intimate partner violence, women with disabilities are vulnerable to violence from family members and community members, such as caregivers. We reflect on this on Page 14:

“Research outside the perinatal period suggests elevated interpersonal violence rates also reflect disability-related and economic needs that increase reliance on others, including intimate partners, for support; social stereotypes of disability that reduce personal agency and perceived credibility; communication difficulties; and lack of accessible information and services that promote violence awareness and prevention.[7-10]”

3. It would be easier for me to follow if the methods explicitly stated the outcome measurement (ie "the outcome was …violence captured within an ED, hospitalization, death" - what do you mean captured? The number of unique encounters over the study period for those with and without disabilities?)

➔ We have re-phrased our description of our outcome to be clearer. As the Reviewer will see, the primary outcome was any ED visit, hospital admission, or death related to violence, while we also look at the number of such violence-related health care encounters in secondary analyses. See Page 4 and Page 7:

Page 2: “The outcome was any emergency department visit, hospital admission, or death related to physical, sexual, or psychological violence between conception and 365 days postpartum.”

Page 6: “The primary outcome was any emergency department visit, hospital admission, or death related to physical, sexual, or psychological interpersonal violence between conception up to 365 days postpartum (Appendix 2).[23,24] External cause of injury codes have 85% accuracy compared to clinical records as a reference standard.[25,26] These data capture severe manifestations of interpersonal violence, i.e., those resulting in acute care use or death.”

4. It is hard for me to be sure I'm understanding the first sentence of the results. It starts with a rate percent (do you mean a prevalence?) and then end with aRRs.

   ➔ We see how this was confusing. We intended to provide both unadjusted and adjusted data. We have now rephrased to be clearer. See Page 2:

“Individuals with physical (0.8%), sensory (0.7%), intellectual or developmental (5.3%), and multiple disabilities (1.8%) were more likely than those without disabilities (0.5%) to experience perinatal interpersonal violence. The aRR of was 1.40 (95% CI 1.31-1.50) in those with physical, 2.39 (95% CI 1.98-2.88) in those with intellectual or developmental, and 1.96 (95% CI 1.66-2.30) in those with ≥ 2 disabilities.”

5. Conclusion: It may be more precise to say "relative high risk" (line 28) because, I believe later in the paper, the authors report that these events are "not common" (line 196, although I would argue by what metric are we arguing high risk or common events!)

   ➔ Thank you for this suggestion. We have made this change in the Abstract (and respond to the Reviewer’s other comment about ‘not common’ in Point 19, below). See Page 2:

“The perinatal period is a time of relative high risk for interpersonal violence among individuals with a pre-existing disability, especially those with a history of violence.”

6. Introduction: Because the authors have made the choice to use the term interpersonal violence, which is not the standard term I am used to, it would be helpful to share a standardized definition. Source 1 is from the CDC and cites their intimate partner violence data from the NISVS, so the CDC definition may be best if it matches the methodology.

   ➔ Thank you for this suggestion. Reviewer 1 had a similar comment. We now provide a definition of interpersonal violence on the opening paragraph, which we believe addresses the Reviewer’s concerns and clarifies the scope of our paper. See Page 6:

“The World Health Organization defines interpersonal violence as the intentional use of physical force or power against an individual by an intimate partner, family member, or other community member.[1]”

7. The idea that violence increases in pregnancy is intriguing and something I hear/read a lot, but I have never personally found compelling evidence to illustrate this - and sources 2 and 3, from my relatively brief review, do not seem to conclusively support this idea. Thus, the rationale of screening in pregnancy, to me, is because it's a time of high engagement with medical resources and thus potential support/intervention (and, children/potential children are a major motivating factor for IPV survivors to seek additional safety measures which I believe there are data for from social sciences/advocacy groups). Minor point, but a point of much curiosity for me in the past.

   ➔ This is an important point. Bacchus et al. (reference 2) found that 36.8% of intimate partner violence began in pregnancy. We have replaced reference 3 with a seminal paper by Stewart et al. showing that 63.9% of women who experienced abuse during pregnancy reported that it was worse than before pregnancy. We hope that these figures better support the statements in our paper. That being said, we agree with the Reviewer that another reason to focus on perinatal interpersonal violence is the potential for support/intervention. We have added some text to address this. See Page 6:

   "Pregnancy is a time of high risk for interpersonal violence, particularly by an intimate partner: more than 30% of intimate partner violence begins in pregnancy,[3] and pre-existing violence tends to escalate perinatally.[4] Perinatal interpersonal violence has serious negative consequences for pregnant and postpartum people, including elevated risk of mortality[5]—and neonatal consequences, including elevated risk of neonatal morbidity and mortality.[6] Given the perinatal period is a time of increased engagement with medical resources, this period also represents a substantial opportunity for intervention. Such efforts require identification of high-risk groups and development of appropriate resources."

8. Line 39: I would delete "mothers." This term here (inadvertently) reduces the risks of violence in the perinatal period to a pregnant person's identity as a birthing person - these risks affect the person as a whole, not just as mothers or in their relation to recent pregnancy.

   ➔ Thank you for this important point. Related to this, the Editors requested less reliance on gendered terminology, so we have made edits throughout our manuscript to use the language of "individuals" and "people" in pregnancy and postpartum.

9. Line 46: A major contention I have with this article, which may be a byproduct of my naivete regarding the study of people with disabilities, is that this list of people who comprise "women with disabilities" must be remarkably diverse. The life experience of someone with a physical disability, I imagine, has very little likeness to someone with a severe intellectual disability. If it is commonplace to combine these categories of diagnoses, could the authors provide a justification? I presume it is because there are many shared experiences of having

a disability in our society, including the shared vulnerability and risk of victimization (as this paper nicely illustrates later).

➔ Thank you for this important point. We agree that there are differences in the experiences of people with different types of disabilities, as the Reviewer suggests. However, there are many similarities, including common experiences of ableism and discrimination; high rates of poverty; barriers to education and employment; and high rates of chronic physical and mental health conditions that are observed across disability groups – in addition to high rates of interpersonal violence, again observed across disability groups, outside of the perinatal period. As such, disability-related policies most often include all people with disabilities. It is thus common for studies to examine "any disability" as well as "type of disability". See, for example, References 7, 8, 9, 10, 12, 13, 14, 40, 41, and 42 – all of which examine people with "any disability" in some or all of their analyses. We therefore argue that examining individuals with disabilities as a whole in our secondary objective is valid. This was also necessary because a 2x2 interaction is more readily interpretable than a 5x2 interaction.

10. Methods: This seems like nice collection of datasets, but perhaps the preceding text should reflect you are selectively measuring for more severe manifestations of IPV if you are only measuring ED visits, hospitalizations and deaths (as opposed to ambulatory encounters).

➔ Thank you for this important point. We have re-phrased our objective to be more specific to the types of data we had. See Page 7:

"Our objectives were to: (1) compare the risk of interpersonal violence, reported in emergency department visits, hospital admissions, and deaths, among pregnant and postpartum individuals with a physical, sensory, or intellectual or developmental disability to those without disabilities, and (2) examine if a pre-pregnancy history of interpersonal violence puts individuals with disabilities at excess risk of interpersonal violence in the perinatal period, relative to the risk factors of disability or history of interpersonal violence alone."

➔ We have also re-phrased our definition of our outcome in the Methods section, on Page 9:

"The primary outcome was any emergency department visit, hospitalization admission, or death related to physical, sexual, or psychological interpersonal violence between conception up to 365 days postpartum (Appendix 2).[23,24] External cause of injury codes have 85% accuracy compared to clinical records as a reference standard.[25,26] These data capture severe manifestations of interpersonal violence, i.e., those resulting in acute care use or death."

11. Can you help the non-Canadian reader a bit more with who is covered with these databases? It sounds like you identifying essentially all Ontario residents who had an ED/hospital visit or death, correct?

➔ This is correct. Given our universal health care system, we are able to capture the health care use of any Ontario resident. We have clarified this on Page 7:

"We undertook a population-based cohort study in Ontario, Canada, using data from ICES (formerly the Institute for Clinical Evaluative Sciences) (Toronto, Ontario), a research institute that collects administrative data from the health care encounters of all Ontario residents for health system evaluation and improvement. Ontario is Canada's largest province, with 140 000 births per year,[15] and has a universal health care system that provides essential care at no direct cost to residents."

12. Cite the section 45 IRB exemption - that seems like a big deal given the sensitivity of data collected.

➔ We note that this was a secondary analysis of de-identified data collected over the course of the administration of the health care system—i.e., not questions asked of individuals in the context of primary data collection for research. Ontario's health information privacy laws protect the use of health administrative data for research that has implications for health care evaluation and monitoring. We also note that every ICES study is evaluated by ICES Privacy and Legal Office to ensure that it meets the requirement of this exemption. This is described on Pages 7-8:

"ICES is a prescribed entity under Ontario's Personal Health Information Protection Act (PHIPA). Section 45 of PHIPA authorizes ICES to collect personal health information, without consent, for the purpose of analysis or compiling statistical information with respect to the management of, evaluation or monitoring of, the allocation of resources to or planning for all or part of the health system. Projects that use data collected by ICES under section 45 of PHIPA, and use no other data, are exempt from research ethics board review. The use of the data in this project is authorized under section 45 and approved by ICES' Privacy and Legal Office."

13. Line 83: why singletons only?

➔ This paper was part of a broader cohort study on disability and pregnancy wherein multiple births were excluded because of their very different risks of adverse outcomes. Given that multiple births comprise less than 3% of pregnancies, we do not believe that this exclusion will impact the interpretation of our findings. Nevertheless, we have now added a limitation to address this. See Page 15:

"Only singleton pregnancies resulting in a livebirth or stillbirth were included; thus, our findings may not be generalizable to individuals with twins or higher order multiples, or to pregnancies ending in a miscarriage or induced abortion."

14. Outcomes: It sounds like IPV is identified by a list of specific codes. Did you include all encounters that included such codes, regardless of whether it was the primary diagnosis or

primary cause of death? How was this list made? (eg "Counseling related to combined concerns regarding sexual attitude, behavior, and orientation" does not seem specific to sexual violence, but if this is a standardized set of codes to use for the study of SV, it would lend more legitimacy)

➔ Thank you for this question. We have clarified that we included all encounters that included such codes, regardless of whether it was the primary diagnosis or primary cause of death. This is consistent with prior research (see, for example, Reference 23). We felt this was important, given that these complex health care and other encounters can result in multiple diagnoses. See Page 9:

"The primary outcome was any emergency department visit, hospitalization admission, or death related to physical, sexual, or psychological interpersonal violence between conception up to 365 days postpartum (Appendix 2).[23,24] External cause of injury codes have 85% accuracy compared to clinical records as a reference standard.[25,26] These data capture severe manifestations of interpersonal violence, i.e., those resulting in acute care use or death."

➔ The list of codes was based on prior research (see Reference 23, for example) examining assault and maltreatment in Ontario. The Z codes the Reviewer mentioned are infrequently used, but were included based on input from our clinical co-authors given that these codes are often used in reference to counseling around sexual violence.

15. Line 110: I am not sure what health characteristics are indicative of disparities experienced by women with disabilities. May be worth putting in your otherwise comprehensive appendices.

➔ Thank you for this suggestion. We now include an Appendix with further details of how the covariates were measured. See Appendix 3.

16. Line 114: chronic unstable condition is not a term I am familiar with

➔ Another Reviewer had a similar comment. We now provide a clearer definition on Page 9:

"Chronic conditions were identified using collapsed ambulatory diagnostic groups for stable and unstable chronic conditions (excluding codes for disability to avoid overlap) from the Johns Hopkins Adjusted Clinical Groups (ACG)® System version 10 in the two years before conception,[31] where unstable conditions are those that are more likely to have complications and require more ongoing resources such as specialty care."

17. Line 119: "Recent IPV" per the CDC, I believe, is 12 months not 24 months.

➔ Thank you for this comment. Given our reliance on health administrative data and not self-reported data, we felt that a broader lookback period for "recent" interpersonal violence was appropriate. We therefore request to retain our definition.

18. Line 133-144: I know this was one of the primary objectives, but I am trying to appreciate the significance, particularly clinically, of knowing not just the additive but the excess risk of history of IPV + disability diagnosis in understanding perinatal risk. Consider cutting or explaining in the intro/methods why the reader is invested in these calculations.

➔ Additive interaction has public health and clinical importance given that it demonstrates the excess risk associated with two exposures, or, in other words, an exceptionally high risk group that might particularly benefit from intervention. See Page 10:

"To address the second objective, we employed three metrics to determine if a pre-pregnancy history of interpersonal violence puts individuals with disabilities at excess risk of interpersonal violence in the perinatal period, relative to having a disability or a history of interpersonal violence in isolation. This assessment of additive interaction has clinical value because it identifies groups at highest risk of the outcome and therefore most likely to benefit from intervention.[36]"

➔ This analysis flags individuals with disabilities with a pre-pregnancy history of violence as being particularly vulnerable to violence in the perinatal period. This has critical clinical implications, which we describe on Pages 14 and 16:

"The strongest risk factor for perinatal interpersonal violence is a pre-pregnancy history of violence.[39] Our findings supported the hypothesis that disability and pre-pregnancy history of interpersonal violence have synergistic effects, with excess risk for interpersonal violence perinatally in individuals with disabilities with a history of violence. The perinatal period may be a time of extra vulnerability for these individuals due to greater reliance on others for economic and disability-related needs[40] and fears that reporting violence may trigger a report to child protective services.[41] … Finally, given the strongest risk factor for interpersonal violence in the perinatal period, particularly in those with a disability, was a pre-pregnancy history of interpersonal violence, our findings suggest more could be done before pregnancy to offer screening and support at the index encounter, thereby reducing risks of perinatal violence."

➔ We hope that the additions and edits to our text clarify why this analysis is so important. We also note that Reviewer 1 identified this analysis as being particularly novel. We therefore request to retain it in our paper.

19. Discussion: 196: again, "not common" is a tough term to use; compared to what? Does it matter if it's severe IPV?

➔ The Reviewer makes a good point here, given that our focus was on severe manifestations of interpersonal violence. We have deleted this phrase. The sentence on Page 13 now reads:

"In this population-based study, interpersonal violence resulting in an emergency department visit, hospitalization, or violent death in the perinatal period occurred more often in individuals with disabilities."

20. 198 : strikes me as odd to reiterate unadjusted figures here

➔ We believe that the unadjusted values carry public health significance because they show the overall greater risk of interpersonal violence experienced in these vulnerable groups before adjusting for other risk factors. We request to retain these estimates, since we qualify them as unadjusted, but would be happy to reconsider if requested.

21. 202: state those implications; make the case these data have a meaningful impact

➔ Thank you. Our implications section is found in the last paragraph of the Discussion. However, we have added a brief sentence to the first paragraph of the Discussion to allude to these implications which we detail later. See Page 13:

"These data have implications for perinatal violence prevention, demonstrating the importance of appropriate screening tools, accessible violence-related information and services, and health care professional education to meet the needs of individuals with disabilities."

22. 217-221 careful attention to word these proposed reasons as externally (eg societally) generated from the person with disabilities

➔ Thank you. We agree that the focus needs to be on structural determinants of health, and have re-phrased this sentence to reflect that. See Page 14:

"For numerous social and structural reasons,[28] people with disabilities have high rates of many risk factors for interpersonal violence, including low socioeconomic status and mental illness.[39]"

23. A limitation that has been looming large over my interpretation of these data: in measuring IPV, particularly including sexual violence, pregnancy may be the direct result of that violence (eg sexual coercion, rape) rather than a risk factor, which for me, makes exposure (history of IPV among women with disabilities) and outcome (perinatal status with ongoing violence) seem like potential surrogates for one another

➔ This is an important point. Unfortunately, this is not an issue we can disentangle in health administrative data. However, we have added this point to the Limitations section and flag it as an area for potential further inquiry. See Page 15:

"Sexual violence (e.g., sexual coercion, rape) may result in pregnancy as well as ongoing violence in pregnancy, but we were unable to assess this in our study."

24. 238: this comment about perpetrators reframed the entire manuscript for me. I realize that the coding used can include random attacks by strangers. Is this why "interpersonal" violence was used? This highlights how critical clear definitions will be at the start of the paper, particularly because the sources and screening tools mentioned, etc, are for intimate partner violence.

    ➔ We agree. We hope that our definition at the beginning of the Introduction clarifies the focus of our manuscript throughout. We have also carefully edited our manuscript to ensure that we use the appropriate terminology to match the references.

"The World Health Organization defines interpersonal violence as the intentional use of physical force or power against an individual by an intimate partner, family member, or other community member.[1]"

    ➔ We believe that the focus on interpersonal violence broadly in this context is highly relevant for women with disabilities since, in addition to intimate partner violence, women with disabilities are vulnerable to violence from family members and community members, such as caregivers. We reflect on this on Page 14:

"Research outside the perinatal period suggests elevated interpersonal violence rates also reflect disability-related and economic needs that increase reliance on others, including intimate partners, for support; social stereotypes of disability that reduce personal agency and perceived credibility; communication difficulties; and lack of accessible information and services that promote violence awareness and prevention.[7-10]"

25. 242: see duluth model power and control wheel for people with disabilities

    ➔ Thank you for this valuable suggestion. We now reference the Duluth power and control wheel in our implications section (see reference #45).

26. Table 1: Why is >0.10 the cut off?

    ➔ See Reference #33: 0.10 is the standard cut-off for meaningful imbalance as measured by standardized differences. (Note that standardized differences are different than p-values; they are used here because, unlike p-values, they are not influenced by sample size and are therefore appropriate for large cohorts like ours.) We have clarified this in the Methods on Page 10:

"We calculated frequencies and percentages to describe baseline characteristics by disability status, and derived standardized differences to compare the distribution of covariates across

groups, with > 0.10 indicating meaningful imbalance.[27] (Unlike *p*-values, standardized differences are not influenced by sample size and are therefore appropriate for large cohorts.[33])"

27. Figure 1: Unable to read bc of low resolution

    ➔ Thank you for flagging this. We hope that the new figure has better resolution. We can also make the original Excel file available to the Editors should our article be accepted for publication.

RESPONSE TO THE STATISTICAL EDITOR:

1. Abstract: As space permits, need to include some actual rates of violence to contrast with the 0.5% rate against women without a disability.

    ➔ Thank you for this important point. We have made this change.

    "Individuals with physical (0.8%), sensory (0.7%), intellectual/developmental (5.3%), and multiple disabilities (1.8%) were more likely than those without disabilities (0.5%) to experience perinatal violence."

2. lines 82-97: It appears that the unit of observation was a pregnancy from 2001-2019. How many women had more than 1 pregnancy during this time? Since multiple pregnancies would be expected to have some correlation of outcomes and were thus not independent events, what steps were taken to evaluate that influence on the estimates? Should either adjust for intraclass correlation, or randomly chose one pregnancy per woman for the calculation of risk of violence.

    ➔ Thank you for this comment. As described in the Methods, we used generalized estimating equations to account for clustering of multiple deliveries to the same mother over the study period. This method is preferred over random selection of one pregnancy per woman as it maintains the full sample size. See Page 7 and Reference 35:

"To address the first objective, we used modified Poisson regression,[34] with generalized estimating equations to account for clustering of births to the same mother in the study period,[35] to calculate relative risks (RR) and 95% confidence intervals (CI) for any interpersonal violence between conception up to 365 days after delivery."

3. Table 1: Should provide the actual SMDs for comparing the control group vs the disability categories. Could be in another Table if needed.

    ➔ This is a good suggestion. Given the large size of Table 1, we include the standardized difference values in Appendix 4.

RESPONSE TO THE 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.

   ➔ Thank you. We appreciate the transparency of this approach and are happy to have the revision letter and response 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:
   a. 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.
   b. Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
   c. Name the IRB or Ethics Committee institution in the Methods section (if applicable).
   d. Add any information about the specific location of the study (ie, city, state, or country), if necessary for context.

   ➔ We now provide this information in the main text of the manuscript.

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.

   ➔ We have alerted the co-authors.

4. 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."

   ➔ We have deleted all instances of identity-first language, as per journal policy. The only exception is the keyword “Disabled persons” after the abstract, since this is the official MESH term. That said, we note that it is often helpful to use a mixture of identity-first

and person-first language because many people in the disability community have voiced the importance of identity-first language (see, for example, doi:10.1016/j.dhjo.2022.101328 for a thoughtful commentary on this issue). Similar to how changes are being made to gendered language in obstetric research, we hope that there may someday be a reexamination of policies around disability-related language.

5. The journal follows ACOG's Statement of Policy on Inclusive Language (https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fclinical-information%2Fpolicy-and-position-statements%2Fstatements-of-policy%2F2022%2Finclusive-language&data=05%7C01%7Chk.brown%40utoronto.ca%7C64990c33ef414f46824408da60ea01bd%7C78aac2262f034b4d9037b46d56c55210%7C0%7C0%7C637928855775106792%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=SjMYBQo2P4wN5GJZNjv8CtGdr2qP3Cwcm0YQ1LUQwb8%3D&reserved=0). 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."

   ➔ Thank you for this important reminder. We have used the language of “individuals” and “people” throughout the manuscript as much as possible.

6. All submissions that are considered for potential publication are run through CrossCheck for originality. The following lines of text match too closely to previously published works or need to be cited:
   Lines 159-163 are from
   DOI:https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdoi.org%2F10.1016%2Fj.amepre.2021.05.037&data=05%7C01%7Chk.brown%40utoronto.ca%7C64990c33ef414f46824408da60ea01bd%7C78aac2262f034b4d9037b46d56c55210%7C0%7C0%7C637928855775106792%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=smsY3aRFJNosAZJ8CR8ivFbdP9Tv1z5DhV4%2BR9mJpVk%3D&reserved=0. Should be rephrased and cited.

   ➔ Thank you for catching this. The text in the above link is from one of our prior papers examining access to prenatal care in women with disabilities. The text with similarity is the opening paragraph of the Results section describing the baseline characteristics of women with disabilities in the cohort. Although the two papers are from slightly different cohorts and are on distinct topics, there is some overlap in the text of this section of the Results because both cohorts showed similar disparities on neighbourhood income quintile, chronic conditions, mental illness, and substance use disorder. We have rephrased the text of the current paper so that it is now appropriately different from our prior work. We apologize for this oversight.

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://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-obstetrics-data-definitions&data=05%7C01%7Chk.brown%40utoronto.ca%7C64990c33ef414f46824408da60ea01bd%7C78aac2262f034b4d9037b46d56c55210%7C0%7C0%7C637928855775106792%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=95oEL2n3%2B%2Be0j197Thu3I3o9ouA2pN8Z5lvhDSYTAzU%3D&reserved=0 and the gynecology data definitions at https://can01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-gynecology-data-definitions&data=05%7C01%7Chk.brown%40utoronto.ca%7C64990c33ef414f46824408da60ea01bd%7C78aac2262f034b4d9037b46d56c55210%7C0%7C0%7C637928855775106792%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=iyK44YicyIuc3YMkTdOMUl57CoppLAyj4VLm8cxjoz8%3D&reserved=0. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

   ➔ Our language is consistent with these definitions.

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   ➔ Our final word limit is 2865.

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   b. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles.
   c. Abbreviations, jargon, trade names, formulas, and obsolete terminology should not be used.
   d. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," "A Systematic Review," or "A Cost-Effectiveness Analysis" as appropriate, in the subtitle. If your manuscript is not one of these four types, do not specify the type of manuscript in the title.

➔ We have edited our title accordingly to “Disability and interpersonal violence in the perinatal period”.

10. Specific rules govern the use of acknowledgments in the journal. Please review the following guidelines and edit your title page as needed:
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    b. 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.
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    ➔ We had previously used “ED” for “emergency department” but now use the full spelling throughout.

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