

Information Collection Request

Reinstatement

**Monitoring Changes in Attitudes and Practices among Family Planning
Providers and Clinics**

OMB Number 0920-0969

Supporting Statement A

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The goal of the project is:	To monitor changes in attitudes and practices among family planning providers and clinics in the United States related to recommendations included in national contraception guidelines.
The intended use of the resulting data is:	To improve family planning-related public health practice by: 1) understanding the current use of contraception guidance in practice and valued sources of contraceptive information; 2) describing current attitudes and practices among family planning providers and clinics related to recommendations included in national contraception guidelines and assessing changes from previous data collections; and 3) identifying targeted training needs in use of guidance and family planning service delivery (e.g., provider tools, continuing education modules).
Methods to be used to collect data:	Mailed surveys with the option to complete online.
The subpopulation to be studied:	Office-based physicians and public-sector family planning providers and clinic administrators in the United States.
How the data will be analyzed:	Descriptive statistics, chi-square tests, multivariable logistic regression.

A. JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

Background

The proposed Information Collection Request (ICR) is classified as a reinstatement with change of OMB Control No. 0920-0969 (expiration date: 05/31/2014). Changes to the proposed ICR from OMB Control No. 0920-0969 are: (1) reduced overall total burden hours; (2) slightly revised survey instruments; (3) reduced average burden per response for one of two proposed surveys; and (4) an additional outreach effort to non-respondents with known email addresses. The proposed ICR requests approval to collect data for 12 months. This information collection request represents a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the HHS Office of Population Affairs (OPA), in an effort to reduce survey burden in the field and strengthen the quality of the overall effort.

The *U.S. Medical Eligibility Criteria for Contraceptive Use* (US MEC), the first national guidance on family planning containing evidence-based recommendations for the safe use of contraceptive methods for women and men with specific characteristics and medical conditions, was first published by the CDC in June 2010.¹ The *U.S. Selected Practice Recommendations for Contraceptive Use* (US SPR), which provides guidance on how to use contraceptive methods safely and effectively once they are deemed to be medically appropriate, was first published by the CDC in June 2013.² The US MEC and US SPR were updated after review of the scientific evidence and consultation with national experts in family planning; the revised US MEC and US SPR were published in August 2016.^{3,4} *Providing Quality Family Planning Services* (QFP), which provides evidence-informed recommendations to improve client care and service delivery infrastructure to support the provision of quality family planning services to women and men of

reproductive age in the United States, was published by CDC and OPA in April 2014.⁵ The US MEC, US SPR, and QFP have been widely disseminated to health care providers and other constituents, via professional organizations, federal program grantees, scientific and programmatic meetings, scientific manuscripts, online resources, and other avenues.

To monitor diffusion and perceived utility of the guidance documents as well as changes in attitudes and practices regarding contraception among family planning providers and clinics over time, we initiated a multi-phase assessment. Phase 1 was initiated in December 2009 (EPI AID No. 2010-024; OMB No. 0920-0008) and collected information before the release of the US MEC. Data were collected from private- and public-sector family planning providers throughout the United States by mail from December 2009 through March 2010. Phase 2 was initiated in June 2013 (OMB No. 0920-0969) and collected information before the release of the US SPR and QFP. Data were collected from private- and public-sector family planning providers and public-sector health center administrators throughout the United States by mail from June 2013 through May 2014. The proposed ICR represents Phase 3 and will collect information related to the US MEC, US SPR and QFP several years after their release through mailed surveys to private- and public-sector family planning providers and public-sector health center administrators. No information in identifiable form (IIF) will be collected via the surveys. The proposed ICR will fill a gap in knowledge related to the awareness and use of the US MEC, US SPR, and QFP (including provider tools), as well as changes over time in attitudes and practices among family planning providers and clinics related to recommendations included in the guidance documents. Authority for CDC to collect this data is granted by Section 301 of the Public Health Service Act (42 U.S.C. 241) (**Attachment A-1**).

A2. Purpose and Use of the Information Collection

The purpose of the proposed ICR is to improve family planning-related public health practice by:

- 1) understanding the current use of contraception guidance in practice and valued sources of contraceptive information, including awareness and use of the US MEC, US SPR, and QFP;
- 2) describing current attitudes and practices among family planning providers and clinics related to content included in the US MEC, US SPR, and QFP and assessing changes from previous collections; and
- 3) identifying targeted training needs in use of guidance and family planning service delivery (e.g., provider tools, continuing education modules).

The proposed ICR is a reinstatement with change of OMB Control No. 0920-0969 (expiration date: 05/31/2014), which resulted in useful knowledge of differences in attitudes and practices of family planning providers based on varying levels of key demographic characteristics (e.g., years since completion of formal health care training) and identification of attitudes not consistent with current scientific evidence (e.g., misconceptions that intrauterine devices are not safe for adolescents or nulliparous women). This information has been used to target the development of slide sets, provider tools, and continuing education opportunities for health care providers, which are available on the CDC Division of Reproductive Health (DRH) website:

<http://www.cdc.gov/reproductivehealth/unintendedpregnancy/training.htm>. DRH staff have also

delivered multiple presentations at professional association meetings to address attitudes and practices not consistent with current scientific evidence.

The *rationale for reinstating the data collection* is to monitor changes in attitudes and practices several years after the release of the US MEC, US SPR, and QFP. Also, Phase 3 will collect new information related to content included in the revised US MEC and US SPR published in August 2016 (e.g., new medical conditions and contraception management recommendations). The data collection will also allow for identification of persisting misconceptions and/or gaps in clinic-level practices (e.g., low provision of preconception health services) that may warrant continued and more tailored dissemination and educational activities.

The *practical utility* of the information to be collected is to optimize the translation of the evidence-based recommendations into widespread practice by allowing CDC and OPA, in collaboration with key partner organizations, to target available resources in ways that will foster and promote future awareness and adoption of the guidance into practice (e.g., additional dissemination activities, development of educational interventions and provider tools to address gaps between evidence and attitudes and practices).

The *negative consequences* of not having the information would be potential underutilization of the practice guidelines, which require extensive federal resources to develop and maintain, and the implementation of less effective practices in the field.

The data will primarily be used by CDC and OPA and may be used on an ongoing basis (i.e., not limited to a given frequency). Other partner organizations may choose to use the results generated by this data collection to enhance translation of research into practice (e.g., the American College of Obstetricians and Gynecologists (ACOG)).

The methodology for data collection for the proposed ICR will largely be the same as OMB Control No. 0920-0969, given our prior positive experience. Overall total burden hours for the proposed ICR are half of what was previously approved, because the prior information collection did not account for anticipated non-response when estimating the annualized burden hours. The surveys proposed in this ICR will change slightly from OMB Control No. 0920-0969. The table below provides an overview of these changes across the various phases. Changes in the survey constructs, survey numbers measuring each construct, and relevant U.S. family planning guidance document are summarized in greater detail in **Attachment B-1**. Changes in survey content for Phase 3 (proposed ICR) from Phase 2 (OMB Control No. 0920-0969) were made to eliminate unnecessary questions, add new questions of interest, modify response options of existing questions, and improve formatting that previously resulted in increased missing data. Average burden per response will be unchanged for the provider survey and reduced for the administrator survey. The proposed ICR also includes an additional outreach effort to private-sector physician non-respondents with known email addresses, as a means to increase response rates; email addresses were not previously available. Other aspects of the methodology and analytic approach will be the same. The table below summarizes survey changes between Phase 3 (proposed ICR) and Phase 2 (OMB Control No. 0920-0969):

Eliminated Unnecessary Questions
<i>Provider Survey</i>
Deleted Phase 2 #2 that measured site-level receipt of non-fee-for-service income to support family planning services (not used in analyses)
Deleted Phase 2 #3 that measured state given information available through other sources
Deleted Phase 2 #19 that measured provider practices related to DMPA for adolescents (no gap between evidence and practice identified during Phase 2)
Deleted Phase 2 #20 that measured provider practices related to COCs for postpartum women (no gap between evidence and practice identified during Phase 2)
Deleted Phase 2 #25 that measured provider recommendations for routine follow-up after contraception initiation (not a high priority topic for Phase 3)
Deleted Phase 2 #29-30 that measured practices related to cervical cancer screening (not a high priority topic for Phase 3)
<i>Administrator Survey</i>
Deleted Phase 2 #1 that measured setting given information available through other sources
Deleted Phase 2 #3 that measured state given information available through other sources
Deleted Phase 2 #19-20 that measured quality improvement systems (not used in analyses)
Added New Questions of Interest
<i>Provider Survey</i>
Added Phase 3 #2 that measure site-level urbanicity (important variable to consider)
Added Phase 3 #12 that measures site-level contraceptive method availability (to enable comparison with Phase 1 estimates, when question was last ascertained)
Added Phase 3 #18 that measures safety attitudes related to emergency contraction for women in different clinical scenarios (to assess new US SPR content)
Added Phase 3 #20 that measures provider practices related to routine urine pregnant testing (important topic with little prior information)
Added Phase 3 #22 that measures provider practices related to medication used during IUD insertion (to assess new US SPR content)
Added Phase 3 #23 that measure provider confidence in LARC insertion/removal (important topic with little prior information)
Added Phase 3 #28 that measures provider practices related to Quick Start initiation of IUDs (important topic with little prior information)
Added Phase 3 #29 that measures provider practices related to Quick Start initiation of implants (important topic with little prior information)
Added Phase 3 #30 that measures the typical number of visits required for LARC insertion (important topic with little prior information)
<i>Administrator Survey</i>
Added Phase 3 #9 on basic infertility services (important topic with little prior information)
Added Phase 3 #24 on receipt of training on OPA's Zika toolkit (new training available since Phase 2)
Added Phase 3 #25 on receipt of training on CDC's STD treatment guidelines (to compare with receipt of OPA training)
Modified Response Options of Existing Questions
<i>Provider Survey</i>

Phase 3 #12: added new response option ('instruction on fertility awareness-based methods')
Phase 3 #13: added new response option ('women at high risk for HIV')
Phase 3 #14: removed some response options where a gap between evidence and practice was not identified; added new response option ('women at high risk for HIV')
Phase 3 #19: added new response option ('presented information regarding potential contraceptive methods based on the patient's preferences regarding contraception'); revised wording of one response option to read 'counseled on the full range of contraceptive choices'
Phase 3 #34: added new response option ('U.S. MEC 2017 update with revised recommendations for the use of hormonal contraception among women at high risk for HIV infection')
<i>Administrator Survey</i>
Phase 3 #6: added age breakdown for male clients
Phase 3 #7: combined separate rows asking about specific hormonal IUDs into a single row and added Kyleena® as a hormonal IUD type; added Xulane® as a patch type; added new response option of 'instruction on fertility awareness-based methods'
Phase 3 #8: added 2 new response options ('assess pregnancy intention/reproductive life plan for women' and 'assess pregnancy intention/reproductive life plan for men')
Phase 3 #9: added new response option ('sexual health assessment')
Phase 3 #11: added 2 new response options ('present information regarding potential contraceptive methods based on the patient's preferences regarding contraception' and 'inform clients about fertility awareness-based methods as a contraceptive option'); revised wording of one response option to read 'inform clients about the full range of contraceptive choices'
Phase 3 #13: added new response option ('provided information clarifying that avoiding sex is an effective way to prevent pregnancy and STDs')
Phase 3 #20: added new response option ('counseling on fertility awareness-based methods')
Improved Formatting that Previously Resulted in Increased Missing Data
<i>Provider Survey</i>
Reformatted Phase 3 #11 from Phase 2 survey #11
Collapsed response categories in Phase 3 survey #13-14 from Phase 2 survey #13-14
Reformatted Phase 3 #25 from Phase 2 survey #22

A3. Use of Improved Information Technology and Burden Reduction

Every individual asked to complete a survey will be given the option of completing the survey online via a password-protected web-based data collection system. The basis for offering the option to complete the surveys online is to decrease costs and transcription errors associated with paper-copy survey data entry, and because increasingly, more health care providers are choosing to complete surveys online. There is also literature to support that mixed-mode survey options improve response rates among physicians.

For those opting to complete the web-based survey, questions that are not applicable to a respondent based on an answer to a previous question, will be automatically skipped. For those opting to complete the paper-copy survey, questions that are not applicable to a respondent based on an answer to a previous question will be skipped via formatting and skip patterns. Both options are designed to minimize burden to the respondent and obtain data as efficiently as possible. We do not anticipate that the burden estimates will vary depending on the format of the survey completed. From experience with OMB Control Number 0920-0969, we expect approximately 20% of respondents to complete the surveys online.

A4. Efforts to Identify Duplication and Use of Similar Information

Although there are some studies that have queried and reported on attitudes and practices of family planning providers related to contraceptive use (mostly intrauterine contraception) among women with certain characteristics or medical conditions,⁷⁻¹¹ these studies were conducted among non-nationally representative samples; did not cover the full range of methods; practices or attitudes being proposed for measurement in this ICR; and were non-specific to the US MEC, US SPR, or QFP. There are no national-level data available that are similar to those being proposed in this ICR, other than those collected as part of our multi-phase assessment to monitor changes over time (Phase 1 – EPI AID No. 2010-024, OMB Control No. 0920-0008; Phase 2 – OMB Control No. 0920-0969). This was confirmed via literature searches of electronic databases and discussions with stakeholders and federal partners.

A5. Impact on Small Businesses or Other Small Entities

Data will be collected from family planning providers in the private- and public-sectors, as well as clinic administrators in the public-sector. The questions have been held to the absolute minimum required for the intended use of the data.

The survey instruments will be presented in a clear and easy to complete format based on previous surveys and recommendations from survey methodology research. Sampled individuals will be able to complete the survey at their leisure, and will answer only questions about themselves and the practice or health center at which they received the survey. The burden of participation in this survey for providers and clinic administrators will not affect the normal functioning of the entities in which they work. The responses will allow federal agencies to target available resources in ways that will foster and promote future awareness and adoption of the guidance into practice.

A6. Consequences of Collecting the Information Less Frequently

The first phase of a multi-phase data collection effort to monitor changes in family planning provider attitudes and practices regarding contraception was initiated with Phase 1 (December 2009-March 2010), which collected information before the release of the US MEC. Phase 2 (June 2013-May 2014) collected information before the release of the US SPR and QFP. Phase 3 of the multi-phase assessment (the current ICR) seeks to collect information related to the US MEC approximately eight years after its initial release, and information related to the US SPR and QFP approximately four to five years after their release. Phase 3 will also collect new

information related to content included in the revised US MEC and US SPR published in August 2016 (e.g., new medical conditions and contraception management recommendations). Participants will be asked to respond once to a Phase 3 survey.

Conducting assessments at the above mentioned intervals allows time for changes to occur in provider and clinic attitudes and practices. Since the data will be used to tailor future dissemination activities and develop needed provider tools to optimize widespread adoption and use of the guidance documents, timely identification of issues (e.g., persisting misconceptions and/or gaps in clinic-level practices) is important. Collection of information less frequently would prevent timely identification of such issues, thereby preventing development of beneficial provider tools and inhibiting necessary public health program planning.

A7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the regulation 5 CFR 1320.5.

A8. Comments in Response to the FRN and Efforts to Consult Outside the Agency

A. Comments in Response to the FRN

A 60-day notice was published in the Federal Register on June 8, 2018, vol. 83, No. 111, pp. 26687-26688 with the title “Monitoring Changes in Attitudes and Practices among Family Planning Providers and Clinics” (**Attachment C-1**). CDC received seven public comments (**Attachment C-2**). One public comment noted the importance of understanding provider attitudes and practices related family planning service provision for improving provider education; one public comment was unrelated to this information collection, and the remaining were non-substantive. The comments and CDC’s responses are summarized in Attachment C-2. No changes to the project are required.

B. Efforts to Consult Outside the Agency

Per DHHS and OMB’s strong encouragement for DHHS agencies to collaborate together to meet mutual and related data needs, CDC and OPA are closely collaborating on this ICR (see section A1 – Background). Additionally, CDC sought consultation on methodology and survey instrumentation outside of the agency from individuals listed in the below table. No major unresolved problems were highlighted during consultation.

Year Consulted	Name, Title, Agency	Contact Information
Office of Population Affairs		
2018	Valerie Huber, Acting Deputy Assistant Secretary, OPA	Valerie.Huber@hhs.gov (240) 401-8034
2015, 2016, 2018	Sue Moskosky, Acting Director, OPA	Susan.Moskosky@hhs.gov (240) 453-2888
2016, 2018	Kate Ahrens, Health Scientist, OPA	Kate.Ahrens@hhs.gov (240) 453-2831

Year Consulted	Name, Title, Agency	Contact Information
2015, 2016	Lorrie Gavin, OPA	Loretta.Gavin@hhs.gov (240) 453-2888
2015, 2016	Tasmeen Weik, OPA	Tasmeen.Weik@hhs.gov (240) 453-2802
Family Planning Experts and Other Specialists		
2015, 2016	Andy Kaunitz, MD, OB/GYN, University of Florida, Jacksonville	Andrew.Kaunitz@jax.ufl.edu (904) 633-0140
2015, 2016	Erin Berry-Bibee, MD, OB/GYN, Emory University	(404) 616-5423
2016	Christine Dehlendorf, MD, MAS, Family Medicine, Direction, Program in Woman-Centered Contraception, UCSF	Christine.Dehlendorf@ucsf.edu (415) 206-8712
2015, 2016	Emily Godfrey, MD, Family Medicine, University of Washington	godfreye@uw.edu 206.528.8000
2016	Marji Gold, MD, Family Medicine, Albert Einstein College of Medicine	Marji.Gold@einstein.yu.edu (718) 920-4678
2016	Krishna Upadyha, MD, Adolescent Medicine, Johns Hopkins University	kupadhy2@jhmi.edu 410-502-2910
2016	Linda Dominguez, NP, Women's Health Nurse Practitioner	linda-dominguez@swcp.com (505) 379-0290
2016	Susan Peck, RNC, MSN-APN, Women's Health Nurse Practitioner	specknp@yahoo.com 973-605-5090
2016	Bonnie Cox, Nurse Consultant, Maternal and Child Health Section, Georgia Department of Public Health	Bonnie.Cox@dph.ga.gov 404-657-3142
2016	Courtney Benedict, MSN, CNM, PPFA	courtneybenedict@yahoo.com
2016	Diana Taylor, RNP, PhD, RNP, FAAN, Co-Chair, Women's Health Expert Panel, American Academy of Nursing	diana.taylor@nursing.ucsf.edu 415-517-6926
2016	Alicia Luchowski, MPH, LARC Program, ACOG	aluchowski@acog.org (202) 638-5577
2016	Carolena Cogdill, Clinic Administrator, Haven Health Clinics	ccogdill@hhcama.org
2016	Lori R. Egan, RN, BSN, CCAP, Health Program Director, NEICAC	(563) 568-1290
2016	Cindy Reilly, Insignia Federal Group	Cindy_Reilly@insigniafederal.com (703) 579-6464
2016	David Burns, Insignia Federal Group	David_Burns@insigniafederal.com (703) 579-6464
2016	Bea Snidow, Insignia Federal Group	Bea_Snidow@insigniafederal.com (703) 579-6464
2016	Jeff Cornish, Insignia Federal Group	Jeff_Cornish@insigniafederal.com (703) 579-6464

A9. Explanation of Any Payment or Gift to Respondents

To encourage participation, as well as to provide important family planning information, a family planning provider tool will be sent to all sampled providers and clinics as part of the initial mailing and invitation to participate. The provider tool will not summarize information to be queried about in the surveys, so as to not bias the survey results. Respondents will also be instructed not to consult any source of clinical guidance when answering questions. The provider tool may include one of the following: recommended actions after late or missed combined hormonal contraception; a chart summarizing birth control method options; or an infographic on making clinics teen-friendly.

Justification for offering a provider tool as a token of appreciation comes from literature examining methodologies for improving response rates among health care providers, including physicians, which typically have lower response rates. One systematic review that examined findings from 66 published reports of efforts to improve response rates to physician surveys found that offering an incentive resulted in improved response rates.⁶

Of note, survey respondents during Phase 2 received hard copy versions of the US MEC and US SPR distributed after the end of data collection.

A10. Protection of the Privacy and Confidentiality of Information Provided by Respondent

This submission has been reviewed by CDC's Privacy Office, which determined that the Privacy Act does not apply (**Attachment J-1**). However, while the Privacy Act is not applicable, the appropriate security controls and rules of behavior will be incorporated to protect the confidentiality of information, proprietary, sensitive, and personally identifiable information (PII) that the contractor may come in contact with during the performance of the contract.

CDC will provide the contractor with names, addresses, and phone numbers of sampled physicians and health centers, obtained from pre-existing data sources for the purpose of mailing out surveys. Information for private-sector physicians specializing in obstetrics and gynecology, family medicine, and adolescent medicine (specialties that provide the bulk of family planning services in the United States) will be obtained from the *AMA Physician Masterfile (AMA)*, which includes information on AMA member and nonmember board-certified physicians residing in the United States and United States territories. Information for public-sector health centers will be obtained from a database of publicly-funded health centers that provide family planning, one that is regularly updated and maintained (i.e., *Guttmacher Institute Database*).

Entities overseeing the AMA Physician Masterfile and the Guttmacher Institute Database will randomly select physicians and health centers to participate in the assessment and will provide CDC with the IIF (i.e., names, addresses, and phone numbers) of those selected to participate. CDC will provide the data collection contractor a file containing the IIF of the physicians and health centers sampled to participate in the assessment. The data collection contractor will assign a unique identification number (UID) and use this UID to track responses.

Each survey will contain this UID printed on the first page of the survey. CDC will not have access to any file linking names, addresses, and phone numbers of physicians and health centers with their assigned UIDs. Each mailed survey will be accompanied by a business reply return envelope addressed to the contractor via a rented postal office box. Respondents will also be given the option to complete the survey online via a password-protected web-based data collection system.

Technical (i.e., password-protected files) and administrative controls will be used to protect respondent information. CDC will use a password-protected electronic file to transmit the names, addresses, and phone numbers of physicians and health centers selected to participate in the survey to the contractor. The password to unlock the file will be provided to the contractor via telephone and not in written form (technical control). CDC will not have access to any file linking the names and addresses of physicians and health centers with their UID. The contractor will be the sole source of a password-protected electronic file linking sampled physicians and health centers with their assigned UIDs (technical control). This list will be destroyed within eight months after the end of the data collection period. Survey data transmitted to CDC at the end of the data collection period will not contain any IIF; instead, only de-identified UIDs will be provided. The data collection contractor will work closely with CDC's National Center for Chronic Disease Prevention and Health Promotion's Office of Informatics and Information Resources to ensure that technical and security standards, processes, and procedures are followed (administrative control).

To track responses, the contractor will create a tracking database that only contains the UIDs and not the IIF. When it is time to make follow-up contacts to non-respondents (e.g., reminder postcards, emails to physician non-respondents, second survey package mailings), the contractor will create a list of UIDs of those who have yet to respond, based on information available in the tracking database. These UIDs will be provided to a contractor staff member who has access to the file with IIF, who will initiate the follow-up contact efforts. To send emails to private-sector physician non-respondents sampled from the AMA Physician Masterfile, a contractor staff member will generate a list of physician non-respondents and provide the list to the company overseeing management of the AMA Physician Masterfile. This company will distribute the emails on behalf of the contractor since they do not share email addresses of physicians in their database.

Information held by the contractor is housed on a network that is controlled and protected through strict administrative controls. Access to the web-based server requires two-factor authentication and advanced, complex passwords with strict rules established by the IT Manager. Non-admin users are prevented from sharing any company owned or managed files. In the event of a data breach or loss of company owned equipment, the IT Manager will initiate a remote wipe which will delete all company data and any local copies of files from a computer when that computer comes online. Data in transit is encrypted using industry standard SSL/TLS with AES 128-bit encryption and data stored on the cloud servers are encrypted with AES 256-bit.

At CDC, password protection will impose user name and password log-in requirements to prevent unauthorized access. Each user name will be assigned limited access rights to files and

directories at varying levels to control file sharing. Computer facilities at all sites are protected from potential fire or water damage. Further, CDC is in compliance with applicable federal law requiring the protection of federal computer networks from cybersecurity risks like hacking, internet attacks, and other security weakness; computer network experts working for, or on behalf, of the government, may intercept and review information sent through government networks for cyber threats if the information is sent through the government network triggers a cyber threat indicator.

Data collected online will be downloaded into electronic databases (one for the provider survey and one for the health center administrator survey) on a regular basis. Paper-copy survey data will be entered into electronic databases (one for the provider survey and one for the health center administrator survey). The databases, stripped of any identifiers other than the UID, will be permanent federal records and will be maintained in accordance with CDC's records control schedule (<http://isp-v-maso-apps/RecSched/ViewSchedule.aspx?RID=29>). Paper-copy surveys will be shredded within eight months after completion of data entry. Respondents will not be re-contacted after survey completion to validate any potentially unclear data elements.

A11. Institutional Review Board (IRB) and Justification for Sensitive Questions

The proposed data collection was approved as non-research, public-health practice by the National Center for Chronic Disease Prevention and Health Promotion (**Attachment J-2**), and thus institutional review board (IRB) approval is not required. No sensitive questions will be included.

The cover letters and the first page of both surveys contain the following statements to inform them of protections on their privacy:

- Be assured that your responses will be maintained in a secure manner.
- Results will only be released in summary form.
- This survey has been approved by the Centers for Disease Control and Prevention as non-research public health practice.

Additionally, the first page of the administrator survey and the cover letter sent to public-sector clinics contains the following statement:

- The information will not be used to assess compliance with federal or other regulations, or as part of your agency's performance reviews.

A12. Estimates of Annualized Burden Hours and Costs

We seek to mail surveys to 10,000 private- and public-sector family planning providers and health center administrators in the United States. Private-sector physicians will be randomly selected from a sampling frame with individual-level information on physicians. To reach public-sector providers and health center administrators, publicly funded health centers that provide family planning services will be randomly selected from a sample frame with health

center-level information. At sampled health centers, one provider and one administrator will be asked to complete surveys. More specifically, we will send surveys to the following providers and administrators:

- 2,000 private-sector office-based physicians (i.e., those specializing in obstetrics/gynecology, family medicine, and adolescent medicine), sampled from the American Medical Association (AMA) Physician Masterfile;
- 2,000 public-sector providers from Title X clinics, sampled from the Guttmacher Institute database of publicly funded family planning health centers; and
- 2,000 public sector providers from non-Title X clinics, sampled from the Guttmacher Institute database of publicly funded family planning health centers.
- 2,000 clinic administrators from Title X clinics, sampled from the Guttmacher Institute database of publicly funded family planning health centers; and
- 2,000 clinic administrators from non-Title X clinics, sampled from the Guttmacher Institute database of publicly funded family planning health centers.

Each sampled private-sector physician and public-sector health center will receive a mailed survey package. The mailed survey package will include a cover letter (private sector: **Attachment D-1**; public sector: **Attachment D-2**) addressed personally to the physician or health center, and will include a description of the assessment, will address the importance of participation, and will include a point of contact to direct inquiries.

For private-sector physicians, each mailed survey package will include a single survey (**Attachment E-1**) to be completed by the physician.

For public-sector health centers, each mailed survey package will include two surveys (**Attachments E-1 and F-1**) – one to be completed by a clinician who provides family planning services to at least two women of reproductive age per week, on average (**Attachment E-1**), and the second to be completed by a health center administrator (**Attachment F-1**). Each respondent will only be asked to complete a single survey.

Potential respondents will also be given the option to complete the surveys online (see **Attachments E-2 and F-2** for screen shots).

Anticipating non-response, a reminder postcard will be sent to those who have not responded to the first mailing after approximately 2-4 weeks (**Attachments G-1, G-2, and G-3**). About one week later, the company overseeing management of the AMA Physician Masterfile will send an email reminder (**Attachment H-1**) to private-sector physician non-respondents. Similar outreach to non-respondents in public-sector health centers is not possible since email addresses are not included in the Guttmacher Institute database. A second copy of the survey, along with a follow-up cover letter (**Attachments I-1, I-2, and I-3**) will be sent to those who have not responded approximately 2-4 weeks after the reminder postcard. Phone calls will be made and emails sent (if email addresses are provided during phone call outreach) to those who have not responded to any of the contact attempts to encourage participation.

A. The following table summarizes the estimated annualized burden hours. The 2018-2019 Survey of Health Care Providers about Family Planning Attitudes and Practices is provided as **Attachment E-1**. The 2018-2019 Survey of Administrators of Health Centers that Provide Family Planning is provided as **Attachment F-1**. While we will mail surveys to 10,000 private- and public-sector family planning providers and health center administrators in the United States, given the 50% response rate based on Phase 2 data collection (OMB No. 0920-0969), we anticipate that 5,000 surveys will be completed. It is estimated that the provider survey will take on average 15 minutes to complete, and the administrator survey will take on average 35 minutes to complete. This was estimated by having various project staff members and external colleagues not familiar with the surveys complete the surveys. The total estimated burden is 1,916 hours.

Estimated Annualized Burden Hours

Respondents	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Office-based physicians (private sector)	2018-2019 Survey of Health Care Providers about Family Planning Attitudes and Practices (Att E)	1,000	1	15/60	250
Title X clinic providers (public sector)	2018-2019 Survey of Health Care Providers about Family Planning Attitudes and Practices (Att E)	1,000	1	15/60	250
Non-Title X clinic providers (public sector)	2018-2019 Survey of Health Care Providers about Family Planning Attitudes and Practices (Att E)	1,000	1	15/60	250
Title X clinic administrators (public sector)	2018-2019 Survey of Administrators of Health Centers that Provide Family Planning (Att F)	1,000	1	35/60	583
Non-Title X clinic administrators (public sector)	2018-2019 Survey of Administrators of Health Centers that Provide Family Planning (Att F)	1,000	1	35/60	583
TOTAL					1,916

B. The table below summarizes the estimated annualized burden costs. The estimates of hourly wages were obtained from the Department of Labor.¹² The total estimated annualized cost to respondents is \$137,074.

Estimated Annualized Burden Costs

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Average Hourly Wage	Total Cost
Office-based physicians (private sector)	2018-2019 Survey of Health Care Providers about Family Planning Attitudes and Practices (Att E)	1,000	1	15/60	250	\$100.27	\$25,068
Title X clinic providers (public sector)	2018-2019 Survey of Health Care Providers about Family Planning Attitudes and Practices (Att E)	1,000	1	15/60	250	\$35.36	\$8,840
Non-Title X clinic providers (public sector)	2018-2019 Survey of Health Care Providers about Family Planning Attitudes and Practices (Att E)	1,000	1	15/60	250	\$35.36	\$8,840
Title X clinic administrators (public sector)	2018-2019 Survey of Administrators of Health Centers that Provide Family Planning (Att F)	1,000	1	35/60	583	\$53.69	\$31,301
Non-Title X clinic administrators (public sector)	2018-2019 Survey of Administrators of Health Centers that Provide Family Planning (Att F)	1,000	1	35/60	583	\$53.69	\$31,301
Total							\$105,350

A13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

There are no costs to respondents other than their time.

A14. Annualized Cost to the Federal Government

This ICR will be funded through a contract in the amount of \$779,006.38. The sources of this funding come from CDC's DRH (\$379,006.38) and OPA (\$400,000). The contract expenses will cover operational costs and supplies.

Personnel costs of federal employees involved in oversight of the contract, technical assistance, and analysis of data (i.e., direct costs to the federal government) will include those of 11

CDC/DRH and OPA staff (1 project lead at .4 FTE, 8 project staff at .125 FTE, and 2 project staff at .1 FTE).

The total estimated annual cost to the government is \$970,644.45.

Estimated Annual Cost to the Government				
Expense Type	Expense Explanation			Annual Costs (dollars)
Federal government staff salaries	Project lead	GS-13	.4 FTE/year or 768 hours	\$ 38,215.68
	Project staff	GS-14	.125 FTE/year or 240 hours	\$ 14,112.00
	Project staff	GS-14	.125 FTE/year or 240 hours	\$ 14,112.00
	Project staff	GS-12	.125 FTE/year or 240 hours	\$ 10,044.00
	Project staff	GS-12	.125 FTE/year or 240 hours	\$ 10,044.00
	Project staff	GS-13	.125 FTE/year or 240 hours	\$ 11,942.40
	Project staff	GS-13	.125 FTE/year or 240 hours	\$ 11,942.40
	Project staff	GS-13	.125 FTE/year or 240 hours	\$ 11,942.40
	Project staff	GS-13	.125 FTE/year or 240 hours	\$ 11,942.40
	Project staff	GS-15	.1 FTE/year or 192 hours	\$ 13,670.40
	Project staff	GS-15	.1 FTE/year or 192 hours	\$ 13,670.40
Total Salary				\$ 161,638.08
Printing				\$30,000.00
Contract				\$779,006.37
TOTAL				\$970,644.45

A15. Explanation for Program Changes or Adjustments

This ICR is a reinstatement with change of OMB Control No. 0920-0969 (expiration date: 05/31/2014). *Changes noted between the proposed ICR from OMB Control No. 0920-0969 will be (1) reduced overall total burden hours; (2) revised surveys; (3) reduced average burden per response for one survey; and (4) an additional outreach effort to non-respondents with known email addresses.* Other aspects of the methodology and the analytic approach will be the same. Overall total burden hours for the proposed ICR are half of what was approved for OMB Control No. 0920-0969. This is because the prior information collection did not adjust for anticipated non-response (50%) when estimating the annualized burden hours. The surveys will change slightly to eliminate unnecessary questions, add new questions of interest, modify response options of existing questions, and improve formatting that previously resulted in increased missing data. As a result of changes to the administrator survey, the average burden time per response will be reduced from 40 minutes to 35 minutes. Email addresses for potential respondents were not previously available. However, as email addresses will be available for select potential respondents for the proposed ICR (i.e., physicians sampled from the private-sector), we plan to conduct an additional outreach effort via email to private-sector non-respondent physicians to increase response rates.

A16. Plans for Tabulation and Publication and Project Time Schedule

Our analytic plans are described below by objective. Please refer to Appendix 1 in this document for a summary of survey constructs, survey question numbers measuring each construct, and relevant U.S. family planning guidance documents for each construct.

In addition to the analytic plans described by each objective below, we will describe our sample by demographic and training characteristics using questions #1-11 on the phase 3 provider survey, and questions #1-6, 21-26 on the phase 3 administrator survey.

Objective 1: To understand the current use of contraception guidance in practice and valued sources of contraceptive information, including awareness and use of the US MEC, US SPR and QFP.

- We will analyze questions #32-34 on the phase 3 provider survey and question #23 on the phase 3 administrator survey.
- We will generate descriptive frequencies for each response option of each question.
- For the questions from the provider survey, frequencies will be generated for the entire sample collectively, as well as stratified by provider type (i.e., private-sector OB/GYN, private-sector family medicine physician, private-sector adolescent medicine physician, public-sector Title X clinic provider, and public-sector non-Title X clinic provider). We may also compare private-sector providers with public-sector providers.
- For the question from the administrator survey, frequencies will be generated for the entire sample collectively, as well as stratified by public-sector Title X clinic administrator and public-sector non-Title X clinic administrator.
- To examine differences between subgroups, bivariate analyses will be conducted using the appropriate statistical test. For example, to examine differences in the percent of providers having used the US MEC or US MEC provider tools (#343; coded as yes/no), chi-square tests will be computed. Findings will be considered statistically significant if the p-value is <0.05.

Objective 2: To describe current attitudes and practices among family planning providers and clinics related to content included in the US MEC, US SPR, and QFP and assess changes from previous phases.

A. To describe current attitudes and practices among family planning providers and clinics:

(1) Related to content included in the US MEC:

- We will analyze questions #13-15 and 21 on the phase 3 provider survey.
- We will generate descriptive frequencies for each response option of each question.
- Frequencies will be generated for the entire sample collectively, as well as stratified by provider type (i.e., private-sector OB/GYN, private-sector family medicine physician, private-sector adolescent medicine physician, public-sector Title X clinic provider, and public-sector non-Title X clinic provider). We may also compare private-sector providers with public-sector providers.
- To examine differences between subgroups, bivariate analyses will be conducted using the appropriate statistical test. For example, to examine differences in provider perceptions of the safety of intrauterine devices (IUDs) for nulliparous women (#15), we will conduct a chi-square test comparing the distributions of 'safe', 'unsafe' and 'don't know' by provider type. Those responding 'don't

Objective 1: To understand the current use of contraception guidance in practice and valued sources of contraceptive information, including awareness and use of the US MEC, US SPR and QFP.

know' may also be deleted from the analysis or combined with the 'unsafe' group. Findings will be considered statistically significant if the p-value is <0.05.

(2) Related to content included in the US SPR:

- We will analyze questions #16-18, 20, 22, 24-31 on the phase 3 provider survey.
- We will generate descriptive frequencies for each response option of each question.
- Frequencies will be generated for the entire sample collectively, as well as stratified by provider type (i.e., private-sector OB/GYN, private-sector family medicine physician, private-sector adolescent medicine physician, public-sector Title X clinic provider, and public-sector non-Title X clinic provider). We may also compare private-sector providers with public-sector providers.
- To examine differences between subgroups, bivariate analyses will be conducted using the appropriate statistical test. For example, to examine differences in provider perceptions of the safety of quick start for combined hormonal contraceptives for adolescents (#16), we will conduct a chi-square test comparing the distributions of 'safe', 'unsafe' and 'don't know' by provider type. Those responding 'don't know' may also be deleted from the analysis or combined with the 'unsafe' group. Findings will be considered statistically significant if the p-value is <0.05.

(3) Related to content included in the QFP:

- We will analyze question #19 on the phase 3 provider survey and questions #7-19 on the phase 3 administrator survey.
- We will generate descriptive frequencies for each response option of each question.
- Frequencies will be generated for the entire sample collectively, as well as stratified by public-sector Title X clinic administrator and public-sector non-Title X clinic administrator.
- To examine differences between subgroups, bivariate analyses will be conducted using the appropriate statistical test. For example, to examine differences in health center provision of preconception health care for women in the past three months (#8), we will conduct a chi-square test comparing the distributions of 'never', 'rarely', 'occasionally', and 'frequently' by health center characteristic. Response options may be combined. Findings will be considered statistically significant if the p-value is <0.05.

B. To assess changes from previous phases:

(1) Related to content included in the US MEC:

- We will analyze questions #13-15 and 21 on the phase 3 provider survey; and questions #15-17 and 21-22 from the phase 1 provider survey.
- We will compare estimates from phase 1 and phase 3 by conducting chi-square tests examining each attitude or practice by time (coded as phase 1 or phase 3). Findings will be considered statistically significant if the p-value is <0.05. We

expect that most statistically significant changes will also represent conceptually significant changes. A change $\geq 10\%$ that is statistically significant will in general also be conceptually important. However, the percent change that will be considered conceptually important is dependent on the parameter being assessed and the size of the denominator. For example, a 10% improvement in the prevalence of adolescent medicine physicians reporting that IUDs are safe for adolescents may or may not be statistically significant due to smaller numbers of such providers in our sample, but may be considered conceptually significant. Comparisons between phase 1 and phase 3 will be done for the entire sample collectively (excluding public-sector non-Title X clinic providers who were not included in phase 1), as well as stratified by provider types included in both phases (i.e., private-sector OB/GYN, private-sector family medicine physician, private-sector adolescent medicine physician, and public-sector Title X clinic provider). We may also compare private-sector providers with public-sector providers.

- We will also examine differences in each attitude or practice among phase 3 respondents only, by both awareness of the US MEC (#33 in the phase 3 provider survey) and use of any of the US MEC provider tools (#34 in the phase 3 provider survey).

(2) *Related to content included in the US SPR:*

- We will analyze questions #16-17, 24-31 on the phase 3 provider survey; and questions #17, 22-24, and 26-27 from the phase 2 provider survey.
- We will compare estimates from phase 2 and phase 3 by conducting chi-square tests examining each attitude or practice by time (coded as phase 2 or phase 3). Findings will be considered statistically significant if the p-value is < 0.05 . We expect that most statistically significant changes will also represent conceptually significant changes. A change $\geq 10\%$ that is statistically significant will in general also be conceptually important. However, the percent change that will be considered conceptually important is dependent on the parameter being assessed and the size of the denominator. For example, a 10% improvement in the prevalence of adolescent medicine physicians reporting that ‘quick start’ of DMPA is safe for adolescents may or may not be statistically significant due to smaller numbers of such providers in our sample, but may be considered conceptually significant. Comparisons between phase 2 and phase 3 will be done for the entire sample collectively, as well as stratified by provider type (i.e., private-sector OB/GYN, private-sector family medicine physician, private-sector adolescent medicine physician, public-sector Title X clinic provider, and public-sector non-Title X clinic provider). We may also compare private-sector providers with public-sector providers.
- We will also examine differences in each attitude or practice, among phase 3 respondents only, by both awareness of the US SPR (#33 in the phase 3 provider survey) and use of any of the US SPR provider tools (#34 in the phase 3 provider survey).

(2) *Related to content included in the QFP:*

- We will analyze question #19 on the phase 3 provider survey and questions #7-19 on the phase 3 administrator survey; and question #18 on the phase 2

- provider survey and questions #9-18 and 21 on the phase 3 administrator survey.
- We will compare estimates from phase 2 and phase 3 by conducting chi-square tests examining each practice by time (coded as phase 2 or phase 3). Findings will be considered statistically significant if the p-value is <0.05. We expect that most statistically significant changes will also represent conceptually significant changes. A change $\geq 10\%$ that is statistically significant will in general also be conceptually important. However, the percent change that will be considered conceptually important is dependent on the parameter being assessed and the size of the denominator. For example, a 10% improvement in the prevalence of community health centers reporting ‘frequently’ providing preconception health care for women may or may not be statistically significant due to smaller numbers of respondents from community health centers in our sample, but may be considered conceptually significant. Comparisons between phase 2 and phase 3 will be done for the entire sample collectively, as well as stratified by clinic type (e.g., health department, community health center). We may also compare responses from public-sector Title X clinic administrators with public-sector non-Title X clinic administrators.

Objective 3: To identify targeted training needs in use of guidance and family planning service delivery (e.g., provider tools, continuing education modules).

- Generation of frequency distributions of the various attitudes and practices (described in objective 2) will allow project team members to identify attitudes and practices that are inconsistent with current evidence and recommendations in the various guidance documents. It may be that specific provider groups are targeted for educational interventions or receipt of provider tools.

Additionally, after exploring the data as described above, we also intend to conduct select multivariable analyses examining factors associated with key outcomes of interest. For example, we are interested in examining provider characteristics independently associated with attitudes surrounding provision of IUDs to postpartum women, quick start attitudes and practices for IUDs and implants, and use of medications during or prior to IUD insertion.

The anticipated project time schedule is outlined in the table below. Results will be available to the public health community via peer-reviewed publications. Developed provider tools will, at a minimum, be made available on the CDC/DRH website for downloading.

Project Time Schedule	
Activity	Time Schedule
Survey packages sent to sampled providers/clinics	2 weeks to 1 month after OMB approval
2 nd contact mailing (reminder postcard) to non-respondents	~2-4 weeks after 1 st contact mailing
3 rd contact mailing (repeat survey) to non-respondents	~2-4 weeks after 2 nd contact mailing
Phone/email follow-up contact to non-respondents	3-9 months after OMB approval
End data collection	9-12 months after OMB approval
Data entry/validation of data	12-15 months after OMB approval

Project Time Schedule	
Activity	Time Schedule
Analyses of data	15-36 months after OMB approval
Publication of findings	24-36 months after OMB approval

A17. Reason(s) Display of OMB Expiration Date is Inappropriate

The display of the OMB expiration date is not inappropriate.

A18. Exceptions to Certification for Paperwork Reduction Act Submission

There are no exceptions to the certification.

REFERENCES

See **Attachment K-1 for a copy of references listed below.**

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