Supporting Statement: Part A

Evaluation of U.S. Family Planning Guidelines – Phase II

Submitted by:

Centers for Disease Control and Prevention (CDC)
National Center for Chronic Disease Prevention and Health Promotion
Division of Reproductive Health
Women's Health and Fertility Branch

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August 20, 2012

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Acronyms

AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ACOG	American College of Obstetricians and Gynecologists
AMA	American Medical Association
ASRM	American Society for Reproductive Medicine
CDC	Centers for Disease Control and Prevention
FRN	Federal Register Notice
HRSA/BPHC	Health Resources and Services Administration/Bureau of Primary Health Care
ICR	Information Collection Request
IIF	Information in identifiable form
IRB	Institutional Review Board
NACHC	National Association of Community Health Centers
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NFPRHA	National Family Planning and Reproductive Health Association
OPA	Office of Population Affairs
PPFA	Planned Parenthood Federation of America
QFPS	*Guidance for Proving Quality Family Planning Services*
US MEC	*U.S. Medical Eligibility Criteria for Contraceptive Use*
US SPR	*U.S. Selected Practice Recommendations for Contraceptive Use*
WHO SPR	*World Health Organization Selected Practice Recommendations for Contraceptive Use*

A. JUSTIFICATION

A1. Circumstances Making the Collection of Information Necessary

Background

This Information Collection Request (ICR) is new, and represents a collaborative effort between the Centers for Disease Control and Prevention (CDC) and the HHS Office of Population Affairs (OPA). CDC needs to collect data about family planning practices among private-sector physicians and public-sector providers after releasing one set of national CDC contraceptive guidelines and before releasing a second set of national CDC contraceptive guidelines. At the same time, OPA needs to collect baseline information about family planning practices among public-sector providers and health center administrators before the release of revised national programmatic guidelines developed to serve federal grantees. Given that both agencies need to collect data from public-sector providers about family planning practices, CDC and OPA chose to collaborate, reduce survey burden in the field, and strengthen the quality of the overall data collection effort.

Unintended pregnancy rates remain high in the United States; about 50% of all pregnancies are unintended, with higher proportions among adolescents and young women, women of racial and ethnic minorities, and women with less education and lower incomes.[1] Unintended pregnancies increase risk for poor maternal and infant outcomes,[2] and cost the United States about $5 billion a year.[3] About half of unintended pregnancies are among women who were not using contraception at the time they became pregnant; the other half are among women who became pregnant despite reported use of contraception.[4] Therefore, strategies to prevent unintended pregnancy should include assisting women at risk to choose appropriate contraceptive methods and helping women use methods correctly and consistently to prevent pregnancy. One way to achieve these strategies is to adapt or develop contraceptive guidance to improve delivery of services in the United States.

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 published by the CDC in June 2010.[5] The US MEC is intended to assist health-care providers when they counsel women, men, and couples about contraceptive method choice, and is meant to be a source of clinical guidance; policy-makers, program managers, and the scientific community may also be users of the guidance.

The *U.S. Selected Practice Recommendations for Contraceptive Use* (US SPR), currently being adapted from the *World Health Organization's Selected Practice Recommendations for Contraceptive Use* (WHO SPR),[6, 7] is expected to be published by the CDC in fall 2012/winter 2013. The US SPR will provide guidance for how to use contraceptive methods safely and effectively once they are deemed to be medically appropriate, and will address common, yet controversial contraceptive management questions. The US SPR is intended to assist health-

care providers when they counsel women, men and couples about contraceptive method use, and is meant to be a source of clinical guidance; policy-makers, program managers, and the scientific community may also be users of the guidance.

The *Guidance for Providing Quality Family Planning Services* (QFPS), currently being developed by the CDC, in collaboration with OPA, is expected to be published by the CDC in fall 2012/winter 2013. The QFPS will update OPA's *Program Guidelines for Project Grants for Family Planning Services* last issued in 2001,[8] and will provide 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. The QFPS is primarily intended to assist family planning providers funded through OPA's Federal Title X Family Planning Program, but may also be of value to other providers of family planning services in non-Title X settings, as well as other primary care providers. The QFPS is meant to be a source of clinical guidance; policy-makers and program managers may also be users of the guidance.

These guidance documents (i.e., US MEC, US SPR, QFPS) have or will be 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, as deemed appropriate.

To evaluate the diffusion of and impact on provider and clinic attitudes and practices of the US MEC, we initiated a multi-phase evaluation, including baseline data collection, in December 2009 (Phase 1) (EPI AID No. 2010-024; OMB No. 0920-0008). Data from private- and public-sector family planning providers throughout the United States were collected by mail from December 2009 through March 2010.

This proposed information collection represents Phase II of the multi-phase evaluation plan. Follow-up data will be collected pertaining to the diffusion, uptake, and impact of the US MEC, as well as baseline data pertaining to the US SPR and QFPS.

The proposed information collection will fill a gap in knowledge related to the awareness of and impact on provider attitudes and practices of the US MEC, and will enable CDC to assess baseline attitudes and practices related to topics that will be addressed in the forthcoming US SPR and QFPS. The information collected will also allow CDC to improve family planning-related public health practice, as CDC will tailor future dissemination activities, and develop needed provider tools, based upon the results. OMB approval is requested for one year.

CDC plans to submit a separate information collection request to OMB for a follow-up survey in about three years.

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)**.

Privacy Impact Assessment

Overview of the Data Collection System

We seek to administer mailed surveys to a random sample of 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 seek to have surveys completed by:

- 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 providers from Title X clinics, sampled from the Guttmacher Institute database of publicly funded family planning health centers; and
- 2,000 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 (Attachments C-1 and C-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. The cover letters will also include signatures of support from partner organizations (i.e., American Academy of Family Physicians [AAFP], American Academy of Pediatrics [AAP], American College of Obstetricians and Gynecologists [ACOG], American Society for Reproductive Medicine [ASRM], Health Resources and Services Administration/Bureau of Primary Health Care [HRSA/BPHC], National Association of Community Health Centers [NACHC], National Family Planning and Reproductive Health Association [NFPRHA], and Planned Parenthood Federation of America [PPFA]).

For private-sector physicians, each mailed survey package will include a single survey (**Attachment D-1**) with survey cover sheet (**Attachment D-2**), to be completed by the physician.

For public-sector health centers, each mailed survey package will include two surveys (**Attachments D-1 and E-1**) with two survey cover sheets (**Attachments D-2 and E-2**) – one to be completed by a clinician who provides family planning services to women of reproductive

age at least twice per week, and the second to be completed by a health center administrator. Each respondent will only be asked to complete a single survey.

Each survey will contain a unique identification number (UID), assigned by the data collection contractor. CDC will not have access to any file linking names and addresses of physicians and health centers in our sample with their assigned UIDs. Each mailed survey will be accompanied by a postage-paid 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.

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 F-1, F-2, and F-3). A second copy of the survey, along with a follow-up cover letter (Attachments G-1, G-2, and G-3) will be sent to those who have not responded to the first survey or reminder postcard approximately 2-4 weeks after the reminder postcard. Phone calls will be made and emails sent (if email addresses are available) to those who have not responded to any of the contact attempts to encourage participation.

Data collected online will be downloaded into an electronic database on a regular basis. Paper-copy survey data will be entered into an electronic database. The two 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.

Items of Information to be Collected

Although no information in identifiable form (IIF) will be collected via the survey, IIF will be used to mail the survey packages to sampled physicians and health centers. Specifically, CDC project staff will obtain health center names, addresses, phone numbers, and email addresses (where available), from the Guttmacher Institute (the data collection contractor will obtain the names and contact information for private-sector physicians). This information will be provided to our contractor to implement the survey. The contractor will assign a UID to each survey being sent out for completion, and use this UID for tracking purposes. The contractor will maintain the sole file linking names of physicians and health centers with UIDs. At no time will CDC have access to linked data or know if a specific health center or physician has responded or not. Information collection will be conducted according to a security plan developed in consultation with NCCDPHP's Office of Informatics and Information Resources.

Identification of Website(s) and Content Directed at Children Under 13 Years of Age

The information collection system will include a web-based data collection method option that is password-protected. Individuals may choose to complete the survey online, as an alternative

to completing the paper-copy survey and returning by postal mail. No person under 13 years old will access the website.

A2. Purpose and Use of the Information Collection

The purposes of this ICR are:

- To understand the current use of contraceptive guidelines in practice and valued sources of contraceptive information, including awareness and use of the US MEC;
- To describe provider attitudes and practices related to contraceptive method use by women with specific characteristics or medical conditions approximately two years after the release of the US MEC, and assess changes from baseline levels (for provider types for which baseline data were collected);
- To describe differences in attitudes and practices between various family planning providers (e.g. private- and public-sector providers);
- To establish baseline attitudes and practices related to select contraceptive practices to be addressed in the forthcoming US SPR and QFPS; and
- To identify gaps between evidence and practice to inform development of educational interventions and provider tools to improve future contraceptive service delivery.

The data will primarily be used by CDC and OPA to assess the impact of the US MEC, US SPR and QFPS. 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. Other key partner organizations supporting the data collection that may also choose to use the results generated by this data collection to enhance translation of research into practice include AAFP, AAP, ACOG, ASRM, HRSA/BPHC, NACHA, NFPRHA, and PPFA. However, these organizations will not have access to the data. The data may be used on an ongoing basis (i.e., not limited to a given frequency).

Although this is a new ICR, similar information pertaining to the US MEC was collected during the Phase I evaluation conducted December 2009 – March 2010 (EPI AID No. 2010-024; OMB No. 0920-0008). Data from this information collection activity resulted in useful knowledge of differences in contraceptive method availability between public- and private-sector providers, 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 and practices that are not consistent with current scientific evidence

(e.g., misconceptions that intrauterine devices are not safe for adolescent or nulliparous women). The *rationale for continuing the data collection* pertaining to the US MEC is to assess changes in provider attitudes and practices approximately two and a half years after the release of the US MEC, and to identify persisting differences between provider types and persisting misconceptions, that may warrant continued and more tailored dissemination and educational activities.

Privacy Impact Assessment Information

No IIF will be collected via the survey, but IIF will be used to send sampled physicians and health centers mailed survey packages. The IIF to be used will include physician and health center names, mailing addresses, phone numbers, and email addresses (where available). The information will be obtained from the appropriate sample frames (e.g., AMA Physician Masterfile, Guttmacher Institute database of publicly funded family planning health centers). The IIF will only be shared with the contractor implementing the surveys, for the purposes of sending out the mailed survey packages and tracking responses. The contractor will assign a UID to each survey sent out for completion, and use this UID to log responses. At no time will CDC have access to identifiable data or know if a specific provider or health center has responded or not. No sensitive information will be collected, so the proposed data collection activity will have little or no effect on the respondent's privacy. 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.

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 this decision was 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.[9]

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. Also, we will only collect the minimum information necessary for the purposes of the ICR.

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,[10-14] these studies were conducted among non-nationally representative samples, did not cover the full range of methods, practices and attitudes being proposed for measurement in this ICR, and were non-specific to the US MEC.

Similar information, pertaining to the US MEC only, was collected by CDC December 2009 through March 2010 (Phase 1) (EPI AID No. 2010-024; OMB No. 0920-0008), where baseline data on specific provider attitudes and practices before the release of the US MEC were assessed. These data do not meet the current needs of the proposed ICR (Phase II), which in part seeks to evaluate the diffusion of and impact on attitudes and practices of the US MEC approximately two and a half years after its release. Previously collected data also do not meet the current needs of the proposed ICR as they do not include information on the US SPR or the QFPS.

There are no national-level data available that are similar to those being proposed in this ICR. 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. 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 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.

A6. Consequences of Collecting the Information Less Frequently

Baseline data for the US MEC (Phase 1) were collected December 2009 through March 2010. This was the first of a multi-phase data collection effort to evaluate the diffusion of and impact on attitudes and practices of the US MEC. Phase II of the evaluation (the current ICR) seeks to collect follow-up information on the US MEC approximately two and a half years after its release, as well as baseline data on attitudes and practices related to the forthcoming US SPR and QFPS. We plan to conduct Phase III approximately two and a half years to three years after the release of the US SPR and QFPS. There are currently no plans to conduct further evaluation assessments after Phase III.

Conducting assessments approximately two and a half to three years after the release of the guidance documents allows time for changes to occur in provider 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, this assessment interval is adequate to characterize issues of concern (e.g., large gaps between science and practice) without losing timeliness of data. Collection of information less frequently would prevent timely identification of issues that limit full or accurate use of the guidance, thereby preventing development of beneficial provider tools and inhibiting necessary public health program planning.

A7. Special Circumstances Relating to the Guidelines of 5 CRF 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

The 60-day Federal Register Notice was published in the Federal Register on April 9, 2012, Vol. 77, No. 68, pp. 2 (**Attachment B-1**). One non-substantive public comment was received on April 9, 2012; CDC's standard response was sent (**Attachment B-2**).

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). CDC sought consultation on methodology and survey instrumentation outside of the agency from individuals listed in the below table.

Year Consulted	Name, Title, Agency	Email / Phone #
2012	Marilyn Keefe, Deputy Assistant Secretary, OPA	Marilyn.Keefe@hhs.gov; 240 453.2805
2012	Christina LaChance, OPA	Christina.LaChance@os.hhs.gov; 240 453.2813
2012	Nancy Mautone-Smith, Public Health Consultant, OPA	Nancy.Mautone-Smith@hhs.gov;
2012	Sue Moskosky, Director, Office of Family Planning, OPA	Susan.Moskosky@hhs.gov; 240.453.2888
2012	Courtney Benedict, PPFA	(650) 574-5823
2012	Clare Coleman, Executive Director, NFPRHA	(202) 293-3114
2012	Jan Chapin, Associate Director, ACOG	jchapin@acog.org
2012	Jennifer Deitrich, Assistant Professor Department of Obstetrics and Gynecology, Baylor College of Medicine	jedietri@texaschildrens.org; 832-826-7464
2012	Linda Dominguez, Chair, Association of Reproductive Health Professionals	linda-dominguez@swcp.com; (505) 379-0290
2012	David Eisenberg, Assistant Professor of Obstetrics & Gynecology, Washington University in Saint Louis	eisenbergd@wudosis.wustl.edu
2012	Jennifer Frost, Senior Research Associate, Guttmacher Institute	jfrost@guttmacher.org; 212-248-1111
2012	Marji Gold, Professor, Albert Einstein College of	Marji.Gold@einstein.yu.edu

	Medicine	
2012	Mark Hathaway, Unity Health Care and Washington Hospital Center	(202) 715-7901
2012	Andy Kaunitz, University of Florida, Jacksonville	Andrew.Kaunitz@jax.ufl.edu
2012	Melissa Kottke, Emory University	MKOTTKE@emory.edu
2012	Arik Marcel, Johns Hopkins University	amarcell@jhsph.edu
2012	Deborah Nucatola, PPFA	202-973-4800
2012	Michael Policar, UCSF Bixby Center	michael.policar@cdph.ca.gov
2012	Diana Taylor, UCSF Bixby Center	diana.taylor@nursing.ucsf.edu; (510) 986-8950
2012	Maria Trent, Associate Professor of Pediatrics, Johns Hopkins School of Medicine	mtrent2@jhmi.edu; 443.287.8945

A9. Explanation of Any Payment of Gift to Respondents

To encourage participation, as well as to provide important family planning information and provider tools, a package of "US MEC provider tools" will be sent to all physicians returning a survey (complete or non-complete), as well as all health centers returning at least one survey (complete or non-complete). The materials will be distributed at the end of data collection. If project funds allow, all non-responding private-sector physicians and public-sector health centers will also receive a package of "US MEC provider tools". The package may include the following: paper-copy US MEC MMWR and updates, US MEC color-coded and laminated summary chart, and US MEC wheel.

Justification for offering the materials as an incentive to participate in the data collection effort 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.[9]

A10. Assurance of Confidentiality Provided to Respondents

Survey cover letters will assure potential respondents that their answers will be maintained in a secure manner, and that results will only be released in summary form.

As previously described, although CDC will obtain IIF (e.g., names, addresses, phone numbers, email addresses [where available]) of physicians and health centers randomly selected to participate in the assessment from the appropriate sampling frames, this information will be given to the data collection contractor who will assign a unique identification number (UID) and use this UID to track responses.

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. 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.

For the survey sent to public-sector health centers to be completed by a health center administrator, querying about clinic-level practices and protocols, it will not be necessary to identify the person completing the survey on behalf of the health center.

IRB Approval

The proposed data collection was approved as non-research, public-health practice by the National Center for Chronic Disease Prevention and Health Promotion, and thus institutional review board (IRB) approval is not required.

Privacy Impact Assessment Information

A. The Privacy Act does not apply based on the items of information collected and transmitted to CDC.

B. Safeguards will exist to minimize the possibility of unauthorized access, use, or dissemination of the information being collected. To transmit the names, addresses, phone numbers and email addresses of health centers selected to participate in the survey, CDC will use a password-protected electronic file to send the information to the contractor. The password to unlock the file will be provided to the contractor via telephone and not in written form.

   After the contractor assigns a UID to each sampled physician/health center, the single file linking the identifiable information to the UID will be maintained in a password-protected electronic file, and destroyed within eight months after the end of data collection.

   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, second survey package mailings), the contractor will create a list of UIDs 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 contract efforts. Data ultimately transmitted to CDC will contain no IIF.

C. Potential respondents will be informed about the voluntary nature of participation in the cover letter that accompanies the survey (**Attachments C-1 and C-2**). Completion of a survey will be considered consent.

D. The voluntary nature of the survey will be described to the potential participants in the cover letter that will accompany the surveys asking individuals to participate (**Attachments C-1 and C-2**).

A11. Justification for Sensitive Questions

No sensitive questions will be included.

A12. Estimates of Annualized Burden Hours and Costs

A. The table below summarizes the estimated annualized burden hours. The 2012-2013 Survey of Health Care Providers is provided as **Attachment D-1**. The 2012-2013 Survey of Administrators of Publicly Funded Health Centers that Provide Family Planning Services is provided as **Attachment E-1**. CDC estimates that the provider survey will take on average 15 minutes to complete, and the administrator survey will take between 20 to 40 minutes to complete. This was estimated by having various project staff members and external colleagues not familiar with the instruments complete the surveys.

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Office-based physicians (private sector)	2012-2012 Survey of Health Care Providers	2,000	1	15/60	500
Title X clinic providers (public sector)	2012-2012 Survey of Health Care Providers	2,000	1	15/60	500
Non-Title X clinic providers (public sector)	2012-2012 Survey of Health Care Providers	2,000	1	15/60	500
Title X clinic administrators (public sector)	2012-2013 Survey of Administrators of Publicly-Funded Health Centers that Provide Family Planning Services	2,000	1	40/60	1,333
Non-Title X clinic administrators (public sector)	2012-2013 Survey of Administrators of Publicly-Funded Health Centers that Provide Family Planning Services	2,000	1	40/60	1,333
				TOTAL	**4,166**

B. The table below summarizes the estimated annualized burden costs. The estimates of hourly wages were obtained from the Department of Labor.[15] The total estimated annualized cost to respondents is $149,080.

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)	2012-2012 Survey of Health Care Providers	2,000	1	15/60	500	$76.88	$38,440
Title X clinic providers (public sector)	2012-2012 Survey of Health Care Providers	2,000	1	15/60	500	$32.42	$16,210
Non-Title X clinic providers (public sector)	2012-2012 Survey of Health Care Providers	2,000	1	15/60	500	$32.42	$16,210
Title X clinic administrators (public sector)	2012-2013 Survey of Administrators of Publicly-Funded Health Centers that Provide Family Planning Services	2,000	1	40/60	1,334	$29.34	$39,110
Non-Title X clinic administrators (public sector)	2012-2013 Survey of Administrators of Publicly-Funded Health Centers that Provide Family Planning Services	2,000	1	40/60	1,334	$29.34	$39,110
						Total	$149,080

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 with Manila in the amount of $1,129,518. The sources of this funding will come from CDC's Division of Reproductive Health ($729,518) and the Office of Population Affairs ($400,000). The contract task will include salaries 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 staff (1 project lead at .375FTE and 10 additional staff at .125FTE).

The total estimated annual cost to the government is $1,286,788.

Expense Type	Expense Explanation			Annual Costs (dollars)
Federal government staff salaries	Project lead	GS-13	.375 FTE	$32,063
	Project staff	GS-14	.125 FTE	$12,629
	Project staff	GS-15	.125 FTE	$14,856
	Project staff	GS-13	.125 FTE	$10,688
	Project staff	GS-13	.125 FTE	$10,688
	Project staff	GS-13	.125 FTE	$10,688
	Project staff	GS-14	.125 FTE	$12,629
	Project staff	GS-13	.125 FTE	$10,688
	Project staff	GS-14	.125 FTE	$12,629
	Project staff	GS-15	.125 FTE	$14,856
	Project staff	GS-15	.125 FTE	$14,856
Contract with Manila Consulting				$1,129,518
TOTAL				**$1,286,788**

*Salary estimates were estimated from 2012 Federal Pay Rates (http://www.fedsmith.com/pay_rates/)

A15. Explanation for Program Changes or Adjustments

This is a new data collection.

A16. Plans for Tabulation and Publication and Project Time Schedule

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.

Activity	Time Schedule
Survey packages sent to sampled providers/clinics	2 weeks to 1 month after OMB approval
2nd contact mailing (reminder postcard) to non-respondents	~2-4 weeks after 1st contact mailing
3rd contact mailing (repeat survey) to non-respondents	~2-4 weeks after 2nd 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
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

No such exception is requested. The OMB control number and expiration date will be displayed on the paper questionnaire and on the data collection internet site.

A18. Exceptions to Certification for Paperwork Reduction Act Submission

There are no exceptions to the certification.

References

[1] Finer LB, Zolna MR. Unintended pregnancy in the United States: incidence and disparities, 2006. *Contraception*. 2011: in press,.

[2] Gipson JD, Koenig MA, Hindin MJ. The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. *Studies in family planning*. 2008; **39**(1): 18-38.

[3] Trussell J. The cost of unintended pregnancy in the United States. *Contraception*. 2007; **75**(3): 168-70.

[4] Finer LB, Henshaw SK. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *PerspectSex ReprodHealth*. 2006; **38**(2): 90-6.

[5] Centers for Disease Control and Prevention. U S. Medical Eligibility Criteria for Contraceptive Use, 2010. *MMWR Recomm Rep*. 2010; **59**(RR-4): 1-86.

[6] World Health Organization. Selected Practice Recommendations for Contraceptive Use. 2nd edn. Geneva: WHO 2004.

[7] World Health Organization. Selected Practice Recommendations for Contraceptive Use 2008 Update. Geneva: WHO 2008.

[8] Office of Population Affairs. Program Guidelines for Project Grants for Family Planning Services Bethesda: OPA 2001.

[9] VanGeest JB, Johnson TP, Welch VL. Methodologies for improving response rates in surveys of physicians: a systematic review. *Eval Health Prof*. 2007; **30**(4): 303-21.

[10] Postlethwaite D, Shaber R, Mancuso V, Flores J, Armstrong MA. Intrauterine contraception: evaluation of clinician practice patterns in Kaiser Permanente Northern California. *Contraception*. 2007; **75**(3): 177-84.

[11] Harper CC, Blum M, de Bocanegra HT, *et al.* Challenges in translating evidence to practice: the provision of intrauterine contraception. *Obstet Gynecol*. 2008; **111**(6): 1359-69.

[12] Madden T, Allsworth JE, Hladky KJ, Secura GM, Peipert JF. Intrauterine contraception in Saint Louis: a survey of obstetrician and gynecologists' knowledge and attitudes. *Contraception*. 2010; **81**(2): 112-6.

[13] Espey E, Ogburn T, Leeman L, Reddy S, Lee C, Qualls C. Conformity with current guidelines on oral contraceptive prescribing for breastfeeding women: a New Mexico survey. *Contraception*. 2006; **74**(5): 389-93.

[14] Stanwood NL, Garrett JM, Konrad TR. Obstetrician-gynecologists and the intrauterine device: a survey of attitudes and practice. *Obstet Gynecol*. 2002; **99**(2): 275-80.

[15] Bureau of Labor Statistics. National Compensation Survey: December 2009 - January 2011. Bureau of Labor Statistics.