

2012–2013 SURVEY of HEALTH CARE PROVIDERS

Form Approved
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I. PROVIDER, PATIENT AND PRACTICE/ HEALTH CENTER CHARACTERISTICS

Please answer each of the following questions as they relate to you, your patients, and the practice/health center at which you received this survey.

1. Which of the following describes the setting of this practice/health center? (select all that apply)

Community health center	<input type="checkbox"/>
Family planning clinic	<input type="checkbox"/>
Health department (state or local)	<input type="checkbox"/>
HMO or Hospital	<input type="checkbox"/>
Indian Health Service	<input type="checkbox"/>
Planned Parenthood affiliate	<input type="checkbox"/>
Private practice	<input type="checkbox"/>
School based health clinic	<input type="checkbox"/>
Sexually transmitted infection clinic	<input type="checkbox"/>
University clinic	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>

2. Does this practice/health center receive any non-fee-for-service income to support family planning services? (select all that apply)

None	<input type="checkbox"/>
Private grant(s)	<input type="checkbox"/>
State appropriations	<input type="checkbox"/>
Section 308 of Public Health Service Act	<input type="checkbox"/>
Title V (MCH Block Grant)	<input type="checkbox"/>
Title X (Family Planning)	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Other _____	<input type="checkbox"/>

3. In what state is your practice/health center located?

4. In this practice/health center, how many health care providers, including you, provide family planning services*?

5. What is your gender?

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

6. What is your role as a health care provider? (select one)

Certified nurse midwife	<input type="checkbox"/>
Nurse practitioner	<input type="checkbox"/>
Nurse	<input type="checkbox"/>
Physician	<input type="checkbox"/>
Physician assistant	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>

7. What is your primary clinical focus at this practice/health center? (select one)

Adolescent health or pediatrics	<input type="checkbox"/>
Family medicine	<input type="checkbox"/>
Obstetrics/gynecology or family planning/reproductive health	<input type="checkbox"/>
Primary (general health) care	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>

8. How many years has it been since you completed your most recent formal clinical training (e.g., medical/nursing school, residency/practicum/ clinical)?

Less than 5 years	<input type="checkbox"/>
5-14 years	<input type="checkbox"/>
15-24 years	<input type="checkbox"/>
25 or more years	<input type="checkbox"/>

9. On average, how many female patients of reproductive age do you see per week? _____

10. To approximately what percentage of your female patients of reproductive age do you provide family planning services*?

0%	<input type="checkbox"/>
1–24%	<input type="checkbox"/>
25–49%	<input type="checkbox"/>
50–74%	<input type="checkbox"/>
75% or more	<input type="checkbox"/>

* For the purpose of this survey, a family planning service is any service related to postponing or preventing pregnancy. Family planning services may include a medical examination related to provision of a method, contraceptive counseling, method prescription or supply visits. A patient may receive a family planning service even if the primary purpose of her visit is not for contraception.

11. Have you ever been formally trained in the insertion of the following contraceptive methods for women during the following time periods?

	Trained to insert during routine care		Trained to insert immediately postpartum		Trained to insert immediately post-abortion	
	Yes	No	Yes	No	Yes	No
Copper intrauterine device (Cu-IUD or ParaGard®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levonorgestrel-releasing intrauterine device (LNG-IUD or Mirena®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive implant (Implanon®/Nexplanon®)	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A	N/A	N/A

12. Approximately what percentages of your female patients of reproductive age have the following characteristics? If unsure, give your best estimate.

	0-24%	25-49%	≥50%
Pay for their visit using Medicaid or other state or federal assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are racial or ethnic minorities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have limited English proficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are 35 years of age or older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. HEALTH CARE PROVIDER ATTITUDES

Please answer each of the following questions as they relate to your attitudes when providing family planning services. Please do not consult any source of guidance when answering the questions.

13. How safe do you consider combined oral contraceptives (COCs) to be for the following groups?

	Very safe	Safe	Unsafe	Very unsafe	Don't know
Breastfeeding women ≥1 month postpartum without other risk factors for venous thromboembolism (VTE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smokers 35 years of age or older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obese women (BMI ≥30 kg/m ²)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with a history of bariatric surgery via restrictive procedures (e.g., vertical banded gastroplasty)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with a history of bariatric surgery via malabsorptive procedures (e.g., Roux-en-Y gastric bypass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with inflammatory bowel disease (i.e., Ulcerative colitis, Crohn's disease) without other risk factors for VTE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How effective do you consider combined oral contraceptives (COCs) to be for the following groups compared to use by healthy women?

	More effective	Equally effective	Less effective	Don't know
Obese women (BMI ≥ 30 kg/m ²)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with a history of bariatric surgery via restrictive procedures (e.g., vertical banded gastroplasty)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with a history of bariatric surgery via malabsorptive procedures (e.g., Roux-en-Y gastric bypass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women on anticonvulsant therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women on antibiotic therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with inflammatory bowel disease (e.g., Ulcerative colitis, Crohn's disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. How safe do you consider intrauterine devices (Cu-IUD or LNG-IUD) to be for the following groups?

	Very safe	Safe	Unsafe	Very unsafe	Don't know
Adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immediately postpartum women (less than 10 minutes after delivery of placenta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postpartum women (10 minutes after delivery of placenta to less than 4 weeks postpartum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nulliparous women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obese women (BMI ≥30 kg/m ²)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with HIV (not AIDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. How safe do you consider DMPA (Depo-Provera®) to be for the following groups?

	Very Safe	Safe	Unsafe	Very unsafe	Don't know
Adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breastfeeding women <1 month postpartum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breastfeeding women ≥1 month postpartum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smokers 35 years of age or older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obese women (BMI ≥30 kg/m ²)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with a history of bariatric surgery via restrictive procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with rheumatoid arthritis not on immunosuppressive therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women with complicated diabetes (i.e., nephropathy, retinopathy, neuropathy, other vascular disease or diabetes of >20 years' duration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. For each of the following contraceptive methods, how safe do you think it is to start a woman on the day of her visit regardless of the timing of her menses ('Quick Start') if you are reasonably certain she is not pregnant? Please answer for both adolescents and adults.

	Adolescents			Adults		
	Safe	Unsafe	Don't know	Safe	Unsafe	Don't know
Combined hormonal contraceptives (COCs, patch, ring)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DMPA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrauterine devices (Cu-IUD or LNG-IUD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. HEALTH CARE PROVIDER PRACTICES

Please answer each of the following questions as they relate to your (or your clinical team's) practices when providing family planning services.

18. In the past month, when counseling your typical female patient of reproductive age on family planning, how often have you (or your clinical team) done the following?

	Very often	Often	Not often	Never
Assessed the patient's reproductive life plan (i.e., asked about their intentions regarding the number and timing of pregnancies in the context of their personal values and life goals)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presented information regarding potential contraceptive methods with the most effective methods presented first (tiered approach)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helped the patient think about potential barriers to using their selected method correctly and develop a plan to deal with these barriers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Used a method-specific informed consent form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Informed adolescents that long-acting reversible contraceptives are safe and effective options	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. In the past year, how often have you (or your clinical team) provided DMPA to adolescents?

Very often or often	<input type="checkbox"/>	} Go to question #20.
Not often or never	<input type="checkbox"/>	
} If "not often or never" please indicate why. (select all that apply)		
a.	I rarely have adolescents as patients	<input type="checkbox"/>
b.	DMPA is unavailable in my practice/health center	<input type="checkbox"/>
c.	I am concerned about the safety of DMPA for adolescents	<input type="checkbox"/>
d.	I am concerned about side effects that may lead to discontinuation	<input type="checkbox"/>
e.	My adolescent patients generally prefer a different method	<input type="checkbox"/>
f.	My practice/health center protocol does not allow it	<input type="checkbox"/>
g.	Other reasons (please specify) _____	<input type="checkbox"/>

20. In the past year, how often have you (or your clinical team) provided or prescribed COCs to breastfeeding women ≥ 1 month postpartum without other risk factors for VTE?

Very often or often	<input type="checkbox"/>	} Go to question #21.
Not often or never	<input type="checkbox"/>	
} If “not often or never” please indicate why. (select all that apply)		
a.	I rarely have postpartum women as patients	<input type="checkbox"/>
b.	I am concerned about the safety of COCs for breastfeeding women ≥ 1 month postpartum without other risk factors for VTE	<input type="checkbox"/>
c.	I am concerned about a decrease in breast milk production	<input type="checkbox"/>
d.	My postpartum patients generally prefer a different method	<input type="checkbox"/>
e.	My practice/health center protocol does not allow it	<input type="checkbox"/>
f.	Other reasons (please specify) _____	<input type="checkbox"/>

21. In the past year, how often have you (or your clinical team) provided intrauterine devices (Cu-IUDs or LNG-IUD) to nulliparous women?

Very often or often	<input type="checkbox"/>	} Go to question #22.
Not often or never	<input type="checkbox"/>	
} If “not often or never” please indicate why. (select all that apply)		
a.	I rarely have nulliparous women as patients	<input type="checkbox"/>
b.	IUDs are generally unavailable in my practice/health center	<input type="checkbox"/>
c.	I am concerned about the safety of IUDs for nulliparous women	<input type="checkbox"/>
d.	I am concerned about the effects on future fertility	<input type="checkbox"/>
e.	I am concerned about difficult insertion	<input type="checkbox"/>
f.	I am not trained in IUD insertion	<input type="checkbox"/>
g.	My nulliparous patients generally prefer a different method	<input type="checkbox"/>
h.	My practice/health center protocol does not allow it	<input type="checkbox"/>
i.	Cost barriers prevent me from providing IUDs to nulliparous women	<input type="checkbox"/>
j.	Other reasons (please specify) _____	<input type="checkbox"/>

22. When initiating the following contraceptive methods, please indicate if you or your practice/health center require the following exams and tests for a healthy client. Please check all exams and tests that apply.

	Blood pressure	Clinical breast exam	Bimanual exam and cervical inspection	Cervical cytology (Pap smear)	Chlamydia/ gonorrhea screening
COCs/patch/ring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Progestin-only pills (POPs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DMPA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cu-IUD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LNG-IUD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. In the past year, when providing or prescribing combined hormonal contraceptives (COCs, patch, ring), how often did you start a woman on the day of her visit regardless of the timing of her menses (“Quick Start”) if you were reasonably certain she was not pregnant? Please answer for both adolescents and adults.

(23a) Adolescents

Very often or often	<input type="checkbox"/>	} Go to question #23b
Not often or never	<input type="checkbox"/>	
} If “not often or never” please indicate why. (select all that apply)		
a.	I do not think it is safe	<input type="checkbox"/>
b.	I have liability concerns	<input type="checkbox"/>
c.	I do not have enough training	<input type="checkbox"/>
d.	I do not think it is appropriate for adolescents	<input type="checkbox"/>
e.	My practice/health center protocol does not allow it	<input type="checkbox"/>
f.	Other (please specify) _____	<input type="checkbox"/>

(23b) Adults

Very often or often	<input type="checkbox"/>	} Go to question #24
Not often or never	<input type="checkbox"/>	
} If “not often or never” please indicate why. (select all that apply)		
a.	I do not think it is safe	<input type="checkbox"/>
b.	I have liability concerns	<input type="checkbox"/>
c.	I do not have enough training	<input type="checkbox"/>
d.	I do not think it is appropriate for adults	<input type="checkbox"/>
e.	My practice/health center protocol does not allow it	<input type="checkbox"/>
f.	Other (please specify) _____	<input type="checkbox"/>

24. In the past year, when providing DMPA, how often did you start a woman on the day of her visit regardless of the timing of her menses ('Quick Start') if you were reasonably certain she was not pregnant? Please answer for both adolescents and adults.

(24a) Adolescents		(24b) Adults	
Very often or often	<input type="checkbox"/> } Go to question #24b	Very often or often	<input type="checkbox"/> } Go to question #25
Not often or never	<input type="checkbox"/> } If "not often or never" please indicate why. (select all that apply)	Not often or never	<input type="checkbox"/> } If "not often or never" please indicate why. (select all that apply)
a.	I do not think it is safe <input type="checkbox"/>	a.	I do not think it is safe <input type="checkbox"/>
b.	I have liability concerns <input type="checkbox"/>	b.	I have liability concerns <input type="checkbox"/>
c.	I do not have enough training <input type="checkbox"/>	c.	I do not have enough training <input type="checkbox"/>
d.	I do not think it is appropriate for adolescents <input type="checkbox"/>	d.	I do not think it is appropriate for adults <input type="checkbox"/>
e.	My practice/health center protocol does not allow it <input type="checkbox"/>	e.	My practice/health center protocol does not allow it <input type="checkbox"/>
f.	Other (please specify) _____ <input type="checkbox"/>	f.	Other (please specify) _____ <input type="checkbox"/>

25. After initiating the following methods, please indicate when you advise healthy adult patients to come back for a follow-up visit.

	4-6 weeks	3 months	6 months	12 months	Only if she has problems or questions
COCs, patch, ring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
POPs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DMPA (routine follow-up other than for re-injection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrauterine device (Cu-IUD or LNG-IUD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. In the past year, how often have you or your clinical team done the following?

	Very often	Often	Not often	Never
Provided an <u>advance prescription</u> for emergency contraception (EC) to a woman not specifically seeking EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided an <u>advance supply</u> of EC to a woman not specifically seeking EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided or prescribed a contraceptive at the same time you provided EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided a Cu-IUD as EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. In the past year, how often did you or your clinical team dispense a year's supply of pills (COCs or POPs) at one visit? Please answer for both new and continuing users.

(27a) New Users		(27b) Continuing Users	
Very often or often	<input type="checkbox"/> } Go to question #27b	Very often or often	<input type="checkbox"/> } Go to question #28
Not often or never	<input type="checkbox"/> } If "not often or never" please indicate why. (select all that apply)	Not often or never	<input type="checkbox"/> } If "not often or never" please indicate why. (select all that apply)
a.	I do not think it is safe <input type="checkbox"/>	a.	I do not think it is safe <input type="checkbox"/>
b.	My practice/health center does not dispense pills <input type="checkbox"/>	b.	My practice/health center does not dispense pills <input type="checkbox"/>
c.	My practice/health center protocol does not allow it <input type="checkbox"/>	c.	My practice/health center protocol does not allow it <input type="checkbox"/>
d.	I have liability concerns <input type="checkbox"/>	d.	I have liability concerns <input type="checkbox"/>
e.	There is not enough supply in my practice/health center <input type="checkbox"/>	e.	There is not enough supply in my practice/health center <input type="checkbox"/>
f.	It is too expensive for my practice/health center <input type="checkbox"/>	f.	It is too expensive for my practice/health center <input type="checkbox"/>
g.	I am concerned about wasting pill packs if the woman discontinues <input type="checkbox"/>	g.	I am concerned about wasting pill packs if the woman discontinues <input type="checkbox"/>
h.	Other (please specify) _____ <input type="checkbox"/>	h.	Other (please specify) _____ <input type="checkbox"/>

28. In general, how important to you are the following sources for staying informed about recommended clinical practices related to contraception? Please answer for each source.

	Important Source	Minor Source	Not Used
Conferences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continuing education programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discussions with colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Institutional practice protocols	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Journals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication package inserts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Online resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional organization publications or notifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Textbooks (e.g., <i>Contraceptive Technology</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U.S. Medical Eligibility Criteria for Contraceptive Use (MEC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHO MEC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WHO Selected Practice Recommendations for Contraceptive Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. For routine health care, at what age do you or your practice/health center recommend that a woman begin routine cervical cancer screening? (select one)

Whenever she becomes sexually active	<input type="checkbox"/>
Starting at age 18	<input type="checkbox"/>
Starting at age 21	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>

30. For routine health care, how often do you provide cervical cancer screening for a sexually active, 25-year old patient with previously normal results?

Every visit	<input type="checkbox"/>
Annually	<input type="checkbox"/>
Every 2 years	<input type="checkbox"/>
Every 3 years	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

IV. AWARENESS OF GUIDELINES

We want to know about your awareness of CDC's contraceptive use guidelines.

31. How did you learn about the following CDC contraceptive use guidelines? Please answer for both sets of guidelines. (select all that apply)

	2010 U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)	2013 U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR)
I did not know about the guidelines before participation in this survey.	<input type="checkbox"/>	<input type="checkbox"/>
Professional organization publications or notifications	<input type="checkbox"/>	<input type="checkbox"/>
Conference attendance	<input type="checkbox"/>	<input type="checkbox"/>
Continuing medical education programs	<input type="checkbox"/>	<input type="checkbox"/>
Discussions with colleagues	<input type="checkbox"/>	<input type="checkbox"/>
Email alert from CDC	<input type="checkbox"/>	<input type="checkbox"/>
Institutional practice protocol	<input type="checkbox"/>	<input type="checkbox"/>
Journals	<input type="checkbox"/>	<input type="checkbox"/>
Online resources	<input type="checkbox"/>	<input type="checkbox"/>
Textbooks (e.g., <i>Contraceptive Technology</i>)	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

32. Have you used any of the following U.S. MEC materials?

U.S. MEC website	<input type="checkbox"/>
U.S. MEC color-coded summary chart in English	<input type="checkbox"/>
U.S. MEC color-coded summary chart in Spanish	<input type="checkbox"/>
U.S. MEC wheel	<input type="checkbox"/>
U.S. MEC iPhone/iPad application	<input type="checkbox"/>
U.S. MEC 2011 update with revised recommendations for postpartum contraceptive use	<input type="checkbox"/>
U.S. MEC 2012 update with revised recommendations for the use of hormonal contraception among women at high risk for HIV infection or infected with HIV	<input type="checkbox"/>

33. What additional medical conditions or patient characteristics would you like to see recommendations for in the U.S. MEC?

(please specify) _____

(please specify) _____

(please specify) _____

Please share any additional comments that you may have in the space below.

Thank you for completing this survey!
Please return using the enclosed postage paid envelope.