

2018–2019 SURVEY of HEALTH CARE PROVIDERS about FAMILY PLANNING ATTITUDES and PRACTICES

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

Please **return this survey within 21** days using the enclosed business reply mail envelope. You may also complete the survey online (*see instructions below*).

To determine if you are eligible to participate in this survey, please answer the following question:

On average, do you provide family planning services* to at least two women of reproductive age per week?

Yes → Please continue and complete the survey.

No → Stop here and return the survey so we can remove you from our list. Thank you for your time.

* 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 the visit is not for contraception.*

Please answer the questions as they relate to you, your patients, and the practice or health center where you are receiving this survey.

- This survey is estimated to take, on average, 15 minutes to complete.
- Do not consult any source of clinical guidance when answering the questions.
- Results will only be released in summary form.
- Thank you for returning this survey within 21 days.

To complete the survey online, visit: www.insertwebsitehere.com

Only authorized users may complete the survey. The web survey is conducted from a secure https (SSL) service using the same type of internet security as is used for handling credit card transactions. If you have any problems accessing or completing the survey, please contact [insert email here]. To access the survey:

Your username is: [insert here]

Your password is: [insert here]



Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0969).

*Insert Survey
ID Here*

I. PROVIDER, PATIENT and PRACTICE/ HEALTH CENTER CHARACTERISTICS

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-based clinic	<input type="checkbox"/>
Planned Parenthood affiliate	<input type="checkbox"/>
Private practice	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>

2. Which best describes the area that your practice/health center serves? (select one)

Mostly rural	<input type="checkbox"/>
Mostly urban/suburban	<input type="checkbox"/>
Combination of rural and urban/suburban	<input type="checkbox"/>

3. 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"/>

4. 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"/>
Preventive medicine or public health	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>

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

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"/>

6. What is your gender?

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

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

8. To approximately what percent of your female patients of reproductive age do you provide family planning services? (select one)

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

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

	0-24%	25-49%	≥50%
a. Pay for their visit using Medicaid or other state or federal assistance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Are racial or ethnic minorities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have limited English proficiency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Are adolescents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Are pregnant or ≤6 weeks postpartum?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Have you been trained in the insertion of the following contraceptive methods for women during routine care?

	Yes	No
a. Copper intrauterine device (Cu-IUD or ParaGard®)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Levonorgestrel-releasing intrauterine device (LNG-IUD or Mirena®, Skyla®, Liletta®, or Kyleena®)?	<input type="checkbox"/>	<input type="checkbox"/>
c. Contraceptive implant (Nexplanon®)?	<input type="checkbox"/>	<input type="checkbox"/>

11. Have you been trained in the insertion of the following contraceptive methods for women immediately postpartum?

	Yes	No
a. Copper intrauterine device (Cu-IUD or ParaGard®)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Levonorgestrel-releasing intrauterine device (LNG-IUD or Mirena®, Skyla®, Liletta®, or Kyleena®)?	<input type="checkbox"/>	<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*

II. CONTRACEPTIVE METHOD AVAILABILITY

12. For each method of contraception, please indicate if it is directly available from a provider or onsite source, prescribed/recommended to obtain off-site, patients are referred offsite to other providers, or if it is not available to patients in your practice/health center. (in each row, select all that apply)

	Directly available onsite	Prescribed/recommended	Referred offsite to other providers	Not available onsite, or by prescription or referral	Don't Know
a. LNG-IUD (Mirena®, Skyla®, Liletta®, or Kylena®)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cu-IUD (ParaGard®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Implant (Nexplanon®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Combined oral contraceptives (COCs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Progestin-only oral pills (POPs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Injectable (DMPA or Depo-Provera®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Patch (Ortho Evra®, Xulane®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Vaginal ring (NuvaRing®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Diaphragm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Male condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Female condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Instruction on fertility awareness-based methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Ulipristal acetate (UPA) emergency contraceptive pills (Ella®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Levonorgestrel (LNG) emergency contraceptive pills (e.g., Plan B®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Cu-IUD (ParaGard®) as emergency contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. HEALTH CARE PROVIDER ATTITUDES

Please answer the following questions as they relate to your attitudes when providing family planning services.

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

	Safe	Unsafe	Don't know
a. Breastfeeding women \geq 1 month postpartum without other risk factors for venous thromboembolism (VTE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Smokers 35 years of age or older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Women with migraine <u>without</u> aura (including menstrual migraine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Women with migraine <u>with</u> aura	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Women at high risk for HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Safe	Unsafe	Don't know
a. Breastfeeding women <1 month postpartum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Women at high risk for HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. 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"/>

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

	Safe	Unsafe	Don't know
a. Adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Immediately postpartum women (less than 10 minutes after delivery of placenta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Postpartum women (10 minutes after delivery of placenta to less than 4 weeks postpartum)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Nulliparous women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Women at high risk for HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. For each of the following contraceptive methods, how safe do you think it is to start an ADOLESCENT on the day of her visit regardless of the timing of her menses ('Quick Start') if you are reasonably certain she is not pregnant?

	ADOLESCENT		
	Safe	Unsafe	Don't know
a. Combined hormonal contraceptives (COCs, patch, ring)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. DMPA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Contraceptive implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Intrauterine devices (Cu-IUD or LNG-IUD)	<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 an ADULT 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?

	ADULT WOMAN		
	Safe	Unsafe	Don't know
a. Combined hormonal contraceptives (COCs, patch, ring)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. DMPA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Contraceptive implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Intrauterine devices (Cu-IUD or LNG-IUD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. For each of the following scenarios, which type(s) of emergency contraception (EC) would you offer, if readily available? (*select all that apply*)

	Cu-IUD	UPA EC pills (Ella®)	LNG EC pills (e.g., Plan B®)	Don't Know
a. A female who had unprotected intercourse 2 days ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. A female who had unprotected intercourse 4 days ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. An obese female (BMI 32 kg/m ²) who had unprotected intercourse 2 days ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. HEALTH CARE PROVIDER PRACTICES

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

19. 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
a. 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"/>
b. Elicited the patient's preferences regarding contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Presented information regarding potential contraceptive methods based on the patient's preferences regarding contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. 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"/>
e. Helped the patient consider other important factors about potential contraceptive methods, such as possible side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Helped the patient think about potential barriers to using their selected method(s) correctly and developed a plan to deal with these barriers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Counseled on the full range of contraceptive choices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Counseled on how to obtain emergency contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Counseled on condom use to prevent STDs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Do patients in your practice/health center routinely undergo a urine pregnancy test before starting a contraceptive method?

Yes

No

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 → **Go to question #22.**

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. How often do you (or your clinical team) use the following medications during or prior to IUD insertion? (if IUDs are not offered/not available in your practice/health center, please mark the appropriate box)

	Routinely use	Sometimes use	Never use
<input type="checkbox"/> IUDs not offered/not available → Go to question #23.			
a. Misoprostol for nulliparous women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Misoprostol for parous women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Misoprostol for women with a recent failed insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Nonsteroidal anti-inflammatory drugs (NSAIDs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Paracervical block with lidocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other pain medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. How confident are you performing the following procedures?

	Confident	Somewhat confident	Not confident
a. Routine IUD insertion in a parous woman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Routine IUD insertion in a nulliparous woman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Routine IUD removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Routine implant insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Routine implant removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	Very often	Often	Not often	Never
a. 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"/>
b. 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"/>
c. Provided or prescribed a contraceptive at the same time you provided EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Provided a Cu-IUD as EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. Before initiating the following contraceptive methods, please indicate if you or your practice/health center require the following exams and tests for a healthy patient. (Many of these exams and tests are appropriate for preventive health care. Here we are asking about exams and tests that are required related to safe initiation of a contraceptive method. If the method is not offered/not available in your practice/health center, please mark the appropriate box.)

	Required	Not Required
I. COCs/patch/ring		
<input type="checkbox"/> Not available onsite or by prescription or referral → Go to question #25(II).		
a. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
b. Clinical breast exam	<input type="checkbox"/>	<input type="checkbox"/>
c. Bimanual exam and cervical inspection	<input type="checkbox"/>	<input type="checkbox"/>
d. Cervical cytology (Pap smear)	<input type="checkbox"/>	<input type="checkbox"/>
e. Chlamydia/gonorrhea screening	<input type="checkbox"/>	<input type="checkbox"/>
II. Progestin-only pills (POPs)		
<input type="checkbox"/> Not available onsite or by prescription or referral → Go to question #25(III).		
a. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
b. Clinical breast exam	<input type="checkbox"/>	<input type="checkbox"/>
c. Bimanual exam and cervical inspection	<input type="checkbox"/>	<input type="checkbox"/>
d. Cervical cytology (Pap smear)	<input type="checkbox"/>	<input type="checkbox"/>
e. Chlamydia/gonorrhea screening	<input type="checkbox"/>	<input type="checkbox"/>
III. DMPA		
<input type="checkbox"/> Not available onsite or by prescription or referral → Go to question #25(IV).		
a. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
b. Clinical breast exam	<input type="checkbox"/>	<input type="checkbox"/>
c. Bimanual exam and cervical inspection	<input type="checkbox"/>	<input type="checkbox"/>
d. Cervical cytology (Pap smear)	<input type="checkbox"/>	<input type="checkbox"/>
e. Chlamydia/gonorrhea screening	<input type="checkbox"/>	<input type="checkbox"/>
IV. Implant		
<input type="checkbox"/> Not available onsite or by prescription or referral → Go to question #25(V).		
a. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
b. Clinical breast exam	<input type="checkbox"/>	<input type="checkbox"/>
c. Bimanual exam and cervical inspection	<input type="checkbox"/>	<input type="checkbox"/>
d. Cervical cytology (Pap smear)	<input type="checkbox"/>	<input type="checkbox"/>
e. Chlamydia/gonorrhea screening	<input type="checkbox"/>	<input type="checkbox"/>
V. Intrauterine device (Cu-IUD or LNG-IUD)		
<input type="checkbox"/> Not available onsite or by prescription or referral → Go to question #26.		
a. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
b. Clinical breast exam	<input type="checkbox"/>	<input type="checkbox"/>
c. Bimanual exam and cervical inspection	<input type="checkbox"/>	<input type="checkbox"/>
d. Cervical cytology (Pap smear)	<input type="checkbox"/>	<input type="checkbox"/>
e. Chlamydia/gonorrhea screening	<input type="checkbox"/>	<input type="checkbox"/>

26. 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.

(26A) ADOLESCENTS

Very often or often → **Go to question #26B**

Not often or never → **Please indicate why. (select all that apply)**

a. I do not think it is safe

b. I have liability concerns

c. I do not have enough training

d. I do not think it is appropriate for adolescents

e. My practice/health center protocol does not allow it

f. Other (please specify) _____

(26B) ADULTS

Very often or often → **Go to question #27**

Not often or never → **Please indicate why. (select all that apply)**

a. I do not think it is safe

b. I have liability concerns

c. I do not have enough training

d. I do not think it is appropriate for adults

e. My practice/health center protocol does not allow it

f. Other (please specify) _____

27. 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.

(27A) ADOLESCENTS

Very often or often → **Go to question #27B**

Not often or never → **Please indicate why. (select all that apply)**

a. I do not think it is safe

b. I have liability concerns

c. I do not have enough training

d. I do not think it is appropriate for adolescents

e. My practice/health center protocol does not allow it

f. Other (please specify) _____

(27B) ADULTS

Very often or often → **Go to question #28**

Not often or never → **Please indicate why. (select all that apply)**

a. I do not think it is safe

b. I have liability concerns

c. I do not have enough training

d. I do not think it is appropriate for adults

e. My practice/health center protocol does not allow it

f. Other (please specify) _____

28. In the past year, when providing an intrauterine device (Cu-IUD or LNG-IUD), 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.

(28A) ADOLESCENTS

Very often or often → **Go to question #28B**

Not often or never → **If "not often or never" please indicate why. (select all that apply)**

a. IUDs are unavailable in my practice/health center

b. I do not think it is safe

c. I have liability concerns

d. I do not have enough training

e. I do not think it is appropriate for adolescents

f. My practice/health center protocol does not allow it

g. Other (please specify) _____

(28B) ADULTS

Very often or often → **Go to question #29**

Not often or never → **If "not often or never" please indicate why. (select all that apply)**

a. IUDs are unavailable in my practice/health center

b. I do not think it is safe

c. I have liability concerns

d. I do not have enough training

e. I do not think it is appropriate for adults

f. My practice/health center protocol does not allow it

g. Other (please specify) _____

29. In the past year, when providing an **implant**, 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.

(29A) ADOLESCENTS

Very often or often → **Go to question #29B**

Not often or never → **If "not often or never" please indicate why. (select all that apply)**

a. *Implants are unavailable in my practice/health center*

b. *I do not think it is safe*

c. *I have liability concerns*

d. *I do not have enough training*

e. *I do not think it is appropriate for adolescents*

f. *My practice/health center protocol does not allow it*

g. *Other (please specify) _____*

(29B) ADULTS

Very often or often → **Go to question #30**

Not often or never → **If "not often or never" please indicate why. (select all that apply)**

a. *Implants are unavailable in my practice/health center*

b. *I do not think it is safe*

c. *I have liability concerns*

d. *I do not have enough training*

e. *I do not think it is appropriate for adults*

f. *My practice/health center protocol does not allow it*

g. *Other (please specify) _____*

30. How many visits are typically required for a patient to receive the following contraceptive methods in your practice/health center? Please count all visits for counseling, assessment, exams and tests, and insertion. (if the method is not offered/not available in your practice/health center, please mark the appropriate box)

	1	2	3+
I. IUDs			
<input type="checkbox"/> Not offered/not available → Go to question #30(II).			
a. IUDs for adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. IUDs for adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Implants			
<input type="checkbox"/> Not offered/not available → Go to question #31.			
a. Implants for adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Implants for adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

(31A) NEW USERS

Very often or often → **Go to question #31B**

Not often or never → **Please indicate why. (select all that apply)**

a. *I do not think it is safe*

b. *My practice/health center protocol does not allow it*

c. *I have liability concerns*

d. *There is not enough supply in my practice/health center*

e. *It is too expensive for my practice/health center*

f. *I am concerned about wasting pill packs if the woman discontinues*

g. *Insurance coverage limitations/restrictions*

h. *Other (please specify) _____*

Very often or often → **Go to question #32**

Not often or never → **Please indicate why. (select all that apply)**

a. *I do not think it is safe*

b. *My practice/health center protocol does not allow it*

c. *I have liability concerns*

d. *There is not enough supply in my practice/health center*

e. *It is too expensive for my practice/health center*

f. *I am concerned about wasting pill packs if the woman discontinues*

g. *Insurance coverage limitations/restrictions*

h. *Other (please specify) _____*

(31B) CONTINUING USERS

32. 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
a. Conferences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Continuing education programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Discussions with colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Institutional practice protocols	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Journals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Medication package inserts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Online resources (e.g., UpToDate) or electronic medical texts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Professional organization publications or notifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Textbooks (e.g., <i>Contraceptive Technology</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Providing Quality Family Planning Services (QFP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

V. AWARENESS AND USE OF CDC'S CONTRACEPTIVE GUIDELINES

33. Have you heard of the following federal contraceptive guidelines?

	Yes	No
a. U.S. Medical Eligibility Criteria for Contraceptive Use (U.S. MEC)	<input type="checkbox"/>	<input type="checkbox"/>
b. U.S. Selected Practice Recommendations for Contraceptive Use (U.S. SPR)	<input type="checkbox"/>	<input type="checkbox"/>
c. Providing Quality Family Planning Services (QFP)	<input type="checkbox"/>	<input type="checkbox"/>

34. Have you used any of the following U.S. MEC, U.S. SPR, or QFP materials?

	Yes	No
a. U.S. MEC print version	<input type="checkbox"/>	<input type="checkbox"/>
b. U.S. SPR print version	<input type="checkbox"/>	<input type="checkbox"/>
c. Providing Quality Family Planning Services (QFP) print version	<input type="checkbox"/>	<input type="checkbox"/>
d. U.S. MEC/U.S. SPR website	<input type="checkbox"/>	<input type="checkbox"/>
e. U.S. MEC color-coded summary chart in English	<input type="checkbox"/>	<input type="checkbox"/>
f. U.S. MEC color-coded summary chart in Spanish	<input type="checkbox"/>	<input type="checkbox"/>
g. U.S. MEC wheel	<input type="checkbox"/>	<input type="checkbox"/>
h. U.S. MEC/U.S. SPR mobile app for android and iOS	<input type="checkbox"/>	<input type="checkbox"/>
i. QFP mobile app for android and iOS	<input type="checkbox"/>	<input type="checkbox"/>
j. Effectiveness of contraceptive methods chart or 2' x 3' poster	<input type="checkbox"/>	<input type="checkbox"/>
k. U.S. MEC 2017 update with revised recommendations for the use of hormonal contraception among women at high risk for HIV infection	<input type="checkbox"/>	<input type="checkbox"/>

35. 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) _____

36.

What additional contraception management topics would you like to see recommendations for in the U.S. SPR?

(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 business reply mail envelope.**