



---

## FIMR/HIV Maternal Interview Form

Case Number: \_\_\_\_\_

Abstraction Completion Date: \_\_\_/\_\_\_/\_\_\_

---

### Beginning the Interview

The first 10 to 15 minutes of the home visit will usually be used to develop rapport with the mother, to thank her for allowing the visit, and to explain the program. Once a comfortable atmosphere has been achieved, the best way to begin the interview is to ask the mother to describe in her own words living with HIV and the events surrounding the birth of her child. The interviewer should call the baby by his/her name, if given by the family. The mother may have already started telling the interviewer about the child's health and HIV status before the interviewer had to ask.

It is important to remain sensitive to the mother's need to expound on or digress from any particular event that generates strong feelings and to give her time to recall details and relate her experiences in her own words. The standardized questionnaire can follow when the mother is able.

### Immediate Assessment (conducted as soon as possible, potentially in the hospital)

Public reporting burden of this collection of information is estimated to average 45 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

### Demographics

1) What is your age? (years) \_\_\_\_\_

2) Where were you born? (country) \_\_\_\_\_

3) What is your race? Please add additional specificity in the space provided if appropriate.  
(choose one or more)

- White \_\_\_\_\_
- Black or African American \_\_\_\_\_
- American Indian or Alaska Native \_\_\_\_\_
- Asian \_\_\_\_\_
- Native Hawaiian or other Pacific Islander \_\_\_\_\_
- Other (specify if volunteered by the respondent): \_\_\_\_\_

4) What was your marital status during the pregnancy?

- Single
- Married
- Widowed
- Divorced
- Separated
- Living in a stable relationship but not married

5) Is [BABY'S NAME]'s father living with you?

- Yes
- No

6) What is the highest grade/year of school or college you completed?

- 0-11
- 12
- 13-14
- 15-16
- 17+

7) Were you employed at any time during your recent pregnancy?

- Yes
- No (skip to #9)

7a) If yes, did you work during: (check all that apply)

- First three months of pregnancy
- Second three months of pregnancy
- Third three months of pregnancy

### HIV Testing

8) When did you first learn that you have HIV?

- Before this pregnancy
- During this pregnancy
- At time of delivery
- After the child's birth

9) Where did you get your first positive HIV test?

- Community health center
- HIV testing organization
- County/local health department clinic
- Health fair
- Primary care provider's office
- Prenatal care provider's office
- Emergency room
- Family planning clinic
- Labor and delivery
- Over the counter test/home collection kit
- Other (specify) \_\_\_\_\_

10) Did you ever have a negative HIV test before your first positive HIV test?

- Yes, before this pregnancy
- Yes, during this pregnancy
- No
- Unknown

11) Why did you get an HIV test? \_\_\_\_\_

12) How do you think you got HIV? \_\_\_\_\_

13) Have you ever been offered an HIV test and did not take the test?

- Yes if yes, explain \_\_\_\_\_
- No

14) Were you ever tested for HIV but did not receive the test results?

- Yes
- No (skip to #16)
- Unknown (skip to #16)

14a) Where was this test done?

- Community health center
- HIV testing organization
- County/local health department clinic
- Health fair
- Primary care provider's office
- Prenatal care provider's office
- Emergency room
- Family planning clinic
- Labor and delivery
- Over the counter test/home collection kit
- Other (specify) \_\_\_\_\_

14b) Why did you not receive those test results? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prenatal Care**

15) How many weeks pregnant were you when you first thought you *might* be pregnant?  
\_\_\_\_\_ weeks pregnant (since you missed your last period)

Don't remember

16) How many weeks pregnant were you when you were *sure* you were pregnant?  
\_\_\_\_\_ weeks pregnant (since you missed your last period)

Don't remember

16a) What happened so that you were sure you were pregnant? (*check all that apply*)

- You took a home pregnancy test
- Doctor or nurse said you were pregnant
- You stopped having periods
- Your abdomen started growing
- You felt the baby moving
- Other (*specify*) \_\_\_\_\_

17) When was your due date?

--	--	--	--	--	--

Month          Day          Year

Don't know

18) How many weeks or months pregnant were you on your first visit for prenatal care?  
(*Don't count a visit that was only for a pregnancy test, sonogram, or WIC appointment.*)  
months \_\_\_\_\_ or weeks \_\_\_\_\_

I can't remember

I did not get prenatal care (*skip to #26*)

19) Where did you go for your first prenatal visit? (*check one answer*)

- Private care (OB/GYN, midwife)
- Adult HIV specialty clinic
- County/Local Health Department
- Managed Care Organization (MCO) or Health Maintenance Organization (HMO)
- Hospital emergency room, other episodic, or as needed care provider
- Community Health Center
- Clinic at work or at school
- Correctional facility
- Other (*specify*): \_\_\_\_\_

20) How long did it usually take you to travel one way to this place?  
\_\_\_\_\_ hours \_\_\_\_\_ minutes

21) How were your prenatal visits paid? *(check all that apply)*

- Private Insurance
- Managed care organization (MCO) or Health maintenance organization (HMO), private payor
- Traditional Medicaid
- Medicaid Managed Care Organization (MCO) or Health Maintenance Organization (HMO)
- Medicaid, type unknown
- Medicare
- CHAMPUS/Military insurance
- Self pay
- Other *(specify)*: \_\_\_\_\_

22) Did you have to change your prenatal care provider during this pregnancy?

- Yes
- No *(skip to #24)*

22a) If yes, why? *(check all that apply)*

- The provider would not accept Medicaid
- Could not pay
- Moved
- To see a specialist *(specify)* \_\_\_\_\_
- Other *(specify)*: \_\_\_\_\_

22b) If you had to change prenatal care providers, where did you receive the rest of your prenatal care? *(check one answer)*

- Private care (OB/GYN, midwife)
- Adult HIV specialty clinic
- County/Local Health Department
- Managed Care Organization (MCO) or Health Maintenance Organization (HMO)
- Community Health Center
- Clinic at work or at school
- Correctional facility
- Other *(specify)*: \_\_\_\_\_

22c) How were these visits paid? *(check all that apply)*

- Private Insurance
- Managed care organization (MCO)/Health maintenance organization (HMO), private pay
- Traditional Medicaid
- Medicaid Managed Care Organization (MCO)/Health Maintenance Organization (HMO)
- Medicaid, type unknown
- Medicare
- CHAMPUS/Military Insurance
- Self pay
- Other *(specify)*: \_\_\_\_\_

23) How satisfied were you with the prenatal care you received? For each of the things listed below, check *one* answer. If you went to more than one place for prenatal care, answer for the place where you received *most* of your care.

The amount of time you had to wait after you arrived for your visits	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied
The amount of time the doctor or nurse spent with you during your visits	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied
The advice you received on how to take care of yourself	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied
The hours the office or clinic was open	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied
The understanding and respect the staff showed toward you as a person	<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied

24) Which of these things did a doctor, nurse or other health worker ask you or talk with you about when you received prenatal care during your most recent pregnancy?

Rights and responsibilities of the pregnant woman	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Signs and symptoms of preterm labor and where to go for help	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Medications or drugs that could affect your pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
How long to wait before having another baby (Child spacing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Finding a doctor or nurse practitioner to care for your baby	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
How smoking during pregnancy could affect your baby	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
How using alcohol (beer, wine, liquor) could affect your baby	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
How using illegal drugs could affect your baby	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Breastfeeding your baby	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Safe sleep/SIDS risk reduction activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Getting tested for HIV (the virus that causes AIDS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
How to avoid getting or transmitting HIV or other STDs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Medicines to help protect your baby from getting HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Importance of HIV medicines for your own health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Medication adherence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
HIV medicines you should receive when in labor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
HIV medicines your baby should receive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
CD4 and viral load tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember

25) During your most recent pregnancy, did you attend any of the following? (*check all that apply*)

- Childbirth education classes
- Parenting classes
- Counseling about stress, family problems or mental problems
- Classes specifically for pregnant women living with HIV
- Support group for women living with HIV
- Other (*specify*) \_\_\_\_\_

26) Which of the following practical problems caused you to have trouble getting prenatal care? (*check all that apply*)

- There was no one to watch your other children
- You had no transportation or unreliable transportation
- You had no money or insurance
- You were in school
- You were working
- You had no free time
- Didn't know where to go
- Other (*specify*) \_\_\_\_\_
- No problems

27) Which of the following problems with clinics caused you to have trouble getting prenatal care? (check all that apply)

- There was no place in your neighborhood to get medical care
- You couldn't get an appointment for several weeks
- The hours the clinic was open were not convenient for you
- The wait is too long when you do have an appointment
- The doctor or nurse didn't spend very much time with you
- The staff doesn't listen to you or treat you with respect
- The staff doesn't speak your language
- You don't like or trust the staff
- Could not get a doctor or nurse to take me as a patient
- Other (specify) \_\_\_\_\_
- No problems

28) Which of the following personal problems caused you to have trouble getting care for yourself? (check all that apply)

- Never went (before) with other pregnancies
- Didn't think I was pregnant
- Doesn't do any good
- Use alternative medicines
- Don't need or want care
- Were worried about pressure to have an HIV test-
- Were worried about drug test
- Have a drinking or drug problem
- Are afraid of being reported to child welfare agency
- Have trouble with the law
- Are worried about your legal/immigration status
- Other (specify) \_\_\_\_\_
- No problems

**Use of Other Health Care and Supportive Institutions**

29) During this pregnancy, did you see any of the following healthcare providers other than your prenatal care provider?

- None of these (skip to #31)
- Emergency room
- Labor and delivery unit a different time *before* you were admitted to deliver
- Maternal-Fetal specialist
- Perinatologist
- HIV specialist
- Other specialist (specify) \_\_\_\_\_
- Other (specify) \_\_\_\_\_

29a) For each provider checked above, why did you see this provider? \_\_\_\_\_  
\_\_\_\_\_

29b) What did these providers do about HIV?

- They offered HIV testing
- They did not discuss HIV or HIV testing
- They mentioned HIV, but did not do anything with me about it
- They helped link you to HIV care
- They helped link you to prenatal care
- Other (specify): \_\_\_\_\_

30) Did you spend time in any of the following types of facilities during this pregnancy? (check all that apply)

- None of these (skip to #32)
- Prison/Correctional facilities
- Mental health facility
- Drug treatment center
- Battered women's shelter
- Homeless shelter
- Home for pregnant teens
- Other (specify) \_\_\_\_\_

30a) If yes, did staff at any of these facilities provide or help you get prenatal care and/or HIV care? (specify) \_\_\_\_\_  
\_\_\_\_\_

31) During your pregnancy, were you on WIC?<sup>2</sup>

- Yes
- No (skip to #33)

31a) Did the WIC office offer any of the following advice or services? (check all that apply)

- Testing for HIV
- Information about HIV
- Referrals for HIV testing or HIV care
- Not to breastfeed your baby
- No advice given
- Don't remember
- Other (specify): \_\_\_\_\_

**Labor and Delivery**

32) Tell me about your labor and delivery experience \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



---

---

---

33) How did you and your provider plan for you to deliver?

- Vaginal birth
- C-section (*skip to #38*)
- We did not make a plan

34) How long before you got to the hospital did your contractions start?

\_\_\_\_\_ hours

35) How did you get to the hospital? (*specify*) \_\_\_\_\_

36) Did you have trouble getting to the hospital?

- Yes *If yes, why?* \_\_\_\_\_
- No

37) When did your water break?

- Before I got to the hospital
- After I arrived at the hospital
- I had a C-section before my water broke

38) Where did you deliver?

- At the hospital in labor and delivery
- At the hospital in the emergency room
- On the way to the hospital
- At home
- Other (*specify*): \_\_\_\_\_

39) Before you left the hospital, did you receive a follow up appointment for yourself?

- Yes
- No

40) Before you left the hospital, did someone make a follow up appointment for [BABY'S NAME]?

- Yes
- No

**HIV Care and Health Beliefs related to HIV**

41) [If diagnosed prior to delivery] Did you receive any medicines for HIV during this pregnancy?

- Yes (*complete table*)
- No (*skip to #42c*)
- Unknown (*skip to #43*)

41a) Which medicines did you take?

Which medicines did you take?	Approximately when did you start the medicine?	OR Date started	Did you stop for any reason?
i. _____	<input type="checkbox"/> Before pregnancy <input type="checkbox"/> 1 <sup>st</sup> trimester <input type="checkbox"/> 2 <sup>nd</sup> trimester <input type="checkbox"/> 3 <sup>rd</sup> trimester	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
ii. _____	<input type="checkbox"/> Before pregnancy <input type="checkbox"/> 1 <sup>st</sup> trimester <input type="checkbox"/> 2 <sup>nd</sup> trimester <input type="checkbox"/> 3 <sup>rd</sup> trimester	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
iii. _____	<input type="checkbox"/> Before pregnancy <input type="checkbox"/> 1 <sup>st</sup> trimester <input type="checkbox"/> 2 <sup>nd</sup> trimester <input type="checkbox"/> 3 <sup>rd</sup> trimester	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
iv. _____	<input type="checkbox"/> Before pregnancy <input type="checkbox"/> 1 <sup>st</sup> trimester <input type="checkbox"/> 2 <sup>nd</sup> trimester <input type="checkbox"/> 3 <sup>rd</sup> trimester	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
v. _____	<input type="checkbox"/> Before pregnancy <input type="checkbox"/> 1 <sup>st</sup> trimester <input type="checkbox"/> 2 <sup>nd</sup> trimester <input type="checkbox"/> 3 <sup>rd</sup> trimester	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
vi. _____	<input type="checkbox"/> Before pregnancy <input type="checkbox"/> 1 <sup>st</sup> trimester <input type="checkbox"/> 2 <sup>nd</sup> trimester <input type="checkbox"/> 3 <sup>rd</sup> trimester	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
vii. _____	<input type="checkbox"/> Before pregnancy <input type="checkbox"/> 1 <sup>st</sup> trimester <input type="checkbox"/> 2 <sup>nd</sup> trimester <input type="checkbox"/> 3 <sup>rd</sup> trimester	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

41b) If you stopped any of your medicines, why did you stop? (check all that apply)

- Side effects
- Provider changed medicines
- Couldn't afford to pay for medicines
- Didn't want to take medicine
- Other (specify):

41c) Why did you not receive medicine for HIV during your pregnancy (check all that apply)?

- I was not offered medicine
- The clinic staff did not know I had HIV
- I could not afford to pay for the medicine
- I declined the medicine (please describe reasons)
- Other (please describe)
- Don't know

42) Besides the HIV medicines we talked about earlier, which of the following medications did you take during this pregnancy? (check all that apply)

- Vitamins
- Sleeping pills or tranquilizers
- Methadone
- Antidepressants or mood regulators (specify):
- Pain killers (specify):
- Herbal remedies (specify):  
What are these remedies for?
- Other (specify): \_\_\_\_\_

43) When you went to the hospital to give birth, how did the staff know you had HIV (check all that apply):

- I told them
- It was in my records
- They tested me for HIV
- They did not know, and I didn't tell them
- Don't know

44) Did you receive medicine for HIV during labor and delivery?

- Yes (skip to #46)
- No
- Unknown (skip to #46)

44a) Why did you not receive medicine for HIV during labor and delivery (check all that apply)?

- I was not offered medicine
- The staff did not know I had HIV
- The hospital did not have the medicine available
- I declined the medicine (please describe reasons)
- Other (please describe)
- Don't know

45) While in the hospital, did a doctor or nurse talk to you about (check all that apply):

How to give your baby AZT syrup	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Not breastfeeding to avoid HIV transmission to your baby	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Suppressing lactation/caring for your breasts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Health care for HIV for yourself	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Contraception/family planning	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Proper disposal of sanitary napkins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Not sharing razors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Importance of taking the baby to the doctor to get care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Importance of taking the baby to the doctor for HIV testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't remember
Other (specify): _____			

46) Please tell me how much you agree or disagree with each of the following:

HIV medicines help people with HIV live longer.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
HIV medications hurt people more than they help.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
Healthcare providers make judgments about you and your lifestyle.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
Taking HIV medicines makes you feel more in control of your health.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
Alternative treatments are as effective as the HIV medications.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
You don't need medicines because you don't believe you are sick.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
Taking HIV medicines makes you feel more hopeful about your health.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion

**Substance Use**

The next series of questions is about your use of cigarettes, alcohol and other drugs. Some of these questions may be personal, but your answers are important to this project. Remember that all your answers are confidential, and that you don't have to answer any of these questions if you don't want to.

47) During your pregnancy, how many cigarettes or packs of cigarettes did you smoke on an average day? (A pack of cigarettes has 20 cigarettes)

\_\_\_\_\_ number of cigarettes or \_\_\_\_\_ packs

- I didn't smoke
- Less than 1 cigarette per day
- I don't know

48) During your pregnancy, how many alcoholic drinks did you have in an average week?

- I didn't drink then (*skip to #51*)
- Less than one drink per week
- 1 to 3 drinks per week
- 4 to 6 drinks per week
- 7 to 13 drinks per week
- 14 or more drinks per week
- I don't know

49) During your pregnancy, how many times did you drink five or more alcoholic drinks at one sitting?

\_\_\_\_\_ times

- I didn't drink then
- I don't know

50) Some mothers tell us that the stress of their pregnancy is so high they use street drugs while they are pregnant. Which of these recreational or street drugs did you take during your pregnancy? Remember, this information is confidential and will not be reported with your name. (*check all that apply*)

- |  |   |
|--|---|
| <input type="checkbox"/> None ( <i>skip to #52</i> )                         |   |
| <input type="checkbox"/> Amphetamines  | <input type="checkbox"/> Hallucinogens        |
| <input type="checkbox"/> Barbiturates  | <input type="checkbox"/> Heroin               |
| <input type="checkbox"/> Benzodiazepines                                     | <input type="checkbox"/> Opiates              |
| <input type="checkbox"/> Crack   | <input type="checkbox"/> Marijuana or hashish |
| <input type="checkbox"/> Cocaine/coke in other forms                         | <input type="checkbox"/> Methadone            |
| <input type="checkbox"/> Crystal meth (methamphetamine)                      | <input type="checkbox"/> PCP, angel dust, LSD |
| <input type="checkbox"/> Ecstasy   | <input type="checkbox"/> Speed/upper          |
| <input type="checkbox"/> Other nonprescribed drugs ( <i>specify</i> ): _____ |   |

50a) If any substances used, were any of the drugs injected?

- Yes (*specify*): \_\_\_\_\_
- No
- Unknown

51) Did your health care providers provide resources for substance abuse treatment during or after this pregnancy?

- Yes
- No (*skip to #53*)

51a) If yes, please describe resources provided: \_\_\_\_\_

51b) Did you receive treatment?

- Yes
- No (*skip to #52d*)

51c) If yes, please describe treatment received: \_\_\_\_\_

51d) Were you able to reduce or end your substance use during your pregnancy?

- Yes
- No

**Stressors, Violence and Social Support**

52) Where were you living during your recent pregnancy? \_\_\_\_\_

53) Is there anything you'd like to tell me about your living situation? \_\_\_\_\_

54) You can choose not to answer this question, but I would like to ask: what was your total family income for the year preceding your most recent delivery? (*Include all income sources*)

- \$7,999 or less
- \$8,000 - \$11,999
- \$12,000 - \$15,999
- \$16,000 - \$19,999
- \$20,000 - \$24,999
- \$25,000 - \$29,999
- \$30,000 - \$39,999
- \$40,000 - \$49,999
- \$50,000 or more
- I don't know

54a) How many people (including yourself) did this support?

55) This question is about things that may have happened during the *12 months before you delivered your new baby*. This includes the months before you got pregnant. It may help to get a calendar.

A close family member was very sick and had to go into the hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No
You got separated or divorced from your husband or partner	<input type="checkbox"/> Yes <input type="checkbox"/> No
You moved to a new address	<input type="checkbox"/> Yes <input type="checkbox"/> No
You were homeless	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your husband or partner lost his job	<input type="checkbox"/> Yes <input type="checkbox"/> No
You lost your job even though you wanted to continue working	<input type="checkbox"/> Yes <input type="checkbox"/> No
You and your husband or partner argued more than usual	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your husband or partner said he did not want you to be pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
You had a lot of bills you couldn't pay	<input type="checkbox"/> Yes <input type="checkbox"/> No
You were involved in a physical fight	<input type="checkbox"/> Yes <input type="checkbox"/> No
You or your husband or partner went to jail	<input type="checkbox"/> Yes <input type="checkbox"/> No
Someone in your household had a bad problem with drinking or drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Someone very close to you died	<input type="checkbox"/> Yes <input type="checkbox"/> No
You were afraid of violence in your neighborhood	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other stressful event ( <i>specify</i> ): _____	

56) During the 12 months *before your delivery*, who would have helped you if a problem had come up? (For example, if you needed a ride to the clinic or needed to borrow \$20.) (*check all that apply*)

- My husband or partner
- A friend
- My mother, father or inlaws
- Other family member or relative
- No one would have helped me
- Don't know
- Other (*specify*): \_\_\_\_\_

57) During your most recent pregnancy, did any of these people physically abuse you? (*check all that apply*)

- My husband or partner
- A family or household member *other than* my husband or partner
- A friend
- Someone else (*please tell us whom*): \_\_\_\_\_
- No one physically abused me during my pregnancy

**Pregnancy Intention and Prevention**

58) Before you became pregnant, how do you remember feeling about becoming pregnant? (*check all that apply*)

- I wanted to be pregnant sooner
- I wanted to be pregnant later
- I wanted to be pregnant then
- I didn't want to be pregnant then
- I didn't want to be pregnant then or at any time in the future

I don't know

59) Did you ever consider not continuing your pregnancy?

Yes

No

If yes, what happened? \_\_\_\_\_

60) In the three months before you got pregnant, were you using any kind of birth control?

Yes

No (skip to #63)

61) What kind of contraception (birth control) were you using during the three months before you got pregnant? (check all that apply)

None (skip to #63)

Condom (Rubbers)

Hormonal contraception (oral pill/transdermal patch/vaginal ring)

Foam, Jelly or Cream

Injectable (e.g., Depo-Provera)

Implantable (e.g., Norplant)

Diaphragm

Intrauterine device (IUD)

Withdrawal (Pulling Out)

Rhythm

Other (specify): \_\_\_\_\_

62) Why were you not using contraception (birth control) during the three months before you got pregnant? (check all that apply)

I wanted to get pregnant

I didn't think I could get pregnant

I had trouble getting birth control

I didn't think I was going to have sex

I didn't like using birth control

I was having side effects from the birth control I was using

Other (specify): \_\_\_\_\_

63) Shortly before this pregnancy, did you or the baby's father obtain medical treatments to help you become pregnant?

Yes

No

64) Do you expect to have more children?

Definitely yes

- Probably yes
- Probably no (*skip to #68*)
- Definitely no (*skip to #68*)
- Don't know

65) How many more children do you expect to have?

\_\_\_\_\_ no. of children

- Don't know

66) When would you want to have another child?

\_\_\_\_\_ months

- Don't know

**Language Barriers and Translation Services**

67) What language do you speak at home?

- English (*skip to #69*)
- Spanish
- Creole
- French
- Italian
- Russian
- Polish
- Vietnamese
- Mandarin/Cantonese
- Other (*specify*) \_\_\_\_\_

67a) How comfortable are you speaking and listening to English?

- Very comfortable/fluent (*skip to #69*)
- Somewhat comfortable
- Fairly uncomfortable
- Not comfortable at all/do not speak English

67b) Were you offered interpretation or translation services when you sought medical care in the following settings during this pregnancy?

Prenatal care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
HIV care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Reproductive care/Family planning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
At the emergency room	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
At the hospital when you delivered	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
At the hospital after you delivered	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
At [BABY'S NAME]'s doctor's visits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable

67c) Do you feel that you received different care than other women because you did not speak English well? Please explain. \_\_\_\_\_

**Closing**



---

I have asked these questions so I can understand more about you and your experiences during your recent pregnancy.

68) Is there anything else you'd like to tell me about your experience during your pregnancy that you feel is important for me to know? \_\_\_\_\_

---

69) Thinking back on this entire experience, is there anything about the care you or your new baby received that you think can be improved? \_\_\_\_\_

---

Interviewer's notes: please use this space to document any additional information, including pertinent details elicited by the interview but not recorded elsewhere, description of surroundings during the interview, etc. \_\_\_\_\_

---

---

---

---

**Follow up Assessment (conducted 2-4 weeks after the birth of the baby)**

Public reporting burden of this collection of information is estimated to average **45** 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

**Post-Delivery Health Care and HIV Medication Adherence**

70) Have you seen a doctor, nurse or health care provider for a postpartum checkup?

Yes

No *if no, why not?* \_\_\_\_\_

71) Have you had any complications since delivery?

Yes *if so, what?* \_\_\_\_\_

No

72) How do you feel about your health in general since delivery? \_\_\_\_\_

---

73) Did you ever breastfeed [BABY'S NAME]?

Yes

No (*skip to #75*)

73a) If yes, why?

Doctor or nurse encouraged breastfeeding

I really wanted to breastfeed my baby

I didn't have formula

I was afraid people would ask why I wasn't breastfeeding

I didn't know I was HIV positive

I think breastfeeding is good for my baby

My baby is taking medicines to prevent HIV

Other (*specify*): \_\_\_\_\_

74) Have you seen a doctor, nurse or health care provider for HIV care after delivery?

Yes

No (*skip to #77*)

75) Where are you going for HIV care for yourself? (*name of clinic or doctor*) \_\_\_\_\_

---

---

76) If you are not seeing someone for HIV care, what are the barriers?

- You have no transportation or unreliable transportation
  - You have no money or insurance
  - There is no one to watch your children
  - Don't know where to go
  - You have no free time
  - You can't get an appointment
  - The wait is too long when you do have an appointment
  - The staff doesn't listen to you
  - The staff doesn't speak your language
  - You don't like or trust the staff
  - Could not get a doctor or nurse to take me as a patient
  - Don't need or want care
  - I don't think it helps me
  - I don't want to take medicine
  - Other (*specify*) \_\_\_\_\_
- 

77) Are you currently taking medicines for HIV?

- Yes
- No (*skip to #83*)

78) When you take your medicine, how often do you take the medicine exactly as prescribed?

- Always or close to 100% of the time
- Most of the time or about 75%
- Half the time or about 50%
- Some of the time or about 25%
- Rarely or never (less than 25% of the time)
- Don't know

79) In no particular order, list your HIV medications.

---

---

---

---

---

80) Do you ever have problems taking your medicine because...

You can't get medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You run out of medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You get side effects, like an upset stomach?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You forget?	<input type="checkbox"/> Yes <input type="checkbox"/> No
When you take your pills, it reminds you that you have HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your housing situation is unstable or changing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You have legal problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You're worried someone will find out that you have HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You're not getting a lot of support from the people around you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You're worried about what the HIV medicines might do to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other problems ( <i>specify</i> ) _____	

81) How confident are you that you will be able to:

Take your medicine exactly as prescribed by your doctor for the <u>next three days</u> ?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently <input type="checkbox"/> Almost always
Take your medicine exactly as prescribed by your doctor for the <u>next month</u> ?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently <input type="checkbox"/> Almost always
Take your medicine exactly as prescribed by your doctor for the <u>next year</u> ?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently <input type="checkbox"/> Almost always

**Stressors, Violence and Social Support**

82) Since you gave birth, who would have helped you if a problem had come up? (For example, if you needed a ride to the clinic or needed to borrow \$20.) (*check all that apply*)

- My husband or partner
- A friend
- My mother, father or inlaws
- No one would have helped me
- Other family member or relative
- Don't know
- Other (*specify*): \_\_\_\_\_

83) The following is a list of services that are often provided by a Ryan White Title IV provider. Please indicate whether you have used these services during your pregnancy, since your pregnancy, and if you have not used these services since you became pregnant but would like to have access to such a service.

Title IV Service	Used during pregnancy?	Used since pregnancy?	Would like to use?
Case management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buddy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pre-planning for child welfare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary and specialty medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home medical visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutritional counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rehabilitation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antiretroviral medication assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antiretroviral treatment adherence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Linkage to clinical trials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Logistical support and coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respite care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food bank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

83a) If you used any of the services listed above, please specify which provider or organization offered these services. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

84) Have you ever been the victim of physical violence?  
 Yes *if yes, please tell me more about it* \_\_\_\_\_  
 No

**Pregnancy Intention and Prevention**

85) Are you currently pregnant?  
 Yes  
 No *(skip to #87)*  
 Unknown *(skip to #87)*

85a) If yes, how many weeks pregnant are you now? \_\_\_\_\_  
 Unknown

86) Are you currently using birth control?  
 Yes *(skip to #88)*  
 No

86a) If no, why are you not using birth control?

- I want to get pregnant
- I am not having sex
- I can't afford birth control
- I had my tubes tied
- I don't believe in birth control
- My partner does not want me to use birth control
- I don't know where to find out about birth control
- Other (specify): \_\_\_\_\_

**Disclosure**

87) After you were diagnosed with HIV, did you feel that you were treated better or worse than usual during health care visits? Please describe: \_\_\_\_\_

\_\_\_\_\_

88) Have you disclosed your HIV status to all of your health care providers and your infant's health care providers?

- Yes (skip to #90)
- No
- Don't know

88a) As a reminder, your answers are confidential. Which providers have you not told and why not? (specify): \_\_\_\_\_

\_\_\_\_\_

89) Have you had any bad experiences as a result of telling someone that you had HIV? For example, you had a fight, you lost your job, etc. Please describe: \_\_\_\_\_

\_\_\_\_\_

90) Is there anyone you would like to tell that you have HIV but you need some help telling them? For example, your current or past sexual partners, your children, etc. Please describe: \_\_\_\_\_

91) Have you ever used PCRS (Partner Counseling and Referral Services), where someone from the health department helped you contact your past sexual or drug injecting partners (or anonymously contacted them for you) to let them know that they may have been exposed to HIV?

- Yes
- No → provide referral to PCRS if desired

92) Do you have a current partner?

- Yes
- No (skip to #95)

93) Has your partner been tested for HIV?

- Yes
- No (skip to #95)
- Don't know (skip to #95)

93a) If yes, what is your partner's HIV status?

- HIV positive
- HIV negative
- Don't know (specify): \_\_\_\_\_

94) If you have other children, have they been tested for HIV?

- Yes
- No (skip to #96)
- Don't know (skip to #96)
- No other children (skip to #96)

94a) Are any of your other children HIV-infected?

- Yes
- No
- Don't know → provide resources for HIV testing of other children

**Mental Health**

95) Please indicate the answer which comes closest to how you have felt *in the past 7 days*, not just how you feel today:

<b>I have been able to laugh and see the funny side of things.</b>			
As much as I always could	Not quite so much now	Definitely not so much now	Not at all
<b>I have looked forward with enjoyment to things.</b>			
As much as I ever did	Rather less than I used to	Definitely less than I used to	Hardly at all
<b>I have blamed myself unnecessarily when things went wrong.</b>			
Yes, most of the time	Yes, some of the time	Not very often	No, never
<b>I have been anxious or worried for no good reason.</b>			
No, not at all	Hardly ever	Yes, sometimes	Yes, very often
<b>I have felt scared or panicky for not very good reason.</b>			
Yes, quite a lot	Yes, sometimes	No, not much	No, not at all
<b>Things have been getting on top of me.</b>			
Yes, most of the time I haven't been able to cope at all	Yes, sometimes I haven't been coping as well as usual	No, most of the time I have coped quite well	No, I have been coping as well as ever
<b>I have been so unhappy that I have had difficulty sleeping.</b>			
Yes, most of the time	Yes, sometimes	Not very often	No, not at all
<b>I have felt sad or miserable.</b>			
Yes, most of the time	Yes, quite often	Not very often	No, not at all
<b>I have been so unhappy that I have been crying.</b>			
Yes, most of the time	Yes, quite often	Only occasionally	No, never
<b>The thought of harming myself has occurred to me.</b>			
Yes, quite often	Sometimes	Hardly ever	Never

Source: Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.

**Closing**

I have asked these questions so I can understand more about you and your experiences since your recent pregnancy.

96) Is there anything else you'd like to tell me about your experiences since your pregnancy that you feel is important for me to know? \_\_\_\_\_

\_\_\_\_\_

97) Thinking back on this entire experience, is there anything about the care you or your baby received that you think can be improved? \_\_\_\_\_

\_\_\_\_\_

98) What do you think needs to be done to help women living with HIV and their children and families? \_\_\_\_\_

\_\_\_\_\_

Interviewer's notes: please use this space to document any additional information, including pertinent details elicited by the interview but not recorded elsewhere, description of surroundings during the interview, etc. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Infant Assessment (to be completed with the baby's caregiver)**

99) What is your relationship to [BABY'S NAME]?

- Biological mother
- Biological father
- Grandparent
- Other relative
- Foster or adoptive parent
- Friend
- Other (specify) \_\_\_\_\_

**HIV Medication Adherence for Infant and Health Beliefs related to HIV Medications**

100) Is [BABY'S NAME] currently prescribed HIV-related medications?

- Yes
- No (skip to #107)
- Don't know (skip to #107)

101) Who gives [BABY'S NAME] [his/her] HIV medicine most of the time (more than 3 days a week)?

- You do
- Other (specify) \_\_\_\_\_
- Don't know

102) When you give [BABY'S NAME] [his/her] medicine, how often do you or someone else give the medicine exactly as prescribed?

- Always or close to 100% of the time
- Most of the time or about 75%
- Half the time or about 50%
- Some of the time or about 25%
- Rarely or never (less than 25% of the time)
- Don't know

103) Now, I'd like to know the names of [BABY'S NAME] HIV medications. In no particular order, list the baby's medications.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

104) Do you ever have a problem giving [BABY'S NAME] [his/her] medicine because...

You can't get medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You run out of medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
The baby spits it up?	<input type="checkbox"/> Yes <input type="checkbox"/> No
The baby gets side effects?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You're worried about what the HIV medicines might do to the baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You're not getting a lot of support from the people around you to give the baby the medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You forget to give the baby medicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Giving the baby medicine interferes with your schedule and sleep time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(IF MOTHER IS BEING INTERVIEWED) You're worried someone might find out you have HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
You're worried someone will find out that the baby may have HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other problems ( <i>specify</i> ) _____	

105) Do you or someone else use any of the following things to help give medicine to [BABY'S NAME]? (*check all that apply*)

- Labels on medicines
- Calendar
- Beepers or other timers
- Directly observed therapy (DOTs) or home-based nurse visits your home
- Other (*specify*): \_\_\_\_\_
- No reminders used

106) Please tell me how much you agree or disagree with each of the following:

HIV medicines help prevent [BABY'S NAME] from getting HIV.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
HIV medications are bad for children and babies.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
Healthcare providers make judgments about you and your ability to take care of your children.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
Giving HIV medicines to [BABY'S NAME] makes me feel more in control of [his/her] health.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
Alternative treatments for [BABY'S NAME] are as effective as the HIV medications.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
[BABY'S NAME] doesn't (didn't) need medicines because you don't believe [he/she] has (had) HIV	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion
Giving HIV medicines to [BABY'S NAME] makes (made) me feel more hopeful about [his/her] health.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> No Opinion

**Newborn Health and HIV Testing and Care**

107) Where is [BABY'S NAME] getting routine care? (*name of clinic or doctor*) \_\_\_\_\_

108) Has [BABY'S NAME] gone as many times as you wanted for *routine care*?

- Yes
- No

109) Did any of these things keep [BABY'S NAME] from having *routine care*? (check all that apply)

- You have no transportation or unreliable transportation
- You have no money or insurance for [BABY'S NAME]
- There is no one to watch your children
- Don't know where to go
- You have no free time
- You can't get an appointment for [BABY'S NAME]
- The wait is too long when you do have an appointment
- The staff doesn't listen to you
- The staff doesn't speak your language
- You don't like or trust the staff
- Could not get a doctor or nurse to take [BABY'S NAME] as a patient
- I don't think it helps [BABY'S NAME]
- Other (specify): \_\_\_\_\_

110) Where is [BABY'S NAME] getting care for HIV exposure and HIV testing? (name of clinic or doctor) \_\_\_\_\_

- Same provider as routine baby care

111) Has [BABY'S NAME] gone as many times as you wanted for *HIV care*?

- Yes
- No

112) Did any of these things keep [BABY'S NAME] from having *HIV care*? (check all that apply)

- You have no transportation or unreliable transportation
- You have no money or insurance for [BABY'S NAME]
- There is no one to watch your children
- Don't know where to go
- You have no free time
- You can't get an appointment for [BABY'S NAME]
- The wait is too long when you do have an appointment
- The staff doesn't listen to you
- The staff doesn't speak your language
- You don't like or trust the staff
- Could not get a doctor or nurse to take [BABY'S NAME] as a patient
- I don't think it helps [BABY'S NAME]
- I don't want to give [BABY'S NAME] medicine
- Other (specify): \_\_\_\_\_

113) How do you pay for [BABY'S NAME]'s care? (check all that apply)

- Private Insurance
- Managed care organization (MCO) or Health maintenance organization (HMO), private payor
- Traditional Medicaid
- Medicaid Managed Care Organization (MCO) or Health Maintenance Organization (HMO)
- Medicaid, type unknown
- Medicare
- CHAMPUS/Military Insurance
- State Child Health Insurance Program (SCHIP)
- Self pay
- Other (specify): \_\_\_\_\_

114) After [BABY'S NAME] came home, approximately how many times did you take [him/her] to the doctor because [he/she] was sick?

- \_\_\_\_\_ times
- Don't remember

115) Has [BABY'S NAME] developed any of the following problems or illnesses?

Cold	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____
Eye infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____
Ear infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____
Respiratory infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____
Injury from a bad fall or accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____
Other illness/injury (specify): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of times: _____

116) After [BABY'S NAME] came home from the hospital after delivery, did [he/she] have to go back into the hospital overnight for any reason?

- Yes
- No (skip to #118)

116a) How many times was [BABY'S NAME] hospitalized overnight after [he/she] first came home from the hospital after delivery?

- One time
- Two times
- Three times or more
- Don't remember

116b) Why was [BABY'S NAME] hospitalized each of these times? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

117) Before you took [BABY'S NAME] home from the hospital, did you know where to take [him/her] if [he/she] got sick?

- Yes
- No

118) Have you ever had a problem paying for medical care when [BABY'S NAME] was sick?

- Yes
- No
- Don't remember

119) After [BABY'S NAME] came home, did you receive financial help or support from any program or organization? *(check all that apply)*

- Mental health service
- Medicaid
- Financial planning
- Methadone maintenance program
- Genetic evaluation/counseling
- Employment office
- Family planning
- Child protective services
- WIC
- Ongoing social work case management
- Housing authority
- PHN home assessment/follow-up
- Group shelters
- Smoking cessation program
- Homemaker/home health aide
- Other *(specify)*: \_\_\_\_\_

120) Did [BABY'S NAME] receive any health program assistance? *(check all that apply)*

- Public health nursing home visits or care
- Respite/day care
- County/state funded medical care, treatments or equipment
- Infant child health program
- Social Security
- WIC
- Physically handicapped child program
- Other *(specify)*: \_\_\_\_\_

121) What has [BABY'S NAME]'s doctor/nurse said about [his/her] HIV status?

\_\_\_\_\_

\_\_\_\_\_

122) Is there anything else you would like to tell me about [BABY'S NAME]'s health? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

123) Does [BABY'S NAME] have a case manager or social worker?

- Yes
- No (skip to #125)

123a) What does [BABY'S NAME]'s case manager/social worker do for [him/her] or how do they help? \_\_\_\_\_

**Closing**

I have asked these questions so I can understand more about the early weeks of [BABY'S NAME]'s life.

124) Is there anything else you'd like to tell me about your experiences caring for [BABY'S NAME] that you feel is important for me to know? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

125) Thinking back on this entire experience, is there anything about the care [BABY'S NAME] received that you think can be improved? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

126) What do you think needs to be done to help women living with HIV and their children and families? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Interviewer's notes: please use this space to document any additional information, including pertinent details elicited by the interview but not recorded elsewhere, description of surroundings during the interview, etc. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This document was developed through funding and support by the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention (CDC) along with its partners the American College of Obstetricians and Gynecologists (the College), CityMatCH, and the National Fetal and Infant Mortality Review Program (NFIMR).