


# Puerto Rico PRAMS Grantee Web Questionnaire In PRAMS Integrated Data Collection System [PIDS]

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## Welcome to Pregnancy Risk Assessment Monitoring System (PRAMS) Survey

1 ————— 2 ————— 3


Please enter the User ID and Passcode that were provided in your letter.

User ID \*

Passcode \*


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**Form Approved**  
OMB No. 0920-1273  
Exp. Date 11/30/2022


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Please confirm your year of birth.

Mother's Year Of Bir... ▾

Email Address (optional)

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Choose a language:





- English
- Spanish

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**Important Information About PRAMS**

***Please Read Before Starting the Survey***

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a research project sponsored by the Centers for Disease Control and Prevention and the Puerto Rico Department of Health

The purpose of the study is to find out why some babies are born healthy and others are not.


We are asking 1,400 women in Puerto Rico to answer the same questions. All of your names were picked by a computer from recent birth certificates.

It takes about 25 to 42 minutes to answer all questions. Some questions may be sensitive, such as questions about smoking or drinking during pregnancy.

You are free to do the survey or not. If you don't want to participate at all, or if you don't want to answer a particular question, that's okay. There is no penalty or loss of benefits for not participating or answering all questions.


Your survey may be combined with information the health department has from other





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sources.

If you choose to do the survey, your answers will be kept private and will be used only to answer questions related to the purpose of this study. This is so because this study has been given a Certificate of Confidentiality. This means that we may not share information that may identify you in legal suits or proceeding, even if a court orders us to do so, unless you say it's okay.

If you are currently in jail, your participation in the study will have no effect on parole.

Your name will not be on any reports from PRAMS.

Your answers will be grouped with those from other women. What we learn from PRAMS will be used to plan programs to help mothers and babies in Puerto Rico.


If you have any questions about your rights in the project, please call at 701-231-8995.

If you have any questions about PRAMS, please contact us at .

I understand and consent to proceed with the survey

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**Choose how you would like to answer questions about height and weight:**

- feet, inches, pounds
- centimeters, kilograms




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**The first questions are about *you*.**


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**1. How tall are *you* without shoes?**

Feet


Inches

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**1. How tall are *you* without shoes?**


Centimeters

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**2. *Just before* you got pregnant with your *new* baby, how much did you weigh?**


Pounds

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**2. Just before you got pregnant with your *new* baby, how much did you weigh?**

Kilos

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3. What is your date of birth?




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The next questions are about the time before you got pregnant with your new baby.

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**4. During the 3 months before you got pregnant with your new baby, did you have any of the following health conditions?** For each one, check **No** if you did not have the condition or **Yes** if you did.

	No	Yes
Type 1 or Type 2 diabetes ( <b>not</b> gestational diabetes or diabetes that starts during pregnancy)	<input type="radio"/>	<input type="radio"/>
High blood pressure or hypertension	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>
Anemia (poor blood, low iron)	<input type="radio"/>	<input type="radio"/>
Heart problems	<input type="radio"/>	<input type="radio"/>
Epilepsy (seizures)	<input type="radio"/>	<input type="radio"/>
Thyroid problems	<input type="radio"/>	<input type="radio"/>
PCOS (polycystic ovarian syndrome)	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>


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**5. During the *month* before you got pregnant with your new baby, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?**

I didn't take a multivitamin, prenatal vitamin, or folic acid vitamin in the *month* before I got pregnant


1 to 3 times a week

4 to 6 times a week

Every day of the week


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**6. In the 12 months before you got pregnant with your new baby, did you have any health care visits with a doctor, nurse, or other health care worker, including a dental or mental health worker?**

No

Yes


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

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**7. Why didn't you have any health care visits in the 12 months before you got pregnant with your new baby? Check ALL that apply**

	No	Yes
I didn't have health insurance to cover the cost of the visit	<input type="radio"/>	<input type="radio"/>
I felt fine and did not think I needed to have a visit	<input type="radio"/>	<input type="radio"/>
I couldn't get an appointment when I wanted one	<input type="radio"/>	<input type="radio"/>
I didn't have any transportation to get to the clinic or doctor's office	<input type="radio"/>	<input type="radio"/>
I had too many things going on	<input type="radio"/>	<input type="radio"/>
I couldn't take time off from work	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

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

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**8. What type of health care visit did you have in the 12 months before you got pregnant with your new baby? Check ALL that apply**

	No	Yes
Regular checkup at my family doctor's office	<input type="radio"/>	<input type="radio"/>
Regular checkup at my OB/GYN's office	<input type="radio"/>	<input type="radio"/>
Visit for an illness or chronic condition	<input type="radio"/>	<input type="radio"/>
Visit for an injury	<input type="radio"/>	<input type="radio"/>
Visit for family planning or birth control	<input type="radio"/>	<input type="radio"/>
Visit for depression or anxiety	<input type="radio"/>	<input type="radio"/>
Visit to have my teeth cleaned by a dentist or dental hygienist	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

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**9. During any of your health care visits in the 12 months before you got pregnant, did a doctor, nurse, or other health care worker do any of the following things? For each item, check **No** if they did not or **Yes** if they did.**

	No	Yes
Tell me to take a vitamin with folic acid	<input type="radio"/>	<input type="radio"/>
Talk to me about maintaining a healthy weight	<input type="radio"/>	<input type="radio"/>
Talk to me about controlling any medical conditions such as diabetes or high blood pressure	<input type="radio"/>	<input type="radio"/>
Talk to me about my desire to have or not have children	<input type="radio"/>	<input type="radio"/>
Talk to me about using birth control to prevent pregnancy	<input type="radio"/>	<input type="radio"/>
Talk to me about how I could improve my health before a pregnancy	<input type="radio"/>	<input type="radio"/>
Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis	<input type="radio"/>	<input type="radio"/>
Ask me if I was smoking cigarettes	<input type="radio"/>	<input type="radio"/>
Ask me if someone was hurting me emotionally or physically	<input type="radio"/>	<input type="radio"/>
Ask me if I was feeling down or depressed	<input type="radio"/>	<input type="radio"/>
Ask me about the kind of work I do	<input type="radio"/>	<input type="radio"/>
Test me for HIV (the virus that causes AIDS)	<input type="radio"/>	<input type="radio"/>


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**The next questions are about your *health insurance coverage* before, during and after your pregnancy with your *new baby*.**





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**10. During the month before you got pregnant with your new baby, what kind of health insurance did you have? Check ALL that apply**

	No	Yes
Private health insurance from my job or the job of my husband or partner	<input type="radio"/>	<input type="radio"/>
Private health insurance from my parents	<input type="radio"/>	<input type="radio"/>
Medicaid (Government Health Plan, Reforma, "Mi Salud")	<input type="radio"/>	<input type="radio"/>
TRICARE or other military health care	<input type="radio"/>	<input type="radio"/>
Other health insurance	<input type="radio"/>	<input checked="" type="radio"/>


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I did not have any health insurance during the *month before* I got pregnant

No

Yes


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**Did you go for prenatal care?**

No

Yes


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

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**11. During your *most recent pregnancy*, what kind of health insurance did you have for your *prenatal care*? Check ALL that apply**

	No	Yes
I did not go for prenatal care	<input type="radio"/>	<input type="radio"/>
Private health insurance from my job or the job of my husband or partner	<input type="radio"/>	<input type="radio"/>
Private health insurance from my parents	<input type="radio"/>	<input type="radio"/>
Medicaid (Government Health Plan, Reforma, "Mi Salud")	<input type="radio"/>	<input type="radio"/>
TRICARE or other military health care	<input type="radio"/>	<input type="radio"/>
Other health insurance	<input type="radio"/>	<input checked="" type="radio"/>


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I did not have any health insurance for my *prenatal care*

No

Yes

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**12. What was the reason that you did not have any health insurance to pay for your *prenatal care*? Check ALL that apply**

	No	Yes
Health insurance was too expensive	<input type="radio"/>	<input type="radio"/>
I could not get health insurance from my job or the job of my husband or partner	<input type="radio"/>	<input type="radio"/>
I applied for health insurance, but was waiting to get it	<input type="radio"/>	<input type="radio"/>
I had problems with the health insurance application or website	<input type="radio"/>	<input type="radio"/>
My income was too high to qualify for Medicaid (Government Health Plan, Reforma, "Mi Salud")	<input type="radio"/>	<input type="radio"/>
I didn't know how to get health insurance	<input type="radio"/>	<input type="radio"/>
I am not a US citizen or I don't have the right residency documents	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

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8%

**13. What kind of health insurance do you have now? Check ALL that apply**

- |  | No                    | Yes                              |
|--|-----------------------|----------------------------------|
| Private health insurance from my job or the job of my husband or partner | <input type="radio"/> | <input type="radio"/>            |
| Private health insurance from my parents                                 | <input type="radio"/> | <input type="radio"/>            |
| Medicaid (Government Health Plan, Reforma, "Mi Salud")                   | <input type="radio"/> | <input type="radio"/>            |
| TRICARE or other military health care                                    | <input type="radio"/> | <input type="radio"/>            |
| Other health insurance   | <input type="radio"/> | <input checked="" type="radio"/> |


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I do not have health insurance *now*

No


Yes

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**14. Thinking back to *just before* you got pregnant with your new baby, how did you feel about becoming pregnant? Check ONE answer**


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

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**The next questions are about the prenatal care you received during your most recent pregnancy. Prenatal care includes visits to a doctor, nurse, or other health care worker before your baby was born to get checkups and advice about pregnancy. It may help to look at the calendar when you answer these questions.**

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**15. How many weeks or months pregnant were you when you had your first visit for prenatal care?**


Weeks

Months

I didn't go for prenatal care


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**16. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? Please count only discussions, not reading materials or videos. For each item, check **No** if no one talked with you about it or **Yes** if someone did.**

	No	Yes
How smoking during pregnancy could affect my baby	<input type="radio"/>	<input type="radio"/>
Breastfeeding my baby	<input type="radio"/>	<input type="radio"/>
How drinking alcohol during pregnancy could affect my baby	<input type="radio"/>	<input type="radio"/>
Using a seat belt during my pregnancy	<input type="radio"/>	<input type="radio"/>
Medicines that are safe to take during my pregnancy	<input type="radio"/>	<input type="radio"/>
How using illegal drugs could affect my baby	<input type="radio"/>	<input type="radio"/>
Doing tests to screen for birth defects or diseases that run in my family	<input type="radio"/>	<input type="radio"/>
The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)	<input type="radio"/>	<input type="radio"/>
What to do if I feel depressed during my pregnancy or after my baby is born	<input type="radio"/>	<input type="radio"/>
Physical abuse to women by their husbands or partners	<input type="radio"/>	<input type="radio"/>
Foods that are good to eat during pregnancy	<input type="radio"/>	<input type="radio"/>
Exercise during pregnancy	<input type="radio"/>	<input type="radio"/>
Programs or resources to help me gain the right amount of weight during pregnancy	<input type="radio"/>	<input type="radio"/>
Programs or resources to help me lose weight after pregnancy	<input type="radio"/>	<input type="radio"/>
What can happen if a baby is shaken	<input type="radio"/>	<input type="radio"/>

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**17. During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you any of the things listed below?** For each item, check **No** if they did not ask you about it or **Yes** if they did.

	No	Yes
If I knew how much weight I should gain during pregnancy	<input type="radio"/>	<input type="radio"/>
If I was taking any prescription medication	<input type="radio"/>	<input type="radio"/>
If I was smoking cigarettes	<input type="radio"/>	<input type="radio"/>
If I was drinking alcohol	<input type="radio"/>	<input type="radio"/>
If someone was hurting me emotionally or physically	<input type="radio"/>	<input type="radio"/>
If I was feeling down or depressed	<input type="radio"/>	<input type="radio"/>
If I was using drugs such as marijuana, cocaine, crack, or meth	<input type="radio"/>	<input type="radio"/>
If I wanted to be tested for HIV (the virus that causes AIDS)	<input type="radio"/>	<input type="radio"/>
If I planned to breastfeed my new baby	<input type="radio"/>	<input type="radio"/>
If I planned to use birth control after my baby was born	<input type="radio"/>	<input type="radio"/>


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**18. During the *last 3 months* of your most recent pregnancy, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?**

- I did not take a multivitamin, prenatal vitamin or folic acid vitamin at all
- 1 to 3 times a week
- 4 to 6 times a week
- Every day of the week

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19. During the 12 months *before the delivery* of your new baby, did a doctor, nurse, or other health care worker *offer* you a flu shot or *tell* you to get one?

- No
- Yes

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**20. During the 12 months *before the delivery* of your new baby, did you *get* a flu shot? Check ONE answer**

- No
- Yes, before my pregnancy
- Yes, during my pregnancy

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**21. During *your most recent* pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?**

- No
- Yes

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22%

**22. This question is about other care of your teeth during your most recent pregnancy.** For each item, check **No** if it is not true or does not apply to you or **Yes** if it is true.

- |   | No                    | Yes                   |
|---|-----------------------|-----------------------|
| I knew it was important to care for my teeth and gums during my pregnancy                   | <input type="radio"/> | <input type="radio"/> |
| A dental or other health care worker talked with me about how to care for my teeth and gums | <input type="radio"/> | <input type="radio"/> |
| I had insurance to cover dental care during my pregnancy                                    | <input type="radio"/> | <input type="radio"/> |
| I <u>needed</u> to see a dentist for a <b>problem</b>                                       | <input type="radio"/> | <input type="radio"/> |
| I <u>went</u> to a dentist or dental clinic about a <b>problem</b>                          | <input type="radio"/> | <input type="radio"/> |

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**23. During your most recent pregnancy, what kind of problem did you have with your teeth or gums?** For each item, check **No** if you did not have this problem during pregnancy or **Yes** if you did.

- |  | No                    | Yes                              |
|--|-----------------------|----------------------------------|
| I had cavities that needed to be filled        | <input type="radio"/> | <input type="radio"/>            |
| I had painful, red, or swollen gums            | <input type="radio"/> | <input type="radio"/>            |
| I had a toothache                              | <input type="radio"/> | <input type="radio"/>            |
| I needed to have a tooth pulled                | <input type="radio"/> | <input type="radio"/>            |
| I had an injury to my mouth, teeth, or gums    | <input type="radio"/> | <input type="radio"/>            |
| I had some other problem with my teeth or gums | <input type="radio"/> | <input checked="" type="radio"/> |

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**24. Did any of the following things make it hard for you to go to a dentist or dental clinic during *your most recent* pregnancy?** For each item, check **No** if it was not something that made it hard for you or **Yes** if it was.

	No	Yes
I could not find a dentist or dental clinic that would take pregnant patients	<input type="radio"/>	<input type="radio"/>
I could not find a dentist or dental clinic that would take Medicaid (Government Health Plan, Reforma, "Mi Salud") patients	<input type="radio"/>	<input type="radio"/>
I did not think it was safe to go to the dentist during pregnancy	<input type="radio"/>	<input type="radio"/>
I could not afford to go to the dentist or dental clinic	<input type="radio"/>	<input type="radio"/>

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**25. During your most recent pregnancy, did you have any of the following health conditions?** For each one, check **No** if you did not have the condition or **Yes** if you did.

	No	Yes
Gestational diabetes (diabetes that <b>started</b> during <i>this</i> pregnancy)	<input type="radio"/>	<input type="radio"/>
High blood pressure (that <b>started</b> during <i>this</i> pregnancy), pre-eclampsia or eclampsia	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>
Anemia (poor blood, low iron)	<input type="radio"/>	<input type="radio"/>
Heart problems	<input type="radio"/>	<input type="radio"/>
Epilepsy (seizures)	<input type="radio"/>	<input type="radio"/>
Thyroid problems	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>


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**26. During *your most recent* pregnancy, did a doctor, nurse, or other health care worker give you a series of weekly shots of a medicine called progesterone, Makena<sup>®</sup>, or 17P (17 alpha-hydroxyprogesterone) to try to keep your new baby from being born too early?**


No

Yes

I don't know


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**The next questions are about smoking cigarettes before, during, and after pregnancy.**

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**27. Have you smoked any cigarettes in the *past 2 years*?**

No


Yes

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**28. In the 3 months before you got pregnant, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.**


- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I didn't smoke then

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**29. In the *last 3 months* of your pregnancy, how many cigarettes did you smoke on an average day? A pack has 20 cigarettes.**


- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I didn't smoke then

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**30. How many cigarettes do you smoke on an average day *now*? A pack has 20 cigarettes.**

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I don't smoke now

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The next questions are about using other tobacco products around the time of pregnancy.

**E-cigarettes (electronic cigarettes) and other electronic nicotine products** (such as vape pens, e-hookahs, hookah pens, e-cigars, e-pipes) are battery-powered devices that use nicotine liquid rather than tobacco leaves, and produce vapor instead of smoke.

**Hookahs** are water pipes used to smoke tobacco. These are not e-hookahs or hookah pens.

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**31. Have you used any of the following products in the *past 2 years*? For each item, check **No** if you did not use it or **Yes** if you did.**

	No	Yes
E-cigarettes or other electronic nicotine products	<input type="radio"/>	<input type="radio"/>
Hookah	<input type="radio"/>	<input type="radio"/>
Chewing tobacco, snuff, snus, or dip	<input type="radio"/>	<input type="radio"/>
Cigars, cigarillos, or little filtered cigars	<input type="radio"/>	<input type="radio"/>


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**32. During the 3 months *before* you got pregnant, on average, how often did you use e-cigarettes or other electronic nicotine products?**


- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

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**33. During the *last 3 months* of your pregnancy, on average, how often did you use e-cigarettes or other electronic nicotine products?**


- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

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**The next questions are about drinking alcohol around the time of pregnancy.**

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**34. Have you had any alcoholic drinks in the *past 2 years*?** A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

No


Yes

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**35. During the 3 months before you got pregnant, how many alcoholic drinks did you have in an average week?**


- 14 drinks or more a week
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

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**Pregnancy can be a difficult time. The next questions are about things that may have happened before and during your most recent pregnancy.**


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**36. In the 12 months before you got pregnant with your new baby, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each person, check **No** if they did not hurt you during this time or **Yes** if they did.**

	No	Yes
My husband or partner	<input type="radio"/>	<input type="radio"/>
My ex-husband or ex-partner	<input type="radio"/>	<input type="radio"/>
Another family member	<input type="radio"/>	<input type="radio"/>
Someone else	<input type="radio"/>	<input type="radio"/>

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**37. During your most recent pregnancy, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way?** For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

	No	Yes
My husband or partner	<input type="radio"/>	<input type="radio"/>
My ex-husband or ex-partner	<input type="radio"/>	<input type="radio"/>
Another family member	<input type="radio"/>	<input type="radio"/>
Someone else	<input type="radio"/>	<input type="radio"/>


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**The next questions are about the time since your new baby was born.**

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**38. When was your new baby born?**

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**39. Did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)?**

- No
- Yes
- I don't know

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**40. Why did your doctor, nurse, or other health care worker try to induce your labor (start your contractions using medicine)? Check ALL that apply**

	No	Yes
My water broke and there was a fear of infection	<input type="radio"/>	<input type="radio"/>
I was past my due date	<input type="radio"/>	<input type="radio"/>
My health care provider worried about the size of the baby	<input type="radio"/>	<input type="radio"/>
My baby was not doing well and needed to be born	<input type="radio"/>	<input type="radio"/>
I had a complication in my pregnancy (such as low amniotic fluid or preeclampsia)	<input type="radio"/>	<input type="radio"/>
I wanted to schedule my delivery	<input type="radio"/>	<input type="radio"/>
I wanted to give birth with a specific health care provider	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

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**41. How was your new baby delivered?**

- Vaginally
- Cesarean delivery (c-section)

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**42. What was the reason that your new baby was born by cesarean delivery (c-section)? Check ALL that apply**

	No	Yes
I had a previous cesarean delivery (c-section)	<input type="radio"/>	<input type="radio"/>
My baby was in the wrong position (such as breech)	<input type="radio"/>	<input type="radio"/>
I was past my due date	<input type="radio"/>	<input type="radio"/>
My health care provider worried that my baby was too big	<input type="radio"/>	<input type="radio"/>
I had a medical condition that made labor dangerous for me (such as heart condition, physical disability)	<input type="radio"/>	<input type="radio"/>
I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor)	<input type="radio"/>	<input type="radio"/>
My health care provider tried to induce my labor, but it didn't work	<input type="radio"/>	<input type="radio"/>
Labor was taking too long	<input type="radio"/>	<input type="radio"/>
The fetal monitor showed that my baby was having problems before or during labor (fetal distress)	<input type="radio"/>	<input type="radio"/>
I wanted to schedule my delivery	<input type="radio"/>	<input type="radio"/>
I didn't want to have my baby vaginally	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>


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I had a previous cesarean delivery (c-section)

My baby was in the wrong position (such as breech)

I was past my due date

My health care provider worried that my baby was too big

I had a medical condition that made labor dangerous for me (such as heart condition, physical disability)

I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor)

My health care provider tried to induce my labor, but it didn't work

Labor was taking too long

The fetal monitor showed that my baby was having problems before or during labor (fetal distress)


I wanted to schedule my delivery

I didn't want to have my baby vaginally

Other

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**43. After your baby was delivered, how long did he or she stay in the hospital?**

- Less than 24 hours (less than 1 day)
- 24 to 48 hours (1 to 2 days)
- 3 to 5 days
- 6 to 14 days
- More than 14 days
- My baby was not born in a hospital
- My baby is still in the hospital

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45%

**44. Is your baby alive now?**

No - *We are very sorry for your loss.*


Yes

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**45. Is your baby living with you now?**

No

Yes

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43%


**46. Before or after your new baby was born, did you receive information about breastfeeding from any of the following sources?** For each one, check **No** if you did not receive information from this source or **Yes** if you did.

- |   | No                    | Yes                              |
|---|-----------------------|----------------------------------|
| My doctor                                   | <input type="radio"/> | <input type="radio"/>            |
| A nurse, midwife, or doula                  | <input type="radio"/> | <input type="radio"/>            |
| A breastfeeding or lactation specialist     | <input type="radio"/> | <input type="radio"/>            |
| My baby's doctor or health care provider    | <input type="radio"/> | <input type="radio"/>            |
| A breastfeeding support group               | <input type="radio"/> | <input type="radio"/>            |
| A breastfeeding hotline or toll-free number | <input type="radio"/> | <input type="radio"/>            |
| Family or friends                           | <input type="radio"/> | <input type="radio"/>            |
| Other                                       | <input type="radio"/> | <input checked="" type="radio"/> |

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**47. Did you ever breastfeed or pump breast milk to feed your new baby, even for a short period of time?**

No

Yes

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45%

**48. What were your reasons for not breastfeeding your new baby? Check ALL that apply**

- |                                      | No                    | Yes                              |
|--------------------------------------|-----------------------|----------------------------------|
| I was sick or on medicine            | <input type="radio"/> | <input type="radio"/>            |
| I had other children to take care of | <input type="radio"/> | <input type="radio"/>            |
| I had too many household duties      | <input type="radio"/> | <input type="radio"/>            |
| I didn't like breastfeeding          | <input type="radio"/> | <input type="radio"/>            |
| I tried but it was too hard          | <input type="radio"/> | <input type="radio"/>            |
| I didn't want to                     | <input type="radio"/> | <input type="radio"/>            |
| I went back to work                  | <input type="radio"/> | <input type="radio"/>            |
| I went back to school                | <input type="radio"/> | <input type="radio"/>            |
| Other                                | <input type="radio"/> | <input checked="" type="radio"/> |

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45%

**49. After your new baby was born, did you receive the kinds of help with breastfeeding that are listed below?** For each one, check **No** if you did not receive this kind of breastfeeding help, or **Yes** if you did


	No	Yes
Someone to answer my questions	<input type="radio"/>	<input type="radio"/>
Help getting my baby positioned correctly	<input type="radio"/>	<input type="radio"/>
Help knowing if my baby was getting enough milk	<input type="radio"/>	<input type="radio"/>
Help with managing pain or bleeding nipples	<input type="radio"/>	<input type="radio"/>
Information about where to get a breast pump	<input type="radio"/>	<input type="radio"/>
Help using a breast pump	<input type="radio"/>	<input type="radio"/>
Information about breastfeeding support groups	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

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**50. Are you currently breastfeeding or feeding pumped milk to your new baby?**

No


Yes

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**51. How many weeks or months did you breastfeed or feed pumped milk to your baby?**


Less than 1 week

Weeks

Months

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**52. What were your reasons for stopping breastfeeding? Check ALL that apply**

	No	Yes
My baby had difficulty latching or nursing	<input type="radio"/>	<input type="radio"/>
Breast milk alone did not satisfy my baby	<input type="radio"/>	<input type="radio"/>
I thought my baby was not gaining enough weight	<input type="radio"/>	<input type="radio"/>
My nipples were sore, cracked, or bleeding or it was too painful	<input type="radio"/>	<input type="radio"/>
I thought I was not producing enough milk, or my milk dried up	<input type="radio"/>	<input type="radio"/>
I had too many other household duties	<input type="radio"/>	<input type="radio"/>
I felt it was the right time to stop breastfeeding	<input type="radio"/>	<input type="radio"/>
I got sick or I had to stop for medical reasons	<input type="radio"/>	<input type="radio"/>
I went back to work	<input type="radio"/>	<input type="radio"/>
I went back to school	<input type="radio"/>	<input type="radio"/>
My partner did not support breastfeeding	<input type="radio"/>	<input type="radio"/>
My baby was jaundiced (yellowing of the skin or whites of the eyes)	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

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**53. This question asks about things that may have happened at the hospital where your new baby was born. For each item, check **No** if it did not happen or **Yes** if it did.**

	No	Yes
Hospital staff gave me information about breastfeeding	<input type="radio"/>	<input type="radio"/>
My baby stayed in the same room with me at the hospital	<input type="radio"/>	<input type="radio"/>
I breastfed my baby in the hospital	<input type="radio"/>	<input type="radio"/>
Hospital staff helped me learn how to breastfeed	<input type="radio"/>	<input type="radio"/>
I breastfed in the first hour after my baby was born	<input type="radio"/>	<input type="radio"/>
My baby was placed in skin-to-skin contact within the first hour of life	<input type="radio"/>	<input type="radio"/>
My baby was fed only breast milk at the hospital	<input type="radio"/>	<input type="radio"/>
Hospital staff told me to breastfeed whenever my baby wanted	<input type="radio"/>	<input type="radio"/>
The hospital gave me a breast pump to use	<input type="radio"/>	<input type="radio"/>
The hospital gave me a gift pack with formula	<input type="radio"/>	<input type="radio"/>
The hospital gave me a telephone number to call for help with breastfeeding	<input type="radio"/>	<input type="radio"/>
Hospital staff gave my baby a pacifier	<input type="radio"/>	<input type="radio"/>
I was too sedated and I could not breastfeed during the first hour postpartum	<input type="radio"/>	<input type="radio"/>

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**54. How old was your new baby the first time he or she had liquids other than breast milk (such as formula, water, juice, or cow's milk)?**

- Weeks
- Months
- My baby was less than 1 week old
- My baby has not had any liquids other than breast milk


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**55. How old was your new baby the first time he or she ate food (such as baby cereal, baby food, or any other food)?**

Weeks


Months

My baby was less than 1 week old


My baby has not eaten any foods





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52%

**56. In which *one* position do you most often lay your baby down to sleep now?**  
Check ONE answer


- On his or her side
- On his or her back
- On his or her stomach

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58%

**57. In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed?**

- Always
- Often
- Sometimes
- Rarely
- Never


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60%


**58. When your new baby sleeps alone, is his or her crib or bed in the same room where you sleep?**

No

Yes

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**59. Listed below are some more things about how babies sleep. How did your new baby *usually* sleep in the past 2 weeks? For each item, check **No** if your baby did not *usually* sleep like this or **Yes** if he or she did.**

	No	Yes
In a crib, bassinet, or pack and play	<input type="radio"/>	<input type="radio"/>
On a twin or larger mattress or bed	<input type="radio"/>	<input type="radio"/>
On a couch, sofa, or armchair	<input type="radio"/>	<input type="radio"/>
In an infant car seat or swing	<input type="radio"/>	<input type="radio"/>
In a sleeping sack or wearable blanket	<input type="radio"/>	<input type="radio"/>
With a blanket	<input type="radio"/>	<input type="radio"/>
With toys, cushions, or pillows, including nursing pillows	<input type="radio"/>	<input type="radio"/>
With crib bumper pads (mesh or non-mesh)	<input type="radio"/>	<input type="radio"/>

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62%

**60. Did a doctor, nurse, or other health care worker tell you any of the following things?** For each thing, check **No** if they did not tell you or **Yes** if they did.

- |  | No                    | Yes                   |
|--|-----------------------|-----------------------|
| Place my baby on his or her back to sleep                    | <input type="radio"/> | <input type="radio"/> |
| Place my baby to sleep in a crib, bassinet, or pack and play | <input type="radio"/> | <input type="radio"/> |
| Place my baby's crib or bed in my room                       | <input type="radio"/> | <input type="radio"/> |
| What things should and should not go in bed with my baby     | <input type="radio"/> | <input type="radio"/> |


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**61. Has your new baby had a well-baby checkup?** A well-baby checkup is a regular health visit for your baby usually at 1, 2, 4, and 6 months of age.

No


Yes

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64%


**62. Are you or your husband or partner doing anything *now* to keep from getting pregnant?** Some things people do to keep from getting pregnant include having their tubes tied, using birth control pills, condoms, withdrawal, or natural family planning.

No

Yes

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**63. What are your reasons or your husband's or partner's reasons for not doing anything to keep from getting pregnant *now*? Check ALL that apply**

- |  | No                    | Yes                              |
|--|-----------------------|----------------------------------|
| I want to get pregnant                             | <input type="radio"/> | <input type="radio"/>            |
| I am pregnant now                                  | <input type="radio"/> | <input type="radio"/>            |
| I had my tubes tied or blocked                     | <input type="radio"/> | <input type="radio"/>            |
| I don't want to use birth control                  | <input type="radio"/> | <input type="radio"/>            |
| I am worried about side effects from birth control | <input type="radio"/> | <input type="radio"/>            |
| I am not having sex                                | <input type="radio"/> | <input type="radio"/>            |
| My husband or partner doesn't want to use anything | <input type="radio"/> | <input type="radio"/>            |
| I have problems paying for birth control           | <input type="radio"/> | <input type="radio"/>            |
| Other  | <input type="radio"/> | <input checked="" type="radio"/> |

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59%

**64. What kind of birth control are you or your husband or partner using now to keep from getting pregnant? Check ALL that apply**

	No	Yes
Tubes tied or blocked (female sterilization or Essure®)	<input type="radio"/>	<input type="radio"/>
Vasectomy (male sterilization)	<input type="radio"/>	<input type="radio"/>
Birth control pills	<input type="radio"/>	<input type="radio"/>
Condoms	<input type="radio"/>	<input type="radio"/>
Shots or injections (Depo-Provera®)	<input type="radio"/>	<input type="radio"/>
Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)	<input type="radio"/>	<input type="radio"/>
IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)	<input type="radio"/>	<input type="radio"/>
Contraceptive implant in the arm (Nexplanon® or Implanon®)	<input type="radio"/>	<input type="radio"/>
Natural family planning (including rhythm method)	<input type="radio"/>	<input type="radio"/>
Withdrawal (pulling out)	<input type="radio"/>	<input type="radio"/>
Not having sex (abstinence)	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

Please tell us:





	No	Yes
Tubes tied or blocked (female sterilization or Essure <sup>®</sup> )	<input type="radio"/>	<input type="radio"/>
Vasectomy (male sterilization)	<input type="radio"/>	<input type="radio"/>
Birth control pills	<input type="radio"/>	<input type="radio"/>
Condoms	<input type="radio"/>	<input type="radio"/>
Shots or injections (Depo-Provera <sup>®</sup> )	<input type="radio"/>	<input type="radio"/>
Contraceptive patch (OrthoEvra <sup>®</sup> ) or vaginal ring (NuvaRing <sup>®</sup> )	<input type="radio"/>	<input type="radio"/>
IUD (including Mirena <sup>®</sup> , ParaGard <sup>®</sup> , Liletta <sup>®</sup> , or Skyla <sup>®</sup> )	<input type="radio"/>	<input type="radio"/>
Contraceptive implant in the arm (Nexplanon <sup>®</sup> or Implanon <sup>®</sup> )	<input type="radio"/>	<input type="radio"/>
Natural family planning (including rhythm method)	<input type="radio"/>	<input type="radio"/>
Withdrawal (pulling out)	<input type="radio"/>	<input type="radio"/>
Not having sex (abstinence)	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>


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67%


**65. Since your new baby was born, have you had a postpartum checkup for yourself?** A postpartum checkup is the regular checkup a woman has about 4-6 weeks after she gives birth.

No

Yes


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68%

**66. During your postpartum checkup, did a doctor, nurse, or other health care worker do any of the following things?** For each item, check **No** if they did not do it or **Yes** if they did.


	No	Yes
Tell me to take a vitamin with folic acid	<input type="radio"/>	<input type="radio"/>
Talk to me about healthy eating, exercise, and losing weight gained during pregnancy	<input type="radio"/>	<input type="radio"/>
Talk to me about how long to wait before getting pregnant again	<input type="radio"/>	<input type="radio"/>
Talk to me about birth control methods I can use after giving birth	<input type="radio"/>	<input type="radio"/>
Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms	<input type="radio"/>	<input type="radio"/>
Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®)	<input type="radio"/>	<input type="radio"/>
Ask me if I was smoking cigarettes	<input type="radio"/>	<input type="radio"/>
Ask me if someone was hurting me emotionally or physically	<input type="radio"/>	<input type="radio"/>
Ask me if I was feeling down or depressed	<input type="radio"/>	<input type="radio"/>
Test me for diabetes	<input type="radio"/>	<input type="radio"/>

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69%

**67. Since your new baby was born, how often have you felt down, depressed, or hopeless?**


- Always
- Often
- Sometimes
- Rarely
- Never

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**68. Since your new baby was born, how often have you had little interest or little pleasure in doing things you usually enjoyed?**


- Always
- Often
- Sometimes
- Rarely
- Never

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71%


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65%

**69. During your most recent pregnancy, did any of the following things happen to you?** For each thing, check **No** if it did not happen to you or **Yes** if it did.

	No	Yes
My husband or partner tried to control my daily activities, for example, controlling who I could talk to or where I could go	<input type="radio"/>	<input type="radio"/>
My husband or partner forced me to take part in touching or any sexual activity when I did not want to	<input type="radio"/>	<input type="radio"/>
My husband or partner threatened to take my child/children away from me	<input type="radio"/>	<input type="radio"/>

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**70. During your most recent pregnancy, did you take or use any of the following drugs for any reason?** Your answers are strictly confidential. For each item, check **No** if you did not use it or **Yes** if you did.

	No	Yes
Over-the-counter pain relievers such as aspirin, Tylenol®, Advil®, or Aleve®	<input type="radio"/>	<input type="radio"/>
Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine	<input type="radio"/>	<input type="radio"/>
Adderall®, Ritalin®, or another stimulant	<input type="radio"/>	<input type="radio"/>
Marijuana or hash	<input type="radio"/>	<input type="radio"/>
Synthetic marijuana (K2, Spice)	<input type="radio"/>	<input type="radio"/>
Methadone, naloxone, subutex, or Suboxone®	<input type="radio"/>	<input type="radio"/>
Heroin (smack, junk, Black Tar, <i>Chiva</i> )	<input type="radio"/>	<input type="radio"/>
Amphetamines (uppers, speed, crystal meth, crank, ice, <i>agua</i> )	<input type="radio"/>	<input type="radio"/>
Cocaine (crack, rock, coke, blow, snow, <i>nieve</i> )	<input type="radio"/>	<input type="radio"/>
Tranquilizers (downers, ludes)	<input type="radio"/>	<input type="radio"/>
Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts)	<input type="radio"/>	<input type="radio"/>
Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing)	<input type="radio"/>	<input type="radio"/>


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71. During any of your prenatal care visits, did a health care worker talk with you about the risks and benefits of vaginal (natural) versus cesarean delivery?


No

Yes

I did not get prenatal care

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68%

**The next questions are about the time during the 12 months before your new baby was born.**

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74%


**72. During the 12 months before your new baby was born, what was your yearly total household income before taxes?** Include your income, your husband's or partner's income, and any other income you may have received. *All information will be kept private* and will not affect any services you are now getting.

- \$0 to \$16,000
- \$16,001 to \$20,000
- \$20,001 to \$24,000
- \$24,001 to \$28,000
- \$28,001 to \$32,000
- \$32,001 to \$40,000
- \$40,001 to \$48,000
- \$48,001 to \$57,000
- \$57,001 to \$60,000
- \$60,001 to \$73,000
- \$73,001 to \$85,000
- \$85,001 or more

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partner's income, and any other income you may have received. *All information will be kept private* and will not affect any services you are now getting.


- \$0 to \$16,000
- \$16,001 to \$20,000
- \$20,001 to \$24,000
- \$24,001 to \$28,000
- \$28,001 to \$32,000
- \$32,001 to \$40,000
- \$40,001 to \$48,000
- \$48,001 to \$57,000
- \$57,001 to \$60,000
- \$60,001 to \$73,000
- \$73,001 to \$85,000
- \$85,001 or more





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69%

**73. During the 12 months before your new baby was born, how many people, including yourself, depended on this income?**

Number of people:


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

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70%


**These next questions are about your experiences with prenatal care, delivery, postpartum care, and infant care during the COVID-19 pandemic.**

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76%

**CV1. During the COVID-19 pandemic, which types of prenatal care appointments did you attend?**

- In-person appointments only
- Virtual appointments (video or telephone) only
- Both, in-person and virtual appointments
- I did not have prenatal care


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80%

**CV2. What are the reasons that you did not attend virtual appointments for prenatal care?** For each one, check **No** if it was not a reason or **Yes** if it was.

	No	Yes
a. Lack of availability of virtual appointments from my provider	<input type="radio"/>	<input type="radio"/>
b. Lack of an available telephone to use for appointments	<input type="radio"/>	<input type="radio"/>
c. Lack of enough cellular data or cellular minutes	<input type="radio"/>	<input type="radio"/>
d. Lack of a computer or device	<input type="radio"/>	<input type="radio"/>
e. Lack of internet service or had unreliable internet	<input type="radio"/>	<input type="radio"/>
f. Lack of a private or confidential space to use	<input type="radio"/>	<input type="radio"/>
g. I preferred seeing my health care provider in person	<input type="radio"/>	<input type="radio"/>
h. Other reason	<input type="radio"/>	<input checked="" type="radio"/>


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89%

**CV3. Were any of your prenatal care appointments canceled or delayed during the COVID-19 pandemic due to the following reasons? For each one, check **No** if your appointments were not canceled or delayed for that reason or **Yes** if they were.**

	No	Yes
a. My appointments were canceled or delayed because my provider's office was closed or had reduced hours	<input type="radio"/>	<input type="radio"/>
b. I canceled or delayed because I was afraid of being exposed to COVID-19 during the appointments	<input type="radio"/>	<input type="radio"/>
c. I canceled or delayed because I lost my health insurance during the COVID-19 pandemic	<input type="radio"/>	<input type="radio"/>
d. I canceled or delayed because I had problems finding care for my children or other family members	<input type="radio"/>	<input type="radio"/>
e. I canceled or delayed because I was worried about taking public transportation and had no other way to get there	<input type="radio"/>	<input type="radio"/>
f. My appointments were canceled or delayed because I had to self-isolate due to possible COVID-19 exposure or infection	<input type="radio"/>	<input type="radio"/>

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90%

**CV4. While you were pregnant, how often did you do the following things to avoid getting COVID-19?**

For each one, check: **A** if you *always* did it, **S** if you *sometimes* did it, or **N** if you *never* did it.

	<b>A</b>	<b>S</b>	<b>N</b>
a. Avoided gatherings of more than 10 people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Stayed at least 6 feet (2 meters) away from others when I left my home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Only left my home for essential reasons	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Made trips as short as possible when I left my home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Avoided having visitors inside my home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Wore a mask or a cloth face covering when out in public	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Washed hands for 20 seconds with soap and water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Used alcohol-based hand sanitizer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Covered coughs and sneezes with a tissue or my elbow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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91%

**CV5. While you were pregnant during the COVID-19 pandemic, did you have any of the following experiences? For each one, check **No** if you did not or **Yes** if you did.**

	No	Yes
a. I had responsibilities or a job that prevented me from staying home	<input type="radio"/>	<input type="radio"/>
b. Someone in my household had a job that required close contact with other people	<input type="radio"/>	<input type="radio"/>
c. When I went out, I found that other people around me did not practice social distancing	<input type="radio"/>	<input type="radio"/>
d. I had trouble getting disinfectant to clean my home	<input type="radio"/>	<input type="radio"/>
e. I had trouble getting hand sanitizer or hand soap for my household	<input type="radio"/>	<input type="radio"/>
f. I had trouble getting or making masks or cloth face coverings	<input type="radio"/>	<input type="radio"/>
g. It was hard for me to wear a mask or cloth face covering (trouble breathing, claustrophobia)	<input type="radio"/>	<input type="radio"/>
h. I was told by a health care provider that I had COVID-19	<input type="radio"/>	<input type="radio"/>
i. Someone in my household was told by a health care provider that they had COVID-19	<input type="radio"/>	<input type="radio"/>

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**CV6. Who was with you in the hospital delivery room as a support person during your labor and delivery?**

- |  | No                    | Yes                              |
|--|-----------------------|----------------------------------|
| My husband or partner                                    | <input type="radio"/> | <input type="radio"/>            |
| Another family member or friend                          | <input type="radio"/> | <input type="radio"/>            |
| A doula  | <input type="radio"/> | <input type="radio"/>            |
| Some other support person (not including hospital staff) | <input type="radio"/> | <input checked="" type="radio"/> |


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The hospital did not allow me to have any support people  **No**  **Yes**

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**CV7. While in the hospital after your delivery, did any of the following things happen to you and your baby because of COVID-19?** For each one, check **No** if it did not happen or **Yes** if it did.

	No	Yes
a. My baby was tested for COVID-19 in the hospital	<input type="radio"/>	<input type="radio"/>
b. I was separated from my baby in the hospital after delivery <u>to protect my baby from COVID-19</u>	<input type="radio"/>	<input type="radio"/>
c. I wore a mask when other people came into my hospital room	<input type="radio"/>	<input type="radio"/>
d. I wore a mask while I was alone caring for my baby in the hospital	<input type="radio"/>	<input type="radio"/>
e. I was given information about how to protect my baby from COVID-19 when I went home	<input type="radio"/>	<input type="radio"/>


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94%

**CV8. Did the COVID-19 pandemic affect breastfeeding for you and your baby in any of the following ways?** For each one, check **No** if it did not apply to you or **Yes** if it did.


	No	Yes
a. I was given information in the hospital about how to protect my baby from infection while breastfeeding	<input type="radio"/>	<input type="radio"/>
b. I wore a mask while breastfeeding in the hospital	<input type="radio"/>	<input type="radio"/>
c. I pumped breast milk in the hospital so someone else could feed my baby to avoid him or her getting infected	<input type="radio"/>	<input type="radio"/>
d. Due to COVID-19, I had trouble getting a visit from a lactation specialist while I was in the hospital	<input type="radio"/>	<input type="radio"/>

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**CV9. In what ways did the COVID-19 pandemic affect your baby's routine health care?** For each one, check **No** if the pandemic did not affect your baby's health care in this way or **Yes** if it did.


	No	Yes
a. My baby's well visits or checkups were canceled or delayed	<input type="radio"/>	<input type="radio"/>
b. My baby's well visits or checkups were changed from in-person visits to virtual appointments (video or telephone)	<input type="radio"/>	<input type="radio"/>
c. My baby's immunizations were postponed	<input type="radio"/>	<input type="radio"/>

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**CV10. During the COVID-19 pandemic, which types of *postpartum* appointments did you attend for yourself?**

- In-person appointments only
- Virtual appointments (video or telephone) only
- Both, in-person and virtual appointments
- I did not have any postpartum appointments for myself

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**CV11. Did any of the following things happen to you due to the COVID-19 pandemic? For each one, check **No** if it did not happen or **Yes** if it did.**

	No	Yes
a. I lost my job or had a cut in work hours or pay	<input type="radio"/>	<input type="radio"/>
b. Other members of my household lost their jobs or had a cut in work hours or pay	<input type="radio"/>	<input type="radio"/>
c. I had problems paying the rent, mortgage, or other bills	<input type="radio"/>	<input type="radio"/>
d. A member of my household or I received unemployment benefits	<input type="radio"/>	<input type="radio"/>
e. I had to move or relocate	<input type="radio"/>	<input type="radio"/>
f. I became homeless	<input type="radio"/>	<input type="radio"/>
g. The loss of childcare or school closures made it difficult to manage all my responsibilities	<input type="radio"/>	<input type="radio"/>
h. I had to spend more time than usual taking care of children or other family members	<input type="radio"/>	<input type="radio"/>
i. I worried whether our food would run out before I got money to buy more	<input type="radio"/>	<input type="radio"/>
j. I felt more anxious than usual	<input type="radio"/>	<input type="radio"/>
k. I felt more depressed than usual	<input type="radio"/>	<input type="radio"/>
l. My husband or partner and I had more verbal arguments or conflicts than usual	<input type="radio"/>	<input type="radio"/>
m. My husband or partner was more physically, sexually, or emotionally aggressive towards me	<input type="radio"/>	<input type="radio"/>



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**These next questions are about the COVID-19 vaccine.**

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**VC1. During your most recent pregnancy, did a doctor, nurse, or other health care worker do any of the following things?** For each one, check **No** if they did not do it or **Yes** if they did.


	No	Yes
a. Talked with me about the COVID-19 vaccine	<input type="radio"/>	<input type="radio"/>
b. Recommended that I get the COVID-19 vaccine	<input type="radio"/>	<input type="radio"/>
c. Offered to give me the COVID-19 vaccine	<input type="radio"/>	<input type="radio"/>
d. Referred me to another place to get the COVID-19 vaccine	<input type="radio"/>	<input type="radio"/>

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**VC2. During your most recent pregnancy, did you get at least one shot or dose of a COVID-19 vaccine?**

No  
 Yes

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**VC3. What were your reasons for not getting a COVID-19 vaccine during your most recent pregnancy?**

- |  | No                    | Yes                   |
|--|-----------------------|-----------------------|
| a. I was not in one of the groups that could get the COVID-19 vaccine                          | <input type="radio"/> | <input type="radio"/> |
| b. The vaccine was not available or ran out in my area   | <input type="radio"/> | <input type="radio"/> |
| c. I couldn't get an appointment or was placed on a waiting list                               | <input type="radio"/> | <input type="radio"/> |
| d. I didn't have transportation to get to a vaccination site                                   | <input type="radio"/> | <input type="radio"/> |
| e. The staff at the vaccination site didn't want to give me the vaccine because I was pregnant | <input type="radio"/> | <input type="radio"/> |
| f. I was concerned about possible side effects of the COVID-19 vaccine for my baby             | <input type="radio"/> | <input type="radio"/> |
| g. I was concerned about possible side effects of the COVID-19 vaccine for me                  | <input type="radio"/> | <input type="radio"/> |
| h. I have an allergy or health condition that prevented me from getting the vaccine            | <input type="radio"/> | <input type="radio"/> |
| i. My doctor or healthcare provider told me not to get the vaccine                             | <input type="radio"/> | <input type="radio"/> |
| j. I had gotten the COVID-19 vaccine <i>before</i> my pregnancy                                | <input type="radio"/> | <input type="radio"/> |
| k. I already had COVID-19  | <input type="radio"/> | <input type="radio"/> |
| l. I didn't have enough information about the vaccine to feel comfortable getting it           | <input type="radio"/> | <input type="radio"/> |
| m. I was concerned that the COVID-19 vaccine was developed too fast                            | <input type="radio"/> | <input type="radio"/> |
| n. I didn't think the vaccine would protect me against COVID-19                                | <input type="radio"/> | <input type="radio"/> |
| o. I didn't think COVID-19 was a serious illness   | <input type="radio"/> | <input type="radio"/> |
| p. I didn't think I was at risk for COVID-19 infection   | <input type="radio"/> | <input type="radio"/> |



h. I have an allergy or health condition that prevented me from getting the vaccine

i. My doctor or healthcare provider told me not to get the vaccine

j. I had gotten the COVID-19 vaccine *before* my pregnancy

k. I already had COVID-19

l. I didn't have enough information about the vaccine to feel comfortable getting it

m. I was concerned that the COVID-19 vaccine was developed too fast

n. I didn't think the vaccine would protect me against COVID-19

o. I didn't think COVID-19 was a serious illness

p. I didn't think I was at risk for COVID-19 infection

q. I preferred using masks and other precautions instead

r. I don't think vaccines are beneficial


s. Other reason

What was the reason? \_\_\_\_\_

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**VC4. Since your new baby was born, have you gotten a COVID-19 vaccine?**

No


Yes

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**VC5. Which ONE of these sources do you trust the *most* for receiving information about the COVID-19 vaccine?**

- My doctor, nurse, or other health care provider
- My pharmacist
- Centers for Disease Control and Prevention (CDC) website or reports
- Food and Drug Administration (FDA) website or reports
- My state or local health department
- Family or friends
- News reports such as television or radio news
- Social media sites like Facebook
- Websites about health or other topics → Please tell us which sites in the space below
- Some other source → Please tell us which source in the space below

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- Food and Drug Administration (FDA) website or reports
- My state or local health department
- Family or friends
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- Social media sites like Facebook
- Websites about health or other topics → Please tell us which sites in the space below
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Please tell us which **websites**

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- My state or local health department
- Family or friends
- News reports such as television or radio news
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**VC6. Which of the following describes your work or volunteer activities during your most recent pregnancy?**


	No	Yes
a. I worked or volunteered providing direct medical care to patients (such as being a doctor, nurse, dentist, therapist, home health care provider, emergency responder)	<input type="radio"/>	<input type="radio"/>
b. I worked or volunteered in a health care setting, but <u>not</u> providing direct medical care to patients (such as being administrative staff, cleaning staff, patient transport, ward clerk)	<input type="radio"/>	<input type="radio"/>
c. I worked or volunteered in a position where I regularly came into contact with the public (such as education, grocery or retail stores, public transportation, restaurants or food service, law enforcement, postal or delivery services)	<input type="radio"/>	<input type="radio"/>
d. I worked or volunteered in a position where I did <u>not</u> regularly come in contact with the public	<input type="radio"/>	<input type="radio"/>

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**No Yes**  
e. None of the above

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Please use this space for any additional comments you would like to make about your experiences around the time of your pregnancy or the health of mothers and babies in Puerto Rico.


Note: Pressing the "Enter" key will close the comment entry box and end the survey. If you want a new line in the comment, press Shift+Enter.

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Thanks for answering our questions. Your answers will help us work to make Puerto Rico mothers and babies healthier. Goodbye.

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