


# Virginia PRAMS Grantee Web Questionnaire

## In PRAMS Integrated Data Collection System [PIDS]

The screenshot shows a web browser window with the URL `prams-test.cdc.gov`. The page header features the CDC logo and the text "Department of Health and Human Services Centers for Disease Control and Prevention". A warning banner is present, followed by a main heading: "Welcome to Pregnancy Risk Assessment Monitoring System (PRAMS) Survey". Below the heading is a progress indicator with three steps, where step 1 is active. The instruction reads: "Please enter the User ID and Passcode that were provided in your letter." The form contains two input fields: "User ID \*" and "Passcode \*", and a "Next" button.

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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 \*


Next



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

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


Public reporting of this collection of information is estimated to average 25-42 minutes per response, including the time for reviewing instructions 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 current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-1273)

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

1 2 3

Please confirm your year of birth.

Mother's Year Of Bir... ▾

Email Address (optional)

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Choose a language:

- English
- Spanish

Next





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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 Virginia Department of Public Health.

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

We are asking 2,000 women in Virginia to answer the same questions. All of your names were picked by a computer from recent birth certificates.

It takes about 25-42 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





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 Virginia.

If you have any questions about your rights in the project, please call Janice Hicks, PhD at 804-864-7675.

If you have questions about PRAMS, please contact us at 1-877-897-7267 or PRAMS@vdh.virginia.gov.

I have read the information above and agree to continue 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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0%

**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"/>

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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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**7. 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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**8. 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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**9. 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"/>            |
| Private health insurance from the Health Insurance Marketplace or HealthCare.gov | <input type="radio"/> | <input type="radio"/>            |
| Medicaid, FAMIS, or FAMIS MOMS   | <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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**10. What was the reason that you did not have any health insurance during the month before you got pregnant with your new baby? 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 (or FAMIS/FAMIS MOMS)	<input type="radio"/>	<input type="radio"/>
My income was too high to qualify for a tax credit from the Health Insurance Marketplace or HealthCare.gov	<input type="radio"/>	<input type="radio"/>
I didn't know how to get health insurance	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

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**Did you go for prenatal care?**

No

Yes

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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"/>            |
| Private health insurance from the Health Insurance Marketplace or HealthCare.gov | <input type="radio"/> | <input type="radio"/>            |
| Medicaid, FAMIS, or FAMIS MOMS   | <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 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"/>            |
| Private health insurance from the Health Insurance Marketplace or HealthCare.gov | <input type="radio"/> | <input type="radio"/>            |
| Medicaid, FAMIS, or FAMIS MOMS   | <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*


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 Yes

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**13. 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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**14. When you got pregnant with your new baby, were you trying to get pregnant?**

No


Yes

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**15. When you got pregnant with your new baby, were you or your husband or partner doing anything 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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15%

**16. What method of birth control were you using when you got pregnant? Check ALL that apply**

- |  | No                    | Yes                              |
|--|-----------------------|----------------------------------|
| 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 implant in the arm (Nexplanon® or Implanon®)   | <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"/>            |
| Natural family planning (including rhythm method)            | <input type="radio"/> | <input type="radio"/>            |
| Withdrawal (pulling out)                                     | <input type="radio"/> | <input type="radio"/>            |
| Other  | <input type="radio"/> | <input checked="" type="radio"/> |


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16%


**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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**17. 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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**18. Did you get prenatal care as early in your pregnancy as you wanted?**

No  
 Yes


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**19. Did any of these things keep you from getting prenatal care when you wanted it? For each item, check **No** if it did not keep you from getting prenatal care or **Yes** if it did.**

	No	Yes
I couldn't get an appointment when I wanted one	<input type="radio"/>	<input type="radio"/>
I didn't have enough money or insurance to pay for my visits	<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"/>
The doctor or my health plan would not start care as early as I wanted	<input type="radio"/>	<input type="radio"/>
I had too many other things going on	<input type="radio"/>	<input type="radio"/>
I couldn't take time off from work or school	<input type="radio"/>	<input type="radio"/>
I didn't have my Medicaid (or FAMIS/FAMIS MOMS) card	<input type="radio"/>	<input type="radio"/>
I didn't have anyone to take care of my children	<input type="radio"/>	<input type="radio"/>
I didn't know that I was pregnant	<input type="radio"/>	<input type="radio"/>
I didn't want anyone else to know I was pregnant	<input type="radio"/>	<input type="radio"/>
I didn't want prenatal care	<input type="radio"/>	<input type="radio"/>


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**20. 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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**21. How did the doctor, nurse, or other health care worker who provided your prenatal care suggest you deliver your new baby? Check ONE answer**


- He or she suggested I deliver my baby vaginally (naturally)
- He or she suggested I have a cesarean delivery (c-section)
- He or she didn't suggest how I deliver my baby

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**22. 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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**23. 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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24%

**24. During *your most recent* pregnancy, did you get a Tdap shot or vaccination? A Tdap vaccination is a tetanus booster shot that also protects against pertussis (whooping cough).**


No

Yes


I don't know

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

No  
 Yes


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**26. 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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**27. 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 (or FAMIS/FAMIS MOMS) 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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28%

**28. During *your most recent* pregnancy, did a home visitor come to your home to help you prepare for your new baby?** A home visitor is a nurse, a health care worker, a social worker, or other person who works for a program that helps pregnant women.

No  
 Yes


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**29. During your most recent pregnancy, did the home visitor who came to your home talk with you about any of the things listed below?** For each one, check **No** if they did not talk with you about it or **Yes** if they did.


	No	Yes
How smoking during pregnancy could affect my baby	<input type="radio"/>	<input type="radio"/>
How drinking alcohol during pregnancy 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 importance of getting tested for HIV or other sexually transmitted infections	<input type="radio"/>	<input type="radio"/>
Physical or emotional abuse to women by their husbands or partners	<input type="radio"/>	<input type="radio"/>
Breastfeeding my baby	<input type="radio"/>	<input type="radio"/>
My emotional well-being	<input type="radio"/>	<input type="radio"/>

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**30. 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"/>
Anxiety	<input type="radio"/>	<input type="radio"/>

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

No


Yes

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33%

**33. 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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34%

**34. 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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**35. During your most recent pregnancy, did you do any of the following things about quitting smoking?** For each thing, check **No** if you did not do it or **Yes** if you did.

	No	Yes
Set a specific date to stop smoking	<input type="radio"/>	<input type="radio"/>
Use booklets, videos, or other materials to help me quit	<input type="radio"/>	<input type="radio"/>
Call a national or state quit line or go to a website	<input type="radio"/>	<input type="radio"/>
Attend a class or program to stop smoking	<input type="radio"/>	<input type="radio"/>
Go to counseling for help with quitting	<input type="radio"/>	<input type="radio"/>
Use a nicotine patch, gum, lozenge, nasal spray or inhaler	<input type="radio"/>	<input type="radio"/>
Take a pill like Zyban® (also known as Wellbutrin® or bupropion) to stop smoking	<input type="radio"/>	<input type="radio"/>
Take a pill like Chantix® (also known as varenicline) to stop smoking	<input type="radio"/>	<input type="radio"/>
Try to quit on my own (e.g., cold turkey)	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input checked="" type="radio"/>

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**36. 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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37%

**37. Which of the following statements best describes the rules about smoking *inside* your home during *your most recent* pregnancy, even if no one who lived in your home was a smoker? Check ONE answer**


- No one was allowed to smoke anywhere inside my home
- Smoking was allowed in some rooms or at some times
- Smoking was permitted anywhere inside my home

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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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38%

**38. 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"/>

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**39. 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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41%

**40. 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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**41. 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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**42. 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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44%

**43. During the *last 3 months* of your pregnancy, 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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**44. During the 12 months before your new baby was born, how often did you feel unsafe in the neighborhood where you lived?**


- Always
- Often
- Sometimes
- Rarely
- Never

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46%

**45. During the 12 months before your new baby was born, did you feel emotionally upset (for example, angry, sad, or frustrated) as a result of how you were treated based on your race?**


No  
 Yes

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47%

**46. 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"/>
Someone else	<input type="radio"/>	<input type="radio"/>

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**47. 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"/>
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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**48. When was your new baby born?**


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

- Vaginally
- Cesarean delivery (c-section)


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**50. 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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**51. Is your baby alive now?**

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

Yes


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

No

Yes

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54%


**53. 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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55%


**54. 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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**55. 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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56%


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

No


Yes

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**57. 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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**58. 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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58%

**59. What kind of health insurance is your new baby covered by 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"/>            |
| Private health insurance from the Health Insurance Marketplace or HealthCare.gov | <input type="radio"/> | <input type="radio"/>            |
| Medicaid, FAMIS, or FAMIS MOMS   | <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 any health insurance for my new baby


- No
- Yes

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**60. Have you ever heard or read about what can happen if a baby is shaken?**

No

Yes

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**61. 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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**62. 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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**63. 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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**64. 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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**65. 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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**66. Since your new baby was born, has a home visitor come to your home to help you learn how to take care of yourself or your new baby?** A home visitor is a nurse, a health care worker, a social worker, or other person who works for a program that helps mothers of newborns.

No

Yes


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**67. Since your new baby was born, did the home visitor who came to your home talk with you about any of the things listed below?** For each one, check **No** if they did not talk with you about it or **Yes** if they did.

	No	Yes
Breastfeeding my baby	<input type="radio"/>	<input type="radio"/>
How long to wait before getting pregnant again	<input type="radio"/>	<input type="radio"/>
Family planning services or using contraception	<input type="radio"/>	<input type="radio"/>
Postpartum depression	<input type="radio"/>	<input type="radio"/>
Resources in my community to support new parents	<input type="radio"/>	<input type="radio"/>
Getting to and staying at a healthy weight after delivery	<input type="radio"/>	<input type="radio"/>
How to quit or keep from smoking	<input type="radio"/>	<input type="radio"/>
How to get the health care that my baby or I need	<input type="radio"/>	<input type="radio"/>


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**68. 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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**69. 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"/> |

Please tell us:





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**70. 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 <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"/>

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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**71. 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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**72. Did any of these things keep you from having a postpartum checkup? 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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**73. 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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**74. Since your new baby was born, how often have you felt down, depressed, or hopeless?**

- Always
- Often
- Sometimes
- Rarely
- Never


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**75. 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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**The next questions are on a variety of topics.**


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**76. During the 12 months before your new baby was born, did you experience discrimination, harassment, or were you made to feel inferior because of the things listed below?** For each item, check **No** if you did not experience these things or **Yes** if you did experience them.


	No	Yes
My race, ethnicity or culture	<input type="radio"/>	<input type="radio"/>
My insurance or Medicaid status	<input type="radio"/>	<input type="radio"/>
My weight	<input type="radio"/>	<input type="radio"/>
My marital status	<input type="radio"/>	<input type="radio"/>

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**77. During any of the following time periods, did your husband or partner threaten you, limit your activities against your will, or make you feel unsafe in any other way? For each time period, check **No** if it did not happen then or **Yes** if it did.**


	No	Yes
During the 12 months before I got pregnant	<input type="radio"/>	<input type="radio"/>
During my most recent pregnancy	<input type="radio"/>	<input type="radio"/>
Since my new baby was born	<input type="radio"/>	<input type="radio"/>

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**78. Did you try to get Medicaid, FAMIS, or FAMIS MOMS coverage during *your most recent* pregnancy?**

No

Yes

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**79. Did you have any problems getting Medicaid, FAMIS, or FAMIS MOMS during *your most recent pregnancy?***

No

Yes


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**80. Did you worry that wearing your seat belt during pregnancy would hurt your new baby?**

No

Yes


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84%

**81. Please tell us if you have heard of the following Virginia programs.** For each item, check **No** if you have not heard about it or **Yes** if you have.

	No	Yes
Quit Now Virginia (1- 800-Quit-Now)	<input type="radio"/>	<input type="radio"/>
2-1-1 Virginia	<input type="radio"/>	<input type="radio"/>
Text4Baby	<input type="radio"/>	<input type="radio"/>
Virginia Department of Health Family Planning Clinics	<input type="radio"/>	<input type="radio"/>
Care Connection for Children	<input type="radio"/>	<input type="radio"/>
Loving Steps / Healthy Start	<input type="radio"/>	<input type="radio"/>
Nurse - Family Partnership (NFP)	<input type="radio"/>	<input type="radio"/>
Healthy Families	<input type="radio"/>	<input type="radio"/>
Part C Early Intervention	<input type="radio"/>	<input type="radio"/>
Project LINK	<input type="radio"/>	<input type="radio"/>
CHIP of Virginia	<input type="radio"/>	<input type="radio"/>
Safety Seat Check Station	<input type="radio"/>	<input type="radio"/>
Low Income Safety Seat Program	<input type="radio"/>	<input type="radio"/>
Head Start	<input type="radio"/>	<input type="radio"/>
Early Head Start	<input type="radio"/>	<input type="radio"/>

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


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

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


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**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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88%

**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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**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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**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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**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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**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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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 Virginia.

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 Virginia mothers and babies healthier. Goodbye.

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