



Pregnancy Risk Assessment Monitoring System

**A survey for healthier babies
in New Jersey**

Your experiences as a new mother
are important.

For questions or comments,
please call toll-free 1-888-816-7929



Important Information About PRAMS

Please Read Before Starting the Survey

- The Pregnancy Risk Assessment Monitoring System (PRAMS) is a research project conducted by the Bloustein Center for Survey Research at Rutgers University on behalf of the New Jersey Department of Health with support from the Centers for Disease Control and Prevention.
- The purpose of the study is to find out why some babies are born healthy and others are not.
- We are asking approximately 145 women per month in New Jersey to answer the same questions. All of your names were picked randomly 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, drinking and domestic violence 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 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 proceedings, even if a court orders us to do so, unless you say it's okay. Your responses will be stripped of all personal identifiers. All computerized records will be encrypted or scrambled and kept in a secure, password-protected database at the CDC. There is a very small risk of loss of confidentiality.
- 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. The booklet has a number so we will know when it is returned.
- 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 New Jersey.
- If you have any questions about your rights in the project, please call the Rowan University IRB Office at 856-566-2712.

If you have questions about PRAMS, or if you want to answer the questions by telephone, please call Marie Fama-McDermott, New Jersey PRAMS Project Coordinator, at toll free 1-888-816-7929 (press 6) or e-mail: NJPRAMS@bcsr.rutgers.edu



Questions Commonly Asked About PRAMS

What is PRAMS?

PRAMS (Pregnancy Risk Assessment Monitoring System) is a joint research project between the New Jersey Department of Health, the Centers for Disease Control and Prevention (CDC), and the Bloustein Center for Survey Research (BCSR) at Rutgers University. Information from PRAMS is used to help plan better health programs for New Jersey mothers and infants – such as improving access to high quality prenatal care, reduction of smoking during pregnancy, and encouraging breastfeeding. To do this, our questionnaire asks new mothers questions about their behaviors and experiences around the time of their pregnancy.

Will my answers be kept private?

Yes—all answers are kept completely private and will only be used to answer questions related to the purpose of this study. All answers given on the questionnaires will be grouped together to give us information on New Jersey mothers of new babies. In reports from this survey, no woman will be identified by name.

Is it really important that I answer these questions?

Yes! Because of the small number of mothers picked, it is important to have everyone's answers. Every pregnancy is different. To get a better overall picture of the health of mothers and

babies in New Jersey we need each mother selected to answer the questions. From the information you give us, we may be able to improve health care for women and children in New Jersey. We need to know what went *right* as well as what went wrong during your pregnancy. Your help is really important to the success of our program.

Some of the questions do not seem related to health care—why are they asked?

Many things in a mother's life may affect her pregnancy. These questions try to get the best picture of the new mother's health care and things that happened to her during pregnancy.

How was I chosen to participate in PRAMS?

Your name was picked by chance, like in a lottery, from the state birth certificate registry. You are one of a small number of women who were chosen to help us in this study.

What if I want to ask more questions about PRAMS?

Please call us at our toll-free number 1-888-816-7929 (press 6) and we will be happy to answer any other questions that you may have about PRAMS. If you prefer to complete the questionnaire over the telephone, please call us on the same number.

Please check the box next to your answer or follow the directions included with the question. You may be asked to skip some questions that do not apply to you.

BEFORE PREGNANCY

The first questions are about *you*.

1. What is *your* date of birth?

<input style="width: 100%; height: 30px; border: 1px solid black;" type="text"/> /	<input style="width: 100%; height: 30px; border: 1px solid black;" type="text"/> /	<input style="width: 100%; height: 30px; border: 1px solid black;" type="text"/>
Month	Day	Year

2. Before you got pregnant, did you...?

For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Have serious difficulty hearing, or are you deaf? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have serious difficulty seeing, even when wearing glasses, or are you blind? .. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have serious difficulty walking or climbing stairs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have difficulty with dressing or bathing yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have difficulty doing errands alone such as visiting a doctor's office or shopping because of a physical, mental, or emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about the time ***before*** you got pregnant.

3. 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 |
|--|--------------------------|--------------------------|
| a. Type 1 or Type 2 diabetes (not gestational diabetes or diabetes that starts during pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure or hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Anemia (poor blood, low iron) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Epilepsy (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| i. PCOS (polycystic ovarian syndrome) | <input type="checkbox"/> | <input type="checkbox"/> |

4. 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 at all
- 1 to 3 times a week
- 4 to 6 times a week
- Every day of the week

5. In the 12 months before you got pregnant with your new baby, did you have any of the following healthcare visits?

For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Regular checkup with a family doctor..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Regular checkup with an OB/GYN | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Visit for an injury, illness, or chronic condition | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Visit to urgent care or the emergency room..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Visit for family planning or to get birth control | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Visit for depression or anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Visit to have my teeth cleaned | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

If you had any healthcare visits in the 12 months before you got pregnant, go to Question 7.

6. Why didn't you have any healthcare visits in the 12 months before you got pregnant with your new baby?

Check ALL that apply

- I didn't know I needed one
- I didn't have enough money or insurance to pay for the visit
- I felt fine and didn't think I needed to have a visit
- I couldn't get an appointment when I wanted one
- I didn't have any transportation to get to the clinic or doctor's office
- I had too many other things going on
- I couldn't take time off from work or school
- I didn't have anyone to take care of my children
- The doctor's office was too far away
- Other → Please tell us:

If you did not have any healthcare visits, go to Question 8.

7. During any of your healthcare visits in the 12 months before you got pregnant, did a healthcare provider do any of the following things? For each one, check **No or **Yes**.**

Talk to me about...

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. My weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Regularly checking my blood pressure.... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My desire to have or not have children.... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Birth control methods | <input type="checkbox"/> | <input type="checkbox"/> |
| e. How I could improve my health before a pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Sexually transmitted infections such as chlamydia, gonorrhea, syphilis, or HIV..... | <input type="checkbox"/> | <input type="checkbox"/> |

Ask me...

- g. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco.....
- h. If someone was hurting me emotionally or physically.....
- i. If I felt depressed or anxious.....

The next questions are about your *health insurance*.

8. During the month before you got pregnant with your new baby, what kind of health insurance did you have?

Check ALL that apply

- Private health insurance (paid for by me, someone else, or through a job)
- Medicaid (such as Presumptive Eligibility or emergency Medicaid) or NJ FamilyCare
- Charity Care
- TRICARE or other military healthcare
- Other health insurance → Please tell us:

- I didn't have any health insurance during the *month before* I got pregnant

If you had health insurance during the month before you got pregnant, go to Question 10.

9. 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

- Health insurance was too expensive
- I couldn't get health insurance from my job or the job of my spouse or partner
- I applied for health insurance but was waiting to get it
- I had problems with the health insurance application or website
- My income was too high to qualify for Medicaid
- My income was too high to qualify for a tax credit from the NJ Health Insurance Marketplace or HealthCare.gov
- I didn't know how to get health insurance
- I'm not a US citizen, or I didn't have the right residency documents
- Other _____ → Please tell us:

10. *During* your most recent pregnancy, what kind of health insurance did you have?

Check ALL that apply

- Private health insurance (paid for by me, someone else, or through a job)
- Medicaid (such as Presumptive Eligibility or emergency Medicaid) or NJ FamilyCare
- Charity Care
- TRICARE or other military healthcare
- Other health insurance _____ → Please tell us:

- I didn't have any health insurance *during my pregnancy*

11. What kind of health insurance do you have now?

Check ALL that apply

- Private health insurance (paid for by me, someone else, or through a job)
- Medicaid (such as Presumptive Eligibility or emergency Medicaid) or NJ FamilyCare
- Charity Care
- TRICARE or other military healthcare
- Other health insurance _____ → Please tell us:

- I don't have any health insurance *now*

12. 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

Go to Question 14

13. How much longer did you want to wait to become pregnant?

- Less than 1 year
- 1 year to less than 2 years
- 2 years to less than 3 years
- 3 years to 5 years
- More than 5 years

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

- No
- Yes _____ →

Go to Page 4, Question 16

15. When you got pregnant with your new baby, were you or your spouse or partner doing anything to keep from getting pregnant? This can include having your tubes tied, using birth control pills, condoms, natural family planning, or other methods.

- No
- Yes

DURING PREGNANCY

The next questions are about your prenatal care. This can include visits to a doctor, nurse, or other healthcare worker before your baby was born to get checkups and advice about pregnancy. (It may help to look at the calendar to answer these questions.)

16. Did you get prenatal care during your *most recent* pregnancy?

- No
 Yes

Go to Question 18

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

- No
 Yes

Go to Question 19

18. Did any of these things keep you from getting prenatal care when you wanted it? For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I couldn't get an appointment when I wanted one..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I didn't have enough money or insurance to pay for my visits..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have any transportation to get to the clinic or doctor's office..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The doctor or my health plan wouldn't start care as early as I wanted..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had too many other things going on..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I couldn't take time off from work or school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't have my Medicaid or NJ FamilyCare card..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I didn't have anyone to take care of my children..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I didn't know that I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I didn't want anyone else to know I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I didn't want prenatal care..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. The doctor's office was too far away..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not get prenatal care, go to Question 20.

19. During any of your prenatal care visits, did a healthcare provider do any of the following things? For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| Talk to me about... | | |
| a. How much weight I should gain during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Doing tests to screen for birth defects or diseases that run in my family..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The signs and symptoms of preterm labor (labor more than 3 weeks before the baby is due)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. What to do if I feel depressed or anxious during my pregnancy or after my baby is born..... | <input type="checkbox"/> | <input type="checkbox"/> |

Ask me...

- | | | |
|--|--------------------------|--------------------------|
| e. If I planned to breastfeed my new baby.. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If I planned to use birth control after my baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If I was taking any prescription medication..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If I smoked cigarettes or used e-cigarettes ("vapes") or other smokeless tobacco..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I was drinking alcohol..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. If I was using illegal drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. If I was using marijuana..... | <input type="checkbox"/> | <input type="checkbox"/> |
| m. If I wanted to be tested for HIV..... | <input type="checkbox"/> | <input type="checkbox"/> |

20. During the 12 months before your new baby was born, did a healthcare provider offer you the following shots or vaccinations? For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Flu shot..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tdap shot (protects against tetanus, diphtheria, and pertussis [whooping cough])..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19 shot..... | <input type="checkbox"/> | <input type="checkbox"/> |

21. Did you get the following shots or vaccinations before or during your pregnancy?
 For each shot, check ALL that apply:
B for **3 months before** pregnancy
D for **During** pregnancy
 or check **N** if you **Did not** get the shot in the 3 months before or during pregnancy

- | | B | D | N |
|-----------------------|--------------------------|--------------------------|--------------------------|
| a. Flu shot..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tdap shot..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. COVID-19 shot..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

No
 Yes

23. During your most recent pregnancy, did you take a class or classes to prepare for childbirth and learn what to expect during labor and delivery?

No
 Yes

24. 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, healthcare provider, doula, childbirth educator, social worker, or another person who works for a program that helps you during your pregnancy.

- No —————→ **Go to Question 26**
- Yes

Go to Question 25

25. Who was the home visitor that came to your home during your most recent pregnancy?

Check ALL that apply

- A nurse, nurse’s aide, or midwife
- A teacher or health educator
- A doula or childbirth educator
- Someone from the Home Visiting Program
- Someone from Healthy Women, Healthy Families Case Management/Community Health Worker
- Someone else —————→ Please tell us:
- I don’t know

26. During your most recent pregnancy, were you on WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children)?

- No —————→ **Go to Question 28**
- Yes

27. During your most recent pregnancy, when you went for your WIC visits, did you speak with a breastfeeding peer counselor or another WIC staff person about breastfeeding?

- No
 Yes

28. During your most recent pregnancy, did a healthcare provider tell you that you had any of the following health conditions?
 For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Gestational diabetes (diabetes that started during <i>this</i> pregnancy) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that started during <i>this</i> pregnancy), pre-eclampsia, or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Anemia (poor blood, low iron) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Epilepsy (seizures) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Thyroid problems..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you **had** high blood pressure **before** or **during** your pregnancy, go to Question 29. If you didn't, go to Question 30.

29. During your most recent pregnancy, did a healthcare provider do any of the following things to help you manage your high blood pressure? For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Refer me to a different healthcare provider..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tell me to regularly check my blood pressure during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about getting to a healthy weight after pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about regularly checking my blood pressure after pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about the risk for having high blood pressure (chronic hypertension) and heart disease after pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |

30. During your most recent pregnancy, did you get information about "warning signs" you should watch for during and after your pregnancy that require immediate medical attention? Some of these "warning signs" include fever, frequent or severe headaches, dizziness, or severe stomach pain.

- No —————> **Go to Question 32**
 Yes

31. During your most recent pregnancy, did you get information about warning signs from any of the following sources? For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. A healthcare provider (such as a doctor, nurse, or midwife) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Websites or social media (such as Facebook, Instagram, or Twitter)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any source of information that used the slogan " Hear Her " (such as websites, social media, or paper handouts)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about cigarettes, e-cigarettes, and other tobacco products.

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

- No —————> **Go to Question 36**
 Yes

33. In the 3 months before you got pregnant, how many cigarettes did you smoke on an average day?

- More than one pack (21 or more cigarettes)
 One-half to one pack (11 to 20 cigarettes)
 Less than half a pack (1 to 10 cigarettes)
 I didn't smoke then

34. In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day?

- More than one pack (21 or more cigarettes)
 One-half to one pack (11 to 20 cigarettes)
 Less than half a pack (1 to 10 cigarettes)
 I didn't smoke then

35. How many cigarettes do you smoke on an average day now?

- More than one pack (21 or more cigarettes)
 One-half to one pack (11 to 20 cigarettes)
 Less than half a pack (1 to 10 cigarettes)
 I don't smoke now

36. In the past 2 years, have you used e-cigarettes ("vapes") or other electronic nicotine products?

- No —————> **Go to Question 40**
 Yes

37. During the 3 months before you got pregnant, on average, how often did you use e-cigarettes ("vapes") or other electronic nicotine products?

- Every day
 Some days
 I didn't use e-cigarettes or other electronic nicotine products then

38. During the *last 3 months* of your pregnancy, on average, how often did you use e-cigarettes (“vapes”) or other electronic nicotine products?

- Every day
 Some days
 I didn't use e-cigarettes or other electronic nicotine products then

39. In the *past 2 years*, did you ever use e-cigarettes (“vapes”) or other electronic nicotine products as a way of cutting down or stopping cigarette smoking?

- No
 Yes

The next questions are about drinking alcohol. A drink can be 1 glass of wine, can or bottle of beer or hard seltzer, shot of liquor, or mixed drink.

40. During the *3 months before* you got pregnant, how many times did you drink 4 or more alcoholic drinks in a 2-hour time span?

Check ONE answer

- 6 or more times
 4 to 5 times
 2 to 3 times
 1 time
 I didn't have 4 or more drinks in a 2-hour time span

41. During your most recent pregnancy, did you have any alcoholic drinks during...?

For each one, check **No** or **Yes**.

No Yes

- a. The first 3 months of pregnancy (1st trimester)? *This includes the time before knowing you were pregnant*.....
b. The second 3 months of pregnancy (2nd trimester)?
c. The last 3 months of pregnancy (3rd trimester)?

If you did not have any alcoholic drinks during your pregnancy, go to Question 43.

42. During your most recent pregnancy, did you have 4 or more alcoholic drinks in a 2-hour time span during...?

For each one, check **No** or **Yes**.

No Yes

- a. The first 3 months of pregnancy (1st trimester)? *This includes the time before knowing you were pregnant*.....
b. The second 3 months of pregnancy (2nd trimester)?
c. The last 3 months of pregnancy (3rd trimester)?

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

43. Did any of the following things happen during the *12 months before* your new baby was born? For each one, check **No or **Yes**.**

No Yes

- a. I got separated or divorced.....
b. I was evicted or forced to move
c. I didn't have a regular place to sleep.....
d. I was homeless or had to sleep outside, in a car, or in a shelter.....
e. My spouse, partner, or I lost a job.....
f. My spouse, partner, or I had a cut in work hours or pay.....
g. I had problems paying the rent, mortgage, or other bills.....
h. My spouse or partner went to jail/prison..
i. I went to jail/prison
j. Someone close to me had a problem with drinking or drugs.....
k. Someone close to me was very sick or died.....

44. During the 12 months before your new baby was born, how often did you feel emotionally upset (for example, angry, sad, or frustrated) because of how you were treated based on your race, ethnicity, or skin color?

- Very often
 Somewhat often
 Not very often
 Never

45. 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 one, check **No** or **Yes**.

- | | No | Yes |
|-------------------------------------|--------------------------|--------------------------|
| a. My spouse or partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-spouse or ex-partner | <input type="checkbox"/> | <input type="checkbox"/> |

46. 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 one, check No or Yes.

- | | No | Yes |
|-------------------------------------|--------------------------|--------------------------|
| a. My spouse or partner..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-spouse or ex-partner | <input type="checkbox"/> | <input type="checkbox"/> |

AFTER PREGNANCY

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

47. When was your new baby born?

<input style="width: 100%;" type="text"/>	/	<input style="width: 100%;" type="text"/>	/	<input style="width: 100%;" type="text"/>
Month		Day		Year

48. How was your new baby delivered?

- Vaginally → Go to Question 51

Cesarean delivery (c-section)

49. What was the reason that your new baby was born by cesarean delivery (c-section)?

Check ALL that apply

- 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 healthcare provider worried that my baby was too big
- I had a medical condition that made labor dangerous for me (such as a heart condition or physical disability)
- I had a complication in my pregnancy (such as pre-eclampsia, placental problems, infection, preterm labor)
- My healthcare 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 → Please tell us:

50. Which statement best describes whose idea it was for you to have a cesarean delivery (c-section)?

Check ONE answer

- My healthcare provider recommended a cesarean delivery **before** I went into labor
- My healthcare provider recommended a cesarean delivery while I was in labor
- I asked for the cesarean delivery

51. Overall, during the delivery of my baby, I felt...

For each one, check **No** or **Yes**.

No Yes

- a. Comfortable asking questions about the *labor and delivery care* that I received
- b. Comfortable declining care if I didn't want it.....
- c. Comfortable accepting the options for care that my provider recommended
- d. I was able to choose the care options that I received
- e. My providers treated me with respect.....
- f. Satisfied with the *labor and delivery care* that I received

52. After the delivery, how long did your new baby stay in the hospital?

- Less than 3 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 →

Go to Question 55

53. Is your baby alive now?

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

Go to Page 11, Question 67

54. Is your baby living with you now?

- No →
- Yes

Go to Page 11, Question 65

Go to Question 55

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

Check ONE answer

- I didn't breastfeed my baby
- I breastfed my baby for less than 1 week
- I breastfed my baby for:
- _____ week(s) OR _____ month(s)
- I'm still breastfeeding or feeding pumped milk to my new baby

If you ever breastfed your baby, go to Page 10, Question 57.

56. What were your reasons for not breastfeeding your new baby?

Check ALL that apply

- I was sick or on medicine
- I had other children to take care of
- I had too many other things going on
- I didn't like breastfeeding
- I tried, but it was too hard
- I didn't want to
- I went back to work
- I went back to school
- Other → Please tell us:

If your baby was not born in a hospital, go to Question 58.

57. During your hospital stay after your new baby was born, did any of the following things happen? For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Hospital staff talked to me about how to breastfeed (how often and long to breastfeed) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My baby stayed in the same room with me at the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hospital staff helped me learn how to breastfeed | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I breastfed as soon as possible after my baby was born | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My baby was placed in skin-to-skin contact as soon as possible after birth | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My baby was fed only breast milk at the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Hospital staff helped me recognize when my baby was hungry..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. The hospital gave me a gift pack with formula | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The hospital gave me information about who I could contact for breastfeeding support when I left the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |

If your baby is still in the hospital, go to Question 65.

58. In the past 2 weeks, how did you place your new baby to sleep at night and during naps? For each one, check **No** or **Yes**.

- | | No | Yes |
|---------------------------|--------------------------|--------------------------|
| a. On their side | <input type="checkbox"/> | <input type="checkbox"/> |
| b. On their back..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. On their stomach | <input type="checkbox"/> | <input type="checkbox"/> |

59. In the past 2 weeks, when you were sleeping, how often has your new baby slept alone in their own crib or bed?

- Always
 Often
 Sometimes
 Rarely
 Never

Go to Question 61

60. In the past 2 weeks, was your baby's crib or bed in the same room where you or another adult slept?

- No
 Yes

61. In the past 2 weeks, where have you placed your new baby to sleep at night or during naps? For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. In a crib, portable crib, or bassinet | <input type="checkbox"/> | <input type="checkbox"/> |
| b. On a twin or larger mattress or bed | <input type="checkbox"/> | <input type="checkbox"/> |
| c. On a couch, sofa, or armchair..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In an infant car seat..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. In a swing, rocker, or other inclined sleeper | <input type="checkbox"/> | <input type="checkbox"/> |
| f. In an in-bed sleeper | <input type="checkbox"/> | <input type="checkbox"/> |
| g. In a baby board or cradleboard | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

62. In the past 2 weeks, has your new baby been placed to sleep with the following?

For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. In a sleeping sack or wearable blanket..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In a swaddled blanket..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Comforters, quilts, blankets, or non-fitted sheets..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Soft toys, cushions, or pillows, including nursing pillows..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Crib bumper pads (mesh or non-mesh) ... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

63. Did a healthcare provider tell you to place your baby to sleep in the following ways?

For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. On their back to sleep..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In a crib, bassinet, or portable crib..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Without a blanket, soft toys, cushions, or pillows in my baby's crib or bed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Place my baby's crib, bassinet, or portable crib in my room..... | <input type="checkbox"/> | <input type="checkbox"/> |

64. 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

65. 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, healthcare provider, doula, social worker, or another person who works for a program that helps families with newborns.

- No → **Go to Question 67**
- Yes

Go to Question 66

66. Who was the home visitor that came to your home since your new baby was born?

Check ALL that apply

- A nurse, nurse's aide, or midwife
- A teacher or health educator
- A doula or childbirth educator
- Someone from the Home Visiting Program
- Someone from Healthy Women, Healthy Families Case Management/Community Health Worker
- Someone else → Please tell us:
- I don't know

67. Are you or your spouse or partner doing anything now to keep from getting pregnant?

This can include having your tubes tied, using birth control pills, condoms, natural family planning, or other methods.

- No
- Yes → **Go to Page 12, Question 69**
- I'm pregnant now → **Go to Page 12, Question 70**

68. What are your reasons for not doing anything to keep from getting pregnant now?

Check ALL that apply

- I want to get pregnant or don't mind if I do
- I had my tubes tied or blocked
- My spouse or partner had a vasectomy
- I don't want to use birth control
- I'm worried about side effects from birth control
- My spouse or partner doesn't want to use condoms
- My spouse or partner doesn't want me to use birth control
- We are same-sex spouses/partners
- I have problems getting birth control I want
- I don't think I can get pregnant because I'm breastfeeding
- I'm not having sex
- Other → Please tell us:

If you're **not** doing anything to keep from getting pregnant **now**, go to Question 70.

69. What kind of birth control are you or your spouse or partner using *now* to keep from getting pregnant?

Check ALL that apply

- Tubes tied or blocked
- My spouse or partner had a vasectomy
- Birth control pills
- Condoms
- Shots or injections
- Contraceptive patch or vaginal ring
- IUD
- Contraceptive implant in the arm
- Withdrawal (pulling out)
- Natural family planning or fertility awareness methods (such as rhythm or calendar method or fertility apps)
- Breastfeeding for birth control (Lactational Amenorrhea Method or LAM)
- Other _____ → Please tell us:

70. Since your new baby was born, have you had a postpartum checkup for yourself? A postpartum checkup is a regular health checkup you have up to 12 weeks after giving birth.

- No _____ → **Go to Question 72**
- Yes

Go to Question 71

71. During your postpartum checkup, did a healthcare provider do any of the following things? For each one, check **No** or **Yes**.

No Yes

Talk to me about...

- a. Healthy eating, exercise, and losing weight gained during pregnancy.....
- b. How long to wait before getting pregnant again.....
- c. Birth control methods.....
- d. Warning signs of medical problems I might be at risk for due to my pregnancy.....
- e. Regularly checking my blood pressure....
- f. What to do if I feel depressed or anxious.....

Ask me...

- g. If I was smoking cigarettes or using e-cigarettes ("vapes") or other smokeless tobacco.....
- h. If someone was hurting me emotionally or physically.....

A healthcare provider...

- i. Tested me for diabetes.....
- j. Prescribed me medication for depression or anxiety.....

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

- Always
- Often
- Sometimes
- Rarely
- Never

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

- Always
- Often
- Sometimes
- Rarely
- Never

74. Since your new baby was born, how often have you felt nervous, anxious, or on edge?

- Always
 Often
 Sometimes
 Rarely
 Never

75. Since your new baby was born, how often have you not been able to stop or control worrying?

- Always
 Often
 Sometimes
 Rarely
 Never

76. Has a healthcare provider asked you a series of questions, in person or on a form, to know if you were feeling down, depressed, anxious, or irritable during the following time periods? For each one, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. During my most recent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Since my new baby was born | <input type="checkbox"/> | <input type="checkbox"/> |

OTHER EXPERIENCES

The next questions are on a variety of topics.

77. Please tell us how often each of the following happened during the 12 months before your new baby was born.

- a. I worried whether my food would run out before I got money to buy more
- Often Sometimes Never
- b. The food that I bought just didn't last, and I didn't have money to get more
- Often Sometimes Never

78. During the 12 months before your new baby was born, did lack of transportation keep you from any of the following?

For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Going to medical appointments | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Going to non-medical appointments, meetings, or work | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Doing errands | <input type="checkbox"/> | <input type="checkbox"/> |

79. Did you use doula support during any of the following time periods? A doula is a trained pregnancy and labor companion who gives comfort, emotional support, and information during birth. A doula does not provide medical care. For each time period, check **No** or **Yes**.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. During my most recent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During the birth of my new baby | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Since my new baby was born | <input type="checkbox"/> | <input type="checkbox"/> |

80. Did you experience any of the following things during your pregnancy or after your baby was born? For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. I felt something wasn't right with my health | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I felt my concerns for my health weren't taken seriously | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I felt my doctor ignored my concerns about my health or symptoms | <input type="checkbox"/> | <input type="checkbox"/> |

81. Did a healthcare provider talk with you about the warning signs of both pregnancy and postpartum complications during any of the following time periods?

For each time period, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. During the 12 months before my most recent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During my most recent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| c. During my labor and delivery hospital stay | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Since my new baby was born | <input type="checkbox"/> | <input type="checkbox"/> |

82. While getting healthcare during your pregnancy, at delivery, or at postpartum care, did you experience discrimination or were you prevented from doing something, hassled, or made to feel inferior?

For each one, check **No** if you did not experience discrimination because of it or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. My race, ethnicity, or skin color | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My disability status | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My immigration status..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My age | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My income..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My sex or gender | <input type="checkbox"/> | <input type="checkbox"/> |
| h. My sexual orientation..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. My religion | <input type="checkbox"/> | <input type="checkbox"/> |
| j. My language or accent | <input type="checkbox"/> | <input type="checkbox"/> |
| k. My type or lack of health insurance..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. My use of substances (alcohol, tobacco, or other drugs)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| m. My involvement with the justice system (jail or prison) | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Another reason..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

83. During your life until now, how often have you been discriminated against, prevented from doing something, hassled, or made to feel inferior because of your race, ethnicity, or skin color?

- Very often
- Somewhat often
- Not very often
- Never

84. Have you ever been treated unfairly due to your race, ethnicity, or skin color in any of the following situations?

For each one, check **No** or **Yes**.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Job (hiring, promotion, firing)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Housing (renting, buying, mortgage) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Police (stopped, searched, threatened).... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. In the courts | <input type="checkbox"/> | <input type="checkbox"/> |
| e. At school or my child's school | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Getting medical care..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

85. During the 12 months before your new baby was born, what was your yearly total household income before taxes? Include your income, your spouse 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 getting now.

- \$0 to \$18,000
- \$18,001 to \$23,000
- \$23,001 to \$27,000
- \$27,001 to \$32,000
- \$32,001 to \$37,000
- \$37,001 to \$42,000
- \$42,001 to \$48,000
- \$48,001 to \$60,000
- \$60,001 to \$85,000
- \$85,001 or more

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

Number of people

87. What is today's date?

/

/

Month

Day

Year

These last questions are about the COVID-19 vaccine.

VC1. During your most recent pregnancy, did a healthcare provider do any of the following things? For each one, check **No** or **Yes**.

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

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

- No
 Yes —————→ **Go to Page 16, Question VC5**

Go to Question VC3

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

Check ALL that apply

- I wasn't in one of the groups that could get the COVID-19 vaccine
 - The vaccine wasn't available or ran out in my area
 - I couldn't get an appointment or was placed on a waiting list
 - I didn't have transportation to get to a vaccination site
 - The staff at the vaccination site didn't want to give me the vaccine because I was pregnant
 - I was concerned about possible side effects of the COVID-19 vaccine for my baby
 - I was concerned about possible side effects of the COVID-19 vaccine for me
 - I have an allergy or health condition that prevented me from getting the vaccine
 - My doctor or healthcare provider told me not to get the vaccine
 - I had gotten the COVID-19 vaccine *before* my pregnancy
 - I already had COVID-19
 - I didn't have enough information about the vaccine to feel comfortable getting it
 - I was concerned that the COVID-19 vaccine was developed too fast
 - I didn't think the vaccine would protect me against COVID-19
 - I didn't think COVID-19 was a serious illness
 - I didn't think I was at risk for COVID-19 infection
 - I preferred using masks and other precautions instead
 - I don't think vaccines are beneficial
 - Other reason
- Please tell us:

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

- No
 Yes

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

Check ONE answer

- My doctor, nurse, or other healthcare 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:

- Some other source
 Please tell us:

VC6. Which of the following describes your work or volunteer activities during your most recent pregnancy?

Check ALL that apply

- I worked or volunteered providing direct medical care to patients (such as being a doctor, nurse, dentist, therapist, home healthcare provider, or emergency responder)
 I worked or volunteered in a health care setting, but not providing direct medical care to patients (such as being administrative staff, cleaning staff, patient transport, or ward clerk)
 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, or postal or delivery services)
 I worked or volunteered in a position where I did not regularly come in contact with the public
 None of the above



STATE AND LOCAL RESOURCES

NJ211 - A place to turn to when you need to find state or local health and human service information.
Within NJ Dial: **2-1-1** Outside NJ: **1- 877- 652-1148** Website: <https://www.nj211.org/>

NJ Parent Link - New Jersey's Early Childhood, Parenting and Professional Resource Center.
Website: <https://www.nj.gov/njparentlink/>

Connecting NJ - A network of partners and agencies that connects New Jersey families - moms, dads, newborns, teens, young adults, and grandparents - with the best health and social resources available in their local community.
Website: <https://nj.gov/connectingnj/>

Family Health Line- Operational 24/7 and is available anywhere in New Jersey. Trained phone counselors provide information and referrals for health screening and treatment.
1- 800-328-3838 Website: <https://www.nj.gov/health/fhs/primarycare/family-health-line/>

ReachNJ - Central call-in-line for NJ residents looking for help to overcome a substance use disorder. Each call is answered by a trained specialist who will provide the caller with a referral to a local treatment provider or other supportive services regardless of insurance or ability to pay.
1-844-732-2465 (24/7) Website: <https://nj.gov/humanservices/reachnj/>

Speak Up When You Are Down - Perinatal mood disorders (PMD) can affect any woman of any age, race or economic background who is pregnant or who has recently had a baby, stopped breastfeeding, or ended a pregnancy or miscarried. **PMD are treatable, but many people do not know the facts.**
1-800- 328-3838 (24/7) Website: <https://www.nj.gov/health/fhs/maternalchild/mentalhealth/>

Special Child Health and Early Intervention Services has information and resources for infants, children, youth and young adults with special health care needs and for infants and toddlers with developmental delays/disabilities. Newborn screening information and resources are also available.
1-609-984-0755 Website: <https://www.nj.gov/health/fhs/sch/index.shtml>

Women's Referral Central is the primary source of information about programs of interest to women in New Jersey. Available 24 hours a day, it assists women in areas as diverse as sexual harassment, child support, and custody, consumer law and safety, to personal growth and development, education, medical referrals, homelessness, personal safety and domestic violence.
1-800-322-8092 Website: <https://www.nj.gov/def/women/hotlines/>

PHONE NUMBERS FOR ADDITIONAL INFORMATION AND ASSISTANCE

Family Helpline 24/7 - If you're feeling stressed out, call the Family Helpline and work through your frustrations before a crisis occurs. You'll speak to sensitive, trained volunteers of Parents Anonymous who will provide empathic listening about parenting and refer you to resources in your community.
1-800-THE-KIDS (843-5437)

Quit Smoking: Mom's Quit Connection – 888-545-519 Website: <https://momsquit.com/>
NJ Quitline - 1-866-NJSTOPS; 1-866-657-8677 Website: <https://www.njquitline.org/>

NJ Women, Infant, and Children Services (WIC): 1-866-44-NJWIC; 1-800-328-3838



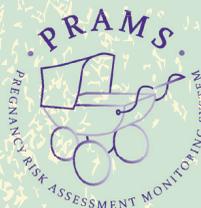
TEAR HERE

TEAR HERE

**We would love to hear more about your story!
Is there anything else you would like to share with us about your experiences
around the time of your pregnancy? Please use this space to tell us.**

Thanks for answering our questions!

Your answers will help us work to make mothers and babies in New Jersey healthier.



RUTGERS

Edward J. Bloustein School
of Planning and Public Policy

This survey is sponsored by the
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Edward J. Bloustein School of Planning and Public Policy
Rutgers, The State University of New Jersey