

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. How tall are *you* without shoes?

____ Feet ____ Inches

OR ____ Centimeters

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

____ Pounds OR ____ Kilos

3. What is *your* date of birth?

____ / ____ / ____
Month Day Year

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

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

- a. Type 1 or Type 2 diabetes (**not** gestational diabetes or diabetes that starts during pregnancy)
- b. High blood pressure or hypertension
- c. Depression

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

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 → **Go to Page 2, Question 9**
- Yes

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

- Regular checkup at my family doctor's office
- Regular checkup at my OB/GYN's office
- Visit for an illness or chronic condition
- Visit for an injury
- Visit for family planning or birth control
- Visit for depression or anxiety
- Visit to have my teeth cleaned by a dentist or dental hygienist
- Other → Please tell us:

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 |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about maintaining a healthy weight..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about controlling any medical conditions such as diabetes or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about my desire to have or not have children..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Talk to me about using birth control to prevent pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Talk to me about how I could improve my health before a pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Talk to me about sexually transmitted infections such as chlamydia, gonorrhea, or syphilis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Ask me if I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Ask me about the kind of work I do | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Test me for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

9. 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 from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the New Mexico Health Insurance Marketplace, <http://www.bewellnm.com>, or HealthCare.gov
- Medicaid or Centennial Care
- SCHIP or CHIP (New MexiKids)
- Family Planning or Title X Program
- TRICARE or other military health care
- Indian Health Service (IHS) or Tribal-638 health care coverage
- Other health insurance —→ Please tell us:
- I did not have any health insurance during the *month before* I got pregnant

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

Check ALL that apply

- I did not go for prenatal care → **Go to Question 12**
- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the New Mexico Health Insurance Marketplace, <http://www.bewellnm.com>, or [HealthCare.gov](http://www.healthcare.gov)
- Medicaid or Centennial Care
- SCHIP or CHIP (New MexiKids)
- Discount/State prenatal HRF or sliding scale
- TRICARE or other military health care
- Indian Health Service (IHS) or Tribal-638 health care coverage
- Other health insurance → Please tell us:

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

If you had health insurance for your *prenatal care*, go to Question 11. Otherwise, go to Question 12.

11. Did the cost of health insurance for your *prenatal care* cause financial problems for you or your family?

- No
- Yes

12. What kind of health insurance do you have *now*?

Check ALL that apply

- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the New Mexico Health Insurance Marketplace, <http://www.bewellnm.com>, or [HealthCare.gov](http://www.healthcare.gov)
- Medicaid or Centennial Care
- SCHIP or CHIP (New MexiKids)
- Family Planning or Title X Program
- TRICARE or other military health care
- Indian Health Service (IHS) or Tribal-638 health care coverage
- Other health insurance → Please tell us:

- I do not have health insurance *now*

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

DURING PREGNANCY

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.)

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

Weeks **OR** Months
 I didn't go for prenatal care → **Go to Question 16**

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

No
 Yes → **Go to Question 17**

Go to Question 16

16. 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 |
|---|--------------------------|--------------------------|
| 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. I couldn't take time off from work or school..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I didn't have my Medicaid or Centennial Care card | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I didn't have anyone to take care of my children | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't know that I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I didn't want anyone else to know I was pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The clinic or doctor's office was too far away | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I did not believe prenatal care was important or that it would help me..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I did not feel prenatal care was culturally appropriate | <input type="checkbox"/> | <input type="checkbox"/> |
| l. I didn't want prenatal care..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

17. Where did you go most of the time for your prenatal care visits? Do not include visits for WIC.

Check ONE answer

- Private doctor's office
- Hospital clinic
- Health department clinic
- Community or Federally Qualified Health clinic
- Indian Health Service (IHS), Tribal-638, or Tribal Urban health facility
- Other → Please tell us:

18. 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 |
|---|--------------------------|--------------------------|
| a. If I knew how much weight I should gain during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If I was taking any prescription medication..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. If I was smoking cigarettes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If I was drinking alcohol..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. If someone was hurting me emotionally or physically..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If I was feeling down or depressed..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If I was using drugs such as marijuana, cocaine, crack, or meth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If I wanted to be tested for HIV (the virus that causes AIDS)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I planned to breastfeed my new baby.. | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If I planned to use birth control after my baby was born..... | <input type="checkbox"/> | <input type="checkbox"/> |

19. How did you feel about the prenatal care you got during your most recent pregnancy? If you went to more than one place for prenatal care, answer for the place where you got *most* of your care. For each item, check **No** if you were not satisfied or **Yes** if you were satisfied.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. The amount of time I had to wait..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. The amount of time the doctor, nurse, or midwife spent with me..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. The advice I got on how to take care of myself..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The understanding and respect shown toward me as a person..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. The cultural understanding or respect demonstrated in my care..... | <input type="checkbox"/> | <input type="checkbox"/> |

20. 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

21. 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

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 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. 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. Labor pains more than 3 weeks before my baby was due (preterm or early labor)..... | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about smoking cigarettes around the time of pregnancy (before, during, and after).

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

- No
 Yes

→ **Go to Question 28**

25. 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

26. 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

27. 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

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.

A **hookah** is a water pipe used to smoke tobacco. It is not the same as an e-hookah or hookah pen.

28. 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 |
|--|--------------------------|--------------------------|
| a. E-cigarettes or other electronic nicotine products..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hookah..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cigars, cigarillos, or little filtered cigars.... | <input type="checkbox"/> | <input type="checkbox"/> |

If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 29. Otherwise, go to Question 31.

29. 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

30. 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

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

31. 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

→ **Go to Question 33**

32. 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

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

33. During the *12 months before* your new baby was born, did you ever eat less than you felt you should because there wasn't enough money to buy food?

- No
- Yes

34. 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

- a. My husband or partner
- b. My ex-husband or ex-partner
- c. Another family member
- d. Someone else

35. 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

- a. My husband or partner
- b. My ex-husband or ex-partner
- c. Another family member
- d. Someone else

AFTER PREGNANCY

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

36. When was your new baby born?

/ / 20
 Month Day Year

37. How was your new baby delivered?

- Vaginally → **Go to Page 8, Question 39**
- Cesarean delivery (c-section)

↓ **Go to Page 8, Question 38**

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

Check ONE answer

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

39. After your baby was delivered, was he or she put in an intensive care unit (NICU)?

- No
- Yes
- I don't know

40. 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 → **Go to Question 43**

41. Is your baby alive now?

- No → *We are very sorry for your loss.*
- Yes → **Go to Page 11, Question 60**

42. Is your baby living with you now?

- No → **Go to Page 11, Question 60**
- Yes

Go to Question 43

43. 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 |
|---|--------------------------|--------------------------|
| a. My doctor | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A nurse, midwife, or doula | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A breastfeeding or lactation specialist | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My baby's doctor or health care provider..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. A breastfeeding support group..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. A breastfeeding hotline or toll-free number..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Family or friends | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

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

- No → **Go to Page 10, Question 52**
- Yes

Go to Question 45

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

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Someone to answer my questions | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Help getting my baby positioned correctly..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Help knowing if my baby was getting enough milk | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Help with managing pain or bleeding nipples..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Information about where to get a breast pump..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Help using a breast pump..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Information about breastfeeding support groups | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Other | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us: _____ →

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

- No
 Yes →

Go to Question 48

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

- Less than 1 week

____ Weeks **OR** ____ Months

48. Have you used a breast pump to express milk to feed to your new baby?

- No →
 Yes

Go to Question 50

Go to Question 49

49. Did your health insurance pay for a breast pump for you to use with your new baby?

- No
 Yes, but I had to make a co-payment
 Yes, with no co-payment
 I did not have health insurance
 I don't know

If your baby was not born in a hospital, go to Page 10, Question 51.

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

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. Hospital staff gave me information about breastfeeding..... | <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. I breastfed my baby in the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Hospital staff helped me learn how to breastfeed | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I breastfed in the first hour after my baby was born | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My baby was placed in skin-to-skin contact within the first hour of life..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My baby was fed only breast milk at the hospital..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Hospital staff told me to breastfeed whenever my baby wanted | <input type="checkbox"/> | <input type="checkbox"/> |
| i. The hospital gave me a breast pump to use..... | <input type="checkbox"/> | <input type="checkbox"/> |
| j. The hospital gave me a gift pack with formula | <input type="checkbox"/> | <input type="checkbox"/> |
| k. The hospital gave me a telephone number to call for help with breastfeeding..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Hospital staff gave my baby a pacifier | <input type="checkbox"/> | <input type="checkbox"/> |

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

Weeks **OR** Months

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

If your baby is still in the hospital, go to Question 60.

52. 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

53. 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

Go to Question 55

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

- No
- Yes

55. 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 |
|---|--------------------------|--------------------------|
| a. In a crib, bassinet, or pack and play | <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 or swing | <input type="checkbox"/> | <input type="checkbox"/> |
| e. In a sleeping sack or wearable blanket | <input type="checkbox"/> | <input type="checkbox"/> |
| f. With a blanket | <input type="checkbox"/> | <input type="checkbox"/> |
| g. With toys, cushions, or pillows, including nursing pillows | <input type="checkbox"/> | <input type="checkbox"/> |
| h. With crib bumper pads (mesh or non-mesh) | <input type="checkbox"/> | <input type="checkbox"/> |

56. 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 |
|---|--------------------------|--------------------------|
| a. Place my baby on his or her back to sleep | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Place my baby to sleep in a crib, bassinet, or pack and play | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Place my baby's crib or bed in my room .. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. What things should and should not go in bed with my baby | <input type="checkbox"/> | <input type="checkbox"/> |

57. How many times has your new baby gone for care when he or she was sick?

Times

- None → **Go to Question 59**
- My baby has not been sick
- My baby is still in the hospital

Go to Question 60

58. Has your new baby gone for care as many times as you wanted when he or she was sick?

- No
 Yes

→ **Go to Question 60**

59. Did any of these things keep you from taking your baby for care when he or she was sick?

Check ALL that apply

- I didn't have health insurance to pay for the visit
 I couldn't get an appointment
 I didn't have a regular doctor for my baby
 I had no way to get my baby to the clinic or doctor's office
 I didn't have anyone to take care of my other children
 Other _____ → Please tell us:

60. 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

→ **Go to Question 62**

Go to Question 61

61. 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

- I want to get pregnant
 I am pregnant now
 I had my tubes tied or blocked
 I don't want to use birth control
 I am worried about side effects from birth control
 I am not having sex
 My husband or partner doesn't want to use anything
 I have problems paying for birth control
 Other _____ → Please tell us:

If you or your husband or partner is *not doing anything to keep from getting pregnant now*, go to Page 12, Question 63.

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

Check ALL that apply

- Tubes tied or blocked (female sterilization or Essure®)
 Vasectomy (male sterilization)
 Birth control pills
 Condoms
 Shots or injections (Depo-Provera®)
 Contraceptive patch (OrthoEvra®) or vaginal ring (NuvaRing®)
 IUD (including Mirena®, ParaGard®, Liletta®, or Skyla®)
 Contraceptive implant in the arm (Nexplanon® or Implanon®)
 Natural family planning (including rhythm method)
 Withdrawal (pulling out)
 Not having sex (abstinence)
 Other _____ → Please tell us:

63. 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

→ **Go to Question 65**

64. 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 |
|--|--------------------------|--------------------------|
| a. Tell me to take a vitamin with folic acid ... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about healthy eating, exercise, and losing weight gained during pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about how long to wait before getting pregnant again | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Talk to me about birth control methods I can use after giving birth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Give or prescribe me a contraceptive method such as the pill, patch, shot (Depo-Provera®), NuvaRing®, or condoms..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Insert an IUD (Mirena®, ParaGard®, Liletta®, or Skyla®) or a contraceptive implant (Nexplanon® or Implanon®) | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Ask me if I was smoking cigarettes | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Ask me if someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Ask me if I was feeling down or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Test me for diabetes | <input type="checkbox"/> | <input type="checkbox"/> |

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

- Always
 Often
 Sometimes
 Rarely
 Never

66. 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

OTHER EXPERIENCES

The next questions are on a variety of topics.

67. Are you Hispanic, Spanish, or Latina?

- No
 Yes

68. Which one or more of the following would you say is your race?

Check ALL that apply

- American Indian or Alaska Native

Tribe: _____

- Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 White
 Other → Please tell us:

69. Which one of these best describes you?

Check ONE answer

- American Indian or Alaska Native
 Asian
 Black or African American
 Hispanic, Spanish, or Latina
 Native Hawaiian or Other Pacific Islander
 White
 Other → Please tell us:

70. Within the past 12 months, when seeking health care, did you feel your experiences were worse than, the same as, or better than for people of other races (or ethnicities)?

Check ONE answer

- Worse than other races
- The same as other races
- Better than other races
- Worse than some races, better than others
- I only encountered people of the same race
- I did not have health care in past 12 months
- Don't know / Not sure

71. During the month before you got pregnant, did you take or use any of the following drugs for any reason? Your answers are strictly confidential. For each item, check **No** if you did not use it or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Prescription for depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Over-the-counter pain relievers such as aspirin, Tylenol®, Advil®, or Aleve® | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Prescription pain relievers such as hydrocodone (Vicodin®), oxycodone (Percocet®), or codeine | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Marijuana (pot, weed, bud, <i>mota</i> or hashish (hash)) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Synthetic marijuana (K2, Spice) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Methadone, naloxone (Narcan®), subutex, or Suboxone® | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Heroin (smack, junk, Black Tar, <i>Chiva</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Amphetamines (uppers, speed, crystal meth, crank, ice, <i>agua</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Cocaine (crack, rock, coke, blow, snow, <i>nieve</i>) | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Tranquilizers (downers, ludes) | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Hallucinogens (LSD/acid, PCP/angel dust, Ecstasy, Molly, mushrooms, bath salts) | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Sniffing gasoline, glue, aerosol spray cans, or paint to get high (huffing) | <input type="checkbox"/> | <input type="checkbox"/> |

72. During your most recent pregnancy, did you receive any of the following services? For each one, check **No** if you did not receive the service or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. Counseling or a support group for depression | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Class or support group to stop smoking cigarettes | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Help to reduce violence in my home | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Healthy Start | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Families FIRST case management | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Doula or midwife support | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Home visiting program | <input type="checkbox"/> | <input type="checkbox"/> |

If your baby is not alive or is not living with you, go to Question 75.

73. Since your new baby was born, have you used any of these services? For each one, check **No** if you did not use the service or **Yes** if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. A breastfeeding class or peer counseling support | <input type="checkbox"/> | <input type="checkbox"/> |
| b. WIC for me or my baby | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Families FIRST case management | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Healthy Start | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Counseling or a support group for depression | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Breastfeeding help from a hospital or clinic | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Breastfeeding help from a community program or lactation consultant | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Home visiting program | <input type="checkbox"/> | <input type="checkbox"/> |

If your baby is still in the hospital, go to Question 75.

74. Please read each statement below about how you feel about your baby's crying or how you manage his or her crying. For each one, check **No** if you did not apply to you or **Yes** if it did.

- | | | |
|---|--------------------------|--------------------------|
| | No | Yes |
| a. I can almost always get my baby to stop crying | <input type="checkbox"/> | <input type="checkbox"/> |
| b. In the past week, I have carried my baby in my arms or in a cloth baby carrier for 5 or more hours every day | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I think that picking up a baby every time he or she cries will spoil the baby | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I sometimes feel overwhelmed by my baby's crying | <input type="checkbox"/> | <input type="checkbox"/> |

75. At any time during your most recent pregnancy, did you work at a job for pay?

- No → **Go to Question 78**
- Yes

76. Have you returned to the job you had during your most recent pregnancy?

Check ONE answer

- No, and I do not plan to return → **Go to Question 78**
- No, but I will be returning
- Yes

77. Did you take leave from work after your new baby was born?

Check ALL that apply

- I took *paid* leave from my job
- I took *unpaid* leave from my job
- I did not take any leave

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

78. 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

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

People

80. What is today's date?

/ /

Month Day Year

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 New Mexico.

Thanks for answering our questions!

Your answers will help us work to keep mothers and babies in New Mexico healthy.

