



Ohio  
SOARS

Study of Associated Risks of Stillbirth

*With your help, we hope to learn  
why stillbirths happen  
and how to improve care.*

Please complete the survey and  
mail it in the enclosed envelope.

Your help is voluntary, and your  
answers are completely confidential.

You must be at least 18 years old  
to participate.

Questions? Please call us  
at 614-366-9851.

## **Important Information about Ohio SOARS Please Read Before Starting the Survey**

The Ohio Study of Associated Risks of Stillbirth (Ohio SOARS) is a research study. Its researchers work at The Ohio State University, which is sponsored by the National Foundation for the Centers for Disease Control and Prevention, Inc. (“CDC Foundation”) in partnership with the Ohio Department of Children and Youth.

The purpose of the study is to help find out why stillbirths happen and how to improve the care that families receive.

We are asking all Ohio women who have experienced a stillbirth from July 2024 through December of 2025 to answer the same questions. Many of the questions in this survey are included in other surveys that collect data from women who had a live birth.

This survey is voluntary. If you don't want to participate at all, or if you don't want to answer a particular question, that is okay. You will not lose any benefits you receive if you choose not to participate. You may stop taking the survey at any time.

It takes about 25-30 minutes to answer all questions. Some question topics may be sensitive, such as physical abuse. If you do not want to answer a particular question, that is okay.

If you choose to respond to the survey, your answers will be kept confidential to the extent allowed by law and will only be seen by research staff. Ohio law requires us to report any suspected instances of child abuse that we discover to the proper authorities.

Your answers will be grouped with those from other women. Your name will not be on any Ohio SOARS reports. The Ohio Department of Children and Youth will keep your data as part of our permanent records. Other researchers may ask to use this data for other studies. They will only be given access if they receive permission from the Ohio Department of Children and Youth review board.

The handmade sterling silver necklace we sent with the initial survey invitation was specially crafted for this project. It is a gift to all potential participants, regardless of survey completion.

There are no direct benefits from participation in this survey. The potential benefit of participation may be a sense of well-being from knowing that you are participating in a study that has the potential to help others.

A risk of participating in this study is that it could cause emotional distress. If you are experiencing emotional distress, please contact the Star Legacy National Telephone Support Line, where you will be connected with grief counselors who have personal experience with pregnancy loss: 952-715-7731; ext 1.

If you have questions about the survey, or no longer want to be contacted, please call the Ohio SOARS team at 614-366-9851 or email CDCFSOARS@osumc.edu.

By completing the survey, you agree that you have been informed of the benefits and risks of participating. You are also freely consenting to participate and confirm that you are at least 18 years of age.

**A list of frequently asked questions, and their answers, can be found in the back of this survey booklet.**

We would like to learn about your experiences to help improve care for women who experience stillbirths. The questions on this survey are about your pregnancy when your baby died, except when otherwise noted. We understand that some questions may be sensitive and we appreciate any information you are able to share. All responses will be kept confidential. Please know that regardless of how you answer these questions, our goal is to learn how our health care system could better serve moms and babies.

**Please mark the circle or 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 question is about *you*.

1. What is *your* date of birth?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M		D	D		Y	Y	Y	Y

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

2. During the **3 months before** you got pregnant, did you have any of the following health conditions? For each one, choose **No** or **Yes**.

	No	Yes
a. Asthma	<input type="radio"/>	<input type="radio"/>
b. Type 1 or type 2 diabetes ( <b>not</b> gestational diabetes or diabetes that starts during pregnancy)	<input type="radio"/>	<input type="radio"/>
c. High blood pressure or hypertension	<input type="radio"/>	<input type="radio"/>
d. Thyroid problems	<input type="radio"/>	<input type="radio"/>
e. PCOS (polycystic ovary syndrome)	<input type="radio"/>	<input type="radio"/>
f. Depression	<input type="radio"/>	<input type="radio"/>
g. Anxiety	<input type="radio"/>	<input type="radio"/>

3. During the **month before** you got pregnant, 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

**We would like to find out about your pregnancy history.**

**4. How many times have you been pregnant?** Please include this pregnancy and ALL pregnancies you have had (both losses and live births).

1 time → **Go to Question 10 on page 5**

2 to 4 times

5 to 7 times

8 or more times

**5. Before this pregnancy, did you have any babies who were born alive?**

No → **Go to Question 8**

Yes

**6. Did your last baby who was born alive weigh 5 pounds, 8 ounces (2.5 kilos) or less at birth?**

No

Yes

**7. Was your last baby who was born alive born earlier than 3 weeks before his or her due date?**

No

Yes

**8. Before this pregnancy, did you have pregnancies that ended in a loss (such as miscarriage or stillbirth)?**

No → **Go to Question 10 on page 5**

Yes

**9. Please indicate the number of previous losses you had that ended in each of the following time periods (not including this baby).**

- a. Number of pregnancies that ended before 12 weeks.....
- b. Number of pregnancies that ended between 12 and 27 weeks.....
- c. Number of pregnancies that ended at 28 weeks or later.....

**10. Thinking back to *just before* you got pregnant, how did you feel about becoming pregnant?**

Choose **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

**The next questions are about your *health insurance coverage* during and after your pregnancy.**

**11. During your pregnancy, what kind of health insurance did you have to pay for your prenatal care?**

Choose **ALL** that apply.

- Private health insurance (paid for by me, someone else, or through a job)
- Ohio Medicaid or an Ohio Medicaid Managed Care Plan (AmeriHealth, Anthem Blue Cross & Blue Shield, Buckeye, CareSource, Humana, Molina, UnitedHealthcare)
- TRICARE or other military health care
- Other health insurance (Please tell us) 

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

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

Choose **ALL** that apply.

- Private health insurance (paid for by me, someone else, or through a job)
- Ohio Medicaid or an Ohio Medicaid Managed Care Plan (AmeriHealth, Anthem Blue Cross & Blue Shield, Buckeye, CareSource, Humana, Molina, UnitedHealthcare)
- TRICARE or other military health care
- Other health insurance (Please tell us) 
- I do not have health insurance **now**

## DURING PREGNANCY

The next questions ask about the prenatal care you received during your pregnancy. Prenatal care includes visits to a doctor, nurse, or other health care worker during your pregnancy to get checkups and advice about pregnancy. (It may help to look at a calendar when you answer these questions.)

### 13. 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 15 on page 7**

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

- No
- Yes → **Go to Question 16 on page 8**

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

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



If you *did not* get prenatal care...

→ Go to Question 17 on page 9

**16. 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 one, choose *No* or *Yes*.**

	No	Yes
a. If I knew how much weight I should gain during pregnancy	<input type="radio"/>	<input type="radio"/>
b. If I was taking any over the counter medications or home remedies	<input type="radio"/>	<input type="radio"/>
c. If I was taking any prescription medication	<input type="radio"/>	<input type="radio"/>
d. If I was smoking cigarettes	<input type="radio"/>	<input type="radio"/>
e. If I was drinking alcohol	<input type="radio"/>	<input type="radio"/>
f. If someone was hurting me emotionally or physically	<input type="radio"/>	<input type="radio"/>
g. If I was feeling down or depressed	<input type="radio"/>	<input type="radio"/>
h. If I was using drugs such as marijuana, cocaine, crack, or meth	<input type="radio"/>	<input type="radio"/>
i. If I wanted to be tested for HIV (the virus that causes AIDS)	<input type="radio"/>	<input type="radio"/>
j. If I planned to breastfeed my new baby	<input type="radio"/>	<input type="radio"/>
k. If I planned to use birth control after my baby was born	<input type="radio"/>	<input type="radio"/>
l. If I knew about recommended sleeping positions during pregnancy	<input type="radio"/>	<input type="radio"/>
m. If I was aware of the risk of stillbirth during pregnancy	<input type="radio"/>	<input type="radio"/>
n. If I knew how to track my baby's movements	<input type="radio"/>	<input type="radio"/>

**17. During your pregnancy, did you keep track of your baby's movements?**

- No
- Yes

**18. Who was the main health care provider for your pregnancy? Choose *ONE* answer.**

- OB/GYN Physician
- Family Physician
- Midwife
- Maternal-Fetal Medicine Physician/Perinatologist
- Other (*Please tell us*) ↴

- I did not have one

**19. Please rate the degree to which you agree or disagree with the following statements. Overall, while making decisions during my pregnancy, I felt:**

	<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Neutral</i>	<i>Agree</i>	<i>Strongly Agree</i>
a. Comfortable asking questions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Comfortable declining care that was offered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Comfortable accepting the options for care that my doctor/ midwife recommended	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Pushed into accepting the options my doctor/ midwife suggested	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I chose the care options that I received	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. My personal preferences were respected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. My cultural preferences were respected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

- No
- Yes

**21. During your pregnancy, did you have any of the following health conditions? For each one, choose **No** or **Yes**.**

	<b>No</b>	<b>Yes</b>
a. Gestational diabetes (diabetes that <b>started</b> during <b>this</b> pregnancy)	<input type="radio"/>	<input type="radio"/>
b. High blood pressure (that <b>started</b> during <b>this</b> pregnancy), pre-eclampsia or eclampsia	<input type="radio"/>	<input type="radio"/>
c. Anxiety	<input type="radio"/>	<input type="radio"/>

**22. Did you have any of the following problems during your pregnancy?** For each one, choose **No** or **Yes**.

	No	Yes
a. Decreased or increased fetal movement	<input type="radio"/>	<input type="radio"/>
b. Vaginal bleeding	<input type="radio"/>	<input type="radio"/>
c. Kidney or bladder (urinary tract) infection (UTI)	<input type="radio"/>	<input type="radio"/>
d. <b>Severe</b> nausea, vomiting, or dehydration that sent me to the doctor or hospital	<input type="radio"/>	<input type="radio"/>
e. Cervix had to be sewn shut (needing a stitch in my cervix)	<input type="radio"/>	<input type="radio"/>
f. Complications with the placenta (such as placenta abruption or placenta previa)	<input type="radio"/>	<input type="radio"/>
g. Labor pains more than 3 weeks before my baby was due (preterm or early labor) <b>and</b> my doctor said that my cervix was dilated	<input type="radio"/>	<input type="radio"/>
h. Water broke more than 3 weeks before my baby was due (preterm premature rupture of membranes [PPROM])	<input type="radio"/>	<input type="radio"/>
i. I was told by a health care provider that I had COVID-19 <b>or</b> I tested positive for COVID-19	<input type="radio"/>	<input type="radio"/>
j. A gut feeling that something was wrong (If yes, please tell us) ↴ <div style="border: 1px solid black; border-radius: 15px; height: 250px; width: 100%; margin-top: 10px;"></div>	<input type="radio"/>	<input type="radio"/>

**23. Were you considered 'high risk' for *this* pregnancy?**

Choose **ALL** that apply.

- No
- Yes, due to a medical condition diagnosed **before** pregnancy
- Yes, due to a medical condition diagnosed **during** pregnancy
- Yes, due to a previous pregnancy complication
- Yes, due to a previous pregnancy loss
- Yes, due to another reason (*Please tell us*) →

- I don't know

**24. Did you have a detailed ultrasound at about 20 weeks (sometimes called an anatomic scan)?**

- No
- Yes

**25. During an ultrasound, were any abnormalities or concerns identified?**

- No
- Yes (*Please tell us*) →

**26. Did any of the tests you had during your pregnancy include Cardiotocography (CTG), also called a Non-Stress Test (NST)?**

- No
- Yes

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

**27. Did you have depression during your pregnancy?**

- No → **Go to Question 31 on page 15**
- Yes

**28. During your pregnancy, did you *ask for help* for depression from a doctor, nurse or other health care worker?**

- No
- Yes

**29. During your pregnancy, did you *get counseling* for depression?**

- No
- Yes

**30. At any time during your pregnancy, did you take prescription medicine for your depression?**

- No
- Yes

**31. During your pregnancy, which of the following statements about basic needs applied to you? For each one, choose **No** or **Yes**.**

	<b>No</b>	<b>Yes</b>
a. I had affordable, reliable transportation	<input type="radio"/>	<input type="radio"/>
b. I skipped meals or ate less because there wasn't enough money to buy food	<input type="radio"/>	<input type="radio"/>
c. I had safe housing	<input type="radio"/>	<input type="radio"/>
d. I had consistent and stable housing	<input type="radio"/>	<input type="radio"/>
e. My house or apartment was too crowded	<input type="radio"/>	<input type="radio"/>
f. I could keep basic utility services on (heat, water, light)	<input type="radio"/>	<input type="radio"/>
g. I had access to a telephone when needed	<input type="radio"/>	<input type="radio"/>
h. I had other basic needs that were not met (If yes, please tell us) ↴	<input type="radio"/>	<input type="radio"/>

**32. This question is about things that may have happened during the 12 months before your baby was delivered. For each one, choose **No** or **Yes**. (It may help to look at a calendar when you answer these questions.)**

	No	Yes
a. I got separated or divorced	<input type="radio"/>	<input type="radio"/>
b. I was evicted or forced to move	<input type="radio"/>	<input type="radio"/>
c. I didn't have a regular place to sleep	<input type="radio"/>	<input type="radio"/>
d. I was homeless or had to sleep outside, in a car, or in a shelter	<input type="radio"/>	<input type="radio"/>
e. My spouse, partner, or I lost a job	<input type="radio"/>	<input type="radio"/>
f. My spouse, partner, or I had a cut in work hours or pay	<input type="radio"/>	<input type="radio"/>
g. I had problems paying the rent, mortgage, or other bills	<input type="radio"/>	<input type="radio"/>
h. My spouse or partner went to jail	<input type="radio"/>	<input type="radio"/>
i. I went to jail	<input type="radio"/>	<input type="radio"/>
j. Someone very close to me had a problem with drinking or drugs	<input type="radio"/>	<input type="radio"/>
k. Someone close to me was very sick or died	<input type="radio"/>	<input type="radio"/>

**33. During your pregnancy, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way? For each one, choose **No** or **Yes**.**

	No	Yes
a. My spouse or partner	<input type="radio"/>	<input type="radio"/>
b. My ex-spouse or ex-partner	<input type="radio"/>	<input type="radio"/>
c. Someone else	<input type="radio"/>	<input type="radio"/>

**If you need assistance relating to question 33, please call 1-800-799-SAFE (7233).  
If you need immediate help, please call 911.**

34. Are there any other details that you would like to share that may have impacted your pregnancy?

## AFTER PREGNANCY

The next questions are about your baby and your experiences around the time of delivery. We understand that some of these options may not apply to you.

35. When was your baby due?

		/			/	2	0		
M	M		D	D		Y	Y	Y	Y

36. When was your baby delivered?

		/			/	2	0		
M	M		D	D		Y	Y	Y	Y

37. What date do you *think* your baby died?

		/			/	2	0		
M	M		D	D		Y	Y	Y	Y

38. What date did you find out that your baby died?

		/			/	2	0		
M	M		D	D		Y	Y	Y	Y

I don't know

**39. When did your baby die?**

- Before delivery
- During delivery
- I don't know

**40. How was your baby delivered?**

- Vaginally → **Go to Question 42**
- Cesarean delivery (c-section)



**41. Which statement best describes whose idea it was for you to have a cesarean delivery (c-section)? Choose **ONE** answer.**

- My health care provider scheduled my cesarean delivery **before** my baby died
- 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

**42. When were you discharged from the hospital after your baby was delivered?**

□	□	/	□	□	/	2	0	□	□
M	M		D	D		Y	Y	Y	Y

- I didn't have my baby in a hospital  
→ **Go to Question 48 on page 22**

**43. Which of the following things were you offered during your hospital stay?** For each one, choose **No** or **Yes**.

	No	Yes
a. Photographs of my baby	<input type="radio"/>	<input type="radio"/>
b. Photographs of my baby with family	<input type="radio"/>	<input type="radio"/>
c. Hand and/or foot prints/impressions	<input type="radio"/>	<input type="radio"/>
d. Holding my baby	<input type="radio"/>	<input type="radio"/>
e. Bathing my baby	<input type="radio"/>	<input type="radio"/>
f. Dressing my baby	<input type="radio"/>	<input type="radio"/>
g. Baptism or blessing of my baby	<input type="radio"/>	<input type="radio"/>
h. Mementos (hat, clothes, etc.)	<input type="radio"/>	<input type="radio"/>
i. Funeral/memorial service resources	<input type="radio"/>	<input type="radio"/>
j. Support groups/peer volunteer resources	<input type="radio"/>	<input type="radio"/>
k. Visit with a religious leader (bishop, chaplain, pastor, priest, rabbi, imam, etc.)	<input type="radio"/>	<input type="radio"/>
l. Visit with a hospital social worker	<input type="radio"/>	<input type="radio"/>
m. To have my baby stay in my room	<input type="radio"/>	<input type="radio"/>
n. A cooling bed	<input type="radio"/>	<input type="radio"/>

**44. Whether or not is was offered, would any of the following things have been helpful? For each one, choose No or Yes.**

	<b>No</b>	<b>Yes</b>
a. Photographs of my baby	<input type="radio"/>	<input type="radio"/>
b. Photographs of my baby with family	<input type="radio"/>	<input type="radio"/>
c. Hand and/or foot prints/impressions	<input type="radio"/>	<input type="radio"/>
d. Holding my baby	<input type="radio"/>	<input type="radio"/>
e. Bathing my baby	<input type="radio"/>	<input type="radio"/>
f. Dressing my baby	<input type="radio"/>	<input type="radio"/>
g. Baptism or blessing of my baby	<input type="radio"/>	<input type="radio"/>
h. Mementos (hat, clothes, etc.)	<input type="radio"/>	<input type="radio"/>
i. Funeral/memorial service resources	<input type="radio"/>	<input type="radio"/>
j. Support groups/peer volunteer resources	<input type="radio"/>	<input type="radio"/>
k. Visit with a religious leader (bishop, chaplain, pastor, priest, rabbi, imam, etc.)	<input type="radio"/>	<input type="radio"/>
l. Visit with a hospital social worker	<input type="radio"/>	<input type="radio"/>
m. To have my baby stay in my room	<input type="radio"/>	<input type="radio"/>
n. A cooling bed	<input type="radio"/>	<input type="radio"/>

**45. Did any of the following things happen to you before you left the hospital? For each one, choose **No** or **Yes**.**

	No	Yes
a. I felt adequately supported by my doctor or midwife in my grieving process	<input type="radio"/>	<input type="radio"/>
b. I felt adequately supported by the hospital nursing staff in my grieving process	<input type="radio"/>	<input type="radio"/>
c. I felt adequately supported by the grief counseling staff in my grieving process	<input type="radio"/>	<input type="radio"/>
d. I was given information about my breast milk coming in	<input type="radio"/>	<input type="radio"/>
e. I was given information about what to do when my breast milk came in	<input type="radio"/>	<input type="radio"/>
f. I was given a bereavement packet with information on where to seek support	<input type="radio"/>	<input type="radio"/>
g. The hospital staff gave me the opportunity to ask questions	<input type="radio"/>	<input type="radio"/>
h. My healthcare provider discussed with me what might have happened to my baby	<input type="radio"/>	<input type="radio"/>

**46. Please tell us if there is anything else that you would like to share about your experience in the hospital:**

The next questions are about autopsy and other exams that may have been done to learn about what caused your baby's death. We are trying to learn more about tests offered in hospitals. We understand that some of the options may not apply to you.

**47. Were any of the following tests *offered* to you during your hospital stay?** For each one, choose **No**, **Yes**, or **Don't Know**.

	No	Yes	Don't Know
a. Blood tests (mother)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Detailed exam of placenta	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Autopsy (full or partial)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Genetic testing of the baby	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**48. Were any of the following tests *performed* on you and/or your baby?** For each one, choose **No**, **Yes**, or **Don't Know**.

	No	Yes	Don't Know
e. Blood tests (mother)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Detailed exam of placenta	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Autopsy (full or partial)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Genetic testing of the baby	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**49. Did your baby have a full or partial autopsy?**

- No
- Yes



**If your baby *did not* have  
a full or partial autopsy...  
→ Go to Question 50**

**If your baby *did* have  
a full or partial autopsy...  
→ Go to Question 51**

**50. What were the reasons that the autopsy was not done?**

Choose **ALL** that apply.

- An autopsy was too expensive
- I was told it would not be covered by insurance
- I declined for personal or religious reasons
- I did not have enough information about the procedure
- The doctors were able to determine the cause(s) of death without an autopsy
- I was told that an autopsy would not provide any answers
- An autopsy was not offered to me
- Other (*Please tell us*) →

**51. Did you learn about what may have caused your baby's death?**

- No → **Go to Question 53 on page 24**
- Yes

**52. Which of the following things *may* have caused your baby's death? Choose **ALL** that apply**

- Complications with the cervix
- Complications with the umbilical cord/cord accident
- Placental abruption (separation of the placenta from the uterus)
- Infection
- Other complications with the placenta
- Hypertension
- Preterm (premature) labor
- Diabetes
- Membranes ruptured
- Congenital defect(s)/birth defect(s)/chromosomal abnormalities
- Other (*Please tell us*) →

**The next questions are about your health since your baby was delivered.**

**53. Since your baby was delivered, 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 → **Go to Question 55 on page 25**
- Yes

**54. During your postpartum checkup, did a doctor, nurse, or other healthcare worker do any of the following things?**

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

	No	Yes
a. Ask me if I want to be pregnant in the future	<input type="radio"/>	<input type="radio"/>
b. Talk to me about how long to wait before getting pregnant again	<input type="radio"/>	<input type="radio"/>
c. Talk to me about birth control methods I can use after giving birth	<input type="radio"/>	<input type="radio"/>
d. Ask me whether I was feeling down or depressed	<input type="radio"/>	<input type="radio"/>



**If you *did* have a postpartum checkup...**

→ **Go to Question 56 on page 26**

**55. Did any of these things keep you from having a postpartum checkup?** For each one, choose **No** or **Yes**.

	No	Yes
a. I didn't know I needed one	<input type="radio"/>	<input type="radio"/>
b. I didn't have enough money or insurance to pay for the visit	<input type="radio"/>	<input type="radio"/>
c. I felt fine and didn't think I needed to have a visit	<input type="radio"/>	<input type="radio"/>
d. I couldn't get an appointment when I wanted one	<input type="radio"/>	<input type="radio"/>
e. I didn't have any transportation to get to the clinic or doctor's office	<input type="radio"/>	<input type="radio"/>
f. I had too many other things going on	<input type="radio"/>	<input type="radio"/>
g. I couldn't take time off from work or school	<input type="radio"/>	<input type="radio"/>
h. I didn't have any one to help me take care of my children	<input type="radio"/>	<input type="radio"/>
i. The doctor's office was too far away	<input type="radio"/>	<input type="radio"/>
j. Other (If yes, please tell us) ↴	<input type="radio"/>	<input type="radio"/>

**56. Since my baby was delivered, overall, I have felt...** For each one, choose **No** or **Yes**.

	No	Yes
a. Comfortable asking questions about the postpartum care that I received	<input type="radio"/>	<input type="radio"/>
b. I could make decisions on the type of care I received like declining care I did <b>not</b> want	<input type="radio"/>	<input type="radio"/>
c. Comfortable accepting the type of care that my healthcare providers recommended	<input type="radio"/>	<input type="radio"/>
d. I was able to choose the care options that I received	<input type="radio"/>	<input type="radio"/>
e. My providers treated me with respect	<input type="radio"/>	<input type="radio"/>
f. Satisfied with the postpartum care I received	<input type="radio"/>	<input type="radio"/>
g. My providers were listening to my concerns	<input type="radio"/>	<input type="radio"/>

**57. The following questions ask about your emotional well-being since your baby was delivered.** For each one, choose **No** or **Yes**.

	No	Yes
a. I answered written questions asking me to rate my mood	<input type="radio"/>	<input type="radio"/>
b. A doctor, nurse, or other healthcare worker told me I had depression	<input type="radio"/>	<input type="radio"/>
c. A doctor, nurse, or other healthcare worker told me I had anxiety	<input type="radio"/>	<input type="radio"/>
d. A doctor, nurse, or other healthcare worker recommended that I take a prescription medication for depression	<input type="radio"/>	<input type="radio"/>
e. I took medication for depression	<input type="radio"/>	<input type="radio"/>
f. I took medication for anxiety	<input type="radio"/>	<input type="radio"/>
g. A doctor, nurse, or other healthcare worker recommended that I get counseling for depression	<input type="radio"/>	<input type="radio"/>
h. I received counseling for depression or anxiety	<input type="radio"/>	<input type="radio"/>
i. I received support or counseling for feelings of grief	<input type="radio"/>	<input type="radio"/>



If you *did not* receive support or counseling for feelings of grief → Go to Question 58

If you *did* receive support or counseling for feelings of grief → Go to Question 59

**58. Did any of the following things keep you from receiving support or counseling?** For each one, choose **No** or **Yes**.

	No	Yes
a. I felt fine and did not think I needed support or counseling	<input type="radio"/>	<input type="radio"/>
b. I didn't know where to go for counseling	<input type="radio"/>	<input type="radio"/>
c. I didn't have insurance to cover the cost of counseling	<input type="radio"/>	<input type="radio"/>
d. I was not aware of support groups in my area	<input type="radio"/>	<input type="radio"/>
e. Other (If yes, please tell us) ↘ <div style="border: 1px solid black; height: 100px; width: 100%; margin-top: 5px;"></div>	<input type="radio"/>	<input type="radio"/>

**59. Are you pregnant now?**

No → Go to Question 61 on page 28

Yes  
↓

**60. What was the first day of your last period?**

/   /  2  0    
M M D D Y Y Y Y

I did not have a period before I became pregnant again

The last questions are about the time during the **12 months before your baby was delivered**.

**61. During the 12 months before your baby was delivered, 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 now getting.

- \$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

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

People

**63. What is today's date?**

/   /      
M M D D Y Y Y Y

**64. Please use this space for any additional comments you would like to share about your pregnancy and baby.**

## Frequently Asked Questions

### **What is Ohio SOARS?**

Ohio SOARS (Ohio Study of Associated Risks of Stillbirth) is a research project funded by the National Foundation for the Centers for Disease Control and Prevention, Inc. ("CDC Foundation"). Our purpose is to find out why stillbirths happen. To do this, our questionnaire asks mothers questions about their behaviors and experiences around the time of their pregnancy. Each year in Ohio, hundreds of babies are stillborn. We need your help to find out why and to improve the care that women and families receive. Your answers will help us learn more about ways to improve outcomes for future mothers and babies in Ohio.

### **Will my answers be kept confidential?**

Yes—all answers are kept completely private to the extent permitted by law. All answers given on the questionnaires will be grouped together to give us information on Ohio mothers experiencing a stillbirth. In reports from this survey, no woman will be identified by name.

### **How was I chosen to participate?**

All women who experience a stillbirth in Ohio between July 2024 - December 2025 are contacted to participate.

### **Is it really important that I answer these questions?**

Yes! 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 Ohio, we would like each mother to answer the questions. From the information you give us, we may be able to improve health care for women and babies in Ohio. 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 this initiative.

### **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 health before, during, and after pregnancy beyond the actual health care she receives. These questions ask about social conditions that may affect health outcomes.

### **What if I want to ask more questions about Ohio SOARS?**

Please call our team at 614-366-9851 or email at CDCFSOARS@osumc.edu. We will be happy to answer any questions that you may have about Ohio SOARS.

Please return your questionnaire  
in the enclosed return envelope  
or mail it to:

**Ohio SOARS**  
**150 Pressey Hall**  
**1070 Carmack Road**  
**Columbus, Ohio 43210**

**Thank you for answering these questions.  
Your answers will help us to learn more about  
stillbirth and how we can improve the care  
received by families.**

**Again, please accept our deepest sympathies to  
you and your family on the loss of your baby.**

The Ohio SOARS project is part of the Building Capacity for Collection of Maternal Self-Reported Experiences Following a Stillbirth project, which is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$2,234,369 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CDC/HHS or the U.S. Government.

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