

## COVID-19 Supplement\_English

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

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

**Check ONE answer**

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

**Go to Question CV3**

**Go to Question CV4**

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

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

Please tell us:

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

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

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

For each one, check:

**A** if you *always* did it,

**S** if you *sometimes* did it, or

**N** if you *never* did it.

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

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

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

**If your baby was not born in the hospital, go to Question CV9.**

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

**Check ALL that apply**

- My husband or partner
  - Another family member or friend
  - A doula
  - Some other support person (not including hospital staff)
- Please tell us:

- The hospital did not allow me to have any support people

If your baby is not alive, go to Question CV10.

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

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

If you did not breastfeed your new baby, go to Question CV9.

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

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

If your baby is not living with you, go to Question CV10.

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

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

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

**Check ONE answer**

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

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

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

**Thank you for answering these questions!**