COPE: Coronavirus Perinatal Experiences - Impact Survey (COPE-IS)

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The Coronavirus Perinatal Experiences Impact Survey (COPE-IS) is a newly developed measure designed to learn about the experiences of new and expectant mothers in the time of the Coronavirus COVID-19 (SARS-CoV-2) pandemic. At present, psychometric properties for the measure have yet to be established and scoring procedures have yet to be determined. In the future, those updates will be available on the Open Science Framework (OSF) at https://osf.io/uqhcv/.

This assessment tool arose as a collaborative effort of more than 100 expert scientists and clinicians around that came together to build a tool that could be sensitive both to the events and circumstances of women's lives and also their unique responses to them. While researchers are named above as having organized this effort, the product is a genuine reflection of collaborative work by a much larger international group that developed this tool.

Given that this tool is already in widespread use, we expect that by the Fall of 2020, it will be possible to track the distribution, use, and demographics of and international COVID-19 pandemic perinatal study sample. Language translations of this assessment tool are already available and will continue to be released on OSF at https://osf.io/uqhcv/, along with project REDCap/Qualtrics files for ease of implementation.

Given the rapid changes in circumstances experienced by individuals and families across our global community, we have developed and released the *COPE: Coronavirus Perinatal Experiences Scale – Impact Update (COPE-IU)*. COPE-IU is a companion to the COPE-IS assessment tool. The COPE-IU is a shorter assessment (50-items) intended as a standalone instrument, or for brief, repeat longitudinal follow-up assessments, or updates.

All materials associated with this assessment tool are completely open source with no restrictions to their rights or use. For researchers planning to distribute this instrument, we welcome opportunity to join our COPE research collaborative. If you wish to join, please email moriah.thomason@nyulangone.org. We will add you to the distribution list of connected researchers using this instrument.

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1. Are you currently pregnant?
   (1) Yes *> move to section: pregnant women*
   (0) No *> move to section: postpartum women*

PREGNANT WOMEN

PART 1: PERINATAL EXPERIENCES RELATED TO THE COVID-19 OUTBREAK

1. When is your due date? *(date field)*:_____

2. Is this your first pregnancy?
   (1) Yes
   (0) No

3. Have you experienced any of the following during your pregnancy? (check all that apply)
   (1) Gestational diabetes
   (2) Hypertension
   (3) Short cervix
   (4) Small fetal size
   (5) Other
   (6) None
   (7) Prefer not to answer
   If other, please describe here: *(open field)*_____

4. Which of the following best describes your pregnancy?
   (1) Singleton
   (2) Twins
   (3) Multiples

5. How well are you currently being supported by your primary prenatal care provider(s)?
   (1) Very well supported
   (2) Somewhat well supported
   (3) Not very well supported

6. **Has the support you receive from your prenatal care practice changed due to the COVID-19 outbreak?**
   - (1) Significantly worsened
   - (1) Somewhat worsened
   - (2) No change
   - (3) Somewhat improved
   - (4) Significantly improved

7. **What resources are currently available to you from your prenatal care practice? (check all that apply)**
   - (1) Regular in-person appointments
   - (2) Virtual care appointments
   - (3) Phone call appointments
   - (4) Online messaging portal for questions/concerns
   - (5) Emergency care
   - (6) Home blood pressure monitoring
   - (7) Home fetal heart rate monitoring
   - (8) Don't know
   - (9) Other

   If other, please describe here: *(open field)* _____

8. **Which of the following changes are you experiencing as a result of the COVID-19 outbreak? (Check all that apply)**
   - (1) Change in schedule for planned C-section or labor induction
   - (2) Changed from planned vaginal birth to induction or C-section
   - (3) Changed from planned home birth to a hospital birth
   - (4) Changed from plan for hospital delivery to a home birth
   - (5) Change in selected hospital or birthing center
   - (6) Change in prenatal health care provider(s)
   - (7) Cancellation of or reduction in frequency of prenatal visit(s)
   - (8) Changed format of prenatal care (i.e. no group classes)
   - (9) Cancellation of hospital tours
   - (10) Transition from in-person prenatal visits to virtual visits
   - (11) None apply

9. **Are you concerned about possible future changes to your <u>medical care during your baby's birth</u> as a result of the COVID-19 outbreak?**
   - (1) Yes
   - (0) No
     a. *If yes,* **please provide concerns**: _____
     b. **How concerned are you?**
        (Likert scale 1-7, 1 = no concern, 7 = highly concerned)

10. **Are you concerned about possible future changes in <u>support and involvement of your family and friends in your baby's birth</u> as a result of the COVID-19 outbreak?**
    - (1) Yes
    - (0) No

a. If yes, please provide concerns: _____
b. How concerned are you?
(Likert scale 1-7, 1 = no concern, 7 = highly concerned)

11. Do you have any concerns about your child's health as a result of the COVID-19 outbreak?
(1) Yes
(0) No

a. If yes, please provide concerns: _____
b. How concerned are you?
(Likert scale 1-7, 1 = no concern, 7 = highly concerned)

12. How important are the following to help you and your family during the COVID-19 outbreak? *(matrix: (1) not important at all, (2) somewhat important, (3) very important)*
(1) More one-on-one conversations with my prenatal care provider
(2) Information about how to reduce stress
(3) Access to a mental health provider
(4) Online support groups
(5) Interaction with other pregnant people
(6) Rapid response to questions and concerns
(7) Examples of how other women are planning for potential changes in their pregnancy, birth and postpartum care

13. Are there other resources that would be helpful to you and your family during the COVID-19 outbreak? *(open field)* _____

14. Would you be interested in in learning more about an opportunity to participate in a new virtual babies-pregnant moms' social group?
(1) Yes
(0) No

If yes, **Do you have a preference that your moms group be local versus national (moms across the US or in your region preferred)?**
(1) Local
(2) National
(3) Both
(4) No preference

(End of section; pregnant moms skip postpartum section and move to section: perinatal experiences)

POSTPARTUM WOMEN

PART 1: PERINATAL EXPERIENCES RELATED TO THE COVID-19 OUTBREAK

[OPTIONAL]
(screening question, only relevant if excluding mothers of infants > 6 months old…)
Are you the mother of an infant under 6 months of age?
(1) Yes > *move forward*

(0) No > *"Thank you for your willingness to respond to our survey asking about experiences and feeling associated with the COVID-19 outbreak. This survey is intended only for pregnant women and women with children younger than 6 months, and therefore, you need not continue with this survey".*

1. **What date was your most recent child born?**

2. **Was this your first pregnancy?**
   (1) Yes
   (0) No

3. **During pregnancy, did you experience any of the following? (check all that apply)**
   (1) Gestational diabetes
   (2) Hypertension
   (3) Short cervix
   (4) Small fetal size
   (5) Low birth weight
   (6) Delivery <37 weeks gestation
   (7) Delivery <32 weeks gestation
   (8) Other (open field)
   (9) None of these apply
   If other, please describe here: *(open field)*_____

4. **Where did you give birth? (choose one)**
   (1) Hospital
   (2) Birth center
   (3) Home birth
   (4) Other not listed
   If 1, 2 or 4, **What is the name of the hospital or birth center where your baby was born?** *(open field)*_____

5. **Where was your baby born? (City, State, Country)** *(open field)*_____

6. **Has your baby received treatment in the NICU or PICU?**
   (1) Yes
   (0) No

7. **Which of the following best describes your pregnancy?**
   (1) Singleton
   (2) Twins
   (3) Multiples

8. **How well have you been supported by your <u>pre- and postnatal care provider(s)</u>?**
   (1) Very well supported
   (2) Somewhat well supported
   (3) Not very well supported

9. **Did the support you received from your <u>pre- and postnatal care provider(s)</u> change due to the COVID-19 outbreak?**
    (1) Significantly worsened
    (2) Somewhat worsened
    (3) No change
    (4) Not relevant (e.g., COVID related events happened after my delivery)
    (5) Somewhat improved
    (6) Significantly improved

10. **How important are the following to help you and your family during the COVID-19 outbreak**
    (matrix: (1) not important at all, (2) somewhat important, (3) very important)
    (1) More one-on-one conversations with my medical provider
    (2) More one-on-one conversations with my child's medical provider
    (3) Information about COVID-19 and infant/child health
    (4) Information about how to reduce stress
    (5) Access to a mental health provider
    (6) Online support groups
    (7) Interaction with other parents
    (8) Rapid response to questions and concerns
    (9) Examples of how other women are planning for potential changes in their postpartum and baby caregiving plans

11. **Are there other resources that would be helpful to you and your family during the COVID-19 outbreak?** *(open field)*_____

12. **Are you currently breastfeeding?**
    (1) Yes
    (0) No
    a. *If yes,* **Are you exclusively breastfeeding?**
        (1) Yes
        (0) No

13. **Did any of your birth plans change as a result of the COVID-19 outbreak? (check all that apply)**
    (1) Reduced access to preferred medications before or after delivery (i.e. nitrous oxide, epidural)
    (2) Change to planned delivery location
    (3) My elective induction or C-section was not permitted as planned
    (4) My elective vaginal birth changed to induction or C-section
    (5) My health care provider (e.g., doctor, doula, midwife) was not available for by baby's birth as planned
    (6) Support people (e.g. partner, family) were not be permitted to attend baby's delivery
    (7) I was separated from baby immediately after delivery
    (8) I was separated from baby for a long period after delivery (e.g., my baby was quarantined in the hospital nursery)
    (9) No change

(10) Other
If other, please describe here: *(open field)*_____

14. Did any of your postnatal experiences change as a result of the COVID-19 outbreak? (check all that apply)

(1) Family and friends were not able to visit me and my baby after birth (e.g., due to social distancing or travel restrictions)
(2) I did not have access to lactation or other antenatal support following discharge from the hospital
(3) My post-partum visit was cancelled
(4) My post-partum visit was a virtual visit
(5) I was unable to get the type of contraception that I wanted
(6) I was unable to discuss "baby blues" or issues related to my mood
(7) My baby's well visits were made virtual
(8) My baby's well visits were canceled
(9) My baby's immunizations were postponed
(10) No change
(11) Other

If other, please describe here: *(open field)*_____

15. In general, what is the level of distress you have experienced about changes to your birth and postnatal experiences due to COVID-19?

(Likert scale 1-7, 1 = No distress, 7 = Highly distressed)

16. Are you concerned about any possible future changes to how you will <u>care for your baby</u> as a result of the COVID-19 outbreak?

(1) Yes
(0) No

a. If yes, please provide concerns: _____
b. How concerned are you?

(Likert scale 1-7, 1 = No concern, 7 = Highly concerning)

17. Do you have any concerns about your child's health as a result of the COVID-19 outbreak?

(1) Yes
(0) No

c. If yes, please provide concerns: _____
d. How concerned are you?

(Likert scale 1-7, 1 = No concerns, 7 = Highly concerning)

18. Are you currently involved in virtual support groups (e.g., virtual mom group, virtual lactation support, etc.)?

(1) Yes
(0) No

If yes, **what kind of group(s) are you involved with?** *(open field)*_____

19. Would you be interested in in learning more about an opportunity to participate in a new virtual babies-moms social group?

(1) Yes
(0) No

If yes, **Do you have a preference that your moms group be local versus national (moms across the US or in your region preferred)?**

(5) Local
(6) National
(7) Both
(8) No preference

(End of section, postpartum moms; advance to next section: perinatal experiences)

ALL RESPONDENTS

PART 2: COVID-19 EXPOSURES AND SYMPTOMS (SELF AND FAMILY)

We are interested in whether you and your family have been exposed to or are experiencing any symptoms like those seen in COVID-19.

Major symptoms: fever or chill, cough, shortness of breath.
Minor symptoms: sore throat, headache, muscle or body aches, runny nose, fatigue, diarrhea/nausea, vomiting, loss of smell or taste, itchy/red eyes.

1. **For all of the following people, please indicate which has occurred. Check all that apply.**
   ROWS (self, partner, newborn, other children, other living in home)
   Section i. COLUMN: (1) No symptoms, (2) currently have symptoms, (3) symptoms in the past
   Section ii. COLUMN: (1) Never tested, (2) Tested positive for COVID-19, (3) Tested negative for COVID-19, (4) Tested and waiting for results
   If click (self) tested, conditional response: **Date of test: _____**

2. **Have any of the following individuals <u>been in contact with someone who has tested positive</u> for COVID-19? (within 14 days before or after a positive test date) (check all that apply)**
   (1) Self
   (2) Partner
   (3) Newborn
   (4) Other children
   (5) Other living in home
   (6) Your parents
   (7) Close friends/neighbors
   (8) Other
   (9) None known

   If other, please specify: *(open field)*_____

3. **Do any if the following individuals have higher risk of contracting COVID-19 due to <u>existing medical condition(s) or advanced age</u>? (check all that apply)**
   (1) Self
   (2) Partner
   (3) Newborn
   (4) Other children

(5) Other living in home
(6) Your parents
(7) Close friends/neighbor
(8) Other
(9) None known

If other, please describe: *(open field)*_____

4. **Would you like to be tested for COVID-19 but have not been able to get tested?**
   (1) Yes
   (0) No

5. **How many people do you know personally (have met in person) who have become ill with COVID-19? (count individual people only once in fields below)**
   (1) Confirmed case number? _____
   (2) Suspected case number? _____

6. **In general, how distressed are you about <u>your own</u> COVID-19 related symptoms or potential illness?**
   (Likert scale 1-7, 1 = No distress, 7 = Highly distressed)

7. **In general, how distressed are you about COVID-19 related symptoms or potential illness <u>in friends and family</u>?**
   (Likert scale 1-7, 1 = No distress, 7 = Highly distressed)

PART 3: COVID-19 FINANCIAL CONSIDERATIONS (CURRENT AND EXPECTED FUTURE)

8. **What type of employment do you have? (Please check all that apply)**
   (1) Working full-time
   (2) Working part-time
   (3) On maternity leave
   (4) On other form of temporary leave
   (5) Looking for a job
   (6) Student
   (7) Unemployed
   (8) Stay at home caregiver
   (9) Retired
   (10) Other
   (11) Prefer not to answer

   If other, please describe: _____

9. **<u>CURRENT</u> employment and financial impacts of the COVID-19 outbreak**
   a. **Which of the following changes in employment have <u>already</u> occurred due to the COVID-19 outbreak? *(check all that apply; leave blank if not relevant)*** *(matrix with columns: (1) Self, (2) Partner)*
   (1) Move to remote work
   (2) Loss of hours
   (3) Decreased pay
   (4) Loss of job

(5) Decreased job security
(6) Disruptions due to childcare challenges
(7) Increased hours
(8) Increased responsibilities
(9) Increased monitoring and reporting
(10) Loss of health insurance
(11) Reduced ability to afford childcare
(12) Reduced ability to afford rent/mortgage
(13) Having to fire or furlough employees
(14) Decrease in value of your retirement, investments or savings

10. In general, what is the level of distress you have experienced relating to employment and financial impacts due to the COVID-19 outbreak?
(Likert scale 1-7, 1 = No distress, 7 = High distress)

11. <u>FUTURE</u> (expected) employment and financial impacts of the COVID-19 outbreak

a. Which of the following changes in employment do you expect <u>will occur</u> in the future? *(check all that apply; leave blank if not relevant)* *(matrix with columns: (1) Self, (2) Partner)*

(1) Move to remote work
(2) Loss of hours
(3) Decreased pay
(4) Loss of job
(5) Decreased job security
(6) Disruptions due to childcare challenges
(7) Increased hours
(8) Increased responsibilities
(9) Increased monitoring and reporting
(10) Loss of health insurance
(11) Reduced ability to afford childcare
(12) Reduced ability to afford rent/mortgage
(13) Having to fire or furlough employees
(14) Decrease in value of your retirement, investments or savings

12. In general, what is the level of distress you have <u>about FUTURE employment and financial impacts</u> of the COVID-19 outbreak?
(Likert scale 1-7, 1 = No distress 7 = Highly distressed)

PART 4: COVID-19 SOCIAL SUPPORT ACTIVITIES

13. How are you currently trying to meet your needs for social support? (Check all that apply)

(1) Phone calls
(2) Electronic communication (e.g. email, text)
(3) Virtual (e.g. video call such as FaceTime)
(4) In-person
(5) Social Media (Facebook, Instagram)
(6) Other

14. Who are you receiving social support from? (Check all that apply)

(1) Family
(2) Friends
(3) Religious community
(4) Mental health care provider
(5) Health care provider
(6) Nonprofit and community organizations
(7) Other

15. Prior to the COVID-19 outbreak, how supported did you feel by your social network?
(Likert scale 1-7, 1 = not supported, 7 = very supported)

16. Currently, how supported do you feel by your social network?
(Likert scale 1-7; 1 = not supported, 7 = very supported)

17. In general, what is the level of distress you have experienced with <u>disruptions to your social support</u> due to the COVID-19 outbreak?
(Likert scale 1-7, 1 = no distress, 7 = high distress)

PART 5: COVID-19 OUTBREAK – RESTRICTED ACTIVITIES

18. Which of the following situations apply to you and your family? (check all that apply)

(1) No restrictions currently
(2) Voluntary quarantine due to fear of exposure
(3) Voluntary quarantine due to confirmed/suspected case in household
(4) Mandated self-isolation/quarantine by medical professional due to confirmed/suspected case (not allowed to go out for any reason including groceries)
(5) Stay-at-home order by local government and/or employer urging people to stay home (e.g., can still take walks and socialize outdoors while maintaining social distancing)
(6) Shelter-in-place order by local government (i.e., only permitted outdoors for essential purposes)

19. Do you agree with the restrictions that have been recommended or required by your local and national government?

(1) I think the restrictions are too lax
(2) I think the restrictions are too strict
(3) I think the restrictions are good

20. In your home do have access to…

(1) An internet connected phone?
  (1) Yes
  (0) No
(2) An internet connected computer?
  (1) Yes
  (0) No

(3) A quiet place for private calls, work or individual activities?
    (1) Yes
    (0) No
(4) Private outdoor space (i.e. yard)?
    (1) Yes
    (0) No
(5) Public outdoor space(s)?
    (1) Yes
    (0) No

21. Which of the following behaviors are you restricting on purpose (you have decided to do these things less)? (check all that apply; leave blank if none apply)

(1) In-person contact with family inside the home (i.e. you have decided to stay separate from one or more members of your household)
(2) In-person contact with family who live outside the home
(3) In-person contact with friends
(4) In-person contact with other pregnant women or parents
(5) In-person contact with colleagues at work
(6) Regular childcare by outside care provider
(7) Family or personal travel
(8) Family activities in outdoor spaces (e.g., beaches, forests, national parks)
(9) Family activities in public spaces (e.g., museums, playgrounds, theatres)
(10) Going to restaurants or stores
(11) Indoor exercise classes or recreational sports
(12) In-person events in the community
(13) In-person religious services

22. Which activity do you miss the most? (choose one)

(1) In-person contact with family and/or friends
(2) In-person contact with colleagues at work
(3) In-person contact with other pregnant women or parents
(4) Breaks from childcare duties
(5) Family or personal travel
(6) Family activities in public spaces (e.g., museums, playgrounds, theatres)
(7) Outdoor recreational activities
(8) Going to restaurants or stores
(9) Indoor exercise classes or recreational sports
(10) In-person events in the community
(11) In-person religious services
(12) Other

If other, please list: _____

23. Do you have any of the following concerns for your family? For items of concern, please indicate your feelings …

(matrix: (1) not of concern, (2) mildly distressing, (3) moderately distressing, (4) highly distressing)

(1) Reduced access to foods or goods in the future
(2) Reduced access to medicine and hygiene supplies in the future

(3) Reduced access to baby supplies (e.g. Formula, diapers, wipes) in the future
(4) Reduced access to mental health care in the future
(5) Reduced access to general health care in the future
(6) Reduced access to positive social interactions due to social distancing and/or quarantine

24. Which one of these sources do you find the most useful for receiving information about the COVID-19 outbreak? (select all that apply)

(1) Prenatal or postpartum medical care providers
(2) Child's pediatrician
(3) Other pregnant women/new moms
(4) Family or friends
(5) International health organizations (e.g. WHO)
(6) Centers for Disease Control and Prevention (CDC)
(7) Federal government
(8) State health department
(9) Local government (city or county)
(10) Social network sites (e.g. Facebook)
(11) National news
(12) Local news
(13) Websites about pregnancy
(14) Other community organization
(15) Other
If other, please list: _____

PART 6: COVID-19 OUTBREAK – COPING AND ADJUSTMENT

25. What are you doing to cope with your stress related to the COVID-19 outbreak? (check all that apply)

(1) Getting a good night's sleep
(2) Meditation and/or mindfulness practices
(3) Talking with friends and family
(4) Engaging in more family activities (e.g., games, sports)
(5) Talking to people who are pregnant or parenting
(6) Increased screen time (i.e. gaming, binge watching shows)
(7) Increased time on social media (Facebook, Instagram and other)
(8) Decreased time on social media (Facebook, Instagram and other)
(9) Increased time following news coverage
(10) Decreased time following news coverage
(11) Eating comfort foods (e.g., candy and chips)
(12) Eating healthier
(13) Increased self-care (e.g., taking baths, giving self a facial)
(14) Increased time reading books, or doing activities like puzzles and crosswords
(15) Exercising
(16) Drinking alcohol
(17) Using tobacco (i.e. smoking, vaping)
(18) Using marijuana (i.e. smoking, vaping, eating)
(19) Using CBD only

(20) Using other recreational drugs
(21) Using new prescription drugs
(22) Using over the counter sleep aids
(23) Talking to my health providers more frequently
(24) Talking with a mental health care provider (e.g. therapist, psychologist, counselor)
(25) Helping others
(26) None
(27) Other
If other, please list: _____

PART 7: COVID-19 OUTBREAK – EMOTIONS AND FEELINGS

[Sources for question 24, below: (items 1-17): Derogatis, L.R.(1993). BSI Brief Symptom Inventory: Administration, Scoring, and Procedure Manual (4th Ed.). Minneapolis, MN: National Computer Systems; (items 18-27) Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov.]

26. In the past 7 days, including today, how often were you distressed by:

Each Q is given response options:
(1) Not at all
(2) A little bit
(3) Moderate
(4) Quite often
(5) Extremely

1. Faintness or dizziness
2. Feeling no interest in things
3. Nervousness or shakiness inside
4. Pains in the heart or chest
5. Feeling lonely
6. Feeling tense or keyed up
7. Nausea or upset stomach
8. Feeling blue
9. Suddenly scared for no reason
10. Trouble getting your breath
11. Feeling of worthlessness
12. Spells of terror or panic
13. Numbness or tingling in parts of your body
14. Feeling hopeless about the future
15. Feeling so restless you couldn't sit still
16. Feeling weak in parts of your body
17. Feeling fearful
18. Feeling super alert or watchful or on guard
19. Feeling jumpy or easily startled
20. Having difficulty concentrating
21. Trouble experiencing positive feelings
22. Feeling guilty or blaming yourself

23. Feeling irritable, angry or aggressive
24. Repeated disturbing and unwanted thoughts about the COVID-19 outbreak
25. Repeated disturbing dreams about the COVID-19 outbreak
26. Trying to avoid information or reminders about the COVID-19 outbreak
27. Taking too many risks or doing things that could cause you harm

27. How has the COVID-19 outbreak changed your <u>stress levels or mental health</u>?

(1) Worsened them significantly
(2) Worsened them moderately
(3) No change
(4) Improved them moderately
(5) Improved them significantly

28. How has the COVID-19 outbreak changed your <u>sleep</u>?

(1) Worsened my sleep significantly
(2) Worsened my sleep moderately
(3) No change
(4) Improved my sleep moderately
(5) Improved my sleep significantly

29. How has the COVID-19 outbreak changed your <u>daily energy levels</u>?

(1) Worsened my energy significantly
(2) Worsened my energy moderately
(3) No change
(4) Improved my energy moderately
(5) Improved my energy significantly

30. How much has the COVID-19 outbreak disrupted your ability to engage in…

a. Social activities
   i. Extreme disruption
   ii. Moderate disruption
   iii. Some disruption
   iv. No disruption

b. Work activities
   i. Extreme disruption
   ii. Moderate disruption
   iii. Some disruption
   iv. No disruption

c. Physical activities (any form of exercise, including walking, running, playing on sports teams and exercise classes)
   i. Extreme disruption
   ii. Moderate disruption
   iii. Some disruption
   iv. No disruption

d. Access to healthy meals

i. Extreme disruption
ii. Moderate disruption
iii. Some disruption
iv. No disruption

31. Overall level of impact to your daily life due to the COVID-19 outbreak.
Likert scale (1-7, 1 = nothing, 7 = extreme)

32. Overall level of stress related to the COVID-19 outbreak.
Likert scale (1-7, 1 = nothing, 7 = extreme)

33. Please indicate the extent to which you view the COVID-19 outbreak as having either a positive or negative impact on your life.
(1) Extremely Negative
(2) Moderate Negative
(3) Somewhat Negative
(4) No Impact
(5) Slightly Positive
(6) Moderately Positive
(7) Extremely Positive

34. How long do you think it will be before things "go back to normal"?
(1) <1 month
(2) 2-3 months
(3) 3-6 months
(4) 6-12 months
(5) 12 months +
(6) never

35. What is the single greatest source of stress due to the COVID-19 outbreak right now? (check only one)
(1) Health concerns
(2) Financial concerns
(3) Impact on your child
(4) Impact on your partner
(5) Impact on your community
(6) Impact on family members (e.g. elderly parents)
(7) Impact on close friends
(8) Impact on society
(9) Access to food
(10) Access to baby supplies (e.g. formula, diapers, wipes)
(11) Access to mental health care
(12) General well-being due to social distancing and/or quarantine
(13) Stress about other (open field)
(14) I am not stressed

Other sources of stress: _____

PART 8: COVID-19 OUTBREAK – HEALTH BACKGROUND, MENTAL HEALTH, AND SUBSTANCE USE

An important area for researchers is to understand the experiences of people that may be more vulnerable to stress associated with the COVID-19 outbreak. The results of this survey are private. This means that responses to this survey shared anywhere outside of the research team are anonymous and not linked to you.

36. Do you have history of any of the following medical conditions? (check all that apply)

(1) Respiratory problems (e.g., Asthma, Tuberculosis)
(2) Diabetes
(3) Heart disease or hypertension
(4) Lung disease
(5) Liver disease
(6) Cancer
(7) A disease compromising the immune system
(8) Mood and/or anxiety disorder
(9) None apply

37. Do members of your household have history of any of the following medical conditions? (check all that apply) *(matrix: (1) partner, (2) child, (3) other member of household)*

(1) Respiratory problems (e.g., Asthma, Tuberculosis)
(2) Diabetes
(3) Heart disease or hypertension
(4) Lung disease
(5) Liver disease
(6) Cancer
(7) A disease compromising the immune system
(8) Mood and/or anxiety disorder
(9) None apply

38. Are you <u>currently</u> receiving treatment for <u>mental health concerns</u> (for example, depression, anxiety, stress, ADHD, bipolar disorder, eating disorder, or PTSD)?

(1) Yes
(2) No
(3) I decline to answer

(if yes…)

Has your mental health treatment changed due to the COVID-19 outbreak?

(1) Significantly worsened
(2) Somewhat worsened
(3) No change
(4) Somewhat improved
(5) Significantly improved

39. Are you <u>currently</u> receiving treatment for <u>substance abuse</u> (problems with illicit drugs, prescription drugs or alcohol)?

(1) Yes

(0) No
(1) I decline to answer

(if yes…)

Has your mental health/substance abuse treatment changed due to the COVID-19 outbreak?

(1) Significantly worsened
(2) Somewhat worsened
(3) No change
(4) Somewhat improved
(5) Significantly improved

40. At any time in your past have you received treatment for any of the following? (check all that apply)

(1) Mental health
(2) Substance abuse (including problems with prescription drugs, illegal drugs or alcohol)
(3) I decline to answer
(4) I have had mental health concerns but have not been treated
(5) I have had substance abuse concerns but have not been treated
(6) None apply

41. Please indicate which of the drugs and medications you have used <u>at any time in your past:</u> *(matrix: (1) Yes, (2) No, (3) Prefer not to answer)*

(1) Marijuana or hashish
(2) Nicotine products (including cigarettes, cigars, vaping)
(3) Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)
(4) Prescription antidepressants (e.g., Prozac, Zoloft, Celera)
(5) Methamphetamine (speed, crystal meth, ice, etc.)
(6) Cocaine (coke, crack, etc.)
(7) Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)
(8) Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, Ghb, etc.)
(9) Street opioids (heroin, opium, etc.)
(10) Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)
(11) Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)

PART 9: DEMOGRAPHIC BACKGROUND

42. What is your date of birth? *(date field)*:_____

43. What is the highest level of education that you have completed?

(1) Less than 10th Grade
(2) 10th – 12th Grade
(3) High School Degree/GED
(4) Trade school/apprenticeship
(5) Partial College

(6) 2-year College Degree
(7) 4-year College Degree
(8) Graduate Degree
(9) Unknown/Unsure

44. Which best describes you? Are you…

(1) Single
(2) Partnered/Married
(3) Divorced/Separated
(4) Widowed
(5) Other

If other, please list: _____

45. Do you currently cohabitate with a partner?

(1) Yes
(0) No

If yes, **How long have you lived with this partner?**

(1) Less than a year
(2) 1-3 years
(3) 3-6 years
(4) 6-9 years
(5) 9 or more years

46. Which best describes where you currently live:

(1) A studio dwelling
(2) A 1-bedroom dwelling
(3) A multi-bedroom dwelling
(4) I do not have a stable housing arrangement
(5) I decline to answer

47. Has your living environment changed since the beginning of the pandemic?

(1) Yes
(0) No

If yes, **Has the change to your living environment had a positive or negative impact?**

(1) Very positive
(2) Somewhat positive
(3) Somewhat Negative
(4) Very Negative
(5) No impact

48. Do you currently own or rent your residence?

(1) Owned by you or someone in the household
(2) Rented
(3) Occupied without payment of rent
(4) Transitional or supportive housing
(5) Emergency shelter
(6) Temporarily living with others
(7) Car, van, truck, or other vehicle

(8) Tent, encampment, or tiny house village
(9) Other
(10) I decline to answer

49. How many people currently live in your home (including self)?

Number of children _____
Number of adults _____

50. Where were you born?

City (open field): _____
State (open field): _____
Country (open field): _____

51. How would you describe your ethnicity?

(1) Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
(2) Not of Hispanic, Latino or Spanish Origin.
(3) I don't know
(4) Prefer not to answer

52. What is your RACE/ETHNICITY? Please select all that apply. Please select other if you do not identify with any of these.

(1) Black or African American
(2) Native American/ Alaska Native
(3) Native Hawaiian/ Pacific Islander
(4) Asian
(5) Hispanic/Latin
(6) White
(7) Other
(8) Decline to answer

If other, please describe here: _____

53. During the LAST year, what was the total income of your household from all sources before taxes and other deductions? Your best guess is fine. (NOTE: This is confidential information and your name is not connected to this data.)

(1) Less than $10,000
(2) $10,000 to $20,000
(3) $20,000 to $30,000
(16) $30,000 to $40,000
(4) $40,000 to $50,000
(5) $50,000 to $60,000
(6) $60,000 to $80,000
(7) $80,000 to $100,000
(8) $100,000 to $120,000
(9) $120,000 to $140,000
(10) $140,000 to $160,000
(11) $160,000 to $180,000
(12) $180,000 to $200,000
(13) $200,000 to $220,000
(14) $220,000 to $250,000
(15) Greater than $250,000

PART 10: CLOSING AND THANKS

1. People are affected by this pandemic in many ways, please share any of your personal experiences or ways in which your life has been changed, including possible positive changes. (Optional) *(open field)*

2. If you were to give advice to other pregnant or new mom's during the COVID-19 outbreak, what would it be? (Optional) *(open field)*

3. Are there any other questions or comments you have for our research team? (Optional) *(open field)*

Thank you for helping us to learn about pregnancy and postpartum experiences during the COVID-19 pandemic.