

PLAN-V: Pregnant, Lactation Women & Newborn COVID-19 Vaccination Survey

Part A: COVID-19 Vaccine status & exposure history

1. Which of the following options best describes your current pregnancy status? Select one option with which you most identify.
 - Pregnant
 - Not pregnant, but planning to become pregnant within the next year
 - Breastfeeding
 - None of the above **these participants will be excluded from participation in the survey**
 - a) *Pregnant*: Which trimester?
 - 1st (1-13 weeks)
 - 2nd (14-27 weeks)
 - 3rd (28-40 weeks)
 - b) *Breastfeeding*: How long ago did you deliver?
 - <4 weeks
 - 4-8 weeks
 - 9-12 weeks
 - 13-24 weeks
 - >24 weeks
2. Based on your lifestyle (i.e., day-to-day life, work/occupation, members of household etc.), how likely do you think you will be infected by COVID-19?
 - Very likely
 - Somewhat/Fairly likely
 - Not very likely
 - Not at all likely
3. How worried are you about the possibility of becoming infected with COVID-19?
 - Very worried
 - Fairly worried
 - Not very worried
 - Not at all worried
4. How worried are you about the possibility of someone else in your household or other close contact becoming infected with COVID-19?

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- Very worried
 - Fairly worried
 - Not very worried
 - Not at all worried
5. If you become infected with COVID-19, how likely do you think you are to become seriously ill?
- Very likely
 - Somewhat/fairly likely
 - Not very likely
 - Not at all likely
6. *Pregnant and pre-conception*: If you become infected with COVID-19, how likely do you think that infection with COVID-19 will impact your pregnancy (e.g., early delivery and other pregnancy complications)?
- Very likely
 - Somewhat/fairly likely
 - Not very likely
 - Not at all likely
7. *Pregnant and pre-conception*: How likely do you think it will impact the health of your fetus/baby while pregnant?
- Very likely
 - Somewhat/fairly likely
 - Not very likely
 - Not at all likely
8. To your knowledge, are you, or have you been infected with COVID-19?
- Yes
 - Was it mild or severe?
 - Mild
 - Moderate
 - Severe
 - Was it confirmed by a test?
 - Confirmed by a test

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- Not confirmed by a test
 - No
9. Have you been vaccinated against COVID-19? Answer 'Yes' if you received at least one dose of the COVID-19 vaccine.
- Yes
 - How many doses of the COVID-19 vaccine have you received so far?
 - One dose
 - When did you receive your first dose of the COVID-19 vaccine?
 - Two doses
 - When did you receive your second dose of the COVID-19 vaccine?
 - No
10. *If 'Yes' to vaccinated against COVID-19:* Which vaccine(s) did you receive? Select all that apply.
- Pfizer and BioNTech mRNA vaccine
 - Modern mRNA vaccine
 - AstraZeneca Oxford vaccine
 - Janssen (Johnson and Johnson) vaccine
 - Other – please specify
 - I don't know
11. *If 'Yes' to vaccinated against COVID-19:* At the time of your 1st and/or 2nd COVID-19 vaccine, were you:
- Thinking of trying to get pregnant in the next 6-12 months
 - Trying to get pregnant
 - Pregnant
 - In which trimester did you receive your 1st dose?
 - 1st (1-13 weeks)
 - 2nd (14-27 weeks)
 - 3rd (28-40 weeks)
 - Breastfeeding
 - None of the above
12. *If 'Yes' to vaccinated against COVID-19:* Why did you decide to get vaccinated against COVID-19? Select all that apply.

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- My family doctor advised that I should receive it
- My maternity care provider (e.g., obstetrician, midwife, family medicine obstetrics provider) advised that I should receive it
- my friends and/or family recommended it to me
- another pregnant person recommended it to me
- public health officials recommended the vaccine for pregnant and breastfeeding individuals
- the scientific evidence proved it was safe during pregnancy and breastfeeding
- I am at high risk of contracting COVID-19
- I am at risk of more severe symptoms and/or outcomes after contracting COVID-19
- To prevent myself from getting COVID-19 or from becoming seriously ill
- To prevent my baby from getting COVID-19 or from becoming seriously ill
- I believe I would be doing my part in fighting against COVID-19 by contributing to herd immunity/herd protection and by making COVID-19 harder to spread and replicate
- Other – please specify:

Part B: Medical History

1. Do you have any of the following health conditions? Select all that apply.

- Diabetes (Type 1, Type 2, gestational diabetes)
- Hypertension (high blood pressure)
- Higher body weight
- Thyroid disease
- Autoimmune disease (conditions that effect your immune system, e.g., lupus, arthritis, Crohn's disease, etc.)
- Immune suppressed
- Respiratory conditions (conditions that effect your breathing and lungs, e.g., asthma, etc.)
- Current or previous diagnoses of cancer
- Severe allergies (anaphylactic, hives/welts, red rash, swollen throat or swollen areas of the body, pale or red colour to the face and body)
- Not applicable
- Other, please specify:

2. In the past year, how many times were you treated by a healthcare provider (not including prenatal/obstetrical care or well-baby visits)?

- 0 times
- 1-4 times
- 5-10 times

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- > 10 times
 - Unsure
3. **Pregnant:** How many prenatal care visits have you attended in your current pregnancy (including in-person and/or virtual visits)?
- I attended all of my scheduled prenatal appointments
 - I attended most of my scheduled prenatal appointments
 - I attended some of my scheduled prenatal appointments
 - I did not attend any prenatal care visits
 - Unsure
4. **Breastfeeding:** How many prenatal care visits did you attend in your most recent pregnancy (including in-person and/or virtual visits)?
- I attended all of my scheduled prenatal appointments
 - I attended most of my scheduled prenatal appointments
 - I attended some of my scheduled prenatal appointments
 - I did not attend any prenatal care visits
 - Unsure
5. **Pregnant:** From which type of healthcare provider are you currently receiving the majority of your prenatal care?
- Obstetrician
 - Family physician
 - Midwife
 - Other, please specify:
6. **Breastfeeding:** From which type of healthcare provider did you receive the majority of your prenatal care for your most recent pregnancy?
- Obstetrician
 - Family physician
 - Midwife
 - Other, please specify:
7. Have you spoken with a healthcare provider about receiving the COVID-19 vaccine while trying to get pregnant, or during pregnancy, or breastfeeding?
- Yes
 - Who did you speak with? Select all that apply.
 - Obstetrician
 - Family physician
 - Midwife

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- Nurse
 - Family/Friend who is a healthcare provider
 - Other – please specify
 - Did they recommend getting the COVID-19 vaccine while trying to get pregnant, or during pregnancy, or breastfeeding?
 - Yes
 - No
 - No
- 8. How many times have you been pregnant (including current pregnancy)? This includes any type of loss (e.g., miscarriage or abortion) before 20 weeks of pregnancy.
 - 0 (*if women select this option, they will be prompted to question 8*)
 - 1
 - 2
 - 3+
- 9. *Participants with previous pregnancy*: How many pregnancies have you had that you delivered after 20 weeks of pregnancy (excluding most recent or current pregnancy)?
 - 0
 - 1
 - 2
 - 3+
- 10. *Participants with previous pregnancy*: How many times have you delivered a live baby (excluding most recent or current pregnancy)?
 - 0
 - 1
 - 2
 - 3+
- 11. *Breastfeeding*: What feeding methods are you currently using, or did you use to feed your infant during the first six months after your most recent pregnancy? Select all that apply.
 - Breast milk
 - Formula or milk supplements
 - Solid food
 - Other – please specify:
- 12. *Pregnant and Breastfeeding*: Did you receive any vaccines during your current or most recent pregnancy?

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- Yes
 - o If yes, please select all that apply.
 - Flu shot/Influenza vaccine
 - Please select the trimester of pregnancy that you received the vaccine:
 - o 1st (1-13 weeks)
 - o 2nd (14-27 weeks)
 - o 3rd (28-40 weeks)
 - Tdap/Pertussis/Adacel vaccine
 - Please select the trimester of pregnancy that you received the vaccine:
 - o 1st (1-13 weeks)
 - o 2nd (14-27 weeks)
 - o 3rd (28-40 weeks)
 - Other – please specify the vaccine and the trimester:
 - Were these vaccines recommended by your healthcare provider?
 - o Yes
 - o No
- No
- Unsure

13. *Participants with previous live birth*: Have you ever decided **not** to vaccinate your child(ren) for reasons other than illness or allergy?

- No
- Yes
 - o Are there any vaccine types/brands in particular?
 - No, all vaccines
 - Yes, please specify:
 - o Please indicate reason why:

14. If you gave birth to a child today, and they had no illness or allergies, would you choose to keep your child up to date with all recommended vaccines?

- Yes
- No
 - o Are there any vaccine types/brands in particular?
 - No, all vaccines
 - Yes, please specify:
 - o Please indicate reason why:

Part C: Intentions to Receive COVID-19 Vaccination

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1. **Pre-conception:** When would you be willing to receive the COVID-19 vaccine? If you have already received the COVID-19 vaccine, please answer hypothetically. Select all that apply.
 - Pre-conception (pre-pregnancy)
 - During pregnancy
 - While breastfeeding
 - After delivery, while not breastfeeding
 - After having all planned children
 - I would never be willing to receive the COVID-19 vaccine (*will be prompted to answer question 4*)
2. **Pregnant:** When would you be willing to receive the COVID-19 vaccine? If you have already received the COVID-19 vaccine, please answer hypothetically. Select all that apply.
 - During pregnancy
 - While breastfeeding
 - After delivery, while not breastfeeding
 - After having all planned children
 - I would never be willing to receive the COVID-19 vaccine (*will be prompted to answer question 4*)
3. **Breastfeeding:** When would you be willing to receive the COVID-19 vaccine? If you have already received the COVID-19 vaccine, please answer hypothetically. Select all that apply.
 - While breastfeeding
 - After delivery, while not breastfeeding
 - After having all planned children
 - I would never be willing to receive the COVID-19 vaccine (*will be prompted to answer question 4*)
4. **If participant answered 'I would not be willing to receive the COVID-19 vaccine':** Please complete the following sentence by selecting all that apply. "I would not receive the COVID-19 vaccine because..."
 - I'm not eligible due to illness or allergy
 - I have a fear of needles
 - there is a lack of information on safety in pregnant and breastfeeding persons
 - there is a lack of information about possible long-term health effects
 - I have concerns about the risks and side effects to myself
 - I have concerns about the risks during pregnancy
 - I have concerns about the risks to my fertility or my ability to get pregnant

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- I have concerns about the effect on my fetus/baby
- I do not believe it is necessary for me to get the vaccine
- I do not believe it will protect me against COVID-19
- of my religious beliefs
- my husband/spouse/significant other prefers that I do not receive the vaccine
- I am still undecided about whether I should receive the vaccine
- I do not feel well informed enough to make a decision at this time
- Other - please specify:

Part D: Perceptions and Factors Influencing COVID-19 Vaccination

1. Please complete the following sentence by selecting all that apply. “I believe...”
 - I have a good understanding of how the COVID-19 vaccine works
 - the COVID-19 vaccine is an effective way to prevent COVID-19
 - pregnant and breastfeeding persons would benefit from receiving the COVID-19 vaccine only if they are at high risk of becoming infected with COVID-19 (e.g., frontline worker, healthcare staff, etc.)
 - pregnant and breastfeeding persons would benefit from receiving the COVID-19 vaccine only if they are at high risk of becoming severely ill with COVID-19, due to other health conditions (e.g., high blood pressure or lung conditions)
 - all pregnant and breastfeeding persons would benefit from receiving the COVID-19 vaccine regardless of state of health or other risk factors
 - pregnant and breastfeeding persons who receive the COVID-19 vaccine can pass protective antibodies to their babies
 - None of the above
 - Other - please specify:

2. Please complete the following hypothetical statement around short and long-term effects of the COVID-19 vaccine by selecting all that apply. “I am worried that if I get the COVID-19 vaccine it may lead to...”
 - infertility (i.e., your ability to get pregnant in the future)
 - pregnancy loss or stillbirth
 - growth and development issues in my current or future unborn baby (e.g., birth defects, preterm birth)
 - behavioral or neurodevelopmental changes in my child in the future (e.g., autism, attention deficit hyperactivity disorder [ADHD], learning disability)
 - an increased chance of cancer or other life-threatening conditions for myself
 - an increased chance of cancer or other life-threatening conditions for my baby
 - I am not worried about any possible short-term or long-term side effects from the COVID-19 vaccine

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- Other - please specify:
3. *Excluded those that have received vaccine*: Please complete the following statement related to individuals influencing your decision to receive the COVID-19 vaccine by selecting all that apply. Please complete the following sentence: “I would be motivated to receive the COVID-19 vaccine if...”
- my family doctor advised that I should receive it
 - My primary maternity care provider (e.g., obstetrician, midwife, family medicine obstetrics provider) advised that I should receive it
 - my friends and/or family recommended it to me
 - another pregnant person recommended it to me
 - public health officials recommended the vaccine for pregnant and breastfeeding individuals
 - the scientific evidence proved it was safe during pregnancy and breastfeeding
 - it was recommended by an international organization (e.g., World Health Organization)
 - it would facilitate travel (i.e., to enter another country) and/or ability to attend social gatherings (i.e., concerts, sporting events, weddings, visiting older relatives etc.)
 - I would never be motivated to receive the COVID-19 vaccine.
 - Other - please specify:
4. From where are you receiving your COVID-19 information? Select all that apply.
- News broadcasting (e.g., television, radio, newspapers, magazines, etc.)
 - Social media (e.g., Facebook, Twitter, Instagram, Snapchat)
 - Health care provider(s)
 - Government issued websites (e.g., Government of Canada, Public Health Ontario, Ottawa Public Health, World Health Organization, Centers for Disease Control and Prevention)
 - Pregnancy and/or breastfeeding professional societies (e.g., Society of Obstetricians and Gynaecologists Canada, American College of Obstetricians and Gynecologists)
 - General pregnancy and childbirth/parenting websites
 - Online forums (e.g., Reddit, Quora)
 - Other - please specify:

PART XX: Demographic Data

1. How old are you?

- <18
- 18-29
- 30-39
- 40-49
- 50-64

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- 65+
- Prefer not to answer

2. What is your gender identity? Select one.

- Women
- Intersex
- Non-binary (genderqueer)
- Transgender
- Gender Fluid
- Questioning
- Two-spirit
- Man
- Do not know
- Prefer not to answer
- Other – please specify:

3. What is your sexual orientation? Select all that apply.

- Heterosexual/straight
- Homosexual (e.g., gay, lesbian, queer)
- Bisexual
- Pansexual
- Asexual
- Prefer not to answer
- Other – please specify:

4. Which race/ethnicity do you most identify with? Select one.

- Asian – East (e.g. Chinese, Japanese, Korean)
- Asian – South (e.g. Malaysian, Filipino, Vietnamese)
- Black – African (e.g. Ghanaian, Kenyan, Somali)
- Black – Caribbean (e.g. Barbadian, Jamaican)
- Black – North American (e.g. Canadian, American)
- First Nations Indian – Caribbean (e.g. Guyanese with origins in India)
- First Nations – origination from North American
- Indigenous/Aboriginal not included elsewhere
- Inuit

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- Metis
- Latin American (e.g. Argentinean, Chilean, Salvadorian)
- Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
- White – European (e.g. English Italian, Portuguese, Russian)
- White – North American (e.g. Canadian, American)
- Mixed Heritage
- Prefer not to answer
- Other, please specify:

5. What religious group do you most identify with?

- Buddhist
- Christian
 - Anglican
 - Baptist
 - Catholic
 - Christian Orthodox
 - Lutheran
 - Pentecostal
 - Presbyterian
 - United Church
 - Other Christian
- Hindu
- Jewish
- Muslim
- Sikh
- Traditional (Aboriginal) Spirituality
- No religious affiliation
- Prefer not to answer
- Other – Please specify:

6. What is your marital status?

- Single
- Married/Common law
- Separated/Divorced
- Prefer not to answer
- Other, please specify:

7. What is your living situation? Select all that apply.

- Alone
- With children
- With parents
- With other family members

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- With non-family roommates
- Prefer not to answer
- Other – please specify

8. Do you currently reside in Canada?

- Yes
 - If yes, please indicate:
 - Province:
 - What is the first three digits of your postal code? (e.g., L1B):
 - Number of years you have resided in Canada:
- No
 - If no, please indicate the country:

9. In which language are you most fluent? (i.e., your mother tongue) Select one.

- English
- French
- Arabic
- Italian
- Spanish
- Chinese (Mandarin, Cantonese, or other Chinese dialect)
- Other:

10. What is your highest level of completed education? Select one.

- Less than high school diploma/high school equivalency
- Completed high school diploma or a high school equivalency certificate
- Trades certificate or diploma
- College, CEGEP or other non-university certificate or diploma (Exclude trades certificates or diplomas)
- University certificate or diploma below the bachelor's level
- Bachelor's degree (e.g., B.A, B.A. (hons), B. Sc., B.Ed., LL.B.)
- University certificate, diploma, or degree above the bachelor's level
- Prefer not to answer

11. Which best applies to your current employment status?

- Full-time
- Part-time
- Unemployed
- Paid or unpaid leave (includes parental leave)
- Prefer not to answer

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12. What is your occupation?

- Front-facing health worker (i.e., face-to-face interaction with patients)
- Non-front-facing health worker (i.e., administrators, managers, clerical, research, etc.)
- Essential services worker (i.e., non-health frontline worker, police, transport service worker, grocery store staff, etc.)
- Educator
- Other work
- Retired
- None of the above

13. Are you a health care professional?

- Yes
 - What is your current role?
 - Doctor
 - Nurse
 - Paramedic/First responder
 - Allied health
 - Community health worker
 - Traditional healer
 - Other health worker
- No

14. What is your total household income before taxes?

- Less than \$30,000
- \$30,000 to \$59,999
- \$60,000 to \$89,999
- \$90,000 to \$119,999
- \$120,000 to \$149,999
- More than \$150,000
- Prefer not to answer

15. How did you hear about this survey?

- Social media (e.g., Facebook, Twitter, Instagram)
- Healthcare provider referral
- Flyer/poster
- Other - please specify:

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16. Please select the date you are completing this survey:

17. Thank you for completing the survey. If you have any other feedback about COVID-19 vaccination during pregnancy, breastfeeding or pre-conception period, please enter them below: