**The main content of the questionnaire**

**Part I ：Sociodemographic characteristics**

**Age** [ single choice ]

|  |
| --- |
| ○ ≤20Ys |
| ○ 20-25Ys |
| ○ 25-30Ys |
| ○ 30-35Ys |
| ○ 35-40Ys |
| ○ ≥40Y |

**Gestational age:** [single choice]

|  |
| --- |
| ○ first trimester（≤13+6 weeks） |
| ○ second trimester（13+6—28 weeks） |
| ○ third trimester（≥28weeks） |

**Occupation:** [single choice]

|  |
| --- |
| ○ Civil servant |
| ○ Company staff |
| ○ Self-employed |
| ○ Farmer |
| ○ Housewife |
| ○ Student |
| ○ Others |

**Pregnancy complication:** [single choice]

|  |
| --- |
| ○Yes：  ①gestational diabetes mellitus；②hypertensive disorder；③placenta previa；  ④preterm birth ⑤fetal- growth disorders |
| ○ No |

**Reproductive history** [single choice]

|  |
| --- |
| ○ Naturally-conceived |
| ○ Non-naturally-conceived |

**Previous children in the family** [single choice]

|  |
| --- |
| ○ Yes |
| ○ No |

**Education:** [single choice]

|  |
| --- |
| ○ Junior high school and below |
| ○ Senior high school and above |

**Household income** [single choice]

|  |
| --- |
| ○ ≤4000 |
| ○ 4000-6000 |
| ○ 6000-10000 |
| ○ ≥10000 |

**Part II ：Knowledge，attitudes and practices towards COVID-19**

**The whole population is susceptible to COVID-19.** [single choice]

|  |
| --- |
| ○ True |
| ○ False |
| ○ I do not know. |

**A coronavirus causes the COVID-19.** [single choice]

|  |
| --- |
| ○ True |
| ○ False |
| ○ I do not know. |

**There is no efficient treatment for COVID-19.** [single choice]

|  |
| --- |
| ○ True |
| ○ False |
| ○ I do not know. |

**What are the routes of transmission for COVID-19？** [single matrix choice]

|  |  |  |  |
| --- | --- | --- | --- |
|  | True | False | I do not know. |
| 1. Respiratory droplets | □ | □ | □ |
| 2. Close contacts | □ | □ | □ |

**The main clinical symptoms of COVID-19**: [single matrix choice]

|  |  |  |  |
| --- | --- | --- | --- |
|  | True | False | I do not know. |
| 1. Fever | □ | □ | □ |
| 2. Fatigue | □ | □ | □ |
| 3. Dry cough | □ | □ | □ |

**How can the public prevent COVID-19?**[single matrix choice]

|  |  |  |  |
| --- | --- | --- | --- |
|  | True | False | I do not know. |
| 1. Wear a mask when going out | ○ | ○ | ○ |
| 2. Wash your hands frequently | ○ | ○ | ○ |
| 3. Avoid public places | ○ | ○ | ○ |
| 4. Open the window frequently for ventilation | ○ | ○ | ○ |
| 5. Balance work and rest | ○ | ○ | ○ |
| 6. Reasonable diet | ○ | ○ | ○ |

**Which media do you trust?** [single choice]

|  |
| --- |
| ○ Non-official |
| ○ Official |

**Attention to the news of COVID-19** [single choice]

|  |
| --- |
| ○ Very concern |
| ○ Concern |
| ○ Not concern |

**How are you worried about contracting COVID-19 during the outbreak?** [single choice]

|  |
| --- |
| ○ Very worried |
| ○ Somewhat worried or not worried |

**Do you concerned about contracting COVID-19 by the probe?** [single choice]

|  |
| --- |
| ○ Yes |
| ○ No |

**How do you schedule your antenatal care?** [single choice]

|  |
| --- |
| ○ Postpone or reduce visit |
| ○ Others |
|  |

**Which kind of PPE do you put on in the hospital?** [multiple choice]

|  |
| --- |
| □ Cap |
| □ Face shield or glasses |
| □ Gloves of hands |
| □ Gloves of foot |

**Do you put on the gown in the hospital?**

|  |
| --- |
| □ Yes |
| □ No |

Zung Self-Rating Anxiety Scale (SAS)

For each item below, please place a checkmark in the column which best describes how often you felt or behaved this way during the past several days.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | A little of the time | Some of the time | A good part of the time | Most of the time |
| 1.I feel more nervous and anxious than usual. | ○ | ○ | ○ | ○ |
| 2.I feel afraid for no reason at all. | ○ | ○ | ○ | ○ |
| 3.I get upset easily or feel panicky. | ○ | ○ | ○ | ○ |
| 4.I feel like I'm falling apart and going to pieces. | ○ | ○ | ○ | ○ |
| 5.I feel that everything is all right and nothing wrong will happen. | ○ | ○ | ○ | ○ |
| 6.My arms and legs shake and tremble. | ○ | ○ | ○ | ○ |
| 7.I am bothered by headaches, neck, and back pain. | ○ | ○ | ○ | ○ |
| 8.I feel weak and get tired quickly. | ○ | ○ | ○ | ○ |
| 9.I feel calm and can sit still easily. | ○ | ○ | ○ | ○ |
| 10.I can feel my heart beating fast. | ○ | ○ | ○ | ○ |
| 11.I am bothered by dizzy spells. | ○ | ○ | ○ | ○ |
| 12.I have fainting spells or feel like it. | ○ | ○ | ○ | ○ |
| 13.I can breathe in and out quickly. | ○ | ○ | ○ | ○ |
| 14.I get feelings of numbness and tingling in my fingers & toes. | ○ | ○ | ○ | ○ |
| 15.I am bothered by stomach aches or indigestion. | ○ | ○ | ○ | ○ |
| 16.I have to empty my bladder often. | ○ | ○ | ○ | ○ |
| 17.My hands are usually dry and warm. | ○ | ○ | ○ | ○ |
| 18.My face gets hot and blushes. | ○ | ○ | ○ | ○ |
| 19.I fall asleep quickly and get a good night's rest. | ○ | ○ | ○ | ○ |
| 20.I have nightmares. | ○ | ○ | ○ | ○ |