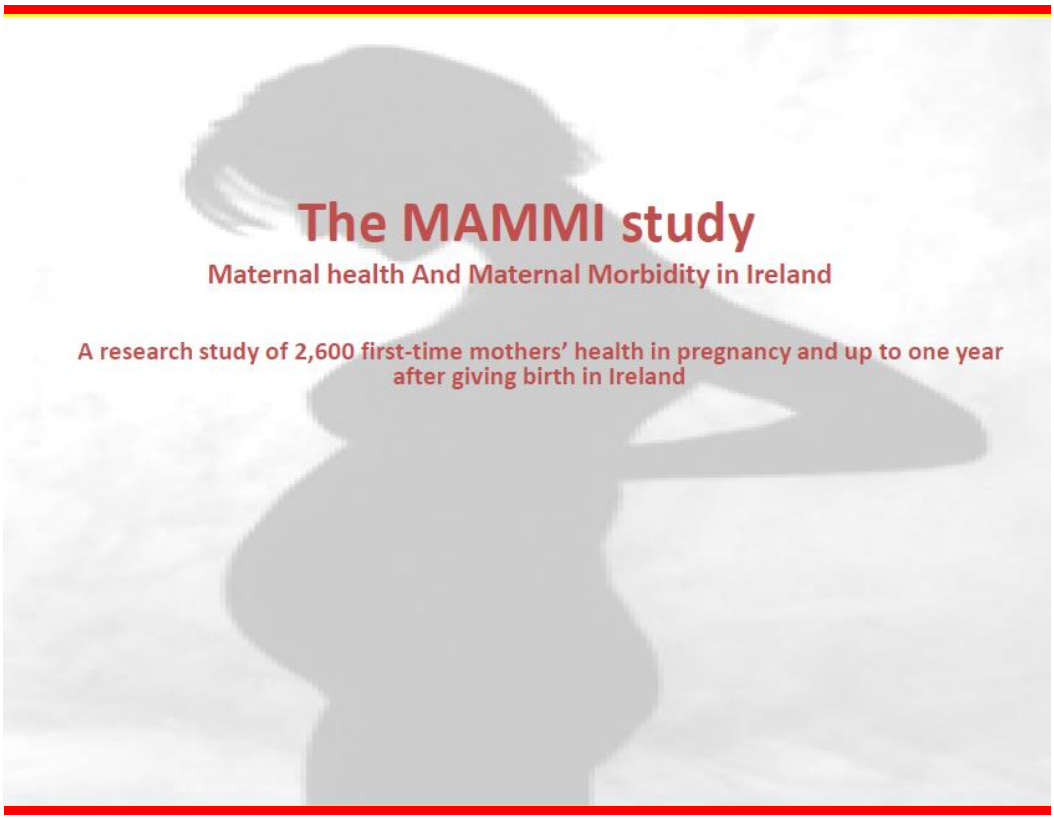
Study No



Survey Booklet Four: 9 Months Postnatal

4

Thank you for taking the time to complete this survey. It will take you about **30-45 minutes** to complete it and your answers are **confidential**. If you have any questions about any part of this survey, or need help answering any of the questions, please feel free to call us **on 087 229 0989.**

The MAMMI study has been approved by the Research Ethics Committees of the Coombe Women and Infants University Hospital and the Faculty of Health Sciences, Trinity College Dublin.

Please tick here if you do not wish to complete this or receive future surveys ☐

Coombe Women & Infants University Hospital
Excellence in the Care of Women and Babies
Foirfeacht i gCúram Ban agus Naíonán

TRINITY COLLEGE DUBLIN
COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH
THE UNIVERSITY OF DUBLIN

Contact: MAMMI Research Team (Deirdre Daly, Sunita Panda, Jamile Marchi, Deirdre O Malley and Francesca Wuytack)
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Structure of the MAMMI Survey

The **M**aternal health **A**nd **M**aternal **M**orbidity in **I**reland (**MAMMI**) study is in six (6) parts: (1) antenatal (early pregnancy); (1A) antenatal (middle to late pregnancy - when you are about 7 months pregnant); (2) 3 months after the birth; (3) 6 months after the birth; (4) 9 months after the birth and (5) 12 months after the birth.

This survey is about your health now, 9 months postnatally (after the birth). It has eight (8) sections, numbered A through to H:

A questions about you, your baby and contact with the health services;

B life with a new baby;

C your health over the past THREE months;

D sex after childbirth;

E your emotional health and well-being now;

F about you and your household;

G about you and your relationships

H comments on the survey.

Please note, there is space after Section H for any comments you might like to make on the survey.

How to fill in the Survey

Most of the questions can be answered by putting a tick in the box next to the answer that best applies to you. For example:

Has tiredness been a problem for you in the PAST month?

Yes ☑

No ☐

A few questions may ask you to fill in a number in a box. For example:

What is your date of birth?

Day 30 /Month 04 / Year 1980

This filled-in sample represents a date of birth of 30th April 1980

Section A: This section is about you, your baby and contact with health services

These questions are about you, your baby and contact with health services. If you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them. However, if you have experienced any of the symptoms or issues asked about, it would help us to understand them and it might help other women to know they are not alone in their experiences when the findings are published. Again, we would like to reassure you that all the information that you provide is **strictly confidential** and all the findings from this survey will be presented and published in a way that does not identify you or **any** individual woman.

A1 What is today's date?

☐☐ / ☐☐ / ☐☐☐☐

d d *m m* *y y y y*

A1a You may be pregnant now or have become pregnant since the birth of your first baby. Please tick ONE response below.

I have not been pregnant since my first baby's birth ☐ 1

I am pregnant now ☐ 2

I was pregnant but I had a miscarriage ☐ 3

I was pregnant but I had an abortion ☐ 4

Please answer this survey in relation to your health and wellbeing AFTER the birth of your first baby. If you were pregnant or are pregnant now, you can add additional comments about your current or last pregnancy at the end of the survey if you wish.

A2 What do you weigh now without clothes or shoes?

☐☐☐ kgs OR ☐☐ stones and ☐☐ pounds

A3 In the past THREE MONTHS, how many times have you visited a local doctor or GP *(Please do NOT include visits to a specialist.)*

a. About your health?		**b. About your baby's health?**	
Never	☐ 1	Never	☐ 1
Once	☐ 2	Once	☐ 2
Twice	☐ 3	Twice	☐ 3
3 times	☐ 4	3 times	☐ 4
4 times	☐ 5	4 times	☐ 5
5-6 times	☐ 6	5-6 times	☐ 6
7 or more times	☐ 7	7 or more times	☐ 7

Please comment if you wish _____

_____

_____

_____

c. If you HAVE visited a doctor or GP more than once in the past THREE MONTHS

	Always	**Mostly**	**Sometimes**	**Rarely/ Never**
a. Did you go to the same place for each visit	☐ 1	☐ 2	☐ 3	☐ 4
b. Did you see the same doctor on each occasion?	☐ 1	☐ 2	☐ 3	☐ 4

c. If you **did not** see the same doctor on each occasion, was this your own personal choice? **Yes** ☐ 1 **No** ☐ 2

A4 In the past THREE MONTHS, has any of the following happened to you?
(Please tick ONE response on EACH line.)

	Yes	No	Not sure
a. D & C *(dilatation and curettage)*	☐ 1	☐ 2	☐ 3
b. Wound breakdown – perineal tear or episiotomy	☐ 1	☐ 2	☐ 3
c. Wound breakdown – caesarean section	☐ 1	☐ 2	☐ 3
d. Repeat repair of perineal tear or episiotomy	☐ 1	☐ 2	☐ 3
e. Repeat repair of caesarean section wound	☐ 1	☐ 2	☐ 3

A5 In the past THREE MONTHS, how many times have you visited a hospital emergency department

a. About your health?		**b. About your baby's health?**	
Never	☐ 1	Never	☐ 1
Once	☐ 2	Once	☐ 2
Twice	☐ 3	Twice	☐ 3
3 times	☐ 4	3 times	☐ 4
4 times	☐ 5	4 times	☐ 5
5-6 times	☐ 6	5-6 times	☐ 6
7 or more times	☐ 7	7 or more times	☐ 7

Please give reasons if you wish _____

_____

_____

_____

A6 In the past THREE MONTHS, how many times have you or your baby been ADMITTED to hospital?

a. You?		**b. Your baby?**	
Never	☐ 1	Never	☐ 1
Once	☐ 2	Once	☐ 2
Twice	☐ 3	Twice	☐ 3
3 times	☐ 4	3 times	☐ 4
4 times	☐ 5	4 times	☐ 5
5-6 times	☐ 6	5-6 times	☐ 6
7 or more times	☐ 7	7 or more times	☐ 7

Please give reasons if you wish _____

_____

_____

_____

A7 If YOU were admitted to hospital in the past three months:

a. How many nights did you spend in the hospital?

First admission	**Second admission**	**Third admission**
☐☐ nights 1	☐☐ nights 2	☐☐ nights 3

b. Please describe the reason(s) for YOUR admission(s)? *(for example, urinary infection)*

_____

_____

_____

_____

A8 If YOUR BABY WAS admitted to hospital in the past THREE MONTHS:

a. How many nights did YOUR BABY spend in the hospital?

First admission	Second admission	Third admission
☐☐ nights 1	☐☐ nights 2	☐☐ nights 3

b. Please describe the reason(s) for YOUR BABY'S admission(s)? *(for example, breathing difficulties, vomiting, diarrhoea, constipation etc.)*

_____

_____

_____

_____

A9 In the past THREE MONTHS, when you went to the doctor did you feel able to talk about things that were troubling you concerning <u>your own health and well-being</u>? *(Please tick ALL statements with which you agree. Leave the statements that you do not agree with blank.)*

a. Yes, my doctor makes it easy for me to talk about anything that is concerning me ☐ 1

b. Yes, but he/she is often busy and doesn't seem to have time to listen ☐ 2

c. Yes, I can talk to my doctor and he/she is very supportive and reassuring ☐ 3

d. I can talk about some issues, but there are other things I do not feel comfortable talking about with my GP ☐ 4

e. There's no point in talking to the doctor about my health because he/she cannot fix any of my problems ☐ 5

f. No, I go to see the doctor about my baby not myself ☐ 6

g. I don't talk to my doctor because I am worried he/she will think I am not coping ☐ 7

h. I don't talk to the doctor because I am concerned he/she might want me to do something that will make the situation worse ☐ 8

i. There are some issues I don't talk about because I am concerned the doctor might tell someone else ☐ 9

A10 In the past THREE MONTHS, has your local doctor or GP asked you directly whether or not you are experiencing any of the following? *(please tick ONE response on EACH line.)*

	Yes	No	Not sure
a. Tiredness or exhaustion	☐ 1	☐ 2	☐ 3
b. Leakage or involuntary loss of urine	☐ 1	☐ 2	☐ 3
c. Leakage or involuntary loss of bowel motion	☐ 1	☐ 2	☐ 3
d. Perineal pain	☐ 1	☐ 2	☐ 3
e. Sexual problems	☐ 1	☐ 2	☐ 3
f. Haemorrhoids	☐ 1	☐ 2	☐ 3
g. Feeling depressed or low	☐ 1	☐ 2	☐ 3
h. Relationship problems	☐ 1	☐ 2	☐ 3

A11 In the past THREE MONTHS, how many times have you visited OR been visited at home by a Public Health Nurse

Never ☐ 1 *(Please go to A14)*

Once ☐ 2

Twice ☐ 3

3 times ☐ 4

4 times ☐ 5

5-6 times ☐ 6

7 or more times ☐ 7

A12 Are you able to talk to your Public Health Nurse about things that are troubling you concerning <u>your own health and well-being</u>? *(Please tick ALL statements with which you agree. Leave the statements that you do not agree with blank.)*

a. Yes, she/he makes it easy for me to talk about anything that is concerning me ☐ 1

b. Yes, but she/he is often busy and doesn't seem to have time to listen ☐ 2

c. Yes, I can talk to her/him and she/he is very supportive and reassuring ☐ 3

d. I can talk to her/him about some issues, but there are other things I do not feel comfortable talking about ☐ 4

e. There's no point in talking to her/him about my health because she/he cannot fix any of my problems ☐ 5

f. No, I go to see her/him about my baby not myself ☐ 6

g. I don't talk to her/him because I am worried she/he will think I am not coping ☐ 7

h. I don't talk to her/him because I am concerned she/he might want me to do something that will make the situation worse ☐ 8

i. There are some issues I don't talk about because I am concerned she/he might tell someone else ☐ 9

A13 In the past THREE MONTHS, has your public health nurse asked you directly whether or not you are experiencing any of the following? *(Please tick ONE response on each line.)*

	Yes	No	Not sure
a. Tiredness or exhaustion	☐ 1	☐ 2	☐ 3
b. Leakage or involuntary loss of urine	☐ 1	☐ 2	☐ 3
c. Leakage or involuntary loss of bowel motion	☐ 1	☐ 2	☐ 3
d. Perineal pain	☐ 1	☐ 2	☐ 3
e. Sexual problems	☐ 1	☐ 2	☐ 3
f. Haemorrhoids	☐ 1	☐ 2	☐ 3
g. Feeling depressed or low	☐ 1	☐ 2	☐ 3
h. Relationship problems	☐ 1	☐ 2	☐ 3

A14. In the PAST THREE MONTHS, has any OTHER health professional (other than your doctor/GP or Public Health Nurse) asked you directly about any of these issues?

	Yes	No	Not sure
a. Tiredness or exhaustion	☐ 1	☐ 2	☐ 3
b. Leakage or involuntary loss of urine	☐ 1	☐ 2	☐ 3
c. Leakage or involuntary loss of bowel motion	☐ 1	☐ 2	☐ 3
d. Perineal pain	☐ 1	☐ 2	☐ 3
e. Sexual problems	☐ 1	☐ 2	☐ 3
f. Haemorrhoids	☐ 1	☐ 2	☐ 3
g. Feeling depressed or low	☐ 1	☐ 2	☐ 3
h. Relationship problems	☐ 1	☐ 2	☐ 3

If yes, please identify the type of health professional i.e. practice nurse, social worker etc.

_____

_____

_____

_____

Section B: Life with a new baby

The next few questions are about your life with a new baby. If you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them. However, if you have experienced any of the symptoms or issues asked about, it would help us to understand them and it might help other women to know they are not alone in their experiences when the findings are published. Again, We would like to reassure you that all the information that you provide is **strictly confidential** and all the findings from this survey will be presented and published in a way that does not identify **you** or **any** individual

B1 Looking back over the past THREE MONTHS at home with your new baby, how would you describe your own health at that time? Did you feel:

Extremely well ☐ 1

Very well ☐ 2

OK ☐ 3

Not very well ☐ 4

Extremely unwell ☐ 5

B2 How confident did you feel about looking after your baby over the past THREE MONTHS at home?

Very confident ☐ 1

Fairly confident ☐ 2

Mixed ☐ 3

Fairly anxious ☐ 4

Not confident ☐ 5

B3 a Did your baby cry a lot in the past THREE MONTHS?

Yes ☐ 1

No ☐ 2

b Now that your baby is nine months old, does he/she cry very much?

Yes ☐ 1

No ☐ 2

c How easy is it to settle your baby NOW once she or he starts crying?

Usually very easy ☐ 1

Usually fairly easy ☐ 2

Sometimes easy and sometimes difficult ☐ 3

Often difficult ☐ 4

Often very difficult ☐ 5

B4 In the last week, which ONE of the following best describes your baby's pattern of sleeping?

My baby has not woken up during the night AT ALL in the past week ☐ 1

My baby has rarely woken up during the night in the last week ☐ 2

My baby has woken up several nights in the last week ☐ 3

My baby has woken up once a night most nights in the last week ☐ 4

My baby has woken up twice a night most nights in the last week ☐ 5

My baby has woken up three or more times a night most nights in the last week ☐ 6

B5 Do you feel like you are getting enough sleep yourself?

Yes ☐ 1

No ☐ 2

B6 a Did you breastfeed your baby (or give expressed breastmilk)?

Yes ☐ 1

No ☐ 2 *(please go to B7)*

b Are you still breastfeeding your baby (or giving expressed breastmilk)?

Yes ☐ 1

No ☐ 2

B7 Has your baby had any problems feeding (breast or bottle) in the past THREE MONTHS?

a. Yes, quite a lot ☐ 1

b. Yes, some ☐ 2

b. No, none ☐ 3

B8 a Has your baby had any health problems or problems with development that have had a major impact on your life in the past three months?

Yes ☐ 1

No ☐ 2

b If YES, please describe:

_____

_____

_____

_____

B9 How confident do you feel NOW about looking after your baby?

a. Very confident ☐ 1

b. Fairly confident ☐ 2

c. Mixed ☐ 3

d. Fairly anxious ☐ 4

e. Not confident ☐ 5

B10 Is there anything else you would like to tell me about your baby?

_____

_____

_____

_____

Section C: Your health over the past THREE months

The next few questions are about your health over the PAST three months. If you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them. However, if you have experienced any of the symptoms or issues asked about, it would help us to understand them and it might help other women to know they are not alone in their experiences when the findings are published. Again, We would like to reassure you that all the information that you provide is **strictly confidential** and all the findings from this survey will be presented and published in a way that does not identify you or **any** individual woman.

C1 In the past THREE MONTHS, have you experienced any of the following:
(Please tick one response on EACH line)

		Never	Rarely	Occasionally	Often
a.	Extreme tiredness or exhaustion	☐ 1	☐ 2	☐ 3	☐ 4
b.	Coughs, colds or other minor illnesses	☐ 1	☐ 2	☐ 3	☐ 4
c.	Severe headaches or migraines	☐ 1	☐ 2	☐ 3	☐ 4
d.	Back pain (in your lower back)	☐ 1	☐ 2	☐ 3	☐ 4
e.	Back pain (in the upper or middle part of your back	☐ 1	☐ 2	☐ 3	☐ 4
f.	Painful or sore perineum (from episiotomy / tear)	☐ 1	☐ 2	☐ 3	☐ 4
g.	Perineal wound infection	☐ 1	☐ 2	☐ 3	☐ 4
h.	Pain from caesarean section wound	☐ 1	☐ 2	☐ 3	☐ 4
i.	Caesarean section wound infection	☐ 1	☐ 2	☐ 3	☐ 4
j.	Uterine (womb) infection	☐ 1	☐ 2	☐ 3	☐ 4
k.	Pain when you pass urine	☐ 1	☐ 2	☐ 3	☐ 4
l.	Urinary tract infection	☐ 1	☐ 2	☐ 3	☐ 4
m.	Pain when passing a bowel motion	☐ 1	☐ 2	☐ 3	☐ 4
n.	Bleeding when you pass a bowel motion	☐ 1	☐ 2	☐ 3	☐ 4

		Never	Rarely	Occasionally	Often
o.	Constipation *(opening your bowels only twice a week or less, or pushing or straining to open your bowels every fourth time you go)*	☐ 1	☐ 2	☐ 3	☐ 4
p.	Haemorrhoids *(Swollen veins around your back passage, sometimes called piles)*	☐ 1	☐ 2	☐ 3	☐ 4
q.	Sore nipples	☐ 1	☐ 2	☐ 3	☐ 4
r.	Mastitis	☐ 1	☐ 2	☐ 3	☐ 4
s.	Pelvic pain	☐ 1	☐ 2	☐ 3	☐ 4
t.	Heavy vaginal bleeding or bleeding that worried you	☐ 1	☐ 2	☐ 3	☐ 4
u.	Other health issues *(please describe)*	☐ 1	☐ 2	☐ 3	☐ 4

_____

_____

_____

C2 a. In the past THREE MONTHS, have you felt depressed for two weeks or longer?

Yes, and I still feel depressed ☐ 1

Yes, I felt depressed a while ago, but I feel better now ☐ 2

No ☐ 3 *(Please go to C3)*

b. When did you start feeling depressed?

Before pregnancy ☐ 1

During pregnancy ☐ 2

After the birth ☐ 3

c. Are you taking tablets or medication, or having treatment for depression?

Yes, I'm taking tablets or medications ☐ 1

Yes, I'm having treatment ☐ 2

No ☐ 3

Please comment if you wish _____

_____

C3 a. SINCE THE BIRTH, have you experienced intense anxiety or panic attacks?

Never ☐ 1 (Please go to C4)

Rarely ☐ 2

Occasionally ☐ 3

Often ☐ 4

b. When did you start experiencing intense anxiety or panic attacks?

Before pregnancy ☐ 1

During pregnancy ☐ 2

After the birth ☐ 3

c. Are you taking tablets/medication or having treatment for anxiety or panic attacks now?

Yes, I'm taking tablets or medications ☐ 1

Yes, I'm having treatment ☐ 2

No ☐ 3

*Please comment if you wish*_____

_____

C4 In the past THREE MONTHS, have you experienced relationship problems with your partner or husband?

Never ☐ 1

Rarely ☐ 2

Occasionally ☐ 3

Often ☐ 4

C5 In the past THREE MONTHS, have you leaked even small amounts of urine:

a. When you coughed, laughed or sneezed, or did physical exercise?

No, never ☐ 1

Yes, less than once a month ☐ 2

Yes, one or several times a month ☐ 3

Yes, one or several times a week ☐ 4

Yes, every day ☐ 5

b. When you were on the way to the toilet?

No, never ☐ 1

Yes, less than once a month ☐ 2

Yes, one or several times a month ☐ 3

Yes, one or several times a week ☐ 4

Yes, every day ☐ 5

c. When you had to wait to use the toilet?

No, never ☐ 1

Yes, less than once a month ☐ 2

Yes, one or several times a month ☐ 3

Yes, one or several times a week ☐ 4

Yes, every day ☐ 5

d. If you did not go to the toilet immediately?

No, never ☐ 1

Yes, less than once a month ☐ 2

Yes, one or several times a month ☐ 3

Yes, one or several times a week ☐ 4

Yes, every day ☐ 5

C6a In the past THREE MONTHS, have you ever felt an URGENT need to urinate which was accompanied by a FEAR of leakage?

No, never ☐ 1

Yes, sometimes ☐ 2

C6b In the past THREE MONTHS, have you ever felt an URGENT need to urinate which was accompanied by ACTUAL leakage?

No, never ☐ 1

Yes, sometimes ☐ 2

If you answered NO to all of the questions in C5 and C6, please go to C11.

C7 When you leak urine, is it?

Drops or just a little ☐ 1

More like a trickle ☐ 2

More than a trickle ☐ 3

C8 Which of the following best describes how you manage this?

It is a minor problem, I ignore it ☐ 1

I carry a change of underwear with me wherever I go ☐ 2

I make sure I know where the nearest toilet is whenever I go out ☐ 3

I wear protection (e.g. pads or panty liners when I need to, e.g. when doing physical exercise) ☐ 4

I wear protection *(*e.g. pads or panty liners) **<u>all</u>** the time ☐ 5

Other *(please describe)* ☐ 6

_____

_____

C9 a. In the past THREE MONTHS have you discussed your bladder problems with anyone?

Yes ☐ 1

No ☐ 2

b. If YES, who did you discuss this with *(Please tick ALL that apply)*

General practitioner / local doctor ☐ 1

Public Health Nurse ☐ 2

GP Practice nurse ☐ 3

Obstetrician/gynaecologist ☐ 4

Physiotherapist ☐ 5

Other health professional ☐ 6

Partner ☐ 7

Friend ☐ 8

Sister ☐ 9

Mother ☐ 10

Other (please describe) ☐ 11

_____

c. If NO, is it because

I have thought about it but haven't felt able to talk about it ☐ 1

I don't want to discuss it ☐ 2

Other (please describe) ☐ 3

_____

_____

C10 How would you describe these problems now

About the same ☐ 1

Better than before ☐ 2

It's no longer a problem ☐ 3

Please comment if you wish _____

_____

C11 a. Have you taken, or have you been prescribed antibiotics for urinary infections in the past THREE MONTHS?

Yes ☐ 1

No ☐ 2

b. If yes, how many times have you taken antibiotics for urinary infections in the past THREE MONTHS?

Once ☐ 1

Twice ☐ 2

Three times or more ☐ 3

Please comment if you wish _____

_____

_____

_____

The next few questions ask about bowel symptoms. Please do not include problems during short-term illnesses such as the flu or a short viral infection.

C12 In the past THREE MONTHS have you

a. Noticed soiling from your back passage on your underwear?

No, never ☐ 1

Minor amount ☐ 2

Major amount ☐ 3

b. Passed wind when you really didn't want to?

No, never ☐ 1

Yes, occasionally ☐ 2

Yes often ☐ 3

C13 a. In the past THREE MONTHS have you ever, even very occasionally, experienced leakage of <u>LIQUID</u> bowel motions at an inappropriate time or an inappropriate place?

No, never ☐ 1

Yes, less than once a month ☐ 2

Yes, one or several times a month ☐ 3

Yes, one or several times a week ☐ 4

Yes, every day ☐ 5

b. If YES, when this happened how much leakage typically occurred?

Small amount *(with stain about the size of a 50 cent coin)* ☐ 1

Moderate amounts *(often requiring a change of pad or underwear)* ☐ 2

Large amounts *(often requiring a complete change of clothes)* ☐ 3

C14 a. In the past THREE MONTHS have you ever, even very occasionally, experienced leakage of <u>SOLID</u> bowel motions at an inappropriate time or inappropriate place?

No, never ☐ 1

Yes, less than once a month ☐ 2

Yes, one or several times a month ☐ 3

Yes, one or several times a week ☐ 4

Yes, every day ☐ 5

b. If YES, when this happened how much leakage typically occurred?

Small amount *(with stain about the size of a 50 cent coin)* ☐ 1

Moderate amounts *(often requiring a change of pad or underwear)* ☐ 2

Large amounts *(often requiring a complete change of clothes)* ☐ 3

C15 In the past THREE MONTHS, have you ever experienced an URGENT need to open your bowels that made you rush to the toilet immediately?

No, never ☐ 1

Yes, less than once a month ☐ 2

Yes, one or several times a month ☐ 3

Yes, one or several times a week ☐ 4

Yes, every day ☐ 5

C15a In the past THREE MONTHS, have you ever experienced an URGENT need to open your bowels that you could not delay or defer for more than 5 minutes?

No, never ☐ 1

Yes, less than once a month ☐ 2

Yes, one or several times a month ☐ 3

Yes, one or several times a week ☐ 4

Yes, every day ☐ 5

C16 Which of the following best describe how you manage?

It doesn't happen very often and I just cope with it when it does	☐ 1
I carry a change of underwear with me wherever I go and change whenever I need to	☐ 2
I make sure I know where the nearest toilet is whenever I go out	☐ 3
I wear protection *(e.g. pads or panty liners)* when I need to	☐ 4
I wear protection *(e.g. pads or panty liners)* **all** the time	☐ 5
Other (*please describe*)	☐ 6

_____

C17 a. In the past THREE MONTHS have you discussed your bowel problems with anyone?

Yes	☐ 1
No	☐ 2

C17 b. If YES, who did you discuss these with? *(Please tick all that apply)*

General practitioner / local doctor	☐ 1
Public Health Nurse	☐ 2
GP Practice Nurse	☐ 3
Obstetrician/Gynaecologist	☐ 4
Physiotherapist	☐ 5
Other health professional	☐ 6
Partner	☐ 7
Friend	☐ 8
Sister	☐ 9
Mother	☐ 10
Other (please describe)	☐ 11

_____

C17c If no, is it because

I have thought about it but haven't felt able to talk about it ☐ 1

I don't want to discuss it ☐ 2

Other *(Please describe)* ☐ 3

_____

_____

C18. If you have experienced bowel problems in the past THREE MONTHS, how would you describe these problems now

About the same ☐ 1

Better than before ☐ 2

It's no longer a problem ☐ 3

The next few questions ask about perineal pain and pelvic floor problems you may have experienced in the past THREE MONTHS. The perineum is the area around the entrance to the vagina, including the labia and other external genital organs. Please answer these questions even if you had a caesarean section.

The words used to describe pain are in increasing order of intensity. Please tick ONE response on EACH line.

C19 How would you describe the worst pain or discomfort you feel CURRENTLY in the perineal area *(around the entrance to your vagina)* when you are*:*

	No pain	Mild	Discomforting	Distressing	Horrible	Excruciating
a. Lying in bed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b. Shifting positions in bed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c. Getting in and out of bed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d. Feeding your baby	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e. Sitting in a chair	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f. Lifting your baby	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g. Walking	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h. Bathing or showering yourself	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
i. Doing physical exercise e.g. running, aerobics, climbing stairs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
j. Carrying your baby for extended periods	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
k. Passing urine	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
l. Passing a bowel movement	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Please comment if you wish _____

_____

C20 a. In the past four weeks have you used any tablets/medication or other therapies for pain or tenderness in the perineal area *(around the entrance to your vagina)*?

Yes ☐ 1

No ☐ 2

b. If yes, which medication have you used (tick ALL that apply)

	Yes	No	Not sure
a Paracetemol *(e.g. Panadol®)*	☐ 1	☐ 2	☐ 3
b. Paracetamol and codeine *(panadeine)*	☐ 1	☐ 2	☐ 3
c. Ponstan®	☐ 1	☐ 2	☐ 3
d. Difene (Voltarol) *(taken orally)*	☐ 1	☐ 2	☐ 3
e. Difene (Voltarol) *(suppository inserted into the back passage)*	☐ 1	☐ 2	☐ 3
f. Nurofen/Isobrufen	☐ 1	☐ 2	☐ 3
g. Aspirin	☐ 1	☐ 2	☐ 3
h. Local anaesthetic gel	☐ 1	☐ 2	☐ 3
i. Herbal remedies	☐ 1	☐ 2	☐ 3
j. Other *(please describe)*	☐ 1		

_____

_____

C21 a. In the past THREE MONTHS, have you discussed this perineal pain with anyone?

Yes ☐ 1

No ☐ 2

b. If YES, who did you discuss it with? *(Please tick ALL that apply.)*

General practitioner / local doctor	☐ 1
Public Health Nurse	☐ 2
GP practice nurse	☐ 3
Obstetrician/Gynaecologist	☐ 4
Physiotherapist	☐ 5
Other health professional	☐ 6
Partner	☐ 7
Friend	☐ 8
Sister	☐ 9
Mother	☐ 10
Other (Please describe)	☐ 11

_____

_____

When you were pregnant and since you gave birth, you may have been encouraged to do **pelvic floor exercises.** These exercises involve contracting your pelvic floor, as you would do if you interrupted the flow of urine midstream. **The pelvic floor is the muscular structure that supports your rectum, uterus and bladder.**

C22 a. To what extent would you say your pelvic floor feels 'back to normal' as opposed to too loose or slack?

Completely back to normal ☐ 1

Almost back to normal ☐ 2

Moderately back to normal ☐ 3

Somewhat back to normal ☐ 4

Not at all back to normal ☐ 5

b. If your pelvic floor does not feel completely back to normal, please describe the ways in which it feels different?

_____

_____

_____

C23 a. In the last month, have you been doing pelvic floor exercises?

Yes, regularly ☐ 1

Yes, when I remember ☐ 2

No ☐ 3

b. If YES, approximately how often do you do them?

☐ Number of days each week ☐☐ Number of times per day

C24 a. In the past THREE MONTHS, has there been any period when you felt as if something was bulging or falling down in the vaginal area?

Yes, often ☐ 1

Yes, sometimes ☐ 2

No, not at all ☐ 3

b. Are you CURRENTLY having trouble with a feeling of bulging or falling down in the vaginal area?

Yes, often ☐ 1

Yes, sometimes ☐ 2

No , not at all ☐ 3

C25 a. To what extent would you say your vagina feels 'back to normal' or like it did before you got pregnant?

Completely back to normal ☐ 1

Almost back to normal ☐ 2

Moderately back to normal ☐ 3

Somewhat back to normal ☐ 4

Not at all back to normal ☐ 5

b. If your vagina does not feel completely back to normal, please describe the way(s) in which it feels different?

_____

_____

_____

_____

The final question in this section asks about abdominal pain *(tummy pain)* **you may have experienced in the past THREE MONTHS. Please answer this question whether you had a caesarean section or a vaginal birth.**

C26 How would you describe the worst pain or discomfort you feel CURRENTLY in your lower abdomen *(below your tummy)* **when you are:**

The words used to describe pain are in increasing order of intensity. Please tick ONE response to EACH line.

		No pain	Mild	Discomforting	Distressing	Horrible	Excruciating
a.	Lying in bed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
b.	Shifting positions in bed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
c.	Getting in and out of bed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
d.	Feeding your baby	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
e.	Sitting in a chair	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
f.	Lifting your baby	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
g.	Walking	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
h.	Bathing or showering yourself	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
i.	Doing physical exercise e.g. running, aerobics, climbing stairs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
j.	Carrying your baby for extended periods	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
k.	Passing urine	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
l.	Passing a bowel movement	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

*Please comment if you wish*_____

_____

_____

_____

C27 a. In the past four weeks have you used any medication or other therapies for pain or tenderness in your tummy area?

Yes ☐ 1

No ☐ 2

b. If yes, which medication have you used (tick ALL that apply)?

	Yes	No	Not sure
a Paracetemol *(e.g. Panadol®)*	☐ 1	☐ 2	☐ 3
b. Paracetamol and codeine *(panadeine)*	☐ 1	☐ 2	☐ 3
c. Ponstan®	☐ 1	☐ 2	☐ 3
d. Difene (Voltarol) *(taken orally)*	☐ 1	☐ 2	☐ 3
e. Difene (Voltarol) *(suppository inserted into the back passage)*	☐ 1	☐ 2	☐ 3
f. Nurofen/Isobrufen	☐ 1	☐ 2	☐ 3
g. Aspirin	☐ 1	☐ 2	☐ 3
h. Local anaesthetic gel	☐ 1	☐ 2	☐ 3
i. Herbal remedies	☐ 1	☐ 2	☐ 3
j. Other *(please describe)*	☐ 1	☐ 2	☐ 3

_____

_____

_____

_____

C28 a. In the past THREE MONTHS, have you discussed this tummy pain with anyone?

Yes ☐ 1

No ☐ 2

b. If YES, who did you discuss it with? *(Please tick ALL that apply.)*

General practitioner / local doctor	☐ 1
Public Health Nurse	☐ 2
GP practice nurse	☐ 3
Obstetrician/Gynaecologist	☐ 4
Physiotherapist	☐ 5
Other health professional	☐ 6
Partner	☐ 7
Friend	☐ 8
Sister	☐ 9
Mother	☐ 10
Other	☐ 11

_____

_____

C29 NOW, 9 months AFTER THE BIRTH of your baby, are you satisfied with your body image?

Always	Sometimes	Never
☐ 1	☐ 2	☐ 3

Please comment if you wish _____

_____

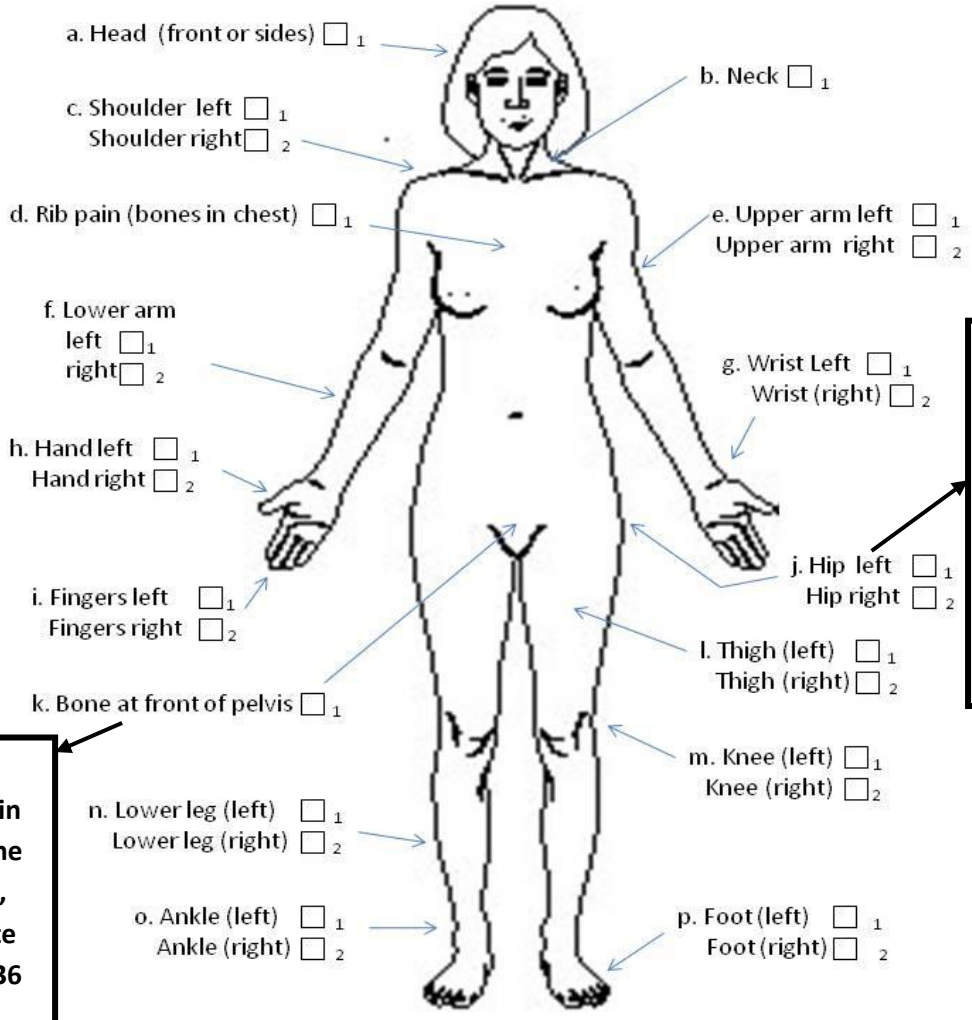
_____

C30 Please look at the two pictures below. Picture A is looking at the body from the front. Picture B is looking at the body from the back. In the past THREE MONTHS, have you experienced pain in any of the parts of the body named?

Yes ☐ 1 No ☐ 2

A. ***Please tick the boxes if you have experienced pain in any of the parts of the body named in the past THREE MONTHS.***

Picture A
Front of Body



If you have experienced pain in any of these areas in the past 3 months, please complete SECTION C31-C36 as well.

If you have experienced pain in this area in the past 3 months, please complete SECTION C31-C36 as well.

If you experienced pain in any other parts not named or shown here, please tick here ☐

Please give details _____

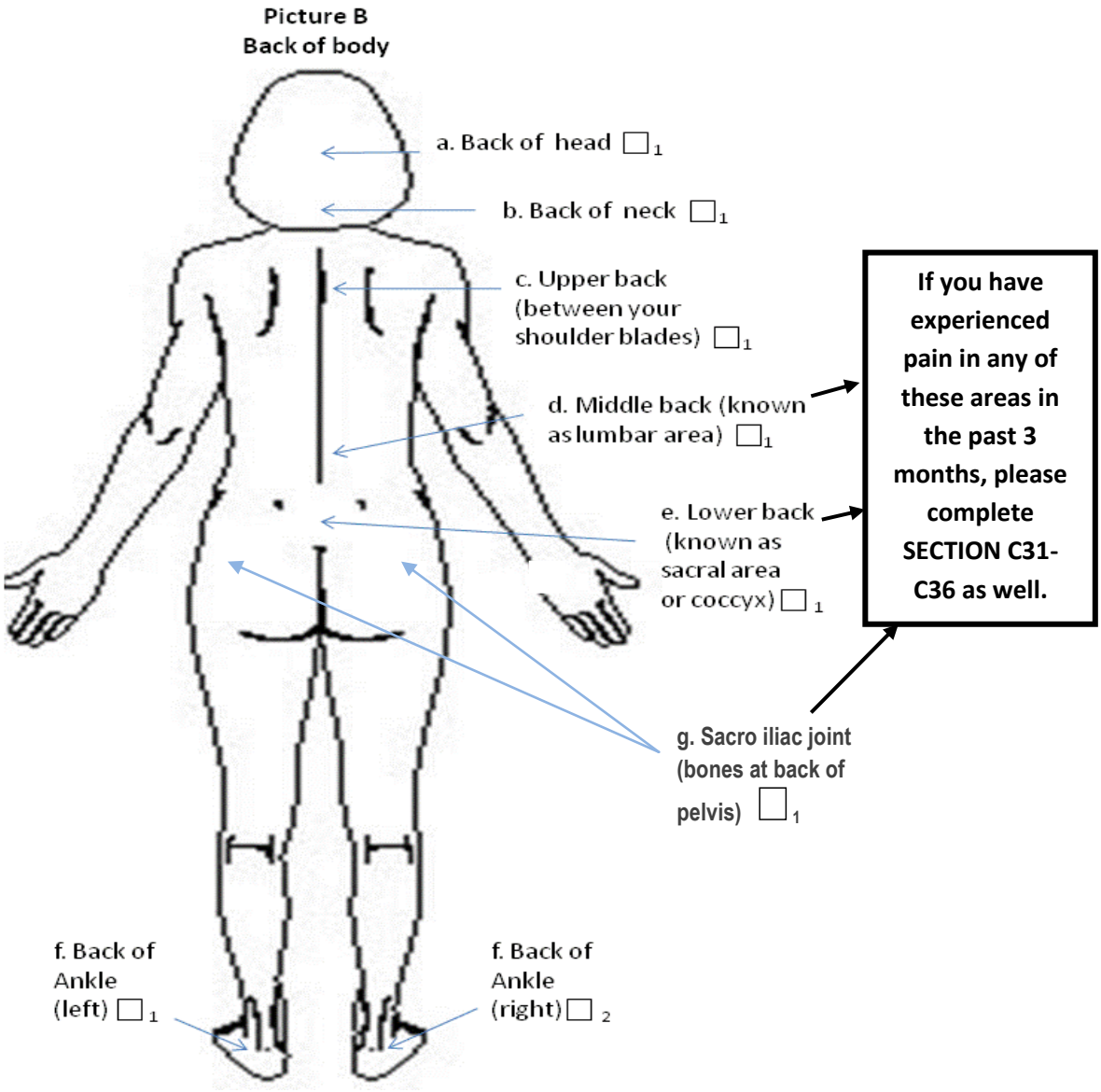
_____

_____

Please tick the boxes if you have experienced pain in any parts of the body named or shown in the past THREE MONTHS.

B. **Picture B**

Back of Body



If you experienced pain in any other parts not named or shown here, please tick here ☐

Please give details _____

_____

Most pain can be treated successfully. If you are worried or concerned about pain and wish to get help, you should discuss it with your doctor or another health professional.

The next few questions ask about your BACK and/or PELVIC GIRDLE PAIN. (If you have not had low back or pelvic girdle pain in the past 3 months, go directly to section D on page 38.)

C31 How problematic is it for you because of your back and/or pelvic girdle pain to do the following:

	Not at all	To a small extent	To some extent	To a large extent
a. Dress yourself	☐ 0	☐ 1	☐ 2	☐ 3
b. Stand for less than 10 minutes	☐ 0	☐ 1	☐ 2	☐ 3
c. Stand for more than 60 minutes	☐ 0	☐ 1	☐ 2	☐ 3
d. Bend down	☐ 0	☐ 1	☐ 2	☐ 3
e. Sit for less than 10 minutes	☐ 0	☐ 1	☐ 2	☐ 3
f. Sit for more than 60 minutes	☐ 0	☐ 1	☐ 2	☐ 3
g. Walk for less than 10 minutes	☐ 0	☐ 1	☐ 2	☐ 3
h. Walk for more than 60 minutes	☐ 0	☐ 1	☐ 2	☐ 3
i. Climb stairs	☐ 0	☐ 1	☐ 2	☐ 3
j. Do housework	☐ 0	☐ 1	☐ 2	☐ 3
k. Carry light objects	☐ 0	☐ 1	☐ 2	☐ 3
l. Carry heavy objects	☐ 0	☐ 1	☐ 2	☐ 3
m. Get up/sit down	☐ 0	☐ 1	☐ 2	☐ 3
n. Push a shopping cart	☐ 0	☐ 1	☐ 2	☐ 3
o. Run	☐ 0	☐ 1	☐ 2	☐ 3
p. Carry out sporting activities	☐ 0	☐ 1	☐ 2	☐ 3
q. Lie down	☐ 0	☐ 1	☐ 2	☐ 3
r. Roll over in bed	☐ 0	☐ 1	☐ 2	☐ 3
s. Have a normal sex life	☐ 0	☐ 1	☐ 2	☐ 3
t. Push something with one foot	☐ 0	☐ 1	☐ 2	☐ 3

C32 How much back and/or pelvic girdle pain do you experience:

	None	Some	Moderate	Considerable
a. In the morning	☐ 0	☐ 1	☐ **2**	☐ 3
b. In the evening	☐ 0	☐ 1	☐ 2	☐ 3

C33 To what extent because of your back and/or pelvic girdle pain:

	Not at all	To a small extent	To some extent	To a large extent
a. Has your leg/have your legs given way?	☐ 0	☐ 1	☐ 2	☐ **3**
b. Do you do things more slowly?	☐ 0	☐ 1	☐ 2	☐ **3**
c. Is your sleep interrupted?	☐ 0	☐ 1	☐ 2	☐ **3**

C34 To what extent because of your back and/or pelvic girdle pain do you have difficulty lifting/ handling your baby?

Not at all	To a small extent	To some extent	To a large extent
☐ **0**	☐ 1	☐ 2	☐ 3

C35 a. In the past four weeks have you used any tablets/medication or other therapies for pain or tenderness in the back and/or pelvic girdle area?

Yes ☐ 1 **No** ☐ 2

b.If YES, which medication have you used (tick ALL that apply)

	Yes	**No**	**Unsure**
a. Paracetemol *(e.g. Panadol®)*	☐ 1	☐ 2	☐ 3
b. Paracetamol and codeine *(panadeine)*	☐ 1	☐ 2	☐ 3
c. Ponstan®	☐ 1	☐ 2	☐ 3
d. Difene (Voltarol) *(taken orally)*	☐ 1	☐ 2	☐ 3
e. Difene (Voltarol) *(suppository inserted into back passage)*	☐ 1	☐ 2	☐ 3
f. Nurofen/Isobrufen	☐ 1	☐ 2	☐ 3
g. Aspirin	☐ 1	☐ 2	☐ 3
h. Local anaesthetic gel	☐ 1`	☐ 2	☐ 3
i. Other *(please describe)*	☐ 1	☐ 2	☐ 3

_____

C36 a. In the past THREE MONTHS, have you discussed this back/pelvic girdle pain with anyone?

Yes ☐ 1 No ☐ 2

b. If YES, who did you discuss it with? *(Please tick ALL that apply.)*

General practitioner / local doctor	☐ 1	Partner	☐ 7
Public Health Nurse	☐ 2	Friend	☐ 8
GP practice nurse	☐ 3	Sister	☐ 9
Obstetrician/Gynaecologist	☐ 4	Mother	☐ 10
Physiotherapist	☐ 5	Other (Please describe below)	☐ 11
Other health professional	☐ 6	_____	

Section D: Sex after childbirth

The next few questions are about your sexuality and sexual health since the birth. Again, if you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them. However, if you have experienced any of the symptoms or issues asked about, it would help us to understand them and it might help other women to know they are not alone in their experiences when the findings are published. Again, we would like to reassure you that all the information that you provide is **strictly confidential** and all the findings from this survey will be presented and published in a way that does not identify you or **any** individual woman.

D1 a. When did you first have sexual or intimate contact again after you had your baby: *(Please include all forms of sexual contact i.e. do not restrict your answer to vaginal intercourse.)*

I have not had sexual or intimate contact since the birth ☐ 1 (Please go to D2)

During the first 3 months ☐ 2

4-6 months after the birth ☐ 3

7-9 months after the birth ☐ 4

b. Did you feel that this was:

Too soon after the birth ☐ 1

Would have liked to start sooner ☐ 2

About the right time after the birth ☐ 3

D2 a. If you have NOT had any sexual or intimate contact since the birth is this because?

You do not have a partner ☐ 1

Other reasons ☐ 2

b. If you have a partner, but have not had any sexual or intimate contact since the birth, please tell me why? *(Please tick ALL that apply.)*

Too tired / exhausted	☐ 1
Relationship problems	☐ 2
Scared it will be painful	☐ 3
Fear of getting pregnant	☐ 4
Baby waking up	☐ 5
Still experiencing pain from perineal wound	☐ 6
Still experiencing pain from caesarean section	☐ 7
Don't feel interested	☐ 8
Other reason (please describe)	☐ 9

_____

_____

_____

If you have not had any sexual or intimate contact since the birth, please go to question D12.

D3 a. Have you had vaginal intercourse since your baby was born?

Yes	☐ 1
Tried on one or more occasions, but it was too painful each time I tried	☐ 2
No	☐ 3

b. When did you first have vaginal intercourse again *(or attempt vaginal intercourse again)* after you had your baby?

I have not had sexual or intimate contact since the birth ☐ 1 (Please go to D12)

During the first 3 months ☐ 2

4-6 months after the birth ☐ 3

7-9 months after the birth ☐ 4

c. Did you feel that this was:

Too soon after the birth ☐ 1

Would have liked to start sooner ☐ 2

About the right time after the birth ☐ 3

D4 How much pain or discomfort, if any, did you feel the first time you attempted to have vaginal intercourse after your baby was born?

No pain ☐ 1

Mild ☐ 2

Discomforting ☐ 3

Distressing ☐ 4

Horrible ☐ 5

Excruciating ☐ 6

D5 a. Other than the first time you tried having vaginal intercourse after your baby's birth, have you experienced pain or discomfort during vaginal intercourse in the past THREE MONTHS?

Yes ☐ 1

No ☐ 2

Haven't tried again ☐ 3

b. If YES, how would you describe the worst pain or discomfort you have experienced?

Mild	☐	1
Discomforting	☐	2
Distressing	☐	3
Horrible	☐	4
Excruciating	☐	5

D6 a. Are you still experiencing pain or tenderness during vaginal intercourse?

Yes	☐	1
No	☐	2

b. If NO, how many weeks after you baby's birth was it when vaginal intercourse stopped being painful?

☐☐ Number of weeks after the birth

D7 How often would you say intercourse is painful for you NOW?

Always painful	☐	1
Painful most of the time	☐	2
Occasionally painful	☐	3
Rarely painful	☐	4

D8 a. How would you describe the pain or discomfort you are experiencing during vaginal intercourse NOW?

- No pain ☐ 1
- Mild pain ☐ 2
- Discomforting ☐ 3
- Distressing ☐ 4
- Horrible ☐ 5
- Excruciating ☐ 6

b. Looking at the following list, please tick the words that apply to the pain or discomfort you are experiencing during vaginal intercourse NOW.

- Aching ☐ 1
- Throbbing ☐ 2
- Shooting ☐ 3
- Stabbing ☐ 4
- Gnawing ☐ 5
- Sharp ☐ 6
- Tender ☐ 7
- Burning ☐ 8
- Exhausting ☐ 9
- Tiring ☐ 10
- Penetrating ☐ 11
- Nagging ☐ 12
- Miserable ☐ 13
- Unbearable ☐ 14

D9 a. Have you discussed the pain or discomfort you are experiencing with anyone?

Yes ☐ 1

No ☐ 2

b. If YES, who have you discussed this with *(Please tick ALL that apply.)*

General practitioner / local doctor ☐ 1

Public Health Nurse ☐ 2

GP Practice Nurse ☐ 3

Obstetrician/Gynaecologist ☐ 4

Physiotherapist ☐ 5

Other health professional ☐ 6

Partner ☐ 7

Friend ☐ 8

Sister ☐ 9

Mother ☐ 10

Other (Please describe) ☐ 11

_____

D10 In the past THREE months, how satisfied are you with your overall sex life?

Very satisfied ☐ 1

Moderately satisfied ☐ 2

Equally satisfied/dissatisfied ☐ 3

Moderately dissatisfied ☐ 4

Very dissatisfied ☐ 5

Prefer not to answer ☐ 6

D11 In the PAST four weeks, have you had:

		Yes	No	Prefer not to answer
a.	Oral sex	☐ 1	☐ 2	☐ 3
b.	Anal sex	☐ 1	☐ 2	☐ 3
c.	Other sexual contact *(i.e. forms of contact with the genital area not leading to intercourse but intended to achieve orgasm)*	☐ 1	☐ 2	☐ 3

D12 How emotionally satisfying have you found your relationship with your partner in the past THREE MONTHS?

- Extremely emotionally satisfying ☐ 1
- Very emotionally satisfying ☐ 2
- Moderately emotionally satisfying ☐ 3
- Slightly emotionally satisfying ☐ 4
- Not at all emotionally satisfying ☐ 5
- Not sure ☐ 6

D13 In the past THREE MONTHS have you experienced any of the following:
(Please tick one response on each line.)

	Yes	No	Prefer not to answer
a. Lack of vaginal lubrication	☐ 1	☐ 2	☐ 3
b. Painful penetration	☐ 1	☐ 2	☐ 3
c. Pain during sexual intercourse	☐ 1	☐ 2	☐ 3
d. Pain on orgasm	☐ 1	☐ 2	☐ 3
e. Difficulty reaching orgasm	☐ 1	☐ 2	☐ 3
f. Unable to reach orgasm	☐ 1	☐ 2	☐ 3
g. Vaginal tightness	☐ 1	☐ 2	☐ 3

	Yes	No	Prefer not to answer
h. Vaginal looseness / lack of muscle tone	☐ 1	☐ 2	☐ 3
i. Bleeding or physical irritation after sex	☐ 1	☐ 2	☐ 3
j. Loss of interest in sex compared with before your pregnancy	☐ 1	☐ 2	☐ 3
k. More interest in sex compared with before your pregnancy	☐ 1	☐ 2	☐ 3
l. Being pressured to take part in unwanted sexual activity	☐ 1	☐ 2	☐ 3
m. Being forced to take part in unwanted sexual activity	☐ 1	☐ 2	☐ 3
n. Other *(Please describe)*	☐ 1	☐ 2	☐ 3

_____

_____

D14 a. Have you ever discussed any of the above with anyone?

Yes ☐ 1

No ☐ 2

b. If YES, who have you discussed this with *(Please tick ALL that apply.)*

General practitioner / local doctor ☐ 1

Public Health Nurse ☐ 2

GP Practice Nurse ☐ 3

Obstetrician/Gynaecologist ☐ 4

Physiotherapist ☐ 5

Other health professional ☐ 6

Partner ☐ 7

Friend	☐	8
Sister	☐	9
Mother	☐	10
Other (Please describe)	☐	11

_____

c. What issues did you discuss? *(Please tick all that apply)*

Lack of vaginal lubrication	☐	1
Painful penetration	☐	2
Pain on orgasm	☐	3
Difficulty reaching orgasm	☐	4
Vaginal tightness	☐	5
Vaginal looseness / lack of muscle tone	☐	6
Bleeding or physical irritation after sex	☐	7
Loss of interest in sex compared with before your pregnancy	☐	8
More interest in sex compared with before your pregnancy	☐	9
Being pressured to take part in unwanted sexual activity	☐	10
Being forced to take part in unwanted sexual activity	☐	11
Other *(Please describe)*	☐	12

_____

_____

D15 During the past THREE MONTHS, which of the following best describes the frequency of your sexual activity *(please tick only one response)*

a. 1-2 times per month ☐ 1

b. 1-2 times per week ☐ 2

c. 3-4 times per week ☐ 3

d. More than 4 times per week ☐ 4

Prefer not to answer ☐ 5

Please comment if you wish _____

D16 Overall, would you say that your sex life has changed in the past THREE MONTHS?

It has improved ☐ 1

It's about the same ☐ 2

Not as good ☐ 3

Not sure ☐ 4

D17 How often have the following issues affected your sex life in the past THREE MONTHS?

		Very often	Often	Sometimes	Rarely	Never
a.	Tiredness / exhaustion	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b.	Feeling, depressed, low or blue	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c.	Relationship problems	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d.	Pain / tenderness	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e.	Lack of time	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f.	Baby waking up / interrupting you	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g.	Other (please describe)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

_____

_____

D18 Is there anything else you would like to tell me about in relation to your sexual and intimate relationships in the past THREE MONTHS?

_____

_____

_____

_____

If you are worried or concerned about pain when having sex and wish to get help, you can discuss it with your doctor.

If you are worried or concerned about unwanted or forced sexual activity and wish to get help, you can call the **Sexual Assault Treatment Unit (SATU)** based in the Rotunda hospital.

SATU telephone number:	01 8171736
SATU e-mail:	SATU@ROTUNDA.IE
Web:	http://www.rotunda.ie/
Opening hours:	9.00am to 4.30pm Mon – Fri
	Outside of these hours please contact the Rotunda Hospital at 01 8171700

Or you can call the **national** Dublin Rape Crisis Centre. The Dublin Rape Crisis Centre was established in 1979 and is a national organisation offering a wide range of services to women and men who are affected by rape, sexual assault, sexual harassment or childhood sexual abuse.

The services include a national **24-hour helpline**, one to one counselling, court accompaniment, outreach services, training, awareness raising and lobbying.

Dublin Rape Crisis Centre telephone number: HELPLINE 1800 778888

Section E: Your emotional health and well-being now

*The next few questions are about your emotional health and well-being now. Again, if you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them, but if you have experienced any of the symptoms or issues asked about, it would help us to understand them. Again, we would like to reassure you that all the information that you provide is **strictly confidential** and all the findings from this survey will be presented and published in a way that does not identify **any** individual woman.*

Please look at the following statements and for each one think about how you have been feeling IN THE LAST WEEK.

E1 a. During the last week I have been able to laugh and see the funny side of things

As much as I always could	☐ 1
Not quite as much now	☐ 2
Definitely not as much now	☐ 3
Not at all	☐ 4

b. During the last week I have looked forward with enjoyment to things

As much as I ever did	☐ 1
Rather less than I used to	☐ 2
Definitely less than I used to	☐ 3
Hardly at all	☐ 4

c. During the last week I have blamed myself unnecessarily when things went wrong

Yes, most of the time	☐ 1
Yes, some of the time	☐ 2
Not very often	☐ 3
No, never	☐ 4

d. During the last week I have felt worried and anxious for no very good reason

No, not at all ☐ 1

Hardly ever ☐ 2

Yes, sometimes ☐ 3

Yes, very often ☐ 4

e. During the last week I have felt scared or panicky for no very good reason

Yes, quite a lot ☐ 1

Yes, sometimes ☐ 2

No, not much ☐ 3

No, not at all ☐ 4

f. During the last week things have been getting on top of me

Yes, most of the time I haven't been able to cope at all ☐ 1

Yes, sometimes I haven't been coping as well as usual ☐ 2

No, most of the time I have copied quite well ☐ 3

No, I have been coping as well as ever ☐ 4

g. During the last week I have been so unhappy that I have had difficulty sleeping

Yes, most of the time ☐ 1

Yes, sometimes ☐ 2

Not very often ☐ 3

No, not at all ☐ 4

h. During the last week I have felt sad or miserable

Yes, most of the time ☐ 1

Yes, quite often ☐ 2

Not very often ☐ 3

No, not at all ☐ 4

i. During the last week I have been so unhappy that I have been crying

Yes, most of the time ☐ 1

Yes, quite often ☐ 2

Only occasionally ☐ 3

No, never ☐ 4

j. During the last week the thought of harming myself has occurred to me

Yes, quite often ☐ 1

Sometimes ☐ 2

Hardly ever ☐ 3

Never ☐ 4

E2 Is there anyone you can talk to about how you are feeling? *(Please tick ALL that apply.)*

Yes, but I am not sure they understand ☐ 1

Yes, and they are very supportive ☐ 2

No, there isn't anyone I can really talk to ☐ 3

I don't particularly want to talk about how I feel ☐ 4

There isn't anything I feel I need to talk about ☐ 5

E3 Looking back over the time in the past THREE MONTHS, would you like to have had more emotional support *(e.g. someone who regularly asked how you were, someone happy to listen to how you were feeling)*?

Yes, definitely ☐ 1

Yes, probably ☐ 2

No, not really ☐ 3

Please comments if you wish _____

_____

E4. Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *OVER THE PAST WEEK*. There are no right or wrong answers. Do not spend too much time on any statement.

		Not at all	Some of the time	A good part of the time	Most of the time
1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g. in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3

		Not at all	Some of the time	A good part of the time	Most of the time
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Section F: About you and your household

The next few questions ask for personal details about your household and social factors. Sometimes social factors can affect women's health in pregnancy and this is why these questions have been included here.

All the information that you provide is **confidential** and cannot be linked to you as an individual or your household and there is no possibility that any of this information will be passed on to any other agency or department, government or otherwise.

F1 Are you currently: *(Please tick ONE only.)*

- Married ☐ 1
- Living with a partner (boyfriend/girlfriend) ☐ 2
- Divorced or separated ☐ 3
- In a relationship - not living together ☐ 4
- Widowed ☐ 5
- Single ☐ 6

F2 Who else lives together with you in your household? *(Please tick ALL that apply.)*

- Your child ☐ 1
- Your partner/husband ☐ 2
- Your mother ☐ 3
- Your father ☐ 4
- Your partner's mother ☐ 5
- Your partner's father ☐ 6
- Partner's child/children from previous relationship ☐ 7
- Your sister(s) and/or brother(s) ☐ 8
- A friend/friends ☐ 9

Nanny/au pair ☐ 10

No one ☐ 11

Other *(please describe)* ☐ 12

_____

F3 How would you describe your CURRENT living accommodation?

House *(with a mortgage)* ☐ 1

House *(with no mortgage)* ☐ 2

Apartment *(with a mortgage)* ☐ 3

Apartment *(with no mortgage)* ☐ 4

Rented house *(rented privately)* ☐ 5

Rented house *(rented from local authority)* ☐ 6

Rented apartment *(rented privately)* ☐ 7

Rented apartment *(rented from local authority)* ☐ 8

Caravan / Mobile Home ☐ 9

Bed and breakfast accommodation ☐ 10

Hostel accommodation ☐ 11

No fixed accommodation *(homeless)* ☐ 12

Other, please give details ☐ 13

Please comment if you wish _____

_____

_____

F4 a. Since having your baby have you gone back to work or study?

Yes, gone back to paid work ☐ 1

Yes, returned to study ☐ 2

Am on paid maternity leave ☐ 3

Am on unpaid maternity leave ☐ 4

No, not in paid work or studying at the present time ☐ 5 *(Please go to F6)*

b. How old was your baby when you returned to paid work or study?

Less than seven weeks old ☐ 1

Between seven weeks old and three months old ☐ 2

More than three months old ☐ 3

c. How many hours did you spend at work or studying last week?

Less than 10 hours ☐ 1

Between 10 and 20 hours ☐ 2

More than 20 hours ☐ 3

F5 How would you describe your current employment status *(please tick one response)*

I gave up my job when my baby was born ☐ 1

Full time paid work ☐ 2

Part-time paid work ☐ 3

Casual paid-work ☐ 4

Looking for first job ☐ 5

Unemployed ☐ 6

Student or pupil ☐ 7

Looking after home/family ☐ 8

Unable to work due to sickness / disability ☐ 9

Unpaid voluntary work ☐ 10

Others *(Please describe)* ☐ 11

_____

_____

F6 a. Are you hoping to have another baby?

Yes ☐ 1

No ☐ 2

Not sure ☐ 3

F6 b. If YES, would you prefer to have?

A vaginal birth ☐ 1

A caesarean section ☐ 2

No particular preference ☐ 3

Section G: you and your relationships

The next few questions are about you and your relationships and ask about your experiences in adult intimate relationships (for example, husband, partner, girlfriend or boyfriend of longer than one month.)

Again, if you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them. However, if you have experienced any of the symptoms or issues asked about, it would help us to understand them and it might help other women to know they are not alone in their experiences when the findings are published. Again, we would like to reassure you that all the information that you provide is **strictly confidential** and all the findings from this survey will be presented and published in a way that does not identify you or **any** individual women.

G1 Are you currently in a relationship?

Yes ☐ 1 No ☐ 2

G2 Are you afraid of your current partner?

Yes ☐ 1 No ☐ 2

G3 Have you ever been afraid of any partner?

Yes ☐ 1 No ☐ 2

Please comment if you wish _____

_____

_____

_____

G4 I would like to know if you have experienced any of the actions listed below and how often they happened during the last THREE months. Please answer, even if you are not with a partner at present. *(Please indicate how often it happened **OVER THE LAST 3-MONTH PERIOD**, by ticking one box on each line)*

My Partner …	Never	Only once	Several times	Once a month	Once a week	Daily
Told me I wasn't good enough	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Tried to turn my family, friends and children against me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Slapped me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Told me I was ugly	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Tried to keep me from seeing or talking to my family	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Threw me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Blamed me for causing their violent behaviour	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Shook me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Pushed, grabbed or shoved me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Became upset if dinner/housework wasn't done when they thought it should be	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Told me I was crazy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Told me no-one would ever want me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Hit or tried to hit me with something	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Did not want me to socialise with my female friends	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Kicked me, bit me or hit me with a fist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Tried to convince my friends, family or children that I was crazy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Told me I was stupid	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Beat me up	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Please comment if you wish _____

_____

_____

_____

G5Have you told anyone about the above experiences? *(Please tick ALL that apply.)*

I have not had any of the above experiences ☐ 1

I have not told anyone ☐ 2

I have told my Public Health Nurse ☐ 3

I have told my regular GP/family doctor ☐ 4

I told someone else *(Please say who)* ☐ 5

_____

If you would like to tell us more about your experiences please use the space below.

_____

_____

_____

_____

_____

Women's Aid - working to end violence against women

If you need help, phone them on:

National Freephone Helpline

1800 341 900 - 10am to 10pm

http://www.womensaid.ie/

Email: info@womensaid.ie

Everton House
47 Old Cabra Road
Dublin 7
Tel: +353 1 868 4721
Fax: +353 1 868 4722

If you or someone you know is experiencing domestic violence, Women's Aid can help:

- **Women's Aid** operate the National Freephone Helpline 1800 341 900 (10am to 10pm, 7 days a week except Christmas Day)
- **Women's Aid** provide one to one support in six locations throughout Dublin including Cabra, Coolock, Swords, Dublin City Centre, Amiens and Ballymun.
- **Women's Aid** provide a court accompaniment service in the Greater Dublin Area.
- **Women's Aid** refer women to local domestic violence support services and refuges.

All of **Women's Aid** services offer **free**, confidential support to women and their children who are experiencing domestic violence in the Republic of Ireland.

H1 Now that you have got to the end of this part of the survey I am interested in knowing how you found it? *(Please tick ALL that apply.)*

I managed to finish it but it took ages.	☐ 1
I was pleased to be asked about my experiences	☐ 2
It was OK	☐ 3
It was interesting	☐ 4
I didn't understand some of the terms or language used	☐ 5
Other (*please say what*)	☐ 6

_____

_____

_____

_____

H2 About the MAMMI Study website http://www.mammi.ie

a. Have you had an opportunity to look at the MAMMI Study website?

Yes ☐ 1 No ☐ 2

b. Did you recommend the website to others?

Yes ☐ 1 No ☐ 2

c. If you have looked at the website, please comment on how you found it and/or what other information **you** would have liked to see on it.

_____

_____

_____

_____

Comments

If you wish to write any further comments please do so on this page. Thank you.

Please help us to keep in touch.

If your address or other contact details have changed *(or you are about to move),* please fill in the details below:

Your NEW address:	Your NEW phone number(s):

Thank you for taking the time to complete this survey.

We are very grateful for the time and trouble you have taken to participate in the study. All the information you provide will help us to fill in some of the gaps in what is currently known about first-time mothers' health during pregnancy and after giving birth.

Please use the reply paid envelope to send it back to us. If no envelope was enclosed with this survey or you have mislaid it, please call us on **087 229 0989** and we will send you out another one.

The fourth survey results will not be available until all of the women taking part in the study have given birth. As soon as the results are available, we will let you know via the website and the study newsletter for participants.

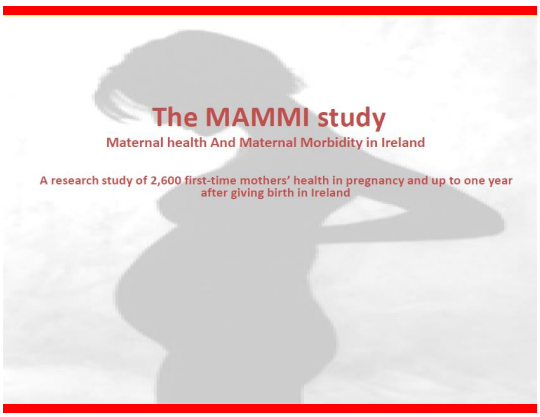
Please call us if you have any questions about the study. We look forward to contacting you again when your baby is nine months old.

Best Wishes

The MAMMI study team

087 229 0989

www.mammi.ie



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