

## Survey Booklet Five: Twelve Months Postnatal

**5**

**Thank** you for taking the time to complete this survey. It will take you about **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 survey has been approved by the Research Ethics Committees of the Coombe Women and Infants University Hospital and the Faculty of Health

## Structure of the MAMMI Survey

The **Maternal health And Maternal Morbidity in Ireland (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 is the final part of the MAMMI study surveys and is about your health now (12 months after childbirth). It has seven (7) sections, numbered A through to G:

- A about you, your baby and contact with health services;
- B life with a 12 month old baby;
- C your health over the past THREE months;
- D sex after childbirth;
- E your emotional health and well-being now;
- F you and your household;
- G you and your relationships.

You may notice that some questions are very similar or the same, however, the questions apply to different times in your life.

**Please note, there is space after Section G 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 /Month /Year  
30 / 04 / 1980

*This filled-in sample represents a date of birth of 30<sup>th</sup> April 1980*

## Section A: 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?

|                      |                      |   |                      |                      |   |                      |                      |                      |                      |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <i>d</i>             | <i>d</i>             |   | <i>m</i>             | <i>m</i>             |   | <i>y</i>             | <i>y</i>             | <i>y</i>             | <i>y</i>             |

### 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

**If you have experienced a miscarriage, and want to talk to someone about your experiences,** the Miscarriage Association of Ireland offer help and support. Their website is at: <http://www.miscarriage.ie/>

Their office is at: Miscarriage Association of Ireland, Carmichael Centre, North Brunswick Street, Dublin 7.

Telephone, (Central Lines): 01- 873 5702. A list of telephone support lines is available on the website. You can also email: <mailto:info@miscarriage.ie>

**If you have experienced an abortion,** and want to talk to someone about your experiences, there are several sources of help and support, some are free and some charge a fee. Choosing the right source of support is a personal matter and the following websites might be a useful starting place for you: **(i) The Crisis pregnancy agency** <http://www.crisispregnancy.ie> ; **(ii) The Irish Family Planning Association** <http://www.ifpa.ie/index.php/eng/Pregnancy-Counselling/About-Abortion> OR **(iii) The Marie Stopes Clinic** <http://www.mariestopes.ie/>.

All the websites provide a range of contacts, telephone numbers and services.

**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?**

Never  <sub>1</sub>

Once  <sub>2</sub>

Twice  <sub>3</sub>

3 times  <sub>4</sub>

4 times  <sub>5</sub>

5-6 times  <sub>6</sub>

7 or more times  <sub>7</sub>

**b. About your baby's health?**

Never  <sub>1</sub>

Once  <sub>2</sub>

Twice  <sub>3</sub>

3 times  <sub>4</sub>

4 times  <sub>5</sub>

5-6 times  <sub>6</sub>

7 or more times  <sub>7</sub>

*Please comment if you wish* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

|  | <b>Always</b>                     | <b>Mostly</b>                     | <b>Sometimes</b>                  | <b>Rarely/<br/>Never</b>          |
|--|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| a. Did you go to the same place for each visit   | <input type="text"/> <sub>1</sub> | <input type="text"/> <sub>2</sub> | <input type="text"/> <sub>3</sub> | <input type="text"/> <sub>4</sub> |
| b. Did you see the same doctor on each occasion? | <input type="text"/> <sub>1</sub> | <input type="text"/> <sub>2</sub> | <input type="text"/> <sub>3</sub> | <input type="text"/> <sub>4</sub> |

**A4 In the past THREE MONTHS, has any of the following happened to you?**

*(Please tick ONE response on EACH line.)*

|  | <b>Yes</b>                            | <b>No</b>                             | <b>Not sure</b>                       |
|--|---------------------------------------|---------------------------------------|---------------------------------------|
| a. D & C ( <i>dilatation and curettage</i> )     | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| b. Wound breakdown – perineal tear or episiotomy | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| c. Wound breakdown – caesarean section           | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| d. Repeat repair of perineal tear or episiotomy  | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |
| e. Repeat repair of caesarean section wound      | <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> |

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

**a. About your health?**

- Never  <sub>1</sub>
- Once  <sub>2</sub>
- Twice  <sub>3</sub>
- 3 times  <sub>4</sub>
- 4 times  <sub>5</sub>
- 5-6 times  <sub>6</sub>
- 7 or more times  <sub>7</sub>

**b. About your baby's health?**

- Never  <sub>1</sub>
- Once  <sub>2</sub>
- Twice  <sub>3</sub>
- 3 times  <sub>4</sub>
- 4 times  <sub>5</sub>
- 5-6 times  <sub>6</sub>
- 7 or more times  <sub>7</sub>

*Please give reasons if you wish* \_\_\_\_\_

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

**a. You?**

- Never  1
- Once  2
- Twice  3
- 3 times  4
- 4 times  5
- 5-6 times  6
- 7 or more times  7

**b. Your baby?**

- Never  1
- Once  2
- Twice  3
- 3 times  4
- 4 times  5
- 5-6 times  6
- 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**

nights 1

**Second admission**

nights 2

**Third admission**

nights 3

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

\_\_\_\_\_  
 \_\_\_\_\_

**A8 a. 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**

nights 1

**Second admission**

nights 2

**Third admission**

nights 3

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

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**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 your own health and well-being?** *(Please tick ALL statements that you agree with. 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.*):

|  | <b>Yes</b>                 | <b>No</b>                  | <b>Not sure</b>            |
|--|----------------------------|----------------------------|----------------------------|
| a. Tiredness or exhaustion                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b. Leakage or involuntary loss of urine        | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| c. Leakage or involuntary loss of bowel motion | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| d. Perineal pain                               | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| e. Sexual problems                             | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| f. Haemorrhoids                                | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| g. Feeling depressed or low                    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| h. Relationship problems                       | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 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 your own health and well-being?** *(Please tick ALL statements that you agree with. 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                     | <input type="checkbox"/> 1 |  | <input type="checkbox"/> 2 |  | <input type="checkbox"/> 3 |
| b. Leakage or involuntary loss of urine        | <input type="checkbox"/> 1 |  | <input type="checkbox"/> 2 |  | <input type="checkbox"/> 3 |
| c. Leakage or involuntary loss of bowel motion | <input type="checkbox"/> 1 |  | <input type="checkbox"/> 2 |  | <input type="checkbox"/> 3 |
| d. Perineal pain                               | <input type="checkbox"/> 1 |  | <input type="checkbox"/> 2 |  | <input type="checkbox"/> 3 |
| e. Sexual problems                             | <input type="checkbox"/> 1 |  | <input type="checkbox"/> 2 |  | <input type="checkbox"/> 3 |
| f. Haemorrhoids                                | <input type="checkbox"/> 1 |  | <input type="checkbox"/> 2 |  | <input type="checkbox"/> 3 |
| g. Feeling depressed or low                    | <input type="checkbox"/> 1 |  | <input type="checkbox"/> 2 |  | <input type="checkbox"/> 3 |
| h. Relationship problems                       | <input type="checkbox"/> 1 |  | <input type="checkbox"/> 2 |  | <input type="checkbox"/> 3 |

**A14. In the past THREE MONTHS, has any OTHER health professional asked you directly about any of these issues?**

|  | Yes                        | No                         | Not sure                   |
|--|----------------------------|----------------------------|----------------------------|
| a. Tiredness or exhaustion                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b. Leakage or involuntary loss of urine        | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| c. Leakage or involuntary loss of bowel motion | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| d. Perineal pain                               | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| e. Sexual problems                             | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| f. Haemorrhoids                                | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| g. Feeling depressed or low                    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| h. Relationship problems                       | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

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

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## Section B: Life with a 12 MONTH old baby

The next few questions are about your life with a 12 month old 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 woman.

**B1 Looking back over the past THREE MONTHS at home with your twelve month old 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 twelve 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?**

Yes, quite a lot  1

Yes, some  2

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:**

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

Very confident  1

Fairly confident  2

Mixed  3

Fairly anxious  4

Not confident  5



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

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**B11 a. Now that your baby is twelve months old, do you ever have time for yourself when someone else looks after your baby? (Please do not include time spent doing paid work.)**

Yes  1

No  2 (please go to B12)

**b. What do you do when you have this time for yourself?**

Relax, put my feet up, watch TV  1

Go walking  2

Go out with a friend (e.g. to the movies, or for a coffee)  3

Read a book or listen to music  4

Have a bath (with the door closed) or a long shower  5

Go shopping for the household  6

Go shopping for myself  7

Play sport (e.g. tennis, netball, golf)  8

Go to a gym, aerobics or another exercise class  9

Go running or bike riding  10

Go swimming  11

Go to an adult education class  12



- |  |                          |    |
|--|--------------------------|----|
| Pay bills, go to the bank                  | <input type="checkbox"/> | 13 |
| Go to the hairdresser or beautician        | <input type="checkbox"/> | 14 |
| Mow the lawn or do some gardening          | <input type="checkbox"/> | 15 |
| Cook ( <i>for enjoyment</i> )              | <input type="checkbox"/> | 16 |
| Go out with partner (boyfriend/girlfriend) | <input type="checkbox"/> | 17 |
| Other ( <i>please describe</i> ) _____     | <input type="checkbox"/> | 18 |
- 
- 
- 
- 

**c. In the LAST MONTH, how often have you had time for yourself?**

- |                                   |                          |   |
|-----------------------------------|--------------------------|---|
| Hardly ever                       | <input type="checkbox"/> | 1 |
| Less than once a fortnight        | <input type="checkbox"/> | 2 |
| About once a fortnight            | <input type="checkbox"/> | 3 |
| About once a week                 | <input type="checkbox"/> | 4 |
| Usually two to three times a week | <input type="checkbox"/> | 5 |
| Usually four or more times a week | <input type="checkbox"/> | 6 |

**B12 a. During the LAST MONTH, have any of the following people given you any practical help? (For example, with meals, housework, helping to care for your baby, etc.)**

- |                                      |                          |   |
|--------------------------------------|--------------------------|---|
| Your partner (boyfriend/girlfriend)  | <input type="checkbox"/> | 1 |
| Your mother                          | <input type="checkbox"/> | 2 |
| Your sister                          | <input type="checkbox"/> | 3 |
| Other relative                       | <input type="checkbox"/> | 4 |
| Friends or neighbours                | <input type="checkbox"/> | 5 |
| Family day care or child care centre | <input type="checkbox"/> | 6 |



- Paid housekeeper  7
- Nanny/au pair  8
- Other (*please describe*)  9 \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**b. PLEASE TICK HERE IF YOU HAVE NOT HAD ANY HELP IN THE LAST MONTH.**

**B13 Looking back over the LAST MONTH, would you have liked more practical help?**  
*(e.g. with cooking meals, housework, caring for baby, etc.)*

- Yes, definitely  1
- Yes, possibly  2
- No, not really  3

**B14 a. Are you happy with the contribution that your husband/partner  
 (boyfriend/girlfriend) makes to household tasks?**

- Yes, definitely  1
- Yes, in the circumstances (*e.g. work commitments*)  2
- No  3
- Not applicable, I do not have a partner  4 (*Please go to B15*)





**b. Are you happy with the contribution that your husband/partner (boyfriend/girlfriend) makes to looking after your baby?**

- Yes, definitely  1
- Yes, in the circumstances (e.g. work commitments)  2
- No  3

**c. How involved would you say your husband/partner is in being a parent?**

- Really involved  1
- Somewhat involved  2
- No, not really  3

*The next few questions ask about physical activities you may have done in the LAST 7 Days.*

**B15 a. In the LAST WEEK, how many times have you walked continuously, for at least 10 minutes, for recreation, exercise or to get from place to place? (e.g. walking with baby in a pusher)**

times <sup>2</sup> None → **Skip to Q B16a.**

**b. What do you estimate was the total time you spent walking in this way in the LAST WEEK?**

hours  minutes

**B16 a. In the LAST WEEK, how many times did you do any vigorous gardening or heavy work around the house or garden which made you breathe harder or puff and pant?**

times <sup>2</sup> None → **Skip to Q B17a.**

**b. What do you estimate was the total time you spent doing vigorous gardening or heavy work around the house or garden in the LAST WEEK?**

hours  minutes

**B17 a. In the LAST WEEK, how many times did you do any strenuous household chores involving moderate physical activity? (For example, vacuum cleaning, washing windows, carrying shopping up several flights of stairs, scrubbing floors)**

times

<sup>2</sup> None → Skip to Q B18a.

- b. What do you estimate was the total time you spent doing these kinds of household chores in the LAST WEEK?

hours     minutes

- B18 a. In the LAST WEEK, how many times have you held your baby continuously for at least ten minutes (in your arms or baby carrier) while standing up in order to soothe or comfort your baby?

times    <sup>2</sup> None → Skip to Q B19a.

- b. What do you estimate was the total time you spent in this way in the LAST WEEK?

hours     minutes

- B19 a. In the LAST WEEK, how many times have you done household chores or shopping while carrying your baby in a baby carrier or back pack?

times    <sup>2</sup> None → Skip to Q B20.

- b. What do you estimate was the total time you spent in this way in the LAST WEEK?

hours     minutes

*The next questions are about the types of exercise, if any, you currently do*

- B20 a. In the LAST WEEK how many times did you do any vigorous physical activity which made you breathe harder or puff and pant? (For example, jogging, cycling, aerobics)

Times    <sup>2</sup> None → Skip to Q B21a.

- b. What do you estimate was the total time you spent doing this vigorous physical activity in the LAST WEEK?

hours     minutes

- B21 a. In the LAST WEEK, how many times did you do any other more moderate physical activity? (For example, gentle swimming)

Times    <sup>2</sup> None → Skip to Q B22.



**b. What do you estimate was the total time you spent doing these activities in the LAST WEEK?**

hours    
   minutes

**B22. If you do any regular exercise (for 10 minutes or more at least ONCE a week), please tick the types of exercise you do and how many times per week you do it.**

| Type of Exercise                  | Times / Week |    |
|-----------------------------------|--------------|----|
| Fast walking                      |              | 1  |
| Jogging/running                   |              | 2  |
| Aerobics                          |              | 3  |
| Weight training                   |              | 4  |
| Dancing                           |              | 5  |
| Swimming                          |              | 6  |
| Cycling                           |              | 7  |
| Ball games (soccer, GAA, rugby)   |              | 8  |
| Racket sports (tennis, badminton) |              | 9  |
| Weight lifting                    |              | 10 |
| Other                             |              | 11 |

**If other please specify:** \_\_\_\_\_

**B23a. Now, 12 months after having your baby, do you AVOID exercise because you leak urine?**

Yes  <sup>1</sup>     No  <sup>2</sup>

**B23 b. If yes, please tell us about the type(s) of exercise you avoid due to leaking urine.**

\_\_\_\_\_



## 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                      | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| b. Coughs, colds or other minor illnesses               | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| c. Severe headaches or migraines                        | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| d. Back pain (in your lower back)                       | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| e. Back pain (in the upper or middle part of your back) | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| f. Painful or sore perineum (from episiotomy / tear)    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| g. Perineal wound infection                             | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| h. Pain from caesarean section wound                    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| i. Caesarean section wound infection                    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| j. Uterine (womb) infection                             | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| k. Pain when you pass urine                             | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| l. Urinary tract infection                              | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| m. Pain when passing a bowel motion                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| n. Bleeding when you pass a bowel motion                | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |

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

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**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) **all** 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 LIQUID 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 SOLID 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

**If you answered NO to all of the questions in C13 and C14 and C15, please go to C19.**

**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 | <input type="checkbox"/> 1  |
| Public Health Nurse                 | <input type="checkbox"/> 2  |
| GP Practice Nurse                   | <input type="checkbox"/> 3  |
| Obstetrician/Gynaecologist          | <input type="checkbox"/> 4  |
| Physiotherapist                     | <input type="checkbox"/> 5  |
| Other health professional           | <input type="checkbox"/> 6  |
| Partner                             | <input type="checkbox"/> 7  |
| Friend                              | <input type="checkbox"/> 8  |
| Sister                              | <input type="checkbox"/> 9  |
| Mother                              | <input type="checkbox"/> 10 |
| Other (please describe)             | <input type="checkbox"/> 11 |
- 

**C17c If no, is it because**

- |  |                            |
|--|----------------------------|
| I have thought about it but haven't felt able to talk about it | <input type="checkbox"/> 1 |
| I don't want to discuss it                                     | <input type="checkbox"/> 2 |
| Other (Please describe)  | <input type="checkbox"/> 3 |
- 
- 

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

- |                          |                            |
|--------------------------|----------------------------|
| About the same           | <input type="checkbox"/> 1 |
| Better than before       | <input type="checkbox"/> 2 |
| It's no longer a problem | <input type="checkbox"/> 3 |
-





**The next few questions ask about perineal pain and pelvic floor problems you may have experienced since the birth. 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.**

**(Please note that questions on sex are in section D)**

**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?  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| b. Shifting positions in bed?                                       | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| c. Getting in and out of bed?                                       | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| d. Feeding your baby?   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| e. Sitting in a chair?  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| f. Lifting your baby?   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| g. Walking?   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| h. Bathing or showering yourself                                    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| i. Doing physical exercise e.g. running, aerobics, climbing stairs? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| j. Carrying your baby for extended periods?                         | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| k. Passing urine?   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| l. Passing a bowel movement   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |

Please comment if you wish \_\_\_\_\_

**If you have not experienced pain in any of these situations, please go to C22 .**

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

Yes  1

No  2 (If no, please go to C22)

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

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

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

Yes  1

No  2 (if NOT, please go to C22)

**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?**

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**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 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?**

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The next few questions in this section ask about abdominal pain (*tummy pain*) you may have experienced since the birth. 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?  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| b. Shifting positions in bed?                                       | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| c. Getting in and out of bed?                                       | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| d. Feeding your baby?   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| e. Sitting in a chair?  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| f. Lifting your baby?   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| g. Walking?   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| h. Bathing or showering yourself?                                   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| i. Doing physical exercise e.g. running, aerobics, climbing stairs? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| j. Carrying your baby for extended periods?                         | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| k. Passing urine?   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| l. Passing a bowel movement?  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 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. Paracetamol ( <i>e.g. Panadol®</i> )                                    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b. Paracetamol and codeine ( <i>panadeine</i> )                            | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| c. Ponstan®  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| d. Difene (Voltarol) ( <i>taken orally</i> )                               | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| e. Difene (Voltarol) ( <i>suppository inserted into the back passage</i> ) | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| f. Nurofen/Isobrufen   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| g. Aspirin   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| h. Local anaesthetic gel   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| i. Herbal remedies   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| j. Other ( <i>please describe</i> )  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

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**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 (Please describe)  11
- 

**C29 NOW, 12 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 \_\_\_\_\_

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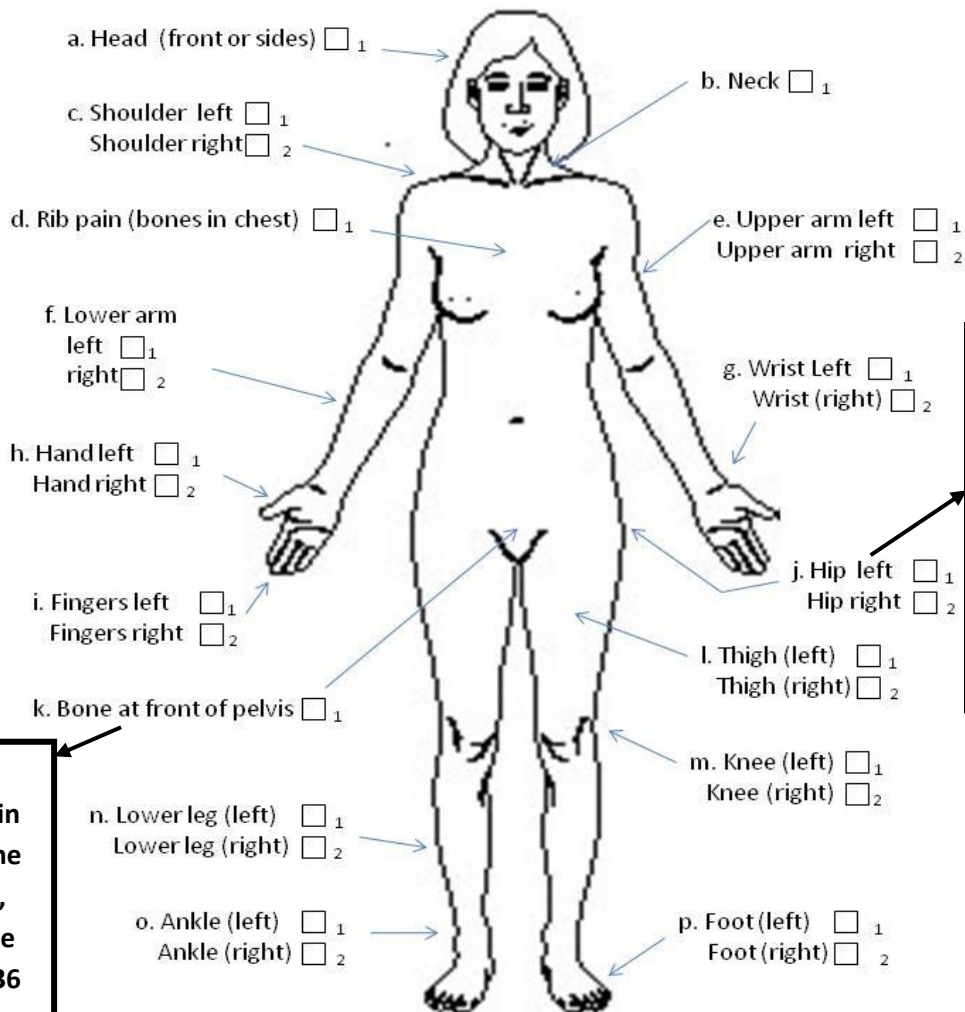
**C30** Please look at the two pictures below. Picture A is looking at the body from the front. Picture B is looking at the body from the back. In the past THREE MONTHS, have you experienced pain in any of the parts of the body named?

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.**

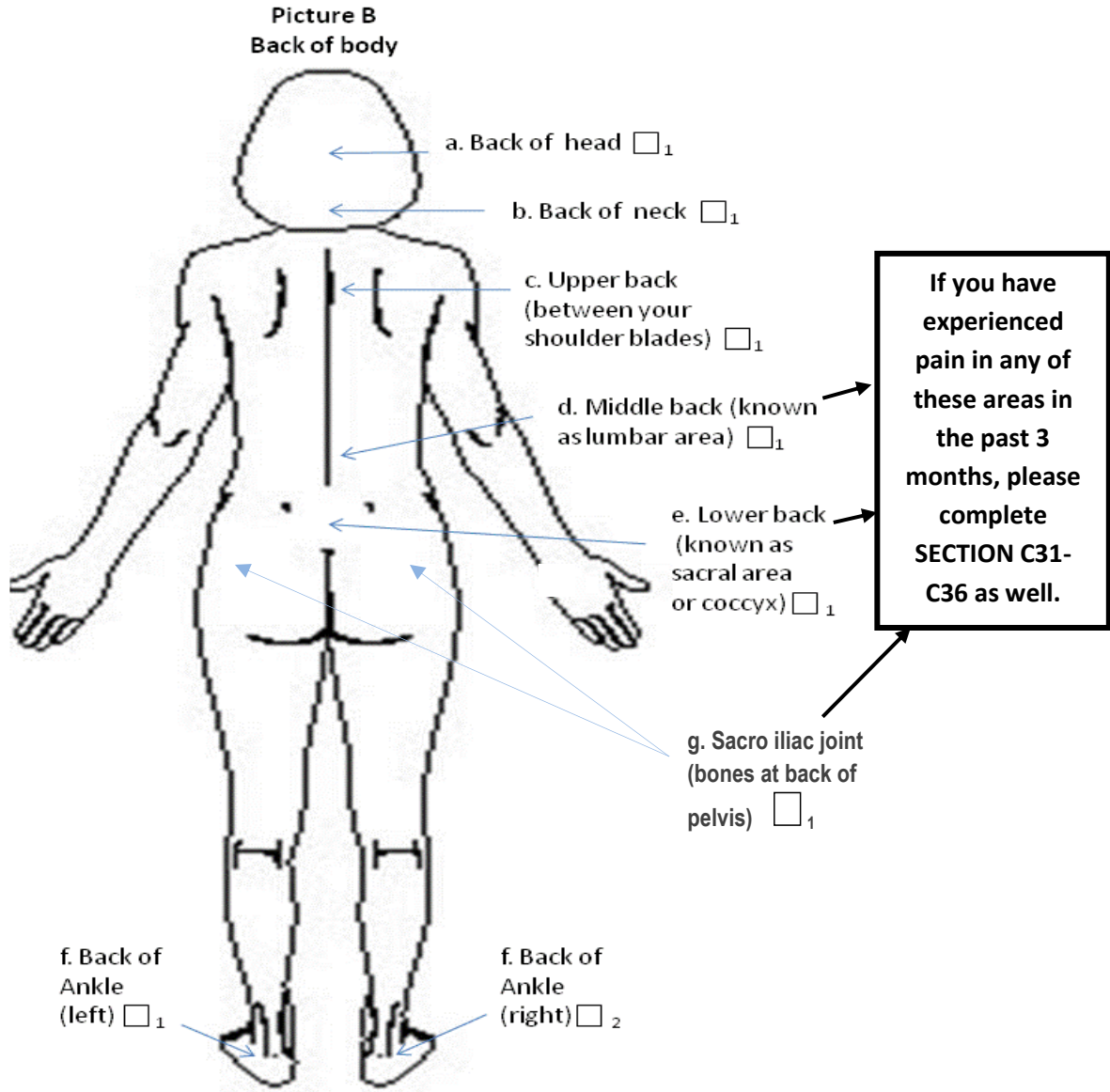
If you experienced pain in any other parts not named or shown here, please tick here

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 44.)**

**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<br>extent       | To some<br>extent          | To a large<br>extent       |
|-----------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Dress yourself                 | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b. Stand for less than 10 minutes | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| c. Stand for more than 60 minutes | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| d. Bend down                      | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| e. Sit for less than 10 minutes   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| f. Sit for more than 60 minutes   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| g. Walk for less than 10 minutes  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| h. Walk for more than 60 minutes  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| i. Climb stairs                   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| j. Do housework                   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| k. Carry light objects            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| l. Carry heavy objects            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| m. Get up/sit down                | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| n. Push a shopping cart           | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| o. Run                            | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| p. Carry out sporting activities  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| q. Lie down                       | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| r. Roll over in bed               | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| s. Have a normal sex life         | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| t. Push something with one foot   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |



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

|                   | <b>None</b>                | <b>Some</b>                | <b>Moderate</b>            | <b>Considerable</b>        |
|-------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a. In the morning | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b. In the evening | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

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

|   | <b>Not at all</b>          | <b>To a small extent</b>   | <b>To some extent</b>      | <b>To a large extent</b>   |
|---|----------------------------|----------------------------|----------------------------|----------------------------|
| a. Has your leg/have your legs given way? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b. Do you do things more slowly?          | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| c. Is your sleep interrupted?             | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

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

| <b>Not at all</b>          | <b>To a small extent</b>   | <b>To some extent</b>      | <b>To a large extent</b>   |
|----------------------------|----------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 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. Paracetamol ( <i>e.g. Panadol®</i> )                                | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b. Paracetamol and codeine ( <i>panadeine</i> )                        | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| c. Ponstan®  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| d. Difene (Voltarol) ( <i>taken orally</i> )                           | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| e. Difene (Voltarol) ( <i>suppository inserted into back passage</i> ) | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| f. Nurofen/Isobrufen   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| g. Aspirin   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| h. Local anaesthetic gel   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| i. Other ( <i>please describe</i> )                                    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 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 | <input type="checkbox"/> 1 | Partner                       | <input type="checkbox"/> 7  |
| Public Health Nurse                 | <input type="checkbox"/> 2 | Friend                        | <input type="checkbox"/> 8  |
| GP practice nurse                   | <input type="checkbox"/> 3 | Sister                        | <input type="checkbox"/> 9  |
| Obstetrician/Gynaecologist          | <input type="checkbox"/> 4 | Mother                        | <input type="checkbox"/> 10 |
| Physiotherapist                     | <input type="checkbox"/> 5 | Other (Please describe below) | <input type="checkbox"/> 11 |
| Other health professional           | <input type="checkbox"/> 6 |                               |                             |



## Section D: Sex after childbirth

**The next few questions are about your sexuality and sexual health in the past three months.**

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.

**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
- 10-12 months after the birth  5

**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

**D2 b. If you have a partner, but have not had any sexual 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

*Please comment if you wish* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***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?**

- 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
- 10-12 months after the birth  5

**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?**

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

**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 *(Please go to D10)*

**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

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**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:**

|  | <b>Yes</b>                 | <b>No</b>                  | <b>Prefer not to answer</b> |
|--|----------------------------|----------------------------|-----------------------------|
| a. Oral sex  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |
| b. Anal sex  | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |
| c. Other sexual contact ( <i>i.e. forms of contact with the genital area not leading to intercourse but intended to achieve orgasm</i> ) | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |

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

|                                   |                            |
|-----------------------------------|----------------------------|
| Extremely emotionally satisfying  | <input type="checkbox"/> 1 |
| Very emotionally satisfying       | <input type="checkbox"/> 2 |
| Moderately emotionally satisfying | <input type="checkbox"/> 3 |
| Slightly emotionally satisfying   | <input type="checkbox"/> 4 |
| Not at all emotionally satisfying | <input type="checkbox"/> 5 |
| Not sure                          | <input type="checkbox"/> 6 |

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

|                                   | <b>Yes</b>                 | <b>No</b>                  | <b>Prefer not to answer</b> |
|-----------------------------------|----------------------------|----------------------------|-----------------------------|
| a. Lack of vaginal lubrication    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |
| b. Painful penetration            | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |
| c. Pain during sexual intercourse | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |
| d. Pain on orgasm                 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |
| e. Difficulty reaching orgasm     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |
| f. Unable to reach orgasm         | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |
| g. Vaginal tightness              | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3  |

|  | Yes                        | No                         | Prefer not to answer       |
|--|----------------------------|----------------------------|----------------------------|
| h. Vaginal looseness / lack of muscle tone                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| i. Bleeding or physical irritation after sex                   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| j. Loss of interest in sex compared with before your pregnancy | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| k. More interest in sex compared with before your pregnancy    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| l. Being pressured to take part in unwanted sexual activity    | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| m. Being forced to take part in unwanted sexual activity       | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| n. Other (please describe)                                     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

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

- Yes  1
- No  2 *(Please go to D15)*

**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                 | <input type="checkbox"/> | 7  |
| Friend                  | <input type="checkbox"/> | 8  |
| Sister                  | <input type="checkbox"/> | 9  |
| Mother                  | <input type="checkbox"/> | 10 |
| Other (please describe) | <input type="checkbox"/> | 11 |

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

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

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**D15** In 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      Prefer not to answer  5
- b. 1-2 times per week  2
- c. 3-4 times per week  3
- d. More than 4 times per week  4

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            | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b. Feeling, depressed, low or blue   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| c. Relationship problems             | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| d. Pain / tenderness                 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| e. Lack of time                      | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| f. Baby waking up / interrupting you | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| g. Other (please describe)           | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 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?**

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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](mailto: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 \_\_\_\_\_

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**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                |

**E4 continued**

|    |   | <b>Not at all</b> | <b>Some of<br/>the time</b> | <b>A good<br/>part of<br/>the time</b> | <b>Most of<br/>the time</b> |
|----|---|-------------------|-----------------------------|--|-----------------------------|
| 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: You and your household

**The next few questions are about you and your household.** 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 be help me to understand them. Again, I 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.

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

- Married  1
- Living with partner (boyfriend/girlfriend)  2
- Same sex relationship  3
- Divorced or separated  4
- In a relationship - not living together  5
- Widowed  6
- Single  7
- Other (Please describe)  8
- 

### F2 Who else lives 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 or brother  8
- A friend  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* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**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 F7)*

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

Weeks old

**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
- Other *(Please describe)*  11

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**F6 Have you had to take time off work due to your own ill health or the ill health of your baby since the birth of your baby?**

- Yes, due to my own ill health  1
- Yes, due to my baby's ill health  2
- No  3 *(please go to F7a)*

**F6b If you have had to take time off work due to your own ill health or the ill health of your baby, was this**

- Paid time off (sick leave, compassionate leave, annual leave)  1
- Unpaid time off (unplanned parental leave, or special unpaid leave)  2

*Please comment if you wish* \_\_\_\_\_

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**F6c If you have had to take time off work, was this:**

**For your OWN ill health**  
**(Please tick ONE response)**

1-3 days  1

4-7 days  2

1-2 weeks  3

3-4 weeks  4

More than 4 weeks  5

**For your BABY's ill health?**  
**(Please tick ONE response)**

1-3 days  1

4-7 days  2

1-2 weeks  3

3-4 weeks  4

More than 4 weeks  5

*Please comment if you wish* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**F7 a. Are you hoping to have another baby?**

Yes,  1

No,  2

Not sure  3

**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** 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.

**Even though you were asked about being pregnant at the beginning of the survey, the next few questions ask you to provide a little more detail please.**

**G1 a. Are you currently pregnant?**

Yes  1

No  2

**b. If YES, how many weeks pregnant are you?**

Number of weeks

**G2 a. Since you had your 12 months old baby, have you had a pregnancy that ended in a miscarriage?**

Yes  1

No  2 (Go to G3)

**b. If YES, please say when this happened:**

month  year

**c. How many weeks pregnant were you when this happened?**

Weeks

**G3 a. Since you had your one-year old baby, have you had a pregnancy that ended in an abortion (termination of pregnancy)?**

Yes  1

No  (Go to G4) 2

**b. If YES, please say when this happened:**

month  year

**c. How many weeks pregnant were you when this happened?**

weeks

**If you have experienced a miscarriage and want to talk to someone about your experiences, the Miscarriage Association of Ireland offer help and support. Their website is at:**

<http://www.miscarriage.ie/>

Their office is at: Miscarriage Association of Ireland, Carmichael Centre, North Brunswick Street, Dublin 7.

Telephone, (Central Lines): 01- 873 5702. A list of telephone support lines is available on the website. You can also email: <mailto:info@miscarriage.ie>

**If you have experienced an abortion and want to talk to someone about your experiences, there are several sources of help and support, some are free and some charge a fee. Choosing the right source of support is a personal matter and the following websites might be a useful starting place for you: (i) The Crisis pregnancy agency <http://www.crisispregnancy.ie> ; (ii) The Irish Family Planning Association <http://www.ifpa.ie/index.php/eng/Pregnancy-Counselling/About-Abortion> OR (iii) The Marie Stopes Clinic <http://www.mariestopes.ie/>.**

All the websites provide a range of contacts, telephone numbers and services.

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

**G4 Are you currently in a relationship?**

Yes  1                      No  2 *(Go to D6)*

**G5 Are you afraid of your current partner?**

Yes  1                      No  2

**G6 Have you ever been afraid of any partner?**

Yes  1                      No  2

*Please comment if you wish* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**G7 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, since you had your baby. 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.)**

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



| My Partner                              | Never                    | Only once                | Several times            | Once a month             | Once a week              | Daily                    |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Kept me from medical care               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Followed me                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Locked me in the bedroom                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Raped me                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hung around outside my house            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Harassed me over the telephone          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tried to rape me                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Harassed me at work                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pushed, grabbed or shoved me            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Used a knife or gun or other weapon     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Took my purse and left me stranded      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Put foreign objects in my vagina        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Refused to let me work outside the home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kicked me, bit me or hit me with a fist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please comment on **ANY** of the issues raised in G7 if you wish

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**G8** Have 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.*

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Women's Aid - working to end violence against women

If you need help, phone them on:

[National Freephone Helpline](tel:1800341900)

1800 341 900 - 10am to 10pm

<http://www.womensaid.ie/>

Email: [info@womensaid.ie](mailto: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](tel:1800341900) 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.

## Comments

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

- |  |                          |   |
|--|--------------------------|---|
| I managed to finish it but it took ages.               | <input type="checkbox"/> | 1 |
| I was pleased to be asked about my experiences         | <input type="checkbox"/> | 2 |
| It was OK  | <input type="checkbox"/> | 3 |
| It was interesting                                     | <input type="checkbox"/> | 4 |
| I didn't understand some of the terms or language used | <input type="checkbox"/> | 5 |
| Other (please say what)                                | <input type="checkbox"/> | 6 |

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

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

Yes <sub>1</sub> No <sub>2</sub>

**b. Did you recommend the website to others?**

Yes <sub>1</sub> No <sub>2</sub>

**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.**

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If you have agreed to being contacted in the coming years and your address has changed or you are about to move home, please fill in the details below:

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

**Thank you for taking the time to complete this survey. Your answers will help us to understand more about the health of first-time mothers before, during and after their pregnancy and it may help other women to know about some of the health problems experienced by women when the findings are published. Again, we want to reassure you that no names will be used in any publication and it will not be possible to identify any individual woman or her responses.**

Please use the reply paid envelope to send this survey 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.

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.

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

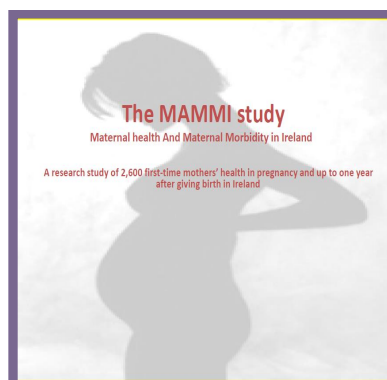
Please call us if you have any questions about the study. I hope you and your family enjoy good health and happiness always.

Best wishes

The MAMMI study team

**087 229 0989**

[www.mammi.ie](http://www.mammi.ie)



Our sincerest thanks to Professor Stephanie Brown, Murdoch Children's Research Institute, Melbourne, Australia for granting us permission to amend and use this survey in an Irish setting.

