Study No. ☐☐☐☐☐

THE MAMMI STUDY

FIVE YEAR FOLLOW-UP SURVEY

FOR WOMEN WHO HAD THEIR FIRST BABY APPROXIMATELY FIVE YEARS AGO

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 087 118 6762

The MAMMI study has been approved by the Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin.

Please tick here if you do not want to complete this survey ☐

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Structure of the MAMMI Study follow-up survey

The **M**aternal health **A**nd **M**aternal **M**orbidity in **I**reland (MAMMI) 5 year follow-up study is designed for women who had their first baby about 5 years ago, regardless of whether or not you have had subsequent children.

The survey is structured as follow:

Section 1- You and your Child/Children

Part A	You and your Child/Children

Section 2- Life Now

Part A	Life Now
Part B	Exercise
Part C	Your Health and Well-Being Now
Part D	Sexual Health Now
Part E	Your Emotional Health and Well-Being Now
Part F	You and Your Household
Part G	You and Your Relationships
Part H	Your Treatment and Costs of Care
Part I	Views on Data Sharing
Part J	Comments

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			
3	0	0	4	1	9	8	0
d	d	m	m	y	y	y	y

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

Section 1, Part A: You and Your Child/Children

These questions are about your history of pregnancies since you had your first baby.

A1 What is today's date?

☐☐ / ☐☐ / ☐☐☐☐
d d / m m / y y y y

A2(a) What is your FIRST baby's date of birth?

☐☐ / ☐☐ / ☐☐☐☐
d d / m m / y y y y

A2(b) To help us identify which follow-up survey to send you, please tell us a little bit about any pregnancies and/or births you may have had since your first baby's birth.

Please tick the response below that applies to you NOW:

I haven't been pregnant since my first baby's birth ☐ 1 Skip to A4

I have had a miscarriage/miscarriages and have not given birth since ☐ 2 Skip to A4

I have had a termination/terminations and have not given birth since ☐ 3 Skip to A4

I have had two or more babies ☐ 4 Skip to A3

I am pregnant with my second baby/babies now AND my baby is due on [please insert date below]: ☐ 5 Skip to A4

☐☐ / ☐☐ / ☐☐☐☐
d d / m m / y y y y

A3 Please tell us your second and subsequent children's birth dates, and how you gave birth. (Please tick if these were twin births)

My **second** baby/child was born on:

☐☐ / ☐☐ / ☐☐☐☐ Twin? ☐
d d / m m / y y y y

I had normal vaginal birth ☐ 1

I had assisted vaginal birth ☐ 2 (e.g. vacuum [ventouse, kiwi], forceps, etc.)

I had a caesarean section ☐ 3

My **third** baby/child was born on:

☐☐ / ☐☐ / ☐☐☐☐ Twin? ☐
d d / m m / y y y y

I had normal vaginal birth ☐ 1

I had assisted vaginal birth ☐ 2 (e.g. vacuum [ventouse, kiwi], forceps, etc.)

I had a caesarean section ☐ 3

A3 contd. My **fourth** baby/child was born on:

d	d	/	m	m	/	y	y	y	y	Twin?

I had normal vaginal birth ☐ 1

I had assisted vaginal birth ☐ 2
(e.g. vacuum [ventouse, kiwi], forceps, etc.)

I had a caesarean section ☐ 3

A4 **Is there anything you wish to tell us about trying to become pregnant, choosing not to become pregnant, or any subsequent pregnancies and/or births in the years since you had your first baby?** There is additonal space for comments at the end of the survey if required

A5(a) **Since the birth of your first child, how many miscarriages, if any, have you had?**

None ☐ 1 Number of miscarriages ☐ 2 Prefer not to answer ☐ 3

A5(b) **Since the birth of your first child, how many babies have you had that were stillborn?**

None ☐ 1 Number of stillbirths ☐ 2 Prefer not to answer ☐ 3

A5 (c) **Since the birth of your first child, how many termination(s) of pregnancy, if any, have you had?**

None 1 Number of terminations ☐ 2 Prefer not to answer ☐ 3

A5 (d) **If YES where did you have the termination(s) ?**

Ireland ☐ 1 Abroad ☐ 2

Please comment if you wish:

If you have experienced any of the issues raised in these questions and feel you need help or support please see page 5 for a list of organisations that you may wish to contact

A 6 **Since the birth of your first child, did you use any form of family planning or contraception?**

Yes ☐ 1 No ☐ 2

If you answered 'no', can you tell us the reason for your choice:

I was trying for another baby	☐ 1	I could not afford it	☐ 4
I am not in a relationship	☐ 2	My partner and I don't have sex	☐ 5
I am in a same sex relationship	☐ 3	I prefer not to say	☐ 6

Other (Please describe) _____

A 7 **What do you currently weigh without clothes or shoes?**

☐☐☐ kgs **OR** ☐☐ stone ☐☐ pounds

A 8 **Are you hoping to have another baby?**

Yes ☐ 1 No ☐ 2 Not sure ☐ 3 I am pregnant now ☐ 4 Skip to A 11

A 9 **Are you currently trying to conceive?**

Yes ☐ 1 No ☐ 2 Skip to A 12

A 10 **Are you receiving any infertility treatment?**

Yes ☐ 1 No ☐ 2

A 11 **Would you prefer to have:**

A vaginal birth ☐ 1 A caesarian section ☐ 2 No particular preference ☐ 3

A 12 **If you wish, please comment regarding future pregnancies or mode of birth**

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you are affected by any of the issues raised in this section and feel you would like to talk to someone, the following is a list of organisations that provide help and support:

Feileacain
(Stillbirth and Neonatal Death Association of Ireland)
Website: www.feileacain.ie
Tel: 085 249 6464
Email: info@feileacain.ie

Miscarriage Association of Ireland
Website: www.miscarriage.ie
Tel: 01 873 5702
Email: info@miscarriage.ie

A Little Lifetime Foundation
(Formerly Irish Stillbirth and Neonatal Death Society)
Website: www.alittlelifetime.ie
Tel: 01 882 9030
Send an email through their website: www.alittlelifetime.ie/contact

FirstLight
(formerly The Irish Sudden Infant Death Association)
Website: www.firstlight.ie
Tel: 1850 391 391
Email: support@firstlight.ie

Support Organisation For Trisomy (SOFT)
(Support for Trisomy 18, 13 and other related chromosomal disorders)
Website: www.softireland.com/
Tel: 1800 213 218
Email: soft.contactme@gmail.com

NISIG (National Infertility support and Information Group)
Website: www.nisig.com
Tel: 087 797 5058
Email: nisigireland@gmail.com

Ectopic Pregnancy Ireland
Website: www.ectopicireland.ie
Tel: 089 436 5742
Email: info@ectopicireland.ie

Section 2, Part A: Life Now

The next few questions are about your life now.

A1 **Looking back over the past THREE MONTHS at home with your child/children, how would you describe your own health during this time?**
Did you feel: (Tick one)

Extremely well	Very well	Okay	Very unwell	Extremely unwell
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

A2 **How confident did you feel about looking after your child/children over the past THREE MONTHS at home?** (Tick one)

Very confident	Fairly confident	Mixed	Fairly anxious	Not confident
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

A3 **Do you feel like you are getting enough sleep yourself?**

Yes ☐ 1 No ☐ 2

A4(a) **Does your child/children have any health or developmental problems that have had a major impact on your life?**

Yes ☐ 1 No ☐ 2

A4(b) **If YES, please describe and indicate to which child it applies (1st, 2nd, etc.):**

_____

_____

_____

_____

A5 **Is there anything else you would like to tell us about your children?**

_____

_____

_____

_____

A6 (a) **In the PAST THREE MONTHS did you have time for yourself when someone else looked after your child/children?** (Please do not include time spent doing paid work.)

Yes ☐ 1 No ☐ 2

A6(b) What do you do when you have this time for yourself? Please tick all that apply.

Relax, put my feet up, watch TV	☐ 1	Go running or bike riding	☐ 10
Go walking	☐ 2	Go swimming	☐ 11
Go out with a friend (e.g. to the movies, or for a coffee)	☐ 3	Go to an adult education class	☐ 12
Read a book or listen to music	☐ 4	Pay bills, go to the bank	☐ 13
Have a bath (with the door closed) or a long shower	☐ 5	Go to the hairdresser or beautician	☐ 14
Go shopping for the household	☐ 6	Mow the lawn or do some gardening	☐ 15
Go shopping for myself	☐ 7	Cook (for enjoyment)	☐ 16
Play sport (e.g. tennis, netball, golf)	☐ 8	Go out with partner	☐ 17
Go to a gym, aerobics or another exercise class	☐ 9	Other (please describe)	☐ 18

_____

A6(c) In the LAST MONTH, how often have you had time for yourself?

(Tick one)

Hardly ever	Less than once a fortnight	About once a fortnight	About once a week	Usually two to three times a week	Usually four or more times a week
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

A7(a) During the LAST MONTH, have any of the following people given you any practical help? (For example, with preparing meals, doing housework, providing childcare, etc.)

(Tick all that apply)

Your partner	☐ 1	Family day care or child care centre	☐ 6
Your mother	☐ 2	Paid housekeeper	☐ 7
Your sister	☐ 3	Nanny/au pair	☐ 8
Other relative	☐ 4	Other (please describe)	☐ 9
Friends or neighbours	☐ 5	_____	

A7(b) Looking back over the LAST MONTH, would you have liked more practical help? (e.g. with preparing meals, doing housework, assistance with childcare, etc.)

Yes, definitely ☐ 1 Yes, possibly ☐ 2 No, I had all the help I needed ☐ 3

A8(a) Are you happy with the contribution that your partner (husband/wife/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

A8(b) Are you happy with the contribution that your partner (husband/wife/boyfriend/ girlfriend) makes to looking after your child/children?

Yes, definitely ☐ 1

Yes, in the circumstances (e.g. work commitments) ☐ 2

No ☐ 3

A8(c) How involved would you say your partner (husband/wife/boyfriend/girlfriend) is in being a parent?

Really involved ☐ 1

Somewhat involved ☐ 2

Not really involved ☐ 3

Section 2, Part B: Exercise

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

B1(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?

None ☐ Skip to Q B2 (a)

Yes ☐ : Number of times ☐☐☐

B1(b) What do you estimate was the total time you spent walking in this way in the LAST WEEK?

Hours ☐☐ Minutes ☐☐

B2(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?

None ☐ Skip to Q B3 (a)

Yes ☐ : Number of times ☐☐☐

B2(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 ☐☐

B3(a) In the LAST WEEK, how many times did you do any strenuous household chores involving moderate physical activity? (i.e., vacuuming, washing windows, carrying shopping up several flights of stairs, scrubbing floors)

None ☐ Skip to Q B4 (a)

Yes ☐ : Number of times ☐☐☐

B3(b) What do you estimate was the total time you spent doing these kinds of household chores in the LAST WEEK?

Hours ☐☐ Minutes ☐☐

B4(a) In the LAST WEEK, how many times have you held your child(ren) continuously for at least ten minutes (in your arms or baby carrier) while standing up in order to soothe or comfort your child(ren)?

None ☐ Skip to Q B5 (a)

Yes ☐ : Number of times ☐☐☐

B4(b) What do you estimate was the total time you spent in this way in the LAST WEEK?

Hours ☐☐ Minutes ☐☐

B5(a) In the LAST WEEK, how many times have you done household chores or shopping while carrying your baby in a back pack or a baby carrier?

None ☐ Skip to Q B6(a)

Yes ☐ : Number of times ☐☐☐

B5(b) What do you estimate was the total time you spent in this way in the LAST WEEK?

Hours ☐☐ Minutes ☐☐

B6(a) **In the LAST WEEK how many times did you do any <u>vigorous physical activity</u> which made you breathe harder or puff and pant?** (For example, jogging, cycling, aerobics)

None ☐
Skip to Q B7(a)

Yes ☐ : Number of times ☐☐☐

B6(b) **What do you estimate was the total time you spent doing this vigorous physical activity in the LAST WEEK?**

Hours ☐☐ Minutes ☐☐

B7(a) **In the LAST WEEK, how many times did you do any other more <u>moderate physical activity</u>? (For example, gentle swimming)**

None ☐
Skip to Q B8

Yes ☐ : Number of times ☐☐☐

B7(b) **What do you estimate was the total time you spent doing these activities in the LAST WEEK?**

Hours ☐☐ Minutes ☐☐

B8 **If you do any regular exercise (for 10 minutes or more at least ONCE a week), please indicate the exercise you do AND how many times per week you take part in each exercise.**

TYPE OF EXERCISE	NUMBER OF TIMES A WEEK	TYPE OF EXERCISE	NUMBER OF TIMES A WEEK
Fast walking	☐ 1	Swimming	☐ 6
Jogging/running	☐ 2	Cycling	☐ 7
Aerobics	☐ 3	Ball games (soccer, GAA, rugby)	☐ 8
Weight training	☐ 4	Racket sports (tennis, badminton)	☐ 9
Dancing	☐ 5	Weight lifting	☐ 10
		Other (please specify below)	☐ 11

B9 **Do you have access to childcare to allow you to exercise?** (Tick all that apply)

I pay for childcare while I exercise	☐ 1	I do not exercise because I don't have access to childcare	☐ 3
Family or friends mind my child(ren) while I exercise	☐ 2	I can bring my child/children with me (e.g. mum & baby exercise groups)	☐ 4

Section 2, Part C: Your Health and Well-Being Now

The next few questions are about your health over the **PAST THREE MONTHS**

C1 **In the past THREE MONTHS, have you experienced any of the following:**

(tick one ON EACH LINE)

	Never	Rarely	Occasionally	Often
(a) Extreme tiredness or exhaustion	☐ 1	☐ 2	☐ 3	☐ 4
(b) Coughs, colds or other minor illnesses	☐ 1	☐ 2	☐ 3	☐ 4
(c) Severe headaches or migraines	☐ 1	☐ 2	☐ 3	☐ 4
(d) Back pain in your lower back	☐ 1	☐ 2	☐ 3	☐ 4
(e) Back pain in the upper or middle part of your back	☐ 1	☐ 2	☐ 3	☐ 4
(f) Painful or sore perineum from episiotomy/tear	☐ 1	☐ 2	☐ 3	☐ 4
(g) Perineal wound infection	☐ 1	☐ 2	☐ 3	☐ 4
(h) Pain from caesarean section wound	☐ 1	☐ 2	☐ 3	☐ 4
(i) Caesarean section wound infection	☐ 1	☐ 2	☐ 3	☐ 4
(j) Uterine (womb) infection	☐ 1	☐ 2	☐ 3	☐ 4
(k) Pain when you pass urine	☐ 1	☐ 2	☐ 3	☐ 4
(l) Urinary tract infection	☐ 1	☐ 2	☐ 3	☐ 4
(m) Pain when passing a bowel motion	☐ 1	☐ 2	☐ 3	☐ 4
(n) Bleeding when you pass a bowel motion	☐ 1	☐ 2	☐ 3	☐ 4
(o) Constipation (opening your bowels only twice a week or less, or pushing or straining to open your bowels every fourth time you go)	☐ 1	☐ 2	☐ 3	☐ 4
(p) Haemorrhoids (swollen veins around your back passage, sometimes called piles)	☐ 1	☐ 2	☐ 3	☐ 4
(q) Sore nipples	☐ 1	☐ 2	☐ 3	☐ 4
(r) Mastitis	☐ 1	☐ 2	☐ 3	☐ 4
(s) Pelvic pain	☐ 1	☐ 2	☐ 3	☐ 4
(t) Heavy vaginal bleeding or bleeding that worried you	☐ 1	☐ 2	☐ 3	☐ 4
(u) Other health issues (please specify)	☐ 1	☐ 2	☐ 3	☐ 4

_____

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

Yes, and I still feel depressed ☐ 1 | Yes, I felt depressed, but I feel better now ☐ 2 | No ☐ 3 Skip to C3

C2(b) Are you receiving treatment (e.g. medication, psychotherapy or counselling) for depression? (Tick all that apply)

Yes, I'm taking tablets or medications (antidepressants) ☐ 1

Yes, I'm having psychotherapy or counselling ☐ 3

No ☐ 2

I have been referred to a psychiatrist or psychotherapist ☐ 4

Other (Please specify) _____

C2(c) How does depression affect your life? (If you wish, you can describe what it's like)

_____

_____

_____

C3 During or after which, if any, pregnancies did you feel depressed? (Tick one)

None ☐ 1

During pregnancy or after the birth of my FIRST child only ☐ 2

During pregnancy or after the birth of my SECOND child only ☐ 3

During pregnancy or after the birth of ALL my children ☐ 4

Please comment if you wish _____

C4(a) In the past THREE MONTHS, have you experienced anxiety or panic attacks?

Never ☐ 1 Skip to C5 | Rarely ☐ 2 | Occasionally ☐ 3 | Often ☐ 4

C4(b) Are you receiving treatment for anxiety or panic attacks? (Tick all that apply)

Yes, I'm taking tablets or medication ☐ 1

Yes, I'm having psychotherapy or counselling ☐ 3

No ☐ 2

I have been referred to a psychiatrist or psychotherapist ☐ 4

Other (Please specify) _____

C4(c) How does anxiety affect your life? (If you wish, you can describe what it's like)

_____

_____

_____

C5 During or after which, if any, pregnancies did you experience anxiety or panic attacks? (Tick one)

None ☐ 1

During pregnancy or after the birth of my FIRST child only ☐ 2

During pregnancy or after the birth of my SECOND child only ☐ 3

During pregnancy or after the birth of ALL my children ☐ 4

Please comment if you wish _____

C6(a) In the past THREE MONTHS, have you leaked even small amounts of urine in the following situations? (Tick one on each line)

	Never	Less than once a month	Several times a month	Several times a week	Every day
When you coughed, laughed or sneezed, or did physical exercise	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
When you were on the way to the toilet	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
When you had to wait to use the toilet	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
If you did not go to the toilet immediately	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

C6(b) 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

C6(c) 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 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 How does urine leakage affect your life? (i.e. limits your everyday and physical activities or requires use of protective products etc.) (Please describe)

_____

_____

_____

C9 Do you AVOID exercise because you leak urine?

Yes ☐ 1 No ☐ 2

If yes, please tell us about the types of exercise you avoid _____

C10(a) In the past THREE MONTHS have you discussed your bladder problems (leaking urine) with anyone?

Yes ☐ 1 No ☐ 2

C10(b) If YES, who did you discuss it with? (Please tick ALL that apply)

GP / Family 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 specify) ☐ 11

_____

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

Yes ☐ 1 No ☐ 2

C11(b) If yes, how many times have you taken antibiotics for urinary infections in the past THREE MONTHS?

Once ☐ 1 Twice ☐ 2 Three or more times ☐ 3

Please comment if you wish _____

_____

_____

C12 During or after which, if any, of your pregnancies did you experience urine leakage?
(Tick one)

None ☐ 1

During pregnancy or after the birth of my FIRST child only ☐ 2

During pregnancy or after the birth of my SECOND child only ☐ 3

During pregnancy or after the birth of ALL my children ☐ 4

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.

C13 In the past THREE MONTHS have you (Place an X in the box for your answer)

	No, never	Minor amount	Major amount
Noticed soiling from your back passage on your underwear?	☐ 1	☐ 2	☐ 3
Passed wind when you really didn't want to?	☐ 1	☐ 2	☐ 3

C14(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?

Never	Less than once a month	Several times a month	Several times a week	Every day
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

C14(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(c) In the past THREE MONTHS have you ever, even very occasionally, experienced leakage of SOLID bowel motions at an inappropriate time or an inappropriate place?

Never	Less than once a month	Several times a month	Several times a week	Every day
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

C14(d) 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(a) In the past THREE MONTHS, have you ever experienced an URGENT need to open your bowels that made you rush to the toilet immediately?

Never	Less than once a month	Several times a month	Several times a week	Every day
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

C15(b) 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?

Never	Less than once a month	Several times a month	Several times a week	Every day
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

If you answered NO to all of questions C13 to C15, please go to C18

C16 **How does the leakage of bowel motions affect your life? (i.e. limits your everyday and physical activities or requires use of protective products etc.)** (Please describe)

_____

_____

_____

C17(a) **In the past THREE MONTHS have you discussed your leakage of bowel motions with anyone?**

Yes ☐ 1 No ☐ 2

C17(b) **If YES, who did you discuss it with?** (Please tick ALL that apply)

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

_____

C18 **During or after which, if any, of your pregnancies did you experience leakage of bowel motions?** (Tick one)

None	☐ 1	During pregnancy or after the birth of my SECOND child only	☐ 3
During pregnancy or after the birth of my FIRST child only	☐ 2	During pregnancy or after the birth of ALL my children	☐ 4

Please comment if you wish _____

If you are worried or concerned about leaking urine or soiling from your back passage and wish to get help, please talk to your doctor about it.

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

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.

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:

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

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

Please comment if you wish _____

_____

If you have not experienced pain in any of these situations, please go to C22 (a) Page 19.

C20(a) In the past MONTH 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 Skip to C21

C20(b) If yes, which medications have you used? (tick all that apply)

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

_____

C21(a) In the past THREE MONTHS have you discussed perineal pain with anyone?

Yes ☐ 1 No ☐ 2 Skip to C22 (a), Page 19

C21(b) If YES, who did you discuss it with? (Please tick ALL that apply)

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

_____

The following questions ask about your pelvic floor and 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? (Place an X in the box for your answer)

Completely normal	Almost back to normal	Moderately back to normal	Somewhat back to normal	Not at all normal
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

C22(b) If your pelvic floor does not feel completely back to normal, please describe the ways in which it feels different?

_____

_____

C23(a) In the last MONTH, have you been doing pelvic floor exercises?

Yes, regularly ☐ 1 Yes, when I remember ☐ 2 No ☐ 3

C23(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

C24(b) Are you CURRENTLY having trouble with a feeling of bulging or as if there were something 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 your child/children were born? (Place an X in the box for your answer)

Completely normal	Almost back to normal	Moderately back to normal	Somewhat back to normal	Not at all normal
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

C25(b) If your vagina does not feel completely back to normal, please describe the ways in which it feels different?

_____

_____

C26 During or after which, if any, of your pregnancies did your pelvic floor feel loose?

(Tick one)

- None ☐ 1
- During pregnancy or after the birth of my FIRST child only ☐ 2
- During pregnancy or after the birth of my SECOND child only ☐ 3
- During pregnancy or after the birth of ALL my children ☐ 4

Please comment if you wish _____

C27 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 on EACH line.)

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

Please comment if you wish _____

_____

C28 **Are you satisfied with your body image?**

(Tick one)

Always ☐ 1 Sometimes ☐ 2 Never ☐ 3

Please comment if you wish _____

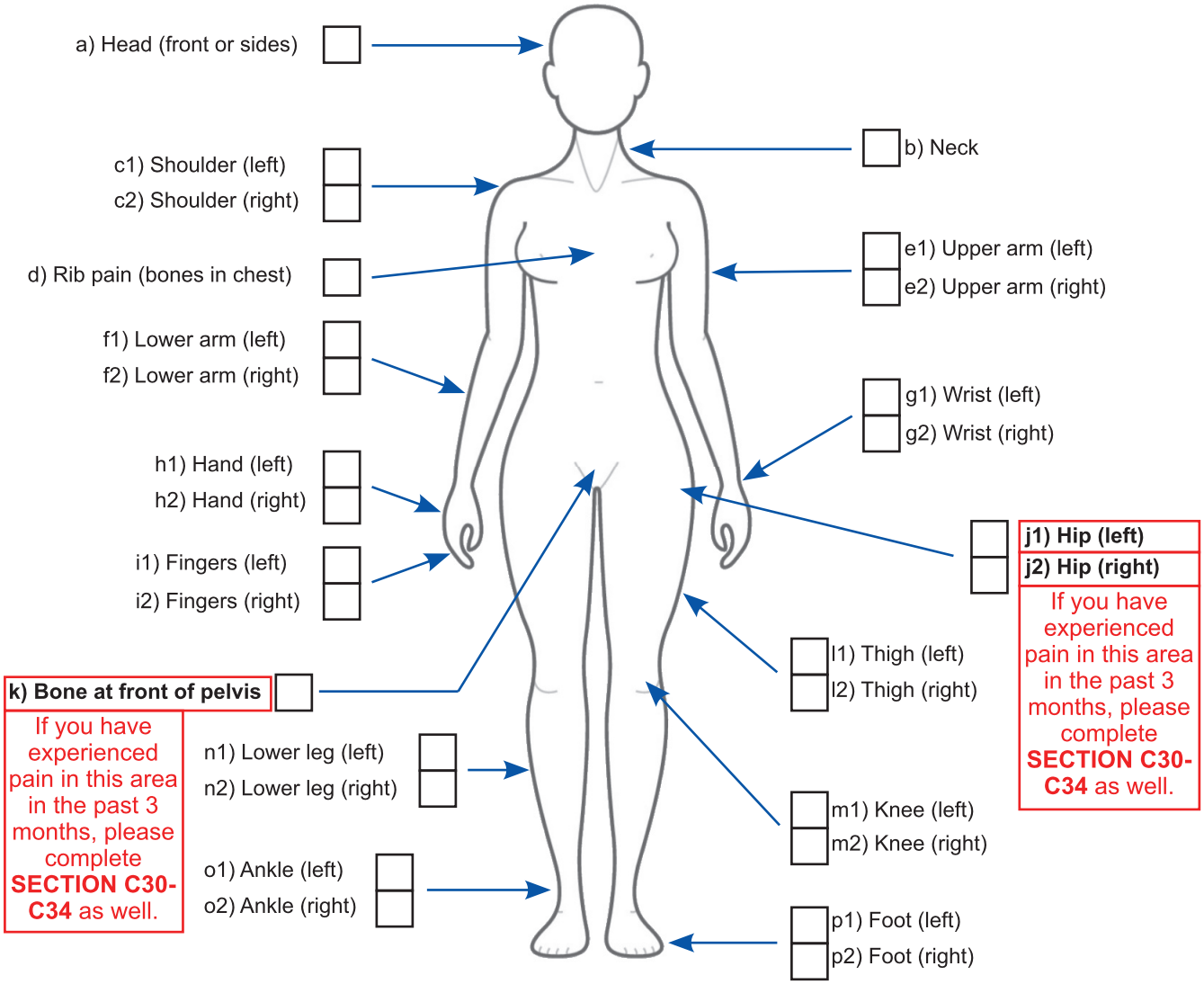
_____

C29 **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 (Skip to C35)

(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

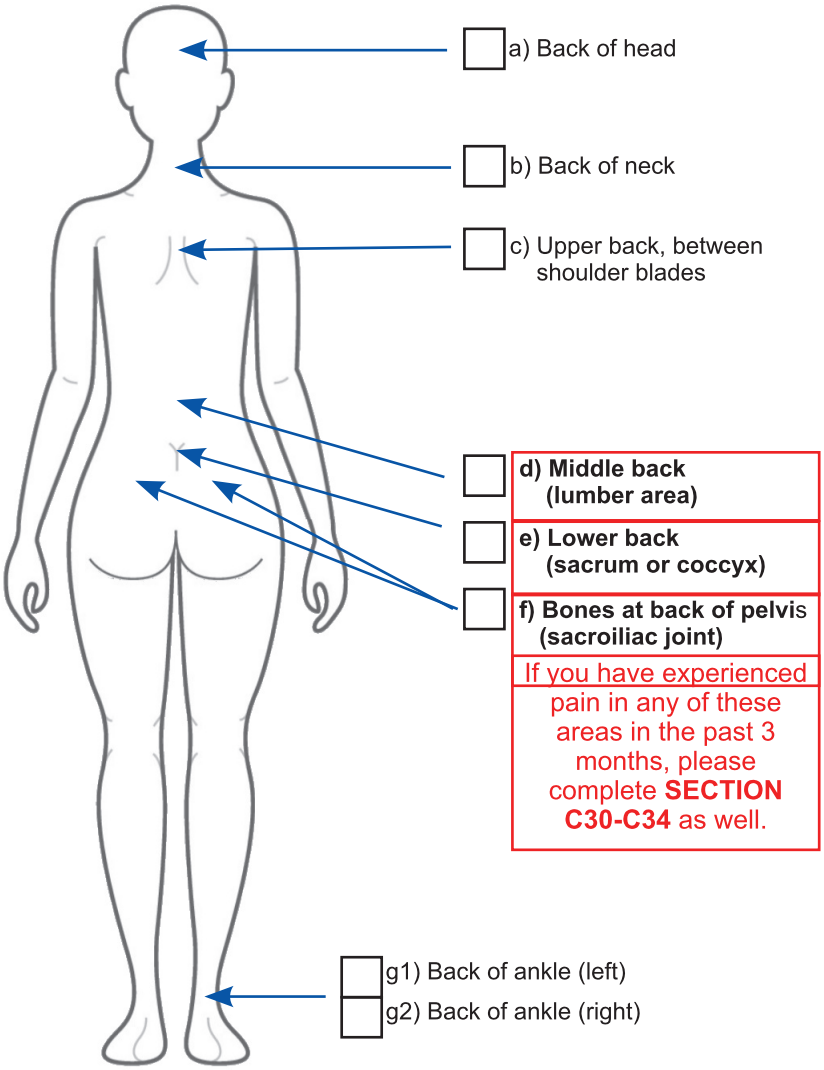


If you experienced pain in any other parts not named or shown here, please tick here ☐

Please specify _____

C29 contd. (b) Please tick the boxes if you have experienced pain in any of the parts of the body named in the past THREE MONTHS.

Picture B - Back of body



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

Please specify _____

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 in the **PAST 3 MONTHS**.
(If you have not had low back or pelvic girdle pain in the **PAST 3 MONTHS**, go to question C35 page 25)

C30 **How problematic is it for you because of your back and/or pelvic girdle pain to do the following:** (Place an X in the box for your answer)

		NOT AT ALL	TO A SMALL EXTENT	TO SOME EXTENT	TO A LARGE EXTENT
(a)	Dress yourself	☐ 0	☐ 1	☐ 2	☐ 3
(b)	Stand for less than 10 minutes	☐ 0	☐ 1	☐ 2	☐ 3
(c)	Stand for more than 60 minutes	☐ 0	☐ 1	☐ 2	☐ 3
(d)	Bend down	☐ 0	☐ 1	☐ 2	☐ 3
(e)	Sit for less than 10 minutes	☐ 0	☐ 1	☐ 2	☐ 3
(f)	Sit for more than 60 minutes	☐ 0	☐ 1	☐ 2	☐ 3
(g)	Walk for less than 10 minutes	☐ 0	☐ 1	☐ 2	☐ 3
(h)	Walk for more than 60 minutes	☐ 0	☐ 1	☐ 2	☐ 3
(i)	Climb stairs	☐ 0	☐ 1	☐ 2	☐ 3
(j)	Do housework	☐ 0	☐ 1	☐ 2	☐ 3
(k)	Carry light objects	☐ 0	☐ 1	☐ 2	☐ 3
(l)	Carry heavy objects	☐ 0	☐ 1	☐ 2	☐ 3
(m)	Get up/sit down	☐ 0	☐ 1	☐ 2	☐ 3
(n)	Push a shopping cart	☐ 0	☐ 1	☐ 2	☐ 3
(o)	Run	☐ 0	☐ 1	☐ 2	☐ 3
(p)	Carry out sporting activities	☐ 0	☐ 1	☐ 2	☐ 3
(q)	Lie down	☐ 0	☐ 1	☐ 2	☐ 3
(r)	Roll over in bed	☐ 0	☐ 1	☐ 2	☐ 3
(s)	Have a normal sex life	☐ 0	☐ 1	☐ 2	☐ 3
(t)	Push something with one foot	☐ 0	☐ 1	☐ 2	☐ 3

C31 How much back and/or pelvic girdle pain do you experience:
(Place an X in the box for your answer)

		None	Some	Moderate	Considerable
(a)	In the morning	☐ 0	☐ 1	☐ 2	☐ 3
(b)	In the evening	☐ 0	☐ 1	☐ 2	☐ 3

C32 To what extent because of your back and/or pelvic girdle pain:
(Place an X in the box for your answer)

		Not at all	To a small extent	To some extent	To a large extent
(a)	Has your leg/have your legs given way?	☐ 0	☐ 1	☐ 2	☐ 3
(b)	Do you do things more slowly?	☐ 0	☐ 1	☐ 2	☐ 3
(a)	Is your sleep interrupted?	☐ 0	☐ 1	☐ 2	☐ 3
(b)	Do you have difficulty lifting/handling your child(ren)?	☐ 0	☐ 1	☐ 2	☐ 3

C33(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

C33(b) If YES, which medications have you used? (tick all that apply)

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

_____

C34(a) In the past THREE MONTHS have you discussed your back or pelvic girdle pain with anyone?

Yes ☐ 1 No ☐ 2

C34(b) If YES, who did you discuss it with? (Please tick all that apply)

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

_____

C35 During which pregnancies did you experience lower back/pelvic girdle pain? (Tick one).

None	☐ 1	During the pregnancy of my SECOND child only	☐ 3
During the pregnancy of my FIRST child only	☐ 2	During the pregnancy of ALL my children	☐ 4

Please comment if you wish _____

C36 How would you describe any low back/pelvic girdle pain since the birth of your FIRST CHILD? (If you have not had any back/pelvic girdle pain, tick option 6).

Constant	☐ 1
Episodic (1 to 2 episodes per year)	☐ 2
Episodic (2 to 6 episodes per year)	☐ 3
Episodic (approximately monthly)	☐ 4
My symptoms started only in the past 3 months	☐ 5
I have not had any back/pelvic girdle pain since the birth of my first child	☐ 6
Other (Please specify)	☐ 7

_____

Section 2, Part D: Sexual Health Now

The next few questions are about your sexuality and sexual health 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.

D1(a) In the past THREE MONTHS have you had any sexual or intimate contact with a partner? (Please include all forms of sexual contact, do not restrict your answer to vaginal intercourse.)

Yes ☐ 1 — Skip to D3 (a)

No ☐ 2 — Continue to D2

No, I do not have a partner ☐ 3 — Skip to D9

D2 If you have a partner, but have not had any sexual contact in the past THREE MONTHS, please tell us why? (Please tick ALL that apply)

Too tired / exhausted	☐ 1	Child waking up	☐ 5
Relationship problems	☐ 2	Experiencing perineal pain	☐ 6
Scared it will be painful	☐ 3	Experiencing pain from previous C-section	☐ 7
Fear of getting pregnant	☐ 4	Don't feel interested	☐ 8
		Other (please specify)	☐ 9

_____

_____

If you have not had any sexual or intimate contact in the past THREE MONTHS, please go to question D9, page 29.

D3(a) Do you experience pain, discomfort or tenderness during vaginal intercourse NOW?

Yes ☐ 1 No ☐ 2 Skip to D4, page 27

D3(b) If YES, how much pain, discomfort or tenderness do you experience?

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

D3(c) How long have you been experiencing pain, discomfort or tenderness during vaginal intercourse? (Please indicate the number of weeks, months or years)

Weeks ☐☐ Months ☐☐ Years ☐☐

D3(d) How often would you say vaginal intercourse is painful for you NOW?

Always	Most of the time	Occasionally	Rarely	Never
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

D3(e) In the past THREE MONTHS, have you discussed the pain or discomfort you are experiencing with anyone?

Yes ☐ 1 No ☐ 2 Please skip to D4

D3(f) If YES, who did you discuss it with? (Please tick ALL that apply)

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

D4 In the past THREE MONTHS, how satisfied are you with your overall sex life?

Very satisfied	Moderately satisfied	Equally satisfied and dissatisfied	Moderately satisfied	Very dissatisfied	Prefer not to answer
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

D5 In the last MONTH, how physically pleasurable have you found your sexual relationship?

Extremely pleasurable	Very pleasurable	Moderately pleasurable	Sometimes pleasurable sometimes not	Not at all pleasurable	Not sure
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

D6 In the last MONTH, have you had:

	YES	NO	PREFER NOT TO ANSWER
Oral sex	☐ 1	☐ 2	☐ 3
Anal sex	☐ 1	☐ 2	☐ 3
Other sexual contact (i.e. forms of contact with the genital area not leading to intercourse but intended to achieve orgasm)	☐ 1	☐ 2	☐ 3

D7 **In the past THREE MONTHS have you experienced any of the following:**

(Please tick one response on each line)

	YES	NO	PREFER NOT TO ANSWER
(a) Lack of vaginal lubrication	☐ 1	☐ 2	☐ 3
(b) Painful penetration	☐ 1	☐ 2	☐ 3
(c) Pain during sexual intercourse	☐ 1	☐ 2	☐ 3
(d) Pain on orgasm	☐ 1	☐ 2	☐ 3
(e) Difficulty reaching orgasm	☐ 1	☐ 2	☐ 3
(f) Unable to reach orgasm	☐ 1	☐ 2	☐ 3
(g) Vaginal tightness	☐ 1	☐ 2	☐ 3
(h) Vaginal looseness / lack of muscle tone	☐ 1	☐ 2	☐ 3
(i) Bleeding or physical irritation after sex	☐ 1	☐ 2	☐ 3
(j) Loss of interest in sex compared with before having a child(ren)	☐ 1	☐ 2	☐ 3
(k) More interest in sex compared with before having a child(ren)	☐ 1	☐ 2	☐ 3
(l) Being pressured to take part in unwanted sexual activity	☐ 1	☐ 2	☐ 3
(m) Being forced to take part in unwanted sexual activity	☐ 1	☐ 2	☐ 3
(n) Other (please describe)	☐ 1	☐ 2	☐ 3

_____

_____

D8 **In the past THREE MONTHS, please describe the frequency of your sexual activity**

Number of times per month ☐ Prefer not to answer ☐

Please comment if you wish _____

_____

D9 **How often have the following issues affected your sex life in the past THREE MONTHS** (Place an X in the box for your answer)

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

_____

D10 **During or after which, if any, of your pregnancies did your experience any sexual health problems?** (Tick one)

None ☐ 1

During pregnancy or after the birth of my FIRST child only ☐ 2

During pregnancy or after the birth of my SECOND child only ☐ 3

During pregnancy or after the birth of ALL my children ☐ 4

Please comment if you wish _____

D11(a) Have you ever discussed any of the above with anyone?

Yes ☐ 1 No ☐ 2 Skip to D12, page 30

D11(b) If YES, who did you discuss it with? (Please tick ALL that apply)

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

_____

D12 **Is there anything else you would like to tell us about in relation to your sexual and intimate relationships in the past THREE MONTHS?**

_____

_____

_____

_____

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

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

SATU telephone number:	**01 8171736 (Dublin)**	
	091 765751 (Galway)	
SATU e-mail:	**SATU@ROTUNDA.IE**	
Web:	**http://www.rotunda.ie/**	
Opening hours:	**8.00am to 4.00pm**	**Mon – Fri (Dublin)**
	8.00am to 4.00pm	**Mon – Fri (Galway)**

Outside of these hours please contact the Rotunda Hospital at 01 8171700
Or you can call the national Rape Crisis Centre.

The Rape Crisis Centre 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
Galway Rape Crisis Centre telephone number: HELPLINE 1800 355355

Section 2, Part E: Your Emotional Health and Well-being Now

The next few questions are about your emotional health and wellbeing 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.

E1 **Please look at the following statements and for each one think about how you have been feeling IN THE LAST WEEK.**

Please place an X in each box that applies to you.

(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 coped 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, some of the time ☐ 2

Not very often ☐ 3

No, never ☐ 4

(h) During the last week I have felt sad or miserable

Yes, most of the time ☐ 1

Yes, some of the time ☐ 2

Not very often ☐ 3

No, never ☐ 4

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

Yes, most of the time ☐ 1

Yes, some of the time ☐ 2

Not very often ☐ 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

Please comment if you wish

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 comment if you wish

E4 **Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you OVER THE PAST WEEK.**

There are no right or wrong answers. Do not spend too much time on any statement.

		NOT AT ALL	SOME OF THE TIME	A GOOD PART OF THE TIME	MOST OF THE TIME
1.	I found it hard to wind down	0	1	2	3
2.	I was aware of dryness of my mouth	0	1	2	3
3.	I couldn't seem to experience any positive feeling at all	0	1	2	3
4.	I experienced breathing difficulty (e.g. 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
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

If you are experiencing any problems with your emotional health and wellbeing and wish to talk to someone, you can talk to your GP and telephone or email the Aware (Depression) Helpline on 1890 303 302, or Anew on (01) 635 1492 (hello@anew.ie).

ONLINE information and support
A number of support services are now using the internet to reach out to people.

For example, www.yourmentalhealth.ie

Section 2, Part F: You and Your Household

The next few questions are about you and your household.

F1 **Are you currently** (Please tick all that apply)

- 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 specify) ☐ 8

_____

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

- Your child/children ☐ 1
- Your partner (husband/wife/boyfriend/girlfriend) ☐ 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 specify) ☐ 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 specify) ☐ 13

_____

Please comment if you wish _____

_____

_____

F4 (a) **Are you currently in work or study?** (Please tick all that apply)

- I am in paid work ☐ 1
- I am on paid maternity leave ☐ 2
- I am on unpaid maternity leave ☐ 3
- I am working and studying part-time ☐ 4
- I am in full-time study ☐ 5
- I am not in paid work or studying at the present time ☐ 6

F4 (b) In the last week how many hours did you spend at work and, if applicable, in education/study?

Hours per week spent in work: ☐☐ Hours per week spent in education/studying: ☐☐

F5 How would you describe your current employment status (Please tick all that apply)

Private sector employee	☐ 1	Unemployed	☐ 8
Public sector employee	☐ 2	I gave up my job after my first child was born	☐ 9
Self-employed	☐ 3	I gave up my job after my second child was born	☐ 10
Student or pupil	☐ 4	I gave up my job after my third child was born	☐ 11
Looking after home/family	☐ 5	Full-time paid work	☐ 12
Unable to work due to sickness or disability	☐ 6	Part-time paid work	☐ 13
Looking for first job	☐ 7	Casual paid-work	☐ 14
		Other (Please specify)	☐ 15

F6(a) Could you please indicate which of the below best describes the area in which you work? (Please tick one)

Agriculture, forestry and fishing	☐ 1	Financial, insurance and real estate activities	☐ 8
Industry	☐ 2	Professional, scientific and technical activities	☐ 9
Construction	☐ 3	Administrative and support service activities	☐ 10
Wholesale and retail trade	☐ 4	Public administration and defence, compulsory social security	☐ 11
Transportation and storage	☐ 5	Education	☐ 12
Accommodation and food service activities	☐ 6	Human health and social work activities	☐ 13
Information and communication	☐ 7	Other (Please specify)	☐ 14

F7 This section is about times when you may have had to take days off work due to physical or mental health problems associated with pregnancy and childbirth (maternal health problems) WITH YOUR FIRST CHILD

1. Did you ever have to take time off work because of physical or mental maternal health problems after having your **first** child

Yes ☐ 1 No ☐ 2 Skip to F8

F7 contd.

2. How many days did you **take off work** due to physical or mental maternal health problems BEFORE GOING ON MATERNITY LEAVE with your **first** child

☐ Days — Please provide your best estimate, or a range if you prefer

3. How many days did you **take off work** due to physical or mental maternal health problems in the FIRST YEAR AFTER RETURNING TO WORK following the birth of your **first** child

☐ Days — Please provide your best estimate, or a range if you prefer

4. How many days did you **take off work** due to physical or mental maternal health problems in the SECOND YEAR AFTER RETURNING TO WORK following the birth of your **first** child

☐ Days — Please provide your best estimate, or a range if you prefer

F8 **This section is about the number of days you had to take off work due to YOUR FIRST CHILD'S health, including time off work to look after them when they were unwell, or bring them to doctor or hospital appointments. This includes routine postnatal check-ups and vaccinations.**

1. Did you ever have to **take time off work** due to YOUR **FIRST** CHILD'S health?

Yes ☐ 1 No ☐ 2 Skip to F9

2. How many days did you need to **take off work** due to YOUR **FIRST** CHILD'S health in the FIRST YEAR AFTER RETURNING TO WORK

☐ Days — Please provide your best estimate, or a range if you prefer

3. How many days did you need to **take off work** due to YOUR **FIRST** CHILD'S health in the SECOND YEAR AFTER RETURNING TO WORK

☐ Days — Please provide your best estimate, or a range if you prefer

F9 **Could you estimate to the best of your ability how often the days you had to take off work were UNPAID and resulted in a loss of earnings for you?**

Never (0%)	Rarely (less than third)	Sometimes (between one third and two thirds)	Often (more than two thirds)	Always (100%)
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Please comment if you wish _____

_____

_____

F10(a) This section asks about times when you may have had to attend work even though you were feeling physically or mentally unwell due to health problem associated with pregnancy or childbirth (maternal health problems) with yout first child.

1. Have you ever had to **attend work even though you were feeling physically or mentally unwell** due to any maternal health problems?

   Yes ☐ 1 No ☐ 2 Skip to F11

2. To the best of your ability could you estimate how many days you **attended work even though you were physically or mentally unwell** due to maternal health problems BEFORE GOING ON MATERNITY LEAVE with your **first** child

   ☐ Days Please provide your best estimate, or a range if you prefer

3. To the best of your ability could you estimate how many days you **attended work even though you were physically or mentally unwell** due to maternal health problems in the FIRST YEAR AFTER RETURNING TO WORK following your **first** child

   ☐ Days Please provide your best estimate, or a range if you prefer

4. To the best of your ability could you estimate how many days you **attended work even though you were unwell** due to physical or mental maternal health problems in the SECOND YEAR AFTER RETURNING TO WORK following your **first** child

   ☐ Days Please provide your best estimate, or a range if you prefer

F10(b) On days you had to attend work even though you were feeling physically or mentally unwell due to any health problem associated with pregnancy or childbirth, how much of an impact did it generally have on your job performance, compared to normal?

Please circle one point on the scale

0 1 2 3 4 5 6 7 8 9 10

No impact on job performance compared to normal

Major impact on job performance compared to normal

F11 In your opinion what impact has becoming a mother had on your career, and your future prospects for career progression? (Please tick one)

- STRONG POSITIVE IMPACT on current and future career prospects ☐ 1
- MODERATE POSITIVE IMPACT on current and future career prospects ☐ 2
- NO OR VERY LITTLE IMPACT on current and future career prospects ☐ 3
- MODERATE NEGATIVE IMPACT on current and future career prospects ☐ 4
- STRONG NEGATIVE IMPACT on current and future career prospects ☐ 5

Please comment if you wish _____

_____

_____

F12 **This section asks about times when other people may have had to take care of your child when you were unwell due to any physical or mental illness associated with pregnancy and childbirth (maternal health problems) after the birth of your first child.**

This includes any type of childcare required because you were unwell, over and above routine childminding arrangements that were in place.

1. Has anyone else, such as a partner, parent, relative, friend or other carer needed to take care of your child because you were unwell due to any maternal health problem after the birth of your **first** child?

   Yes ☐ 1 No ☐ 2 Skip to F13

2. To the best of your ability could you estimate how many days someone else needed to take care of your child because YOU were unwell due to any maternal health problem in the FIRST YEAR after the birth of your **first** child

   ☐ Days Please provide your best estimate, or a range if you prefer

3. To the best of your ability could you estimate how many days someone else needed to take care of your child because YOU were unwell due to any maternal health problem in the SECOND YEAR after the birth of your **first** child

   ☐ Days Please provide your best estimate, or a range if you prefer

4. Who usually cared for your child when you were unwell? (List as many as needed)

   _____

   _____

F13 **This section asks about times when other people had to take care of your first child when your child was unwell**

This includes any type of childcare required because your child was unwell, over and above routine childminding arrangements that were in place.

1. After the birth of your **first** child, did anyone else, such as a partner, parent, relative, friend or other carer needed to take care of your child because YOUR CHILD was unwell?

   Yes ☐ 1 No ☐ 2 Skip to G1

2. To the best of your ability could you estimate how many days someone else needed to take care of your child because YOUR CHILD was unwell in the FIRST YEAR after the birth of your **first** child

   ☐ Days Please provide your best estimate, or a range if you prefer

3. To the best of your ability could you estimate how many days someone else needed to take care of your child because YOUR CHILD was unwell in the SECOND YEAR after the birth of your **first** child

   ☐ Days Please provide your best estimate, or a range if you prefer

Section 2, Part G: You and Your Relationships

The next few questions are about you, your relationships and any major life events.
If you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them.

G1 **This section asks about MAJOR LIFE EVENTS:**
During your first pregnancy and since the birth of your first child, have you experienced any of the following:

		Yes	No
(a)	Death of a parent	☐ 1	☐ 2
(b)	Death of other close family member	☐ 1	☐ 2
	Please specify _____		
(c)	Death of close friend	☐ 1	☐ 2
(d)	Divorce/separation	☐ 1	☐ 2
(e)	Moved house	☐ 1	☐ 2
(f)	Moved country	☐ 1	☐ 2
(g)	Child or family member taken into foster home or residential care	☐ 1	☐ 2
(h)	Major change in financial situation e.g. you or your partner being made redundant/fired at work	☐ 1	☐ 2
(i)	Serious illness/injury of a family member	☐ 1	☐ 2
(j)	Drug taking/alcoholism in the immediate family	☐ 1	☐ 2
(k)	Mental illness of a family member	☐ 1	☐ 2
(l)	Partner or immediate family member in prison	☐ 1	☐ 2
(m)	Loss of a baby before or after birth	☐ 1	☐ 2
(n)	Other disturbing event	☐ 1	☐ 2
	Please specify _____		

The next few questions are about you and your experiences in adult intimate relationships with your husband/wife or boyfriend/girlfriend **of longer than one month.**
If you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them.

G2 Are you currently in a relationship?

Yes ☐ 1 No ☐ 2 Skip to G3 (b)

G3 (a) Are you afraid of your current partner?

Yes ☐ 1 No ☐ 2

G3 (b) Have you ever been afraid of any partner?

Yes ☐ 1 No ☐ 2

Please comment if you wish _____

_____

_____

_____

_____

_____

_____

G4 In the past THREE MONTHS, have you experienced relationship problems with your partner (husband/wife/boyfriend/girlfriend) Please tick one

Never ☐ 1 Rarely ☐ 2 Occasionally ☐ 3 Often ☐ 4

G5 If you are NO LONGER in a relationship with your first child's father/co-parent, have you experienced relationship problems with this person in the past THREE MONTHS? Please tick one

Never ☐ 1 Rarely ☐ 2 Occasionally ☐ 3 Often ☐ 4 Not applicable ☐ 5

G6 How emotionally satisfying have you found your relationship with your partner in the past THREE MONTHS?

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

G7 **We would like to know if you have experienced any of the actions listed below and how often they happened during the last THREE MONTHS. You can answer, even if you are not with a partner at present.**

These questions may be upsetting as they ask about partners physically, emotionally and sexually hurting mothers. You can skip this question if you prefer not to complete it.

Please indicate how often it happened OVER THE LAST 3 MONTH PERIOD, by ticking one box on each line.

My partner...	Never	Only once	Several times	Once a month	Once a week	Daily
Told me I wasn't good enough	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Kept me from medical care	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Followed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Tried to turn my family, friends and children against me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Locked me in the bedroom	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Slapped me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Raped me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Told me I was ugly	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Tried to keep me from seeing or talking to my family	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Threw me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Hung around outside my house	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Blamed me for causing their violent behaviour	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Harassed me over the telephone	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Shook me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Tried to rape me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Harassed me at work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Pushed, grabbed or shoved me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Used a knife or gun or other weapon	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Became upset if dinner or house work wasn't done when they thought it should be	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

G7 contd. Please indicate how often it happened OVER THE LAST 3 MONTH PERIOD, by ticking one box on each line.

My partner...	Never	Only once	Several times	Once a month	Once a week	Daily
Told me I was crazy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Told me no-one would ever want me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Took my wallet and left me stranded	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Hit or tried to hit me with something	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Did not want me to socialise with my female friends	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Put foreign objects in my vagina	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Kicked me, bit me or hit me with a fist	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Refused to let me work outside the home	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Tried to convince my friends, family or children that I was crazy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Told me I was stupid	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Beat me up	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

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

_____

_____

_____

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.

_____

_____

_____

Women's Aid work to end violence against women

If you need help, phone them on:
National Freephone Helpline
1800 341 900 – 24hrs/day, 7 days a week

www.womensaid.ie

Email: info@womensaid.ie

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

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

- **Women's Aid operate the National Freephone Helpline 1800 341 900 (24hrs/day, 7 days a week except Christmas Day)**
- **Women's Aid provide one to one support in six locations throughout Dublin.**
- **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.**
- **COPE – Waterside house women's refuge provides refuge in Galway (091 565985) and the Domestic Violence response also provide support in Galway (091 866740)**

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.

Section 2, Part H: Your Treatment and Costs of Care

This is a new section of the MAMMI survey that looks at the treatment you received for maternal health problems and how this was paid for

H. What type of MATERNITY CARE did you have for your:

	Public	Semiprivate	Private	Not applicable
a) First baby:	☐ 1	☐ 2	☐ 3	☐ 4
b) Second baby:	☐ 1	☐ 2	☐ 3	☐ 4
c) Third baby:	☐ 1	☐ 2	☐ 3	☐ 4

H1. Were you covered by private health insurance when you had your first baby?

Yes ☐ 1 No ☐ 2

H2 Did you have a medical card or GP visit card when you had your first baby?

No ☐ 1 Medical Card ☐ 2 GP visit card ☐ 3

The following sections ask about the treatment you received, or continue to receive, for any maternal health problem you experienced before or after the birth of your first child.

This includes:

- *appointments you had with healthcare professionals*
- *procedures or tests that were carried out*
- *medications or supplements that you were taking*
- *devices, equipment or other products used*
- *any other costs associated with these health problems*
- *treatment that was delayed or not obtained due to the financial cost*

*We realise that some of the questions relate to things that may have happened up to five years ago so if you are unsure about anything **please try to just answer to the best of your ability**.*

For instance if you cannot remember the exact number of times you spoke to your GP about a particular health problem, please provide your best estimate, or a range if you prefer.

Please proceed to question H3(a) on the next page.

H3(a) Did you experience pelvic girdle or low back pain during pregnancy or after the birth of your first baby?

Yes ☐ 1 No ☐ 2 Skip to H3(b), page 49

1. Please tell us the total number of times you saw each of the following healthcare professionals about your pelvic girdle or low back pain before and after the birth of your first child, and how those visits were paid for.

Health Professional	Total number of visits	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
GP (including visits covered by the free maternity care scheme)					
Consultant (please specify type) (i)_____					
(ii)_____					
Physiotherapist					
Other health professional (e.g chiropractor, etc, please specify) (i)_____					
(ii)_____					
Other non-healthcare professional (e.g. complementary therapist, pilates or yoga classes, please specify) (i)_____					
(ii)_____					

2. Did you have any procedures, tests or surgery carried out to diagnose or treat your pelvic girdle or low back pain before and after the birth of your first child, and how were they paid for?

Procedures or tests carried out	Total number	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. imaging tests such as x-ray, MRI, or procedures such as nerve blocks, steroid injections, surgery, etc. please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

H3(a) contd.

3. Did you take any prescription or non-prescription medication, supplements or gels to treat your pelvic girdle or low back pain before and after the birth of your **first** child, and how were they paid for?

Medications, supplements or gels	How long were you taking it for?	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. painkillers such as nurofen, voltarol etc., please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

4. Did you use any aids, appliances, devices or other products or equipment for your pelvic girdle or back pain before and after the birth of your **first** child and how was this paid for?

Products, devices or equipment	Quantity	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. support belt, heat packs, special furniture or bedding, etc., please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

5. Were there any other costs associated with the treatment you received for pelvic girdle or low back pain before and after the birth of your **first** child, apart from the cost of the treatment itself?

e.g. public transport or accommodation costs in order to attend appointments, additional childminding costs, payments for additional help around the house, etc.?

Yes ☐ 1 No ☐ 2

If Yes, please specify what additional costs you incurred and the estimated amount

_____

_____

_____

6. Did you ever have to delay or do without treatment for pelvic girdle or low pain before or after the birth of your **first** child due to the financial costs involved?

Yes ☐ 1 No ☐ 2

If Yes, please specify what treatment you had to delay or do without and the estimated costs involved

_____

_____

H3(b) Did you experience leaking urine during pregnancy or after the birth of your first baby?

Yes ☐ 1 No ☐ 2 Skip to H3(c), page 51

1. Please tell us the total number of times you saw each of the following healthcare professionals about leaking urine before and after the birth of your **first** child, and how those visits were paid for.

Health Professional	Total number of visits	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
GP (including visits covered by the free maternity care scheme)					
Consultant (please specify type) (i)_____					
(ii)_____					
Physiotherapist					
Other health professional (e.g nurse, etc, please specify) (i)_____					
(ii)_____					
Other non-healthcare professional (e.g. complementary therapist, pilates or yoga classes, please specify) (i)_____					
(ii)_____					

2. Did you have any procedures, tests or surgery carried out to diagnose or treat leaking urine before and after the birth of your **first** child, and how were they paid for?

Procedures or tests carried out	Total number	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. imaging tests such as ultrasound scans, or procedures such as urodynamic tests, endoscopy, botox injections, surgery, etc. please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

H3(b) contd.

3. Did you take any prescription or non-prescription medication or supplements to treat leaking urine before and after the birth of your **first** child, and how were they paid for?

Medications or supplements	How long were you taking it for?	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. tolterodine, oxybutynin etc., please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

4. Did you use any aids, appliances, devices or other products or equipment for leaking urine before and after the birth of your **first** child and how was this paid for?

Products, devices or equipment	Quantity	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. pads, special underwear, weighted vaginal cones, etc., please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

5. Were there any other costs associated with the treatment you received for leaking urine before and after the birth of your **first** child, apart from the cost of the treatment itself?

e.g. public transport or accommodation costs in order to attend appointments, additional childminding costs, payments for additional help around the house, etc.?

Yes ☐ 1 No ☐ 2

If Yes, please specify what additional costs you incurred and the estimated amount

_____

_____

_____

6. Did you ever have to delay or do without treatment for leaking urine before or after the birth of your **first** child due to the financial costs involved?

Yes ☐ 1 No ☐ 2

If Yes, please specify what treatment you had to delay or do without and the estimated costs involved

_____

_____

H3(c) Did you experience leaking bowel movements during pregnancy or after the birth of your first baby?

Yes ☐ 1 No ☐ 2 Skip to H3(d), page 53

1. Please tell us the total number of times you saw each of the following healthcare professionals about leaking bowel movements before and after the birth of your first child, and how those visits were paid for.

Health Professional	Total number of visits	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
GP (including visits covered by the free maternity care scheme)					
Consultant (please specify type) (i)_____					
(ii)_____					
Physiotherapist					
Other health professional (e.g nurse, etc, please specify) (i)_____					
(ii)_____					
Other non-healthcare professional (e.g. complementary therapist, pilates or yoga classes, please specify) (i)_____					
(ii)_____					

2. Did you have any procedures, tests or surgery carried out to diagnose or treat leaking bowel movements before and after the birth of your first child, and how were they paid for?

Procedures or tests carried out	Total number	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. imaging tests such as MRI or ultrasound scans, or procedures such as endoscopy, surgery, etc. please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

H3(c) contd.

3. Did you take any prescription or non-prescription medication or supplements to treat leaking bowel movements before and after the birth of your **first** child, and how were they paid for?

Medications or supplements	How long were you taking it for?	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. anti-diarrheal drugs such as imodium, or laxatives etc., please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

4. Did you use any aids, appliances, devices or other products or equipment for leaking bowel movements before and after the birth of your **first** child and how was this paid for?

Products, devices or equipment	Quantity	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. pads, special underwear, devices, etc., please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

5. Were there any other costs associated with the treatment you received for leaking bowel movements before and after the birth of your **first** child, apart from the cost of the treatment itself?

e.g. public transport or accommodation costs in order to attend appointments, additional childminding costs, payments for additional help around the house, etc.?

Yes ☐ 1 No ☐ 2

If Yes, please specify what additional costs you incurred and the estimated amount

_____

_____

_____

6. Did you ever have to delay or do without treatment for leaking bowel movements before or after the birth of your **first** child due to the financial costs involved?

Yes ☐ 1 No ☐ 2

If Yes, please specify what treatment you had to delay or do without and the estimated costs involved

_____

_____

H3(d) Did you experience any sexual health problems, such as loss of interest in sex, pain during sex or vaginal dryness, during pregnancy or after the birth of your first baby?

Yes ☐ 1 No ☐ 2 Skip to H3(e), page 55

1. Please tell us the total number of times you saw each of the following healthcare professionals about sexual health problems (such as loss of interest in sex, pain during sex or vaginal dryness), before and after the birth of your **first** child, and how those visits were paid for.

Health Professional	Total number of visits	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
GP (including visits covered by the free maternity care scheme)					
Consultant (please specify type) (i)_____					
(ii)_____					
Other health professional (e.g physiotherapist, etc, please specify) (i)_____					
(ii)_____					
Other non-healthcare professional (e.g. complementary therapist, please specify) (i)_____					
(ii)_____					

2. Did you have any procedures, tests or surgery carried out to diagnose or treat sexual health problems such as loss of interest in sex, pain during sex or vaginal dryness before and after the birth of your **first** child, and how were they paid for?

Procedures or tests carried out	Total number	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. imaging tests such as x-ray, MRI, or procedures such as colposcopy, etc. please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

H3(d) contd.

3. Did you take any prescription or non-prescription medication or supplements to treat sexual health problems such as loss of interest in sex, pain during sex or vaginal dryness before and after the birth of your **first** child, and how were they paid for?

Medications or supplements	How long were you taking it for?	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(i)_____					
(ii)_____					
(iii)_____					

4. Did you use any aids, appliances, devices or other products or equipment for sexual health problems such as loss of interest in sex, pain during sex or vaginal dryness before and after the birth of your **first** child and how was this paid for?

Products, devices or equipment	Quantity	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

5. Were there any other costs associated with the treatment you received for sexual health problems before and after the birth of your **first** child, apart from the cost of the treatment itself?

e.g. public transport or accommodation costs in order to attend appointments, additional childminding costs, etc.?

Yes ☐ 1 No ☐ 2

If Yes, please specify what additional costs you incurred and the estimated amount

_____

_____

_____

6. Did you ever have to delay or do without treatment for sexual health problems before or after the birth of your **first** child due to the financial costs involved?

Yes ☐ 1 No ☐ 2

If Yes, please specify what treatment you had to delay or do without and the estimated costs involved

_____

_____

H3(e) Did you experience any mental health issues such as depression and anxiety, during pregnancy or after the birth of your first baby?

Yes ☐ 1 No ☐ 2 Skip to I1, page 58

1. Please tell us the total number of times you saw each of the following healthcare professionals about mental health issues such as depression and anxiety before and after the birth of your first child, and how those visits were paid for.

Health Professional	Total number of visits	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
GP (including visits covered by the free maternity care scheme)					
Psychiatrist					
Other health professional (e.g psychologist, counsellor etc, please specify) (i)_____					
(ii)_____					
Other non-healthcare professional (e.g. complementary therapist, please specify) (i)_____					
(ii)_____					

2. Did you have any procedures or tests carried out to diagnose or treat mental health issues such as depression and anxiety before and after the birth of your first child, and how were they paid for?

Procedures or tests carried out	Total number	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. blood tests, electroconvulsive therapy, etc. please specify) (i)_____					
(ii)_____					

3. Did you have to spend any time in hospital either as a day patient or for a continuous period for treatment for mental health issues such as depression and anxiety before and after the birth of your first child, and how were they paid for?

Hospital stay	Total number of days	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
Inpatient (overnight) hospital admission					
Outpatient (day case) hospital admission					

H3(e) contd.

4. Did you take any prescription or non-prescription medication or supplements to treat mental health issues such as depression and anxiety before and after the birth of your **first** child, and how were they paid for?

Medications or supplements	How long were you taking it for?	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. antidepressants, anxiolytics, etc., please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

5. Did you use any aids or other products or equipment for mental health issues such as depression and anxiety before and after the birth of your **first** child and how was this paid for?

Products, devices or equipment	Quantity	How was this paid for? (Tick all that apply)			
		I paid for it	Public health system	Private health insurance	Don't know
(e.g. educational courses or books, biofeedback devices, please specify) (i)_____					
(ii)_____					
(iii)_____					
(iv)_____					

6. Were there any other costs associated with the treatment you received for mental health issues such as depression and anxiety before and after the birth of your **first** child, apart from the cost of the treatment itself?

e.g. public transport or accommodation costs in order to attend appointments, additional childminding costs, etc.?

Yes ☐ 1 No ☐ 2

If Yes, please specify what additional costs you incurred and the estimated amount

_____

_____

_____

7. Did you ever have to delay or do without treatment for mental health issues such as depression and anxiety before or after the birth of your **first** child due to the financial costs involved?

Yes ☐ 1 No ☐ 2

If Yes, please specify what treatment you had to delay or do without and the estimated costs involved

_____

_____

Why are we collecting this information?

• To find out what treatments are required by women experiencing maternal health problems

• To identify any barriers that make it difficult for women to get access to these services

• To estimate the financial costs that maternal health problems place on women and families

Gathering information on these issues helps to highlight the scale of the problem and ensure it is properly prioritised within the health system. Your information can also show us where improvements can be made in the way these services are delivered and funded in the future.

Request to follow up this survey with a short telephone call

We are hoping to follow up this part of the survey with a short phone call to talk about your experiences in accessing maternity care services in more detail.

This would be extremely beneficial for us as this is the first time that these types of questions are included in the MAMMI survey, and we want to develop our understanding of any barriers that exist in getting the care you wanted.

We would be grateful if you could tick one of the boxes below to indicate if you would be willing to be contacted for a short (15-30 minute) telephone call after you have sent back this survey.

I do want to be contacted ☐

I do not want to be contacted ☐

Section 2, Part I: Views on Data Sharing

These next few questions ask about YOUR VIEWS on data sharing in research in general, **by answering these questions you are NOT giving consent to your MAMMI data being shared:** we will never share your or the MAMMI study data without your consent and without ethical approval.

What is 'Data Sharing'?

'Data sharing', sometimes called 'open science', means making the underlying results and full information from research studies available to others. The aim is to make research findings more transparent and create openness in the science community.

Many of the bodies that fund health research now insist that full datasets from studies are shared with (made easily available to) other researchers. So that they can re-use and do different analyses with the data. This is much more extensive than the usual approach, where only the headline findings of studies are published in journal articles.

All data shared would be anonymised so that no individual could ever be identified, and would be stored on an international database. Researchers wishing to reuse a dataset usually have to successfully submit a detailed proposal before they can gain access. If you are interested in reading more about this topic, please go to https://wellcome.ac.uk/what-we-do/our-work/open-research

While there is a lot of talk about data sharing in media, very little is known about what research participants think or feel about data sharing. We would like to know your views on data sharing and we should be delighted if you would answer the following questions please.

Please be aware that these questions are included here just to ask you about your views, and we will NEVER share your or the MAMMI study data without your consent and without ethical approval.

I. 1 Have you heard about data sharing or open science before?

Yes ☐ 1 No ☐ 2 Not sure ☐ 3

I. 2 Do you think anonymised full findings from scientific research should be made available to other researchers?

Yes ☐ 1 (Continue below) No ☐ 2 (Go to I 6.) Not sure ☐ 3 (Continue below)

I. 3. How should the decision to share the data be made? (tick all that apply)

a. The research team who collected the data should decide after reviewing the scientific, ethical, and public health merit of any request for access to the anonymised data i.e. is the proposed new research or analysis based on sound science? ☐ 1

b. The sponsor/funder of the research should review any request for access to the anonymised data and decide, based on sound science. ☐ 2

c. An independent review board should review any request for access to the anonymised data and decide, based on sound science. ☐ 3

d. The research team should request consent for sharing the anonymised data from participants at the start of the study, before data collection starts. ☐ 4

e. After the study is completed the research team should then contact participants every time a request is made for access to the stored dataset. ☐ 5

I. 4. Why do you think anonymised data should be made available? (tick all that apply)

Scientific advancement	☐ 1	Health benefits emerging from research	☐ 4
Research efficiency	☐ 2	Serving the common good	☐ 5
Transparency	☐ 3	Other (Please specify)	☐ 6

_____

_____

I. 5. To whom should anonymised data be made available? (tick all that apply)

	YES	NO
a) Other health researchers at the same institution	☐ 1	☐ 2
b) Other health researchers at other non-profit institutions/ research organisations		
i) In Ireland	☐ 1	☐ 2
ii) Abroad	☐ 1	☐ 2
c) For-profit research organisations		
i) In Ireland	☐ 1	☐ 2
ii) Abroad	☐ 1	☐ 2
d) Other (Please specify)	☐ 1	☐ 2

_____

_____

I. 6. <u>If you replied 'no' to question 2,</u> why do you think <u>anonymised</u> full findings from scientific research should <u>not</u> be made available? (Please tick all that apply)

(If you ticked **'yes'** in question 2, then skip to question this question and continue tp I. 7.)

Privacy concerns	☐ 1	Concerns about misuse of the data	☐ 3
Concerns about control over the data	☐ 2	Other (Please specify)	☐ 4

_____

I. 7. Please comment on data sharing if you wish:

_____

_____

_____

_____

Part J: Comments

J1 **Now that you have got to the end of the MAMMI 5-year follow up survey, we are interested in knowing how you found it?** (Please tick all that apply)

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

_____

_____

J2 **About the MAMMI Study website (www.tcd.ie/mammi)**

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

   Yes ☐ 1 No ☐ 2

2. Did you recommend the website to others?

   Yes ☐ 1 No ☐ 2

3. 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.

_____

_____

_____

J3 **If you wish to write any further comments about your experience completing this survey, or suggestions for improvement, please do so below.**

_____

_____

_____

_____

_____

_____

_____

_____

If you have any further comments please write them here

Thank you for completing the survey

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:

New Address	New Phone Number

We are very grateful for the time and trouble you have taken to participate in the study. Your answers will help us to understand more about the health of mothers before, during and after their pregnancy(ies) 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 postage 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 087 118 6762 and we will send you out another one.

The final survey results will not be available until all of the women taking part in the study have completed this survey. As soon as all the results are available, we will let you know via the website and the study newsletter. Please call us if you have any questions about the study.

We hope you and your family enjoy good health and happiness always.

Best wishes from the MAMMI follow-up study team Deirdre, Francesca, Patrick and Cecily.

Déirdre

This concludes the MAMMI 5 year follow-up survey.

Please use the postage 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 087 118 6762) or email us (**mammistudy@tcd.ie**) and we will send you out another one.

Thank you.