

Study No.



THE MAMMI STUDY

Second baby follow up survey- 12 months postnatal

FOR WOMEN WHO HAD THEIR SECOND BABY APPROXIMATELY 12 MONTHS 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 or future surveys

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Structure of the MAMMI Study follow-up survey

The **Maternal health And Maternal Morbidity in Ireland (MAMMI) second baby** follow-up study is designed for women who had their second baby in the last year. This survey is for women who had their second baby approximately **12 MONTHS** ago.

The survey is structured as follows:

Section 1- You and your Children

Part A You and your 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 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

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

Section 1: Part A: You and Your Children.

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

A1 (a) 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>

A1 (b) What is your FIRST baby's date of birth?

<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>

A2 Are you pregnant now?

Yes

1

No

2

If **yes**, my baby is due on [please insert date below]:

<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>

A3 (a) In the past SIX MONTHS, how many miscarriages, if any, have you had?

I have had number of miscarriage(s). None. Prefer not to answer.

A3 (b) In the past SIX MONTHS, how many babies have you had that were stillborn?

I have had number of babies that were stillborn. None. Prefer not to answer.

A3 (c) In the past SIX MONTHS, how many termination(s) of pregnancy, if any, have you had?

I have had number of termination(s)/abortion(s) of pregnancy. None

Prefer not to answer

If **yes**, where did you have the termination(s): Ireland 1 Abroad 2

A3 (D) Please comment if you wish:

A4 In the past SIX MONTHS, 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 am not in a relationship ₂

I am in a same sex relationship ₃

I could not afford it ₄

Myself and my partner don't have sex ₅

I prefer not to say ₆

Other (Please describe) ₇

A5 (a) Are you hoping to have another baby?

Yes ₁ No ₂ Please go to A5 (e)
Not sure ₃ I am pregnant now ₄ Please go to A5 (d)

A5 (b) Are you currently trying to conceive?

Yes ₁ No ₂

A5 (c) If YES, are you receiving any infertility treatment?

Yes ₁ No ₂

A5 (d) Would you prefer to have?

A vaginal birth ₁ A caesarean section ₂ No particular preference ₃

A5 (e) If you wish, please comment regarding future pregnancies

A6 What do you currently weigh without clothes or shoes?

--	--	--

kgs

OR

--	--

stones and

--	--

pounds

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.

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

NISIG (National Infertility support and Information Group)

Website: www.nisig.com

Tel: 087 797 5058

Email: nisigireland@gmail.com

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 children, how would you describe your own health during this time? Did you feel: *(Please tick one)*

Extremely well

1

Very well

2

OK

3

Not very well

4

Extremely unwell

5

A2. How confident did you feel about looking after your children over the past THREE MONTHS at home? *(Please tick one)*

Very confident

1

Fairly confident

2

Mixed

3

Fairly anxious

4

Not confident

5

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

Yes

1

No

2

A4 (a) Does your 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 to (1st, 2nd, etc.):

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

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

Yes

1

No

2

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

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

A7 In the LAST MONTH, how often have you had time for yourself?

- | | | | | | |
|--------------------------|----------------------------|--------------------------|--------------------------|-----------------------------------|-----------------------------------|
| 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 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 | 2 | 3 | 4 | 5 | 6 |

A8 (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))

- Please tick here if you have not had any help in the last month.
- | | | | | |
|----------------|--------------------------|--|--------------------------|---|
| Your partner | <input type="checkbox"/> | 1 Friends or neighbours | <input type="checkbox"/> | 5 |
| Your mother | <input type="checkbox"/> | 2 Family day care or child care centre | <input type="checkbox"/> | 6 |
| Your sister | <input type="checkbox"/> | 3 Paid housekeeper | <input type="checkbox"/> | 7 |
| Other relative | <input type="checkbox"/> | 4 Nanny/au pair | <input type="checkbox"/> | 8 |
| | | Other (<i>please describe</i>) | <input type="checkbox"/> | 9 |
-

A9 Looking back over the **LAST MONTH**, would you have liked more practical help?
(e.g. with preparing meals, housework, childcare, etc.)

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

A10 (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 (Go to Section 2; Question B1(a).)

A10 (b) Are you happy with the contribution that you 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

A10 (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

Comment if you wish

Section 2: Part B: Exercise

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

B 1 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?

¹ None ² Yes: times

(Skip to Q B2a.)

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

Hours minutes

B 2 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?

¹ None ² Yes: times

(Skip to Q B3a.)

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

B 3 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)

¹ None ² Yes: times

(Skip to Q B4a.)

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

Hours minutes

B 4 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)?

¹ None ² Yes: times

(Skip to Q B5a.)

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

Hours minutes

B 5 a. In the LAST WEEK, how many times have you done household chores or shopping while carrying a back pack or a baby carrier?

¹ None ² Yes: times

(Skip to Q B6a.)

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

Hours minutes

B 6 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)

¹ None ² Yes: times

(Skip to Q B7a.)

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

Hours minutes

B 7 a. In the **LAST WEEK**, how many times did you do any other more **moderate physical activity**? (For example, gentle swimming)

¹ None ² Yes: times

(Skip to Q B8)

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

Hours minutes

B 8. 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	<input type="text"/> 1	Swimming	<input type="text"/> 6
Jogging/running	<input type="text"/> 2	Cycling	<input type="text"/> 7
Aerobics	<input type="text"/> 3	Ball games (soccer, GAA, rugby)	<input type="text"/> 8
Weight training	<input type="text"/> 4	Racket sports (tennis, badminton)	<input type="text"/> 9
Dancing	<input type="text"/> 5	Weight lifting	<input type="text"/> 10
		Other (please specify)	<input type="text"/> 11

B 9. 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:

(Please tick 1 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
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 (please describe)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 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

If NO please Skip to C4 (a)

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* 5

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

C3 During/after which pregnancies did you feel depressed:

None of my pregnancies 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 _____

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

Never 1 Rarely 2 Occasionally 3 Often 4
Skip to C5

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

Yes, I'm taking tablets or medications 1 Yes, I'm having psychotherapy or counselling 3
No 2 I have been referred to a psychiatrist or psychotherapist 4
Other *please specify* 5

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

C5 During/after which pregnancies did you experience anxiety or panic attacks?:

- None of my pregnancies 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 _____

The following questions ask about **Urinary Incontinence**.

C6 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 | EVERYDAY |
|--|----------------------------|------------------------------|-----------------------------|----------------------------|----------------------------|
| a. When you coughed, laughed or sneezed, or did physical exercise? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b. When you were on the way to the toilet? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| c. When you had to wait to use the toilet? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| d. If you did not go to the toilet immediately? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

C7 (a) 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

C7 (b) 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 and C7, please go to C11 (page 14)

C8 (a) When you leak urine, is it?

- Drops or just a little 1 More like a trickle 2 More than a trickle 3

C8 (b) 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 During/after which pregnancies did you experience urine leakage?

None of my pregnancies 1 During pregnancy or after the birth of 3
my **SECOND** child only

During pregnancy or after the birth of 2 During pregnancy or after the birth of 4
my **FIRST** child only **ALL** my children

Please comment if you wish

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

Yes 1 No 2 *(Please go to C10 c)*

(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 <i>(Please describe)</i>	<input type="checkbox"/>	11
Other health professional	<input type="checkbox"/>	6			

C10 (c) Do you AVOID exercise because you leak urine?

Yes 1 No 2

C10 (d) If yes, please tell us about the type(s) of exercise you avoid.

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 (Place an X in the box for your answer)

	NO, NEVER		MINOR AMOUNT		MAJOR AMOUNT	
(a) Noticed soiling from your back passage on your underwear?	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
(b) Passed wind when you really didn't want to?	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	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	Yes, less than once a month	Yes, one or several times a month	Yes, one or several times a week	Yes, every day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5

C13 (b) If YES, when this happened how much leakage typically occurred?

Small amount (<i>with stain about the size of a 50 cent coin</i>)	<input type="checkbox"/>	1
Moderate amounts (<i>often requiring a change of pad or underwear</i>)	<input type="checkbox"/>	2
Large amounts (<i>often requiring a complete change of clothes</i>)	<input type="checkbox"/>	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	Yes, less than once a month	Yes, one or several times a month	Yes, one or several times a week	Yes, every day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5

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

Small amount (<i>with stain about the size of a 50 cent coin</i>)	<input type="checkbox"/>	1
Moderate amounts (<i>often requiring a change of pad or underwear</i>)	<input type="checkbox"/>	2
Large amounts (<i>often requiring a complete change of clothes</i>)	<input type="checkbox"/>	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?

No, never	Yes, less than once a month	Yes, one or several times a month	Yes, one or several times a week	Yes, every day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?

No, never

Yes, less than once a month

Yes, one or several times a month

Yes, one or several times a week

Yes, every day

1

2

3

4

5

If you answered NO to all of the questions in C12 to C15, please go to C18.

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

C16 (b) During/after which pregnancies did you experience leakage of bowel motions?

None of my pregnancies

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 _____

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

Yes

1

No

2

(Please go to C18).

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

General practitioner / local doctor

1

Partner

7

Public Health Nurse

2

Friend

8

GP practice nurse

3

Sister

9

Obstetrician/Gynaecologist

4

Mother

10

Physiotherapist

5

Other (Please describe)

11

Other health professional

6

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.

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.

C18 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	<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 C21.

C19 (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 C20)

C19(b) If yes, which medications have you used? (Please 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

C20 (a) In the past THREE MONTHS have you discussed this perineal pain with anyone?

Yes

1

No

2

(Skip to C21)

(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)	<input type="checkbox"/>	11
Other health professional	<input type="checkbox"/>	6			

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.

C21 (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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5

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

C22 (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

C23 (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

C23 (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

C24 (a) To what extent would you say your **VAGINA** feels 'back to normal' or like it did before your 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5

C24 (b) If your vagina does not feel completely back to normal, please describe the way(s) in which it feels different?

c. During/after which pregnancies did you pelvic floor feel loose?

None of my pregnancies 1 During pregnancy or after the birth of 3
my **SECOND** child only

During pregnancy or after the birth of 2 During pregnancy or after the birth of 4
my **FIRST** child only **ALL** my children

Please comment if you wish _____

C25 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

C26 Are you satisfied with your body image? (Please tick one).

Always 1 Sometimes 2 Never 3

Please comment if you wish _____

C27. 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

(If you have not experienced any pain to the front or back of your body please skip to to C33 (page 25))

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

a) Head (front or sides)

b) Neck

c¹) Shoulder (left)
c²) Shoulder (right)

d) Rib pain (bones in chest)

e¹) Upper arm (left)
e²) Upper arm (right)

f¹) Lower arm (left)
f²) Lower arm (right)

g¹) Wrist (left)
g²) Wrist (right)

h¹) Hand (left)
h²) Hand (right)

i¹) Fingers (left)
i²) Fingers (right)

j¹) Hip (left)
j²) Hip (right)

k) Bone at front of pelvis

l¹) Thigh (left)
l²) Thigh (right)

m¹) Knee (left)
m²) Knee (right)

n¹) Lower leg (left)
n²) Lower leg (right)

o¹) Ankle (left)
o²) Ankle (right)

p¹) Foot (left)
p²) Foot (right)

If you have experienced pain in this area in the past three months please complete QUESTION C28-C32 as well.

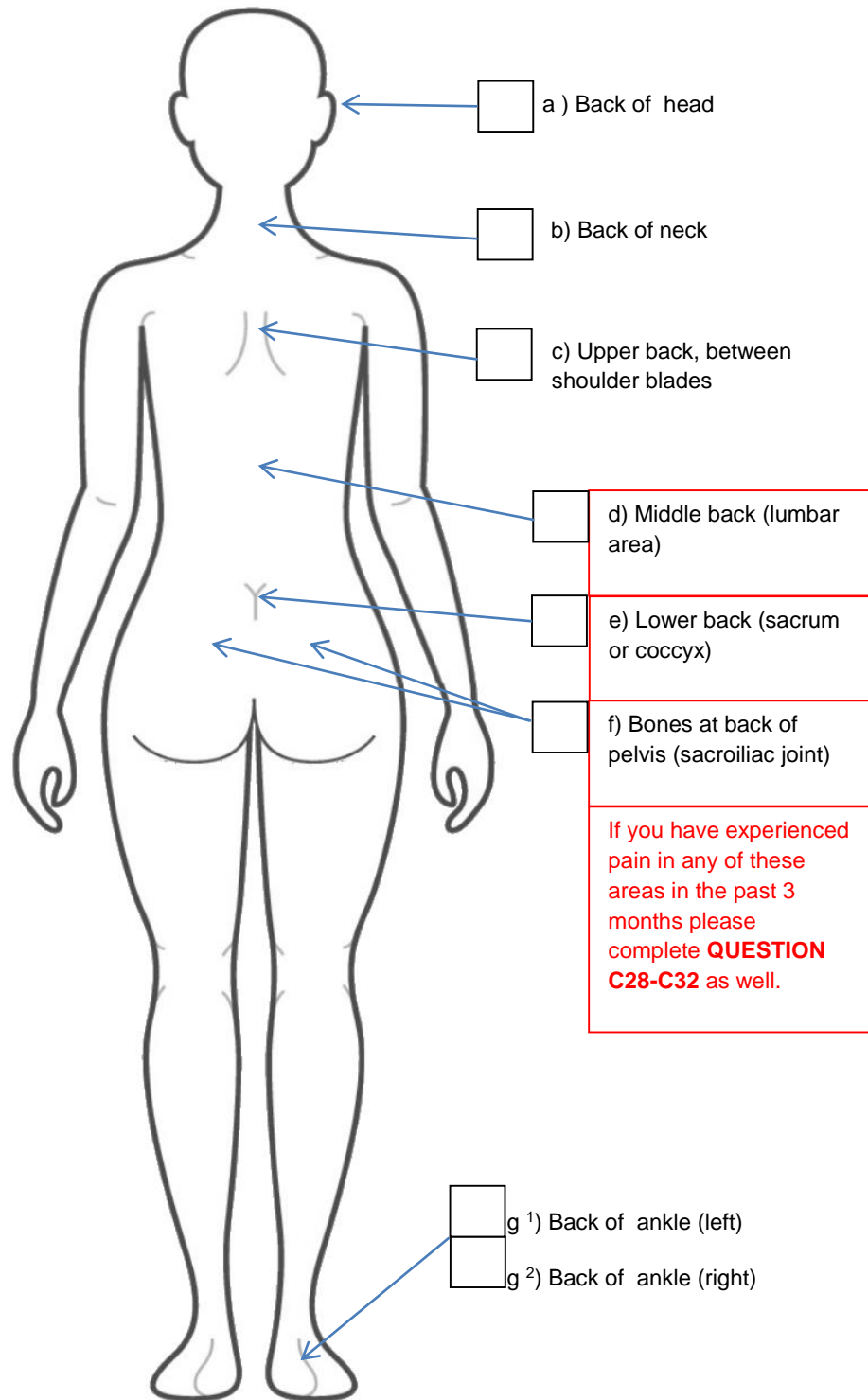
If you have experienced pain in this area in the past three months please complete QUESTION C28-C32 as well.

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

Please give details _____

C 27. Please tick the boxes if you have experienced pain in any parts of the body named or shown 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 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** in the **PAST 3 MONTHS**. (If you have not had low back or pelvic girdle pain in the PAST 3 MONTHS, go to question C 33 page 25.)

C28 How problematic is it for you because of your back and/or pelvic girdle pain to do the following:

	NOT AT ALL	TO A SMALL EXTENT	TO SOME EXTENT	TO A LARGE EXTENT
a. Dress yourself	<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

C29 How much back and/or pelvic girdle pain do you experience:

	NONE	SOME	MODERATE	CONSIDERABLE
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

C30 To what extent because of your back and/or pelvic girdle pain:

	NOT AT ALL	TO A SMALL EXTENT	TO SOME EXTENT	TO A LARGE EXTENT
a. Has your leg/have your legs given way?	<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
d. Do you have difficulty lifting/handling your child(ren)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

C31 (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 medications 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) <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

C32 (a) In the past THREE MONTHS, have you discussed this back/pelvic girdle pain with anyone?

Yes

1

No

2

(Skip to C34)

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

General practitioner / local 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 describe below)

11

C33 During which pregnancies did you experience low back/pelvic girdle pain:

None of my pregnancies

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

C34 How would you describe any low back/pelvic girdle pain in the PAST SIX MONTHS?

(If you have not had any back/pelvic girdle pain, please tick option 6).

Constant

1

Episodic (1- 2 episodes)

2

Episodic (3 - 4 episodes)

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 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.

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 i.e. Do not restrict your answer to vagina intercourse.)*

Yes 1
Go to D3

No 2
Go to D2 (b)

No, I do not have a partner 3
Please go to Section E1 (page 31).

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

- | | | | | | |
|---------------------------|--------------------------|---|---|--------------------------|---|
| Too tired / exhausted | <input type="checkbox"/> | 1 | Experiencing perineal pain | <input type="checkbox"/> | 6 |
| Relationship problems | <input type="checkbox"/> | 2 | Experiencing pain from previous C-section | <input type="checkbox"/> | 7 |
| Scared it will be painful | <input type="checkbox"/> | 3 | Don't feel interested | <input type="checkbox"/> | 8 |
| Fear of getting pregnant | <input type="checkbox"/> | 4 | Other reason <i>(please describe)</i> | <input type="checkbox"/> | 9 |
| Child waking up | <input type="checkbox"/> | 5 | _____ | | |
| | | | _____ | | |

If you have not had any sexual or intimate contact in the past THREE MONTHS, please go to question D13, page 29.

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

Yes 1 No 2 *(please skip to D7)*

D4 (a) How much pain or discomfort or tenderness do you experience?

No Pain	Mild	Discomforting	Distressing	Horrible	Excruciating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6

D4 (b) 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:

D5 How often would you say vaginal intercourse is painful for you NOW?

Always	Most of the time	Occasionally	Rarely	Never
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5

D6 (a) In the past THREE MONTHS, have you discussed the pain or discomfort you are

experiencing with anyone?

Yes 1 No 2 (please skip to D7)

(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)	<input type="checkbox"/>	11
Other health professional	<input type="checkbox"/>	6	_____		

D7 In the past THREE MONTHS, how satisfied are you with your overall sex life?

Very satisfied	Moderately satisfied	Equally satisfied/dissatisfied	Moderately dissatisfied	Very dissatisfied	Prefer not to answer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6

D8 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6

D9 In the past MONTH, have you had:

YES NO PREFER NOT TO ANSWER

Oral sex	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Anal sex	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Other sexual contact (i.e. forms of contact with the genital area not leading to intercourse but intended to achieve orgasm)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

D10 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	<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
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 having a child(ren)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
k. More interest in sex compared with before having a child(ren)	<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

D11 During/after which pregnancies did you experience any of the above:

None of my pregnancies	<input type="checkbox"/> 1	During pregnancy or after the birth of my SECOND child only	<input type="checkbox"/> 3
During pregnancy or after the birth of my FIRST child only	<input type="checkbox"/> 2	During pregnancy or after the birth of ALL my children	<input type="checkbox"/> 4

Please comment if you wish _____

D12 (a) Have you ever discussed any of the above with anyone?

Yes 1 No 2 (Please skip to D13)

(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) | <input type="checkbox"/> | 11 |
| Other health professional | <input type="checkbox"/> | 6 | _____ | | |

D13 In the past THREE MONTHS, please describe the frequency of your sexual activity

Times per month: Prefer not to answer

Please comment if you wish _____

D14 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. Child 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 |

D15 Is there anything else you would like to tell me about in relation to your sexual and intimate relationships in the past THREE MONTHS?

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

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

SATU telephone number: 01 8171736 (Dublin)
091765751 (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 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.

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
- 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 a lot 1
- Yes, sometimes 2
- No, not much 3
- No, not at all 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 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 (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

		Not at all	Some of the time	A good part of the time	Most of the time
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 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. Again, if you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them.

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

- | | | | | | |
|--|--------------------------|---|---|--------------------------|---|
| Married | <input type="checkbox"/> | 1 | In a relationship - not living together | <input type="checkbox"/> | 5 |
| Living with partner (boyfriend/girlfriend) | <input type="checkbox"/> | 2 | Widowed | <input type="checkbox"/> | 6 |
| In a same sex relationship | <input type="checkbox"/> | 3 | Single | <input type="checkbox"/> | 7 |
| Divorced or separated | <input type="checkbox"/> | 4 | Other <i>(Please specify)</i> | <input type="checkbox"/> | 8 |
-

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

- | | | | | | |
|---|--------------------------|---|-------------------------------|--------------------------|----|
| Your child/children | <input type="checkbox"/> | 1 | Your sister or brother | <input type="checkbox"/> | 8 |
| Your partner
(husband/wife/boyfriend/girlfriend) | <input type="checkbox"/> | 2 | A friend | <input type="checkbox"/> | 9 |
| Your mother | <input type="checkbox"/> | 3 | Nanny / Au pair | <input type="checkbox"/> | 10 |
| Your father | <input type="checkbox"/> | 4 | No one | <input type="checkbox"/> | 11 |
| Your partner's mother | <input type="checkbox"/> | 5 | Other <i>(Please specify)</i> | <input type="checkbox"/> | 12 |
| Your partner's father | <input type="checkbox"/> | 6 | | | |
| Your partner's child/ children from a previous relationship | <input type="checkbox"/> | 7 | | | |
-

F3 How would you describe your current living accommodation?

- | | | | | | |
|---|--------------------------|---|---|--------------------------|----|
| House <i>(with a mortgage)</i> | <input type="checkbox"/> | 1 | Rented apartment <i>(rented from local authority)</i> | <input type="checkbox"/> | 8 |
| House <i>(with no mortgage)</i> | <input type="checkbox"/> | 2 | Caravan / Mobile Home | <input type="checkbox"/> | 9 |
| Apartment <i>(with a mortgage)</i> | <input type="checkbox"/> | 3 | Bed and breakfast accommodation | <input type="checkbox"/> | 10 |
| Apartment <i>(with no mortgage)</i> | <input type="checkbox"/> | 4 | Hostel accommodation | <input type="checkbox"/> | 11 |
| Rented house <i>(rented privately)</i> | <input type="checkbox"/> | 5 | No fixed accommodation <i>(homeless)</i> | <input type="checkbox"/> | 12 |
| Rented house <i>(rented from local authority)</i> | <input type="checkbox"/> | 6 | Other <i>(Please specify)</i> | <input type="checkbox"/> | 13 |
| Rented apartment <i>(rented privately)</i> | <input type="checkbox"/> | 7 | | | |
-

Please comment if you wish _____

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

- | | | | | | |
|--------------------------------|--------------------------|---|---|--------------------------|---|
| I am in paid work | <input type="checkbox"/> | 1 | I am working and studying part-time | <input type="checkbox"/> | 4 |
| I am on paid maternity leave | <input type="checkbox"/> | 2 | I am in full-time study | <input type="checkbox"/> | 5 |
| I am on unpaid maternity leave | <input type="checkbox"/> | 3 | I am not in paid work or studying at the present time | <input type="checkbox"/> | 6 |

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

- b)** Hours per week spent in work:
- c)** Hours per week spent in education/ studying:

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

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

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

- | | | | | | |
|---|--------------------------|---|---|--------------------------|----|
| Agriculture, forestry and fishing | <input type="checkbox"/> | 1 | Financial, insurance and real estate activities | <input type="checkbox"/> | 8 |
| Industry | <input type="checkbox"/> | 2 | Professional, scientific and technical activities | <input type="checkbox"/> | 9 |
| Construction | <input type="checkbox"/> | 3 | Administrative and support service activities | <input type="checkbox"/> | 10 |
| Wholesale and retail trade | <input type="checkbox"/> | 4 | Public administration and defence, compulsory social security | <input type="checkbox"/> | 11 |
| Transportation and storage | <input type="checkbox"/> | 5 | Education | <input type="checkbox"/> | 12 |
| Accommodation and food service activities | <input type="checkbox"/> | 6 | Human health and social work activities | <input type="checkbox"/> | 13 |
| Information and communication | <input type="checkbox"/> | 7 | Other <i>(please specify)</i> | <input type="checkbox"/> | 14 |
| | | | _____ | | |

F7) This section is about times when you may have had to take days off work due to physical or mental health problems you experienced that were associated with pregnancy and childbirth (maternal health problems) with your **SECOND child**

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

Yes ¹ No ² (Please skip to F8)

2. How many days did you take off work due to physical or mental maternal health problems BEFORE GOING ON MATERNITY LEAVE with your **second** 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 **second** 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 the health of YOUR SECOND BABY? This includes time off work to look after them when they were unwell, or bring them to doctor or hospital appointments, including routine postnatal check-ups and vaccinations.

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

Yes ¹ No ² (Please skip to F9)

2. How many days did you need to **take off work** due to YOUR **SECOND CHILD'S** health in the FIRST 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 one third)	Sometimes (between one third and two thirds)	Often (more than two thirds)	Always (100%)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 problems associated with pregnancy or childbirth (maternal health problems) with your **second child.**

F10(a) 1. Have you ever had to attend work even though you were feeling physically or mentally unwell due to any maternal health problems experienced during or after the birth of your **second** baby?

Yes ¹ No ² (Please skip to F11)

F10(a).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 **second** child

Days (Please provide your best estimate or a range if you prefer)

F10(a).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 **second** 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?

With 0 meaning no impact at all, and 10 meaning that your job performance was severely affected: 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 having your **second** baby had on your career, and your future prospects for career progression? (please tick one)

- STRONG POSITIVE IMPACT on current and future prospects for career progression 1
- MODERATE POSITIVE IMPACT on current and future prospects for career progression 2
- NO OR VERY LITTLE IMPACT on current and future prospects for career progression 3
- MODERATE NEGATIVE IMPACT on current and future prospects for career progression 4
- STRONG NEGATIVE IMPACT ON current and future prospects for career progression 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 **second** 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 **second** child?

Yes 1 No 2 (Please 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 **second** child

Days

(Please provide your best estimate or a range if you prefer)

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

F13 This section asks about times when other people may have had to take care of your children when **your children were 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 **second** child, did anyone else, such as a partner, parent, relative, friend or other carer needed to take care of your child because YOUR CHILDREN were unwell?

Yes

1

No

2

2. To the best of your ability could you estimate how many days someone else needed to take care of your child because YOUR CHILDREN were unwell in the FIRST YEAR after the birth of your second 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 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. 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	<input type="checkbox"/>	1	<input type="checkbox"/>	2
b. Death of other close family member	<input type="checkbox"/>	1	<input type="checkbox"/>	2
<i>Please specify:</i>				
<hr/>				
c. Death of close friend	<input type="checkbox"/>	1	<input type="checkbox"/>	2
d. Divorce/separation	<input type="checkbox"/>	1	<input type="checkbox"/>	2
e. Moving house	<input type="checkbox"/>	1	<input type="checkbox"/>	2
f. Moving country	<input type="checkbox"/>	1	<input type="checkbox"/>	2
g. Child or family member taken into foster home or residential care	<input type="checkbox"/>	1	<input type="checkbox"/>	2
h. Major change in financial situation e.g. you or your partner being made redundant/fired at work	<input type="checkbox"/>	1	<input type="checkbox"/>	2
i. Serious illness/injury of a family member	<input type="checkbox"/>	1	<input type="checkbox"/>	2
j. Drug taking/alcoholism in the immediate family	<input type="checkbox"/>	1	<input type="checkbox"/>	2
k. Mental illness of a family member	<input type="checkbox"/>	1	<input type="checkbox"/>	2
l. Partner or immediate family member in prison	<input type="checkbox"/>	1	<input type="checkbox"/>	2
m. Loss of a baby before or after birth	<input type="checkbox"/>	1	<input type="checkbox"/>	2
n. Other disturbing event	<input type="checkbox"/>	1	<input type="checkbox"/>	2
<i>Please specify:</i>				
<hr/>				
<hr/>				

The next few questions ask about your experiences in adult intimate relationships (for example, Husband/Wife, Boyfriend/Girlfriend of longer than one month.)

G2 Are you currently in a relationship?

Yes ₁ No ₂ (Go 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)

Never ₁ Rarely ₂ Occasionally ₃ Often ₄

G5 If you are no longer in a relationship with you first child's father/co-parent have you experienced relationship problems with this person in the PAST THREE MONTHS?

Never ₁ Rarely ₂ Occasionally ₃ Often ₄

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.

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. You can answer, even if you are not with a partner at present.

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

My Partner...	Never	Only once	Several times	Once a month	Once a week	Daily
Told me I wasn't good enough	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Kept me from medical care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Followed 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
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
Locked me in the bedroom	<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
Raped 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
Hung around outside my house	<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
Harassed me over the telephone	<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
Tried to rape 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
Harassed me at work	<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
Used a knife or gun or other weapon	<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

My Partner...	Never	Only once	Several times	Once a month	Once a week	Daily
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
Took my wallet and left me stranded	<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
Put foreign objects in my vagina	<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
Refused to let me work outside the home	<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

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 - working 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

The next few questions ask about what treatment you received for any maternal health problems you may have experienced before and after the birth of your second baby

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

	Public		Semi- private		Private		Not applicable	
a) FIRST Baby	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4
b) Second Baby	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4

H1. Are you covered by private health insurance?

Yes 1 No 2

H2. Do you have a medical card or GP visit card for yourself?

None 1 Full medical card 2 GP visit card only 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 **second 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 these questions are quite detailed, 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 **second baby?**

Yes ¹ No ²

H3 (b). 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 **second** child, and how those visits were paid for.

Health professional	Total Number of visits	How was it 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) _____					

H3(c). 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 **second** child, and how were they paid for?

Procedures and tests carried out	Total Number of visits	How was it 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.) (i) _____					
(ii) _____					
(iii) _____					
(iv) _____					

H3(d). 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 **second** child, and how were they paid for?

Medications, supplements or gels	How long were you taking it for?	How was it 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) _____					

H3(e). 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 **second** child and how was this paid for?

Products, devices or equipment	Quantity	How was it 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) _____					

H3(f). 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 **second** child, apart from the cost of the treatment itself? (e.g. such as public transport, accommodation costs in order to attend appointments, additional childminding costs, payments for additional help around the house, etc. ?)

Yes ₁ No ₂

H3(g). If **Yes**, please specify what additional costs you incurred and the estimated amount

H3(h). Have you ever had to delay or do without treatment for pelvic girdle or low pain before and after the birth of your **second** child, due to the financial costs involved?

Yes ₁ No ₂

H3(i). If **Yes**, please specify what treatment you had to delay or do without and the estimated costs involved

H4(a) Did you experience leaking urine during pregnancy or after the birth of your second baby?

Yes ₁ No ₂

H4(b) 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 **second** child, and how those visits were paid for.

Health professional	Total Number of visits	How was it 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) _____					

H4(c) Did you have any procedures, tests or surgery carried out to diagnose or treat leaking urine before and after the birth of your **second** child, and how were they paid for?

Procedures and tests carried out	Total Number	How was it 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 urodynamic tests, endoscopy, botox injections, surgery, etc., please specify) (i) _____					
(ii) _____					
(iii) _____					
(iv) _____					

H4(d) Did you take any prescription or non-prescription medication, supplements or gels to treat leaking urine before and after the birth of your **second** child, and how were they paid for?

Medications, supplements or gels	How long were you taking it for?	How was it 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) _____					

H4(e) Did you use any aids, appliances, devices or other products or equipment for leaking urine before and after the birth of your **second** child, and how was this paid for?

Products, devices or equipment	Quantity	How was it 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) _____					

H4(f) Were there any other costs associated with the treatment you received for leaking urine before and after the birth of your **second** child, apart from the cost of the treatment itself? (e.g. such as public transport, accommodation costs in order to attend appointments, additional childminding costs, payments for additional help around the house, etc. ?)

Yes ₁ No ₂

H4(g) If Yes, please specify what additional costs you incurred and the estimated amount

H4(h) Have you ever had to delay or do without treatment for leaking urine before and after the birth of your **second** child, due to the financial costs involved?

Yes ₁ No ₂

H4(i) If **Yes**, please specify what treatment you had to delay or do without and the estimated costs involved

H5(a) Did you experience leaking bowel movements during pregnancy or after the birth of your second baby?

Yes ₁ No ₂

H5(b) 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 **second** child, and how those visits were paid for.

Health professional	Total Number of visits	How was it 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) _____					

H5(c) Did you have any procedures, tests or surgery carried out to diagnose or treat leaking bowel movements before and after the birth of your **second** child, and how were they paid for?

Procedures and tests carried out	Total Number of visits	How was it 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) _____					

H5(d) Did you take any prescription or non-prescription medication, supplements or gels to treat leaking bowel movement before and after the birth of your **second** child, and how were they paid for?

Medications, supplements or gels	How long were you taking it for?	How was it 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) _____					

H5(e) Did you use any aids, appliances, devices or other products or equipment for leaking bowel movements before and after the birth of your **second** child; and how was this paid for?

Products, devices or equipment	Quantity	How was it 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) _____					

H5(f) Were there any other costs associated with the treatment you received for leaking bowel movements before and after the birth of your **second** child, apart from the cost of the treatment itself? (e.g. such as public transport, accommodation costs in order to attend appointments, additional childminding costs, payments for additional help around the house, etc. ?)

Yes ₁ No ₂

H5(g) If **Yes**, please specify what additional costs you incurred and the estimated amount

H5(h) Have you ever had to delay or do without treatment for leaking bowel movements before and after the birth of your **second** child, due to the financial costs involved?

Yes ₁ No ₂

H5(i) If **Yes**, please specify what treatment you had to delay or do without and the estimated costs involved

H6(a) Did you experience any sexual health problems during pregnancy or after the birth of your second baby?

Yes ¹ No ²

H6(b) 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 **second** child, and how those visits were paid for.

Health professional	Total Number of visits	How was it 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) _____					

H6(c) 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 **second** child, and how were they paid for?

Procedures and tests carried out	Total Number of visits	How was it 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) _____					

H6(d) Did you take any prescription or non-prescription medication, supplements or gels 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 **second** child, and how were they paid for?

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

H6(e) 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 **second** child, and how was this paid for?

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

H6(f) Were there any other costs associated with the treatment you received for sexual health problems before and after the birth of your **second** child, apart from the cost of the treatment itself? (e.g. such as public transport, accommodation costs in order to attend appointments, additional childminding costs, payments for additional help around the house, etc. ?)

Yes ₁ No ₂

H6(g) If Yes, please specify what additional costs you incurred and the estimated amount

H6(h) Have you ever had to delay or do without treatment for sexual health problems before and after the birth of your **second** child, due to the financial costs involved?

Yes ₁ No ₂

H6(i) If **Yes**, please specify what treatment you had to delay or do without and the estimated costs involved

H7(a) Did you experience any mental health issues such as depression and anxiety, during pregnancy or after the birth of your second baby?

Yes 1 No 2

H7(b) 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 **second** child, and how those visits were paid for.

Health professional	Total Number of visits	How was it 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) _____					
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) _____					

H7(c) Did you have any procedures, tests or surgery carried out to diagnose or treat your mental health issues such as depression and anxiety before and after the birth of your **second** child, and how were they paid for?

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

H7(d) 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 **second** child, and how were they paid for?

Hospital stay	Total number of days	How was it 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					

H7(e) Did you take any prescription or non-prescription medication, supplements to treat mental health issues such as depression and anxiety before and after the birth of your **second** child, and how was this paid for?

Medications or supplements	How long were you taking it for?	How was it 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) _____					

H7(f) 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 **second** child, and how was this paid for?

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

H7(g) 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 **second** child, apart from the cost of the treatment itself? (e.g. such as public transport, accommodation costs in order to attend appointments, additional childminding costs, payments for additional help around the house, etc. ?)

Yes ₁ No ₂

H7(h) If Yes, please specify what additional costs you incurred and the estimated amount

H7(i) Have you ever had to delay or do without treatment for mental health issues such as depression and anxiety before and after the birth of your **second** child, due to the financial costs involved.

Yes ₁ No ₂

H7(j) If **Yes**, please specify what treatment you had to delay or do without and the estimated costs involved

Section 2: Part I: Comments

I1 Now that you have got to the end of this 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 |

H2 About the NEW MAMMI Study website www.tcd.ie/mammi

(a) Have you had an opportunity to look at the NEW MAMMI Study website?

- Yes 1 No 2

(b) Did you recommend the website to others?

- Yes 1 No 2

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

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.

Deirdre



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.