

Study No.

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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 AND who did not complete a survey at six months.

The survey is structured in three parts:

Section 1- You and your Children

Part A You and your Children

Section 2- You and your Second Baby

Part A Questions About You And Your Second Baby

Part B Your Labour and Second Baby's Birth

Part C Life with a Second Baby

Part D Sex after the birth of your Second Baby

Section 3- Life Now

Part A Life Now

Part B Exercise

Part C Your Health and Well-Being Now

Part D Sexual Health Now

Part E Your Emotional Health and Well-Being Now

Part F You and Your Household

Part G You and Your Relationships

Part H Your Treatment and Costs of Care

Part I Views on Data Sharing

Part J Comments

How to fill in the Survey

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

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

Yes

☒

No

☐

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

What is your date of birth?

Day	/Month	/Year
30	04	1980

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

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

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

A1 (a) What is today's date?

		/			/				
d	d		m	m		y	y	y	y

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

d	d	/	m	m	/	y	y	y	y

A2. Are you pregnant now?

Yes ☐ ₁ No ☐ ₂

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

d	d	/	m	m	/	y	y	y	y

A3. When and how was your second baby born?

a. Second child

d	d	/	m	m	/	y	y	y	y

b. Was this a Twin birth?

☐

I had normal vaginal birth

☐ ₁

I had assisted vaginal birth

(e.g. vacuum (ventouse, kiwi), forceps etc)

☐ ₂

I had a caesarean section

☐ ₃

A4. Is there anything you wish to say about subsequent pregnancies and births since the birth of your first child?

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

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

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

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

A5 (c) Since the birth of your first child, 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 ☐

A5 (D) If **yes**, where did you have the termination(s): Ireland ☐ ₁ Abroad ☐ ₂

Please comment if you wish:

A6 Since the birth of your first child, did you use any form of family planning or contraception?

Yes ☐ ₁ No ☐ ₂

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

- | | |
|--------------------------------------|---------------------------------------|
| I was trying for another baby | <input type="checkbox"/> ₁ |
| I am not in a relationship | <input type="checkbox"/> ₂ |
| I am in a same sex relationship | <input type="checkbox"/> ₃ |
| I could not afford it | <input type="checkbox"/> ₄ |
| Myself and my partner don't have sex | <input type="checkbox"/> ₅ |
| I prefer not to say | <input type="checkbox"/> ₆ |
| Other (Please describe) | <input type="checkbox"/> ₇ |
-

A7 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: You and Your Second Baby

This section asks questions about you and your second baby, including questions about the birth. If you should have any questions you can contact the MAMMI Team on 087 1186762 or email mammistudy@tcd.ie.

A1 Did you have:

One baby ☐ ¹ Twins ☐ ² Triplets or more ☐ ³

A2 Where did you give birth to your second child?

At home ☐ ¹ At hospital ☐ ² Other ☐ ³

Please comment if you wish _____

A3 What weight was your second baby? *(Please fill one of these options)*

_____pounds and _____ ounces / **OR** _____Kilograms

*(If you had twins or triplets, please insert the weight of twin/triplet born **first** here, and please text us and ask us to send you the 'Twin 2 (or Triplet 3)' survey questions so you can tell us about the other baby's/babies weight(s) and wellbeing)*

A4 How did labour start? (Please complete this question even if you gave birth by planned or emergency caesarean section)

a. **Spontaneously** *(This means you went into labour yourself and needed no medical intervention such as a syntocinon drip or having your waters broken)* ☐ ¹

b. **Induced** *(your labour was started by one/some of the following (Please tick **all** that apply))*

Vaginal Pessary/pessaries ☐ ² My waters were broken artificially ☐ ³ I had a syntocinon drip ☐ ⁴

c. **Accelerated** *(you started labour yourself but your labour was speeded up)*

My waters were broken artificially ☐ ⁵ I had a syntocinon drip ☐ ⁶

d. **I had no labour** *(I had a caesarean section (CS) but never went into labour)* ☐ ⁷

e. If you had CS, did you ask /request it? Yes ☐ ¹ No ☐ ²

f. **Not sure** ☐

Please comment if you wish _____

Section 2: Part B: Your Labour and Second Baby's Birth

B1 How was your baby born? *(Please confirm ONE option)*

a. If you had a VAGINAL birth, did you have:

	YES	NO	NOT SURE
1 Normal vaginal birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2 Vaginal breech (<i>bottom first</i>) birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3 Birth assisted with forceps only (<i>with no rotation of your baby's head</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4 Birth assisted with rotation forceps (<i>to turn your baby's head into the correct position for the birth</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5 Vacuum extraction or ventouse (<i>with <u>no</u> rotation of your baby's head</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6 Vacuum extraction or ventouse (<i>with rotation of your baby's head</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7 Birth assisted with vacuum AND forceps	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8 Doctor rotated your baby's head manually using his/her hands (<i>to turn your baby's head into the correction position for the birth</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

B1 b. If you had a CAESARIAN section, did you have:

9 Caesarean section after unsuccessful attempt to deliver your baby using forceps or vacuum extraction	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
10 Caesarean section with no other procedure used first	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Please comment if you wish _____

If you did **NOT** experience labour please **SKIP** to Section 2: Part B: Question B13 (Page 11).

B2 During labour, did you use any of the following to help relieve pain?

	YES		NO		NOT SURE		I ASKED FOR IT BUT WAS NOT GIVEN IT	
a. Gas and oxygen (<i>Nitrous Oxide</i>)	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4	
b. Injections of Pethidine (<i>or pain killing drugs</i>)	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4	
c. Epidural or spinal injection in your back	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4	
d. TENS	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4	
e. Water pool or bath	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4	
f. Complementary therapies	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4	
g. Hypnotherapy	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4	
h. Other (<i>please give details</i>)	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4	

B3 a. During labour, did you use any of the following to help you deal with contractions?

	YES		NO		NOT SURE
a. Had a shower	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
b. Moved around or tried different positions	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
c. Had a massage	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
d. Used hot packs	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
e. Listened to music / Watched TV	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
f. Went for a walk	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3
g. Birthing ball	<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3

B3 b. Please comment (if you wish) on how you coped/dealt with contractions or on any aspect of your labour in hospital or at home prior to going to the hospital:

B4 During your labour, did you have:

- | | YES | NO | NOT SURE |
|---|----------------------------|----------------------------|----------------------------|
| a. a catheter (tube) inserted <i>(to empty your bladder)</i> and LEFT in place during your labour | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b. a catheter (tube) inserted <i>(to empty your bladder)</i> ONCE | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| c. a catheter (tube) inserted <i>(to empty your bladder)</i> every few hours | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

B5 During the second stage of labour (after your cervix was fully dilated and/or you started pushing), did you spend time in any of the following positions? (Tick as many as necessary)

- | | YES | NO | NOT SURE |
|--|----------------------------|----------------------------|----------------------------|
| a Lying on side | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b Lying flat on back | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| c Propped up leaning back on pillows | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| d Standing | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| e Kneeling | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| f On hands and knees | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| g Squatting | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| h Sitting | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| i In stirrups | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| j In water pool | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| k Other positions <i>(please describe)</i> | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
-

B6 Which of the following methods of pushing were you encouraged to use? (Tick as many as necessary)

- | | YES | NO | NOT SURE |
|---|----------------------------|----------------------------|----------------------------|
| a I was encouraged to follow my own inclinations/ urges to push | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b I was encouraged to hold my breath when pushing | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| c I was encouraged to push down like having a bowel movement | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| d Other <i>(please describe)</i> | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
-

B7 What was the main method of pushing you used? (e.g. follow own urge, hold breath when pushing)

B8 a. Were you told what position your baby was in during the latter (*later/end*) part of your labour?

- | | | | |
|---|--|--------------------------|---|
| a | I was told my baby was in the correct position for the birth | <input type="checkbox"/> | 1 |
| b | I was told my baby was not in the correct position for the birth | <input type="checkbox"/> | 2 |
| c | I was not told what position my baby was in | <input type="checkbox"/> | 3 |
| d | Not sure | <input type="checkbox"/> | 4 |

B8 b. If your baby was not in the correct position, were you told:

- | | | | |
|---|---|--------------------------|---|
| a | that your baby was in a posterior position (<i>with your baby's back towards your back</i>) | <input type="checkbox"/> | 1 |
| b | that your baby's head was (stuck) in a transverse position (<i>head looking sideways</i>) | <input type="checkbox"/> | 2 |

B9 (a) How long did you spend pushing before your baby was born?

hours minutes Not sure ☐

Please comment if you wish _____

B9 (b) How long were you in labour in hospital before your baby was born (including the time you spent pushing)?

hours minutes Not sure ☐

Please comment if you wish _____

B10 What position were you in when your baby was being born?

	YES	NO	NOT SURE
a Lying on side	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b Lying flat on back	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c Propped up leaning back on pillows	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d Standing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e Kneeling	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f On hands and knees	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g Squatting	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
h Sitting	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
i In stirrups	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
j In water pool	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
k Other positions (please describe)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

B11 It is common for women who have a vaginal birth to have either a perineal tear or surgical cut (episiotomy) when their baby is born. (The perineum is the area around the entrance to the vagina including the labia and other external genital organs.)

	YES	NO	NOT SURE
a Did you have an episiotomy (surgical cut to your perineum)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b Did you have a perineal tear?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c Did you have stitches for a tear or episiotomy?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

B12 a. Did you have a tear that affected your rectum?

Yes ☐ 1 No ☐ 2 Not sure ☐ 3

B12 b. If YES, did the midwife or doctor tell you

	YES	NO	NOT SURE
a That the tear had extended to your anal sphincter (the muscle that you tighten when you move your bowels)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b That the tear went all the way around to the lining of the rectum	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Please comment if you wish _____

B13 Thinking back about your labour and birth, were you happy with your methods of pain relief?

Yes ☐ 1 No ☐ 2 Not sure ☐ 3

Please comment if you wish _____

B14 While you were in hospital immediately after you had your baby, were you:

	YES	NO	NOT SURE
a Advised to use laxatives (<i>Tablets/treatments to help you pass a bowel motion (stools/faeces)</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b Told not to strain when passing bowel motions	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

B15 Did any of the following happen to you, either FOR THE BIRTH or immediately afterwards

	YES	NO	NOT SURE
a I had a general anaesthetic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b I had an epidural and/or spinal anaesthetic	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c I had a local anaesthetic (<i>e.g. when stitches were done</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d I had a catheter inserted (<i>to empty my bladder</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

B16 Do you think you were given an active say in making decisions about what happened during your labour and/or birth? (*Please tick the box for your answer*)

Yes, in all cases	Yes, in most cases	At some times and not others	Rarely	Not at all	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

Please comment if you wish _____

B17 a. Was your baby admitted to a special care nursery or neonatal intensive care unit while you were in hospital?

- a Yes, immediately after the birth (within 2 hours of being born) ☐ 1
- b Yes, more than 2 hours after the birth ☐ 2
- c No ☐ 3 *(please skip to B18)*

B17 b. If yes, why was your baby admitted?

B17 c. If yes, how many days did your baby stay in the special care nursery and/or neonatal intensive care unit?

days *(If your baby was admitted to the nursery for less than 24 hours, please write "00" in the boxes.)*

B18 How long did you stay in hospital after your baby was born? *(Please tick the box for your answer)*

Less than 1 day	1-2 days	3-4 days	5-6 days	7-8 days	9 or more days
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6

B19 While in hospital after the birth, did you use any of the following medications for pain?

	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 [by mouth])	<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 <i>(please describe)</i>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

B20 While you were in hospital after the birth, did you use any other medications?

(Please tick one response on each line.)

	YES	NO	NOT SURE
a Antibiotics	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b Anti-depressants	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c Haemorrhoid cream	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d Laxatives	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e Sleeping tablets	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f Other (<i>please describe</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

B21 What did you weigh at the end of your pregnancy without clothes or shoes?

<input type="text"/> <input type="text"/> <input type="text"/>	kgs	OR	<input type="text"/> <input type="text"/>	stones and	<input type="text"/> <input type="text"/>	pounds
--	-----	----	---	------------	---	--------

B22 While you were in hospital after the birth, did you experience any of the following medical complications or health problems?

	YES	NO	NOT SURE
a Painful or sore perineum (<i>from episiotomy or tear</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b Perineum wound infection, breakdown and repeat repair	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c Pain from caesarean section wound breakdown and repeat repair	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d Caesarean section wound infection	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e Postpartum haemorrhage	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f Uterine (womb) infection	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Section 2: Part C: Life with a Second Baby

The next few questions are about life with a Second Baby.

C1 Looking back to your first week at home with your second baby, how would you describe your own health at that time? Did you feel: *(Please tick the box for your answer)*

Extremely well

☐

1

Very well

☐

2

OK

☐

3

Not very well

☐

4

Extremely unwell

☐

5

C2 How confident did you feel about looking after your baby in the first week at home?

Very confident

☐

1

Fairly confident

☐

2

Mixed

☐

3

Fairly anxious

☐

4

Not confident

☐

5

C3 a. Did your baby cry a lot in the first few weeks?

Yes

☐

1

No

☐

2

C3 b. Now that your baby is around twelve months old, does she/he cry very much?

Yes

☐

1

No

☐

2

C3 c. How easy is it to settle your baby NOW once she/he starts crying?

Usually very easy

☐

1

Usually fairly easy

☐

2

Sometimes easy
and sometimes
difficult

☐

3

Often difficult

☐

4

Often very difficult

☐

5

C4 In the last week, which one of the following best describes your baby's pattern of sleeping?

a My baby has not woken up during the night at all in the past week

☐

1

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

☐

2

c My baby has woken up several nights in the last week

☐

3

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

☐

4

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

☐

5

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

☐

6

C5 Do you feel like you are getting enough sleep yourself?

Yes

☐

1

No

☐

2

C6 (a) Did/do you breastfeed your baby (or give expressed breastmilk)?

Yes ☐ 1 No ☐ 2 (please go to C7)

C6 (b) Are you still breastfeeding your baby (or giving expressed breastmilk)?

Yes ☐ 1 No ☐ 2

C6 (c) If you breastfed your baby but have stopped now, how long did you breastfeed your second baby for?

Months	Weeks
<input type="text"/>	<input type="text"/>

C6 (d) Was there a reason why you stopped breastfeeding? [Please comment](#)

C 7 (a) If you needed help with feeding your baby, did you receive it?

Yes ☐ 1 No ☐ 2

C 7 (b) If YES, who did you received help from? [\(Tick all that apply\)](#)

- | | | | |
|--|----------------------------|---|-----------------------------|
| Your mother | <input type="checkbox"/> 1 | Private healthcare professional (e.g. GP, public health nurse, lactation consultant) | <input type="checkbox"/> 7 |
| Your partner | <input type="checkbox"/> 2 | Peer support groups (in person /telephone) | <input type="checkbox"/> 8 |
| Friends/other women | <input type="checkbox"/> 3 | Online peer support | <input type="checkbox"/> 9 |
| Mother-in-law | <input type="checkbox"/> 4 | Voluntary organisations (e.g. La Leche League) | <input type="checkbox"/> 10 |
| Sister | <input type="checkbox"/> 5 | Books/magazines/tv | <input type="checkbox"/> 11 |
| Public healthcare professional (e.g. GP, public health nurse, lactation consultant) | <input type="checkbox"/> 6 | Other (please specify) | <input type="checkbox"/> 12 |

C7 (c) Has your baby had any problems feeding (breast or bottle) since leaving hospital?

Yes, quite a lot ☐ 1 Yes, some ☐ 2 No, none ☐ 3

C8 (a) Has your baby had any health problems, or problems with development that have had a major impact on your life in the last three months?

Yes ☐ ₁ No ☐ ₂

C8 (b) If YES, please describe: _____

C9 How confident do you feel NOW about looking after your baby? *(Please tick the box for your answer)*

Very confident Fairly confident Mixed Fairly anxious Not confident

☐

₁

☐

₂

☐

₃

☐

₄

☐

₅

C10 Is there anything else you would like to tell us about your second baby?

Please comment if you wish _____

C11 (a) Are you hoping to have another baby?

Yes ☐ ₁ No ☐ ₂

Not sure ☐ ₃ I am pregnant now ☐ ₄

Please go to C 11 (e)

Please go to C 11 (d)

C11 (b) Are you currently trying to conceive?

Yes ☐ ₁ No ☐ ₂

C 11 (c) If YES, are you receiving any infertility treatment?

Yes ☐ ₁ No ☐ ₂

C 11 (d) Would you prefer to have:

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

C 11 (e) If you wish, please comment regarding future pregnancies

Comments

If you wish to make any further comments regarding the labour and birth of your second baby or life with a second child please write them here. Thank you.

[illegible]

Section 2: Part D: Sexual Health After the Birth of Your Second Baby

The next few questions are about your sexuality and sexual health after the birth of your second baby. If you feel uncomfortable answering any of these questions or they are too personal, you do not have to answer them.

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

- | | | | |
|---|--------------------------|---|--------------------|
| I have not had sexual or intimate contact since the birth | <input type="checkbox"/> | 1 | (please go to D2) |
| During the first 3 months | <input type="checkbox"/> | 2 | |
| 4-6 months after the birth | <input type="checkbox"/> | 3 | |

D1 b. Did you feel that this was:

- | | | |
|--------------------------------------|--------------------------|---|
| Too soon after the birth | <input type="checkbox"/> | 1 |
| Would have liked to start sooner | <input type="checkbox"/> | 2 |
| About the right time after the birth | <input type="checkbox"/> | 3 |

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

- | | | | |
|---------------------------|--------------------------|---|--|
| You do not have a partner | <input type="checkbox"/> | 1 | (Please skip to Section 3, question A1, page 21) |
| Other reasons | <input type="checkbox"/> | 2 | |

D2 b. If you have a partner, but have not had any sexual contact since the birth of your second baby, please tell me why? *(Please tick ALL that apply.)*

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

Please comment if you wish _____

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

- | | | |
|--|--------------------------|---|
| Yes | <input type="checkbox"/> | 1 |
| Tried on one or more occasions, but it was too painful each time I tried | <input type="checkbox"/> | 2 |
| No | <input type="checkbox"/> | 3 |

D3 (b) When did you first have vaginal intercourse again (or attempt vaginal intercourse again) after you had your second baby?

- I have not had sexual or intimate contact since the birth ☐ 1 (Please go to D6)
- During the first 3 months ☐ 2
- 4-6 months after the birth ☐ 3

D3 (c) Did you feel that this was:

- Too soon after the birth ☐ 1
- Would have liked to start sooner ☐ 2
- About the right time after the birth ☐ 3

D4 How much pain or discomfort, if any, did you feel the first time you attempted to have vaginal intercourse after your second baby was born? Place an X in the box for your answer

- | 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 |

D5 Overall, would you say that your sex life has changed since the birth of your second child?

- | Improved | About the same | Not as Good | Not Sure |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 | 2 | 3 | 4 |

D6 If there anything else you would like to tell us/say about your sexual and intimate relationships since the birth of your second child, please write them here.

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 3: Part A: Life Now

The next few questions are about your life at present.

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: *(Place an X in the box for your answer)*

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? *(Place an X in the box for your answer)*

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 child/children have any health or developmental problems that have had a major impact on your life?

Yes

☐

1

No

☐

2

A4 (b) If YES, please describe and indicate to which child it applies 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

A6 (b) What do you do when you have this time for yourself?

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? (*Please tick the box for your answer*)

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? (*e.g. with preparing meals, housework, childcare, etc.*)

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 3 Q. B1.a.)

A10 (b) Are you happy with the contribution that your partner (husband/wife/boyfriend/girlfriend) makes to looking after your child/children?

Yes, definitely

☐

1

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

☐

2

No

☐

3

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 3: Part B: Exercise

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

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

(Skip to Q B2a.)

☐ ² Yes:

times

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

(Skip to Q B3a.)

☐ ² Yes:

times

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

(Skip to Q B4a.)

☐ ² Yes:

times

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

(Skip to Q B5a.)

☐ ² Yes:

times

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

(Skip to Q B6a.)

☐ ² Yes:

times

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	Hours	<input type="text"/>	<input type="text"/>	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
(Skip to Q B7a.)

² Yes: times

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	Hours	<input type="text"/>	<input type="text"/>	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
(Skip to Q B8)

² Yes: times

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	Hours	<input type="text"/>	<input type="text"/>	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	TIMES PER WEEK		TYPE OF EXERCISE	TIMES PER 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 3: Part C: Your health and Well-being Now

The next few questions are about your health over the **PAST three months**.

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

	Never	Rarely	Occasionally	Often
a. Extreme tiredness or exhaustion	<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

(Please go to C4)

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

Skip to C5

Rarely

☐

2

Occasionally

☐

3

Often

☐

4

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

Yes, I'm taking tablets or 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 to C7, please go to C11.

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 require 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*

C10 (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

C11 (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

- | | 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"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 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"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 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"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 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).

(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 [by mouth])	<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, page 34).

(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

C21 (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	<input type="checkbox"/>	1	Yes, when I remember	<input type="checkbox"/>	2	No	<input type="checkbox"/>	3
----------------	--------------------------	---	----------------------	--------------------------	---	----	--------------------------	---

C22 (b) If YES, approximately how often do you do them?

<input type="text"/>	Number of days each week	<input type="text"/>	<input type="text"/>	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	<input type="checkbox"/>	1	Yes, sometimes	<input type="checkbox"/>	2	No, not at all	<input type="checkbox"/>	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	<input type="checkbox"/>	1	Yes, sometimes	<input type="checkbox"/>	2	No, not at all	<input type="checkbox"/>	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?

C24 (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	1	MILD	2	DISCOMFORTING	3	DISTRESSING	4	HORRIBLE	5	EXCRUCIATING	6
(a) Lying in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Shifting positions in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Getting in and out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Feeding your baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Sitting in a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Lifting your baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Bathing or showering yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Doing physical exercise e.g. running, aerobics, climbing stairs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Carrying your baby for extended periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Passing urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Passing a bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please comment if you wish _____

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

Always		Sometimes		Never
<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>
				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 40)

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) ☐
If you have experienced pain in this area in the past three months please complete SECTION C28-32 as well.

k) Bone at front of pelvis ☐
If you have experienced pain in this area in the past three months please complete SECTION C28-32 as well.

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) ☐

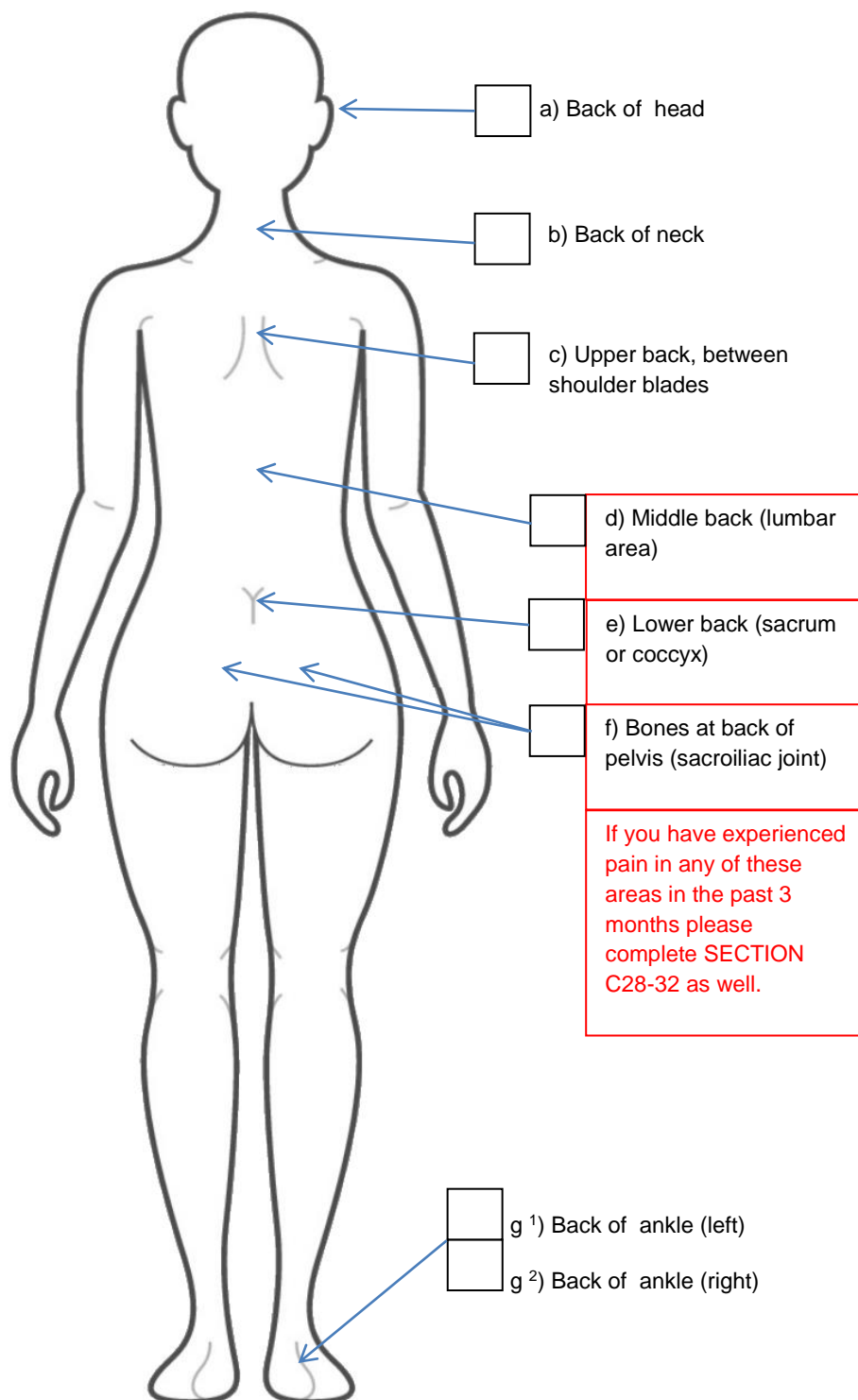
p¹) Foot (left) ☐
p²) Foot (right) ☐

If you 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 40.)

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"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
b. Do you do things more slowly?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
c. Is your sleep interrupted?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
d. Do you have difficulty lifting/handling your child(ren)?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

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	<input type="checkbox"/> 1	No	<input type="checkbox"/> 2
-----	----------------------------	----	----------------------------

C31 (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 [by mouth])	<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

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

Yes

☐

1

No

☐

2

(Skip to C33.)

C32 (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

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 TWELVE 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 3: 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 36).**

D2 (b) 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	<hr/>		

If you have not had any sexual or intimate contact in the past THREE MONTHS, please go to question D13, page 44.

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)

D6 (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)

D12 (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 3: 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 | <input type="checkbox"/> | 1 |
| Not quite as much now | <input type="checkbox"/> | 2 |
| Definitely not as much now | <input type="checkbox"/> | 3 |
| Not at all | <input type="checkbox"/> | 4 |

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

- | | | |
|--------------------------------|--------------------------|---|
| As much as I ever did | <input type="checkbox"/> | 1 |
| Rather less than I used to | <input type="checkbox"/> | 2 |
| Definitely less than I used to | <input type="checkbox"/> | 3 |
| Hardly at all | <input type="checkbox"/> | 4 |

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

- | | | |
|-----------------------|--------------------------|---|
| Yes, most of the time | <input type="checkbox"/> | 1 |
| Yes, some of the time | <input type="checkbox"/> | 2 |
| Not very often | <input type="checkbox"/> | 3 |
| No, never | <input type="checkbox"/> | 4 |

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

- | | | |
|-----------------|--------------------------|---|
| No, not at all | <input type="checkbox"/> | 1 |
| Hardly ever | <input type="checkbox"/> | 2 |
| Yes, sometimes | <input type="checkbox"/> | 3 |
| Yes, very often | <input type="checkbox"/> | 4 |

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

- | | | |
|------------------|--------------------------|---|
| Yes, quite a lot | <input type="checkbox"/> | 1 |
| Yes, sometimes | <input type="checkbox"/> | 2 |
| No, not much | <input type="checkbox"/> | 3 |
| No, not at all | <input type="checkbox"/> | 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 | <input type="checkbox"/> | 1 |
| Yes, sometimes I haven't been coping as well as usual | <input type="checkbox"/> | 2 |
| No, most of the time I have coped quite well | <input type="checkbox"/> | 3 |
| No, I have been coping as well as ever | <input type="checkbox"/> | 4 |

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

- | | | |
|-----------------------|--------------------------|---|
| Yes, most of the time | <input type="checkbox"/> | 1 |
| Yes, some of the time | <input type="checkbox"/> | 2 |
| Not very often | <input type="checkbox"/> | 3 |
| No, never | <input type="checkbox"/> | 4 |

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

- | | | |
|-----------------------|--------------------------|---|
| Yes, most of the time | <input type="checkbox"/> | 1 |
| Yes, some of the time | <input type="checkbox"/> | 2 |
| No, not at all | <input type="checkbox"/> | 3 |
| No, never | <input type="checkbox"/> | 4 |

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

- | | | |
|-----------------------|--------------------------|---|
| Yes, most of the time | <input type="checkbox"/> | 1 |
| Yes, quite often | <input type="checkbox"/> | 2 |
| Only occasionally | <input type="checkbox"/> | 3 |
| No, never | <input type="checkbox"/> | 4 |

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

- | | | |
|------------------|--------------------------|---|
| Yes, quite a lot | <input type="checkbox"/> | 1 |
| Yes, sometimes | <input type="checkbox"/> | 2 |
| No, not much | <input type="checkbox"/> | 3 |
| No, not at all | <input type="checkbox"/> | 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 3: 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 | | | |
| 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 | | | |
| Looking for first job | <input type="checkbox"/> | 7 | Other (Please specify) | <input type="checkbox"/> | 14 |
| Unemployed | <input type="checkbox"/> | 8 | <hr/> | | |

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 (please specify) | <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 | <input type="checkbox"/> | 1 |
| MODERATE POSITIVE IMPACT on current and future prospects for career progression | <input type="checkbox"/> | 2 |
| NO OR VERY LITTLE IMPACT on current and future prospects for career progression | <input type="checkbox"/> | 3 |
| MODERATE NEGATIVE IMPACT on current and future prospects for career progression | <input type="checkbox"/> | 4 |
| STRONG NEGATIVE IMPACT ON current and future prospects for career progression | <input type="checkbox"/> | 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.

- 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 3: 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>				
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>				

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	Rarely	Occasionally	Often
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	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	Rarely	Occasionally	Often
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4

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

Extremely emotionally satisfying	Very emotionally satisfying	Moderately emotionally satisfying	Slightly emotionally satisfying	Not at all emotionally satisfying	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

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	<input type="checkbox"/>	1
I have not told anyone	<input type="checkbox"/>	2
I have told my Public Health Nurse	<input type="checkbox"/>	3
I have told my regular GP/family doctor	<input type="checkbox"/>	4
I told someone else <i>(Please say who)</i>	<input type="checkbox"/>	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 3: 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 (e.g. pads, special underwear, devices, etc., please specify)	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) _____					

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 (e.g. imaging tests such as x-ray, MRI, or procedures such as colposcopy, etc., please specify)	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
(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 (e.g. blood test, electroconvulsive therapy, etc., please specify)	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
(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 Inpatient (overnight) hospital admission Outpatient (day case) hospital admission	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

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 (e.g. antidepressants, anxiolytics, etc., please specify)	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)_____					

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 3: Part I: Views on Data Sharing

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

What is 'Data Sharing'?

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

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

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

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

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

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

Yes ☐ 1 No ☐ 2 Not sure ☐ 3

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

Yes ☐ 1 No ☐ 2 Not sure ☐ 3

(continue below)

(go to question H5)

(continue below)

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

- a. The research team who collected the data should decide after reviewing the scientific, ethical, and public health merit of any request for access to the anonymised data (i.e. is the proposed new research or analysis based on sound science?) ☐ 1
- b. The sponsor/funder of the research should review any request for access to the anonymised data and decide, based on sound science. ☐ 2
- c. An independent review board should review any request for access to the anonymised data and decide, based on sound science. ☐ 3
- d. The research team should request consent for sharing the anonymised data from participants at the start of the study, before data collection starts ☐ 4
- e. After the study is completed the research team should then contact participants every time a request is made for access to the stored dataset. ☐ 5

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

- | | | | | | |
|------------------------|--------------------------|---|--|--------------------------|---|
| Scientific advancement | <input type="checkbox"/> | 1 | Health benefits emerging from research | <input type="checkbox"/> | 4 |
| Research efficiency | <input type="checkbox"/> | 2 | Serving the common good | <input type="checkbox"/> | 5 |
| Transparency | <input type="checkbox"/> | 3 | Other (please specify) | <input type="checkbox"/> | 6 |
-

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

YES

NO

- | | | | | |
|---|--------------------------|---|--------------------------|---|
| a) Other health researchers at the same institution | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 |
| b) Other health researchers at other non-profit institutions/research organisations | | | | |
| i) In Ireland | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 |
| ii) Abroad | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 |
| c) For-profit research organisations | | | | |
| i) In Ireland | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 |
| ii) Abroad | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 |
| d) Other (Please specify) | <input type="checkbox"/> | 1 | <input type="checkbox"/> | 2 |
-

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

(If you ticked 'yes' in question 2, then skip to question H.6).

- | | | | | | |
|--------------------------------------|--------------------------|---|-----------------------------------|--------------------------|---|
| Privacy concerns | <input type="checkbox"/> | 1 | Concerns about misuse of the data | <input type="checkbox"/> | 3 |
| Concerns about control over the data | <input type="checkbox"/> | 2 | Other (please specify) | <input type="checkbox"/> | 4 |

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

Section 3: Part J: Comments

J. 1 . 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.

☐

1

I was pleased to be asked about my experiences

☐

2

It was OK

☐

3

It was interesting

☐

4

I didn't understand some of the terms or language used

☐

5

Other (please say what)

☐

6

J.2. 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.

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

[illegible]

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.