

How to complete this questionnaire

- If you have been pregnant before, please only think about the maternity care you received in your **most recent pregnancy and birth** when answering these questions.
- For most questions, make a cross clearly inside one box or write clearly in the space provided. For some questions where indicated you may mark more than one box.
- Not all sections will apply to you. We estimate that the questionnaire will take around 30 minutes to complete.

Section A: Dates and Your Baby

A1 Did you give birth to a single baby, twins or more in your most recent pregnancy?

A single baby Twins Triplets, quads or more

A2 If you had a single baby this time, is your baby ... ? Please tick one box

A boy OR A girl

If you had a multiple birth, did you have...?

All boys OR All girls OR boy and girl twins, triplets or more

Note: If you had more than one baby in your most recent pregnancy, please fill in the rest of the questionnaire about the baby who was born first as a result of this pregnancy

A3 When was your baby born?

/ / (date / month / year)

A4 Roughly how many weeks pregnant were you when your baby was born?

weeks

A5 How much did your baby weigh at birth? Please remember if you had more than one baby, to fill in this questionnaire about the baby who was born first

Either What your baby weighed in grams

Or What your baby weighed in pounds and ounces

Section B: Antenatal Care

B1 Did you plan to get pregnant with this baby? Yes No

B2 How would you describe your reaction when you realised you were pregnant with this baby? Please tick one box only

- Overjoyed
 Pleased
 Mixed feelings
 A bit unhappy
 Very unhappy
 No particular feelings

B3 Roughly how many weeks pregnant were you when you had your pregnancy 'booking'? (the appointment where you were given your hand held pregnancy records / notes)

weeks

B4 Around the time of your pregnancy booking were you asked about your emotional and mental health?

Yes No

B5 Around the time of your pregnancy booking were you asked about your past mental health or family history of mental health (before this pregnancy)?

Yes No

Antenatal check-ups

A 'check-up' is any contact with a midwife or a doctor to check the progress of your pregnancy. This usually includes having your blood pressure and urine checked. *Please ignore other appointments that did not include these things, such as a visit for a scan or a blood test only.*

B6 During your pregnancy did you have any antenatal check-ups?

Yes No Not sure / Don't know

B7 Roughly how many check-ups did you have at each of these places?

Please write in the number for each

Local clinic

Children's centre

GP surgery

Hospital clinic

At home

Other place *Please give details* _____

B8 Altogether, how many different midwives looked after you during your pregnancy?

Please tick one box only

One Two Three Four Five or more

B9 During your pregnancy did you have a health professional you could talk to about personal or sensitive issues?

Yes, always Yes, to some extent No

B10 During your pregnancy, before you went into labour did you stay in hospital overnight?

(not including admission for induction or before planned caesarean section)

Yes No

B11 Before you went into labour or had your baby did you have any particular worries about the labour and birth? *Please tick one box for each line*

	Very worried	Quite worried	Not very worried	Not at all worried
Not knowing when I would go into labour	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Getting to the hospital in time	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Having to be induced	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Having a long labour	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Pain and discomfort of labour	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Getting effective pain relief	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Not knowing how long labour would take	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Having a forceps or ventouse delivery	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Embarrassment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Needing a caesarean	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Other <i>Please give details</i> _____	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

During your pregnancy

B12 Did you have any long term health problems which made your pregnancy difficult or complicated? (e.g. epilepsy or diabetes)

Yes No Please give details

B13 Did you have specific pregnancy related problems which affected you or your baby? (e.g. high blood pressure, threatened preterm labour, low-lying placenta)

Yes No Please give details

Section C: Your Labour and the Birth of your Baby

C1 Where was your baby born? Please tick one box only

- In hospital, in a midwife-led unit
 In hospital, in a consultant-led unit
 In a midwife-led unit or birth centre separate from hospital
 At home
 Other

C2 Did you have a labour? Yes No **If No, please go to question C7**

C3 How did your labour start? Please tick all that apply

- It started naturally
 I had one or more membrane sweeps
 I was given a vaginal gel or pessary to induce my labour
 My waters were broken by a doctor or a midwife (amniotomy)
 I was given a drip (in my hand or arm) to induce my labour

C4 Roughly how long did your labour last?

hours **AND / OR** minutes

C5 During your labour, did you use any of the following to relieve the pain?

Please tick all that apply

- Gas and air (breathing through a mask)
 Injection of pethidine or a similar painkiller
 Epidural or similar (injection in your back)
 Other Please give details _____

C6 During your labour, how was your baby monitored? Please tick all that apply

- Staff listened with a 'pinard' (ear trumpet) now and then
 Sonicaid (a hand held monitor) was used now and then
 A monitor was used now and then, with a belt around my tummy
 A monitor was used constantly with a belt around my tummy
 A monitor was used constantly with a clip attached to my baby's head
 I had no monitoring / Not sure / Can't remember

The birth of your baby

C7 Thinking about the birth of your baby, what kind of delivery did you have? If you had more than one baby, please answer about the baby who was born first. Please tick one box only

- Normal (vaginal) birth
 Delivery using forceps
 Delivery using vacuum cap on the baby's head (ventouse)
 A caesarean (through a cut in the abdomen)

Caesarean Birth

Note: If you did **not** have a caesarean for this birth, **please go to question C9**

C8 If your baby was born by caesarean this time was this... Please tick one box only

- Planned and carried out before you went into labour?
 Planned, but carried out after you had gone into labour?
 The result of an unforeseen problem during your labour?

Vaginal Birth

C9 If you had a vaginal birth, while your baby was being born did you have an episiotomy (cut) to assist with the delivery of the baby?

- Yes No Don't know / Can't remember

C10 If you had a vaginal birth, while your baby was being born did you have a tear (not a deliberate cut)? Please tick one box only

- No
 Yes, a tear that did not need stitches
 Yes, a tear that needed stitches
 Yes, a serious tear which involved my back passage (third or fourth degree tear)
 Don't know / Can't remember

The staff caring for you during labour and birth

Please answer the following section if you had a vaginal birth **or** a caesarean.

C11 Altogether, how many different midwives looked after you during your labour and / or the birth of your baby? Please tick one box only

- One Two Three Four Five or more

C12 Had you met any of these midwives before you went into labour or gave birth? Please tick one box only

- All of them Some of them None of them

C13 How soon after birth did you...

Hold your baby? minutes hours days

Have skin-to-skin contact with your baby? minutes hours days

C14 We would like to know how you feel you were looked after during your labour and birth. Please circle as many words as you like which describe the staff you saw during labour.

rushed	humorous	insensitive	kind
considerate	unhelpful	supportive	offhand
rude	warm	inconsiderate	polite
sensitive	bossy	informative	condescending

C15 Overall, how do you feel your labour and birth went? Please tick one box only

1 Worse than you expected _2_ More or less as you expected _3_ Better than you expected

Section D: You and Your Baby After the Birth

D1 Did you stay in a maternity unit (or hospital) after your baby was born?

1 Yes _2_ No

D2 If Yes, how long did you stay in the maternity unit (or hospital) after your baby was born?

hours OR days Does not apply

After birth some babies need specialist care, e.g. help with breathing, and are admitted to a neonatal unit, sometimes called a Special Care Baby Unit (SCBU) or Neonatal Intensive Care Unit (NICU).

D3 Was your baby cared for in a neonatal unit at all? _1_ Yes _2_ No

If Yes, for how long? days **OR** weeks

D4 After the birth of your baby, how many times in total did you....

See a midwife at home? times

See a midwife at drop in clinic? times

See a maternity support worker at home? times

Contact a midwife or maternity support worker by phone? times

D5 How old was your baby when you had the last visit or contact with the midwife or maternity support worker?

Age in days **OR** weeks

D6 How many different midwives in total visited you at home after your baby was born?

Please tick one box only

1 None _2_ One _3_ Two _4_ Three or more

D7 Had you met any of these midwives before you had your baby? Please tick one box only

1 All of them _2_ Some of them _3_ None of them

D8 Since your baby was born have you been asked about your emotional and mental health by a health professional?

1 Yes _2_ No

D9 Did you have a postnatal check-up of your own health with your GP (family doctor), usually between 4-8 weeks after the birth?

1 Yes _2_ No

Feeding Your Baby

Note: When we ask about 'breastfeeding' we also mean 'giving your baby expressed breast milk'

D10 Did you ever try to breastfeed your baby, even if it was only once?

Yes No

D11 In the first few days after the birth how was your baby fed? Please tick one box only

- Formula (bottle) milk only
 Breast milk (or expressed breast milk) only
 Both breast and formula (bottle) milk
 Not sure / can't remember

D12 Who helped or advised you with feeding your baby? Please tick all that apply

- | | |
|--|---|
| <input type="checkbox"/> Midwife | <input type="checkbox"/> Voluntary organisation |
| <input type="checkbox"/> Health visitor | <input type="checkbox"/> Online support / social media |
| <input type="checkbox"/> Other health professional | <input type="checkbox"/> DVDs / books / magazines |
| <input type="checkbox"/> Partner / friend / relative | <input type="checkbox"/> I was not given any help or advice |
| <input type="checkbox"/> Breastfeeding support group | <input type="checkbox"/> I did not need any help or advice |
| <input type="checkbox"/> Peer supporter (other mum who has breastfed, trained to give support to other mums) | |

D13 Thinking about the milk that your baby has received over the last 7 days, has he or she had...? Please tick one box only

- Only infant formula / other milk
 Only breast milk
 Both breast milk and infant formula / other milk
 Other *Please give details* _____

D14 Would you have liked more help from a health professional with feeding your baby?

Yes No

D15 If you breastfed, did you do so for as long as you wanted to?

Yes No Does not apply

D16 How old was your baby when he or she was last given breast milk?

days **OR** weeks My baby was never given breast milk

D17 Has your baby ever had any solid foods such as cereal, rusks, baby rice, fruit, vegetables or any other kind of solid food?

Yes No

D18 How old was your baby when he or she first had any solid food apart from milk?

days **OR** weeks

Section E: Your Experience of Maternity Care

E1 Each woman's experience of maternity care is different. How much do you agree with the following statements? *Please tick one box for each row*

Thinking about my care during pregnancy....	Strongly agree	Agree to some extent	Neither agree or disagree	Disagree to some extent	Strongly disagree
I felt I had the right number of antenatal checks with a midwife / doctor	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I did not have enough choice about my care during pregnancy (e.g. who you saw, where and when)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My care provider(s) gave me all the information I needed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I always saw the same midwife / doctor for my antenatal checks	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was not able to contact my midwife or other health professional when I needed to	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was not always treated with respect and kindness by health professionals	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Health professionals did not always talk to me in a way I could understand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Antenatal appointments were too short to discuss any concerns about my pregnancy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was able to speak to a health professional about any worries or sensitive issues	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was not involved enough in decisions about my antenatal care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt listened to when I talked to my care provider about my pregnancy and birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was happy with the number of health professionals who cared for me during my pregnancy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was not given enough explanations about antenatal scans and tests	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was not given enough information to make decisions about my antenatal care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Seeing different midwives / doctors for antenatal care did not matter to me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I would have liked more antenatal checks and scans	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
During pregnancy I was given enough information about where I could give birth to my baby (e.g. home, hospital, midwife unit)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Health professionals always treated me as an individual	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
During pregnancy, I did not feel well cared for by health professionals	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Overall, I was very pleased with the care I received in pregnancy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

During labour and birth

E2 How much do you agree with the following statements? *Please tick one box for each row*

Thinking about my care during labour and birth ...	Strongly agree	Agree to some extent	Neither agree or disagree	Disagree to some extent	Strongly disagree
Before my labour and birth I was well informed by my midwife / doctor about what would happen	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Staff communicated well with me during labour and birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My choices for labour and birth were not always respected	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I needed more staff support during labour and birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Everything was explained to me well during labour and birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was treated as an individual by staff	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was not involved enough in decisions about procedures that were carried out (<i>e.g. breaking waters, epidural, caesarean section</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Health professionals left me alone more than I would have liked	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt that my pain relief needs were not managed well	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I had already met the staff who looked after me during labour and birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt safe in the labour and birth environment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Staff did not listen to my requests in managing my labour and birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
The staff could have done more to help me to feel in control of my labour and birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I had confidence and trust in the staff caring for me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Health professionals helped make labour and birth a really positive experience	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
The personal care I received could have been better during labour and birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I did not mind being looked after by midwives or doctors I had not met before	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
The choices I wanted were not available to me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
My labour and birth experience was not as I expected	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I had the best possible care during labour and birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

After the birth

E3 How much do you agree with the following statements? *Please tick one box for each row*

Thinking about my <u>postnatal care</u> ...	Strongly agree	Agree to some extent	Neither agree or disagree	Disagree to some extent	Strongly disagree
I received enough care and attention from staff on the postnatal ward	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I stayed in hospital as long as I wanted after the birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Staff on the postnatal ward did not respond when I needed them	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was not able to make choices about the postnatal care of me and my baby	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was treated as an individual by midwives / doctors after the birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
After I had given birth, health professionals treated me as though I was no longer important	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I did not know the midwives I saw after bringing my baby home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I had enough information from health professionals about how to care for my baby	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I felt comfortable speaking with healthcare professionals about how I was feeling	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
The health professionals I saw after the birth did not really listen to me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I would have liked to have seen midwives more after the birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was able to build a good relationship with the healthcare professional(s) I saw after coming home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I was not given the advice and information I needed by health professionals after my baby was born	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
There was not enough time to talk over my concerns with health professionals	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
The advice I received from healthcare professionals about caring for my baby was consistent	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
I had all the checks I needed after the birth	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
After the birth of my baby, I knew who to contact if I had questions or concerns	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
As a mother of a new baby I did not feel cared for and supported enough by health professionals	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
The postnatal care I received did not meet the needs of me and my baby	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Overall I was very pleased with the quality of my postnatal care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Section F: Your Baby

F1 When did you first feel your baby really belonged to you? *Please tick one box only*

- During your pregnancy
 Immediately after birth
 In the first few days
 In the first few weeks
 Only recently
 Not quite yet

F2 Does your baby have any health problems now?

- Yes No **If Yes, please give details** _____

F3 How would you describe your baby as he or she is now? *Please read the list and circle as many words as you like which best describe your baby.*

- | | | | |
|------------|-----------|----------|---------------|
| placid | stubborn | cuddly | unresponsive |
| grizzly | active | angry | alert |
| responsive | demanding | sociable | inactive |
| withdrawn | happy | fretful | communicative |

F4 Compared with other babies how would you say your baby is now? *Please tick one box only*

- More difficult than average About average Easier than average

F5 Parents' experiences with a baby vary a great deal.

How have the following been for you during the months since your baby was born?
Please tick one for each line

	Very difficult	Quite difficult	Not very difficult	Not at all difficult	Does not apply
Understanding what your baby needs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Tiredness and lack of sleep	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
The changes in your partner relationship	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Getting everything done	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Feeling you are doing the right thing for your baby	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Organising family life	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Adjusting to having a young baby around	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
Loss of independence	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

F6 Has your baby ever suffered from any of the following problems?

- | | |
|--|---|
| <input type="checkbox"/> Sickness or vomiting | <input type="checkbox"/> Thrush |
| <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Chest problems / infection |
| <input type="checkbox"/> Diarrhoea | <input type="checkbox"/> Not gaining enough weight |
| <input type="checkbox"/> Colic / painful wind | <input type="checkbox"/> Ear problems / infection |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gaining too much weight |
| <input type="checkbox"/> Something else <i>Please give details</i> _____ | |

F7 Since your baby was born... Please tick and write how many times

Including routine appointments, has your baby?	Roughly how many times?
<input type="checkbox"/> Seen a health visitor	<input type="checkbox"/>
<input type="checkbox"/> Been taken to a GP (family doctor)	<input type="checkbox"/>
<input type="checkbox"/> Been taken to a regular baby clinic	<input type="checkbox"/>
<input type="checkbox"/> Been taken to a hospital emergency department (A&E)	<input type="checkbox"/>
<input type="checkbox"/> Been taken to a hospital outpatient clinic	<input type="checkbox"/>
<input type="checkbox"/> Stayed overnight in hospital	<input type="checkbox"/>

F8 How much do you worry about your child's health and development?

Please tick one box only

- A great deal Quite a lot Not very much Not at all

Section G: Your Health and Wellbeing

G1 Did you experience any of the following 10 days, 1 month, and 3 months after the birth of your baby? Please tick all that apply

	10 days after the birth	1 month after the birth	3 months after the birth
'The blues'	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful stitches or wound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaking urine (<i>stress incontinence</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue / severe tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (not related to the baby)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
'Flash-backs' to the labour or birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties in concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other <i>Please give details</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None of these	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G2 Overall, how have you felt physically during the last few days? Please tick one box only

- Very well
 Quite well
 Tired and uncomfortable
 Exhausted all the time
 Very ill

G3 We would like to know how you have been feeling in the last week.

Please circle any of the words below which describe how you have been feeling in the last 7 days.
Circle as many as you wish

calm	tense	relaxed	upset
irritable	happy	miserable	excited
confident	drained	fulfilled	nervous
detached	contented	low	optimistic
cheerful	angry	energetic	impatient
restless	lighthearted	worried	satisfied

Are there any other words you would like to add? _____

G4 The following questions deal with your feelings. How have you felt over the LAST 7 DAYS, not just today. Please circle one box for each row

I have been able to laugh and see the funny side of things	As much as I always could	Not quite so much now	Definitely not as much now	Not at all
I have looked forward with enjoyment to things	As much as I ever did	Rather less than I used to	Definitely less than I used to	Hardly at all
I have blamed myself unnecessarily when things went wrong	Yes, most of the time	Yes, some of the time	Not very often	No, never
I have been anxious or worried for no good reason	No, not at all	Hardly ever	Yes, sometimes	Yes, often
I have felt scared or panicky for no very good reason	Yes, quite a lot	Yes, sometimes	No, hardly ever	No, not at all
Things have been getting on top of me	Yes, most of the time	Yes, sometimes	No, hardly ever	No, not at all
I have been so unhappy, I have had difficulty sleeping	Yes, most of the time	Yes, sometimes	Not very often	No, not at all
I have felt sad and miserable	Yes, most of the time	Yes, sometimes	Not very often	No, not at all
I have been so unhappy that I have been crying	Yes, most of the time	Yes, quite often	Only occasionally	No, never
The thought of harming myself has occurred to me	Yes, most of the time	Sometimes	Hardly ever	Never

Section H: Your future plans

H1 Are you doing any paid work at the moment? Please tick one box only

- ₁ Yes
₂ On paid maternity leave **Please go to question H4**
₃ On unpaid maternity leave **Please go to question H4**
₄ No **If No, go to question H4**

H2 If you are working, how many hours do you work on average each week?

hours

H3 If you are working, what age was your baby when you returned to work?

days **OR** weeks

H4 Do you intend to start or return to work within the next year?

₁ Yes ₂ No ₃ Don't know / not sure ₄ Have returned to work already

How old will your baby be when you return to work? days **OR** weeks

How many hours per week do you intend to work? hours

H5 If you are working or plan to return to work how is your baby to be cared for while you are at work? Please tick all that apply

- ₁ Childminder
₂ Nanny
₃ Nursery
₄ Husband or partner
₅ Friend
₆ Other person *Please give details* _____
₇ Not yet decided
₈ Does not apply

H6 If you have returned to work or plan to return to work is this because.....

Please tick all that apply

- ₁ You want to
₂ You need the money
₃ Work is really important to you
₄ You are sharing childcare with your partner
₅ You always planned to
₆ You have no choice
₇ You need to for your career
₈ You are not working or planning to return to work in the next year

Section J: Your Lifestyle

J1 Have you ever smoked tobacco cigarettes?

Yes No **If No, please go to question J5**

J2 How often did you smoke tobacco cigarettes during each of the following time periods?
(Please tick one box for each row)

	Daily	Less than daily, but at least once a week	Less than weekly, but at least once a month	Less than monthly	Not at all
In the 3 months before you became pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the first 3 months of your pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the second 3 months of your pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the final 3 months of your pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the first 3 months after your baby was born	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you smoke tobacco cigarettes now	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

J3 Did you smoke tobacco cigarettes after you found out you were pregnant?

Yes No

J4 After you found out you were pregnant, did you do any of the following?

Please tick all that apply

- I stopped smoking temporarily (less than one month)
- I stopped smoking temporarily (more than one month)
- I cut down the number of cigarettes I smoked
- I used nicotine replacement therapy (e.g. patch, gum, lozenges, nose spray, inhaler, microtabs)
- I used an electronic cigarette or vaping device
- Other *Please give details* _____

J5 Have you ever used an electronic cigarette or vaping device?

Yes No **If No, please go to question J9**

J6 How often did you use an electronic cigarette or vaping device during each of the following time periods? (Please tick one box for each row)

	Daily	Less than daily, but at least once a week	Less than weekly, but at least once a month	Less than monthly	Not at all
In the 3 months before you became pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the first 3 months of your pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the second 3 months of your pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the final 3 months of your pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the first 3 months after your baby was born	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you use an electronic cigarette or vaping device now	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

J7 Did you use an electronic cigarette or vaping device after you found out you were pregnant?

Yes No

J8 When you used an electronic cigarette or vaping device, did it contain nicotine?

Always Sometimes No, never I don't know

J9 During your pregnancy, did any of the people you lived with smoke tobacco cigarettes?

- Yes, I lived with my partner who smoked
 Yes, someone else I lived with smoked
 No, nobody else who I lived with smoked
 Does not apply – I lived alone

J10 Do any of the people who live with you now smoke tobacco cigarettes?

- Yes, I live with my partner who smokes
 Yes, someone else I live with smokes
 No, nobody else who I live with smokes
 Not applicable – I live alone with my baby

Section K: You and Your Household

Please answer as many of these questions as you can. This will help us to describe the women taking part in this survey and show whether the care offered to women is the same regardless of their background or circumstances.

K1 How old are you now?

years

K2 How old were you when you left full-time education?

16 years or less 17 or 18 years 19 years or over Still in full-time education

K3 Have you had a previous pregnancy (before this one)?

Yes No

K4 Have you given birth before having this baby?

Yes No

If Yes, how many babies have you given birth to before this pregnancy?

babies

K5 Which of the following people live with you? Please tick all that apply

- Your baby / children
- Husband / partner
- Other family members
- Other people in your household

K6 In which country were you born? _____

If you were born outside the United Kingdom, what year did you come to the UK?

K7 What is your ethnic group? Please tick one box only

WHITE

- English / Welsh / Scottish / Northern Irish / British
- Irish
- Gypsy or Irish Traveller
- Any other White background

If other, please write in box

ASIAN OR ASIAN BRITISH

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

If other, please write in box

MIXED

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed / multiple ethnic background

If other, please write in box

BLACK OR BLACK BRITISH

- African
- Caribbean
- Any other Black / African / Caribbean

If other, please write in box

OTHER ETHNIC GROUP

- Arab
- Any other ethnic group

If other, please write in box

If there is anything else you would like to tell us about your care while you were pregnant or since you have had your baby, please add your comments here, or use the back page.

Continue over the page, if you would like to.

If there is anything else you would like to tell us about your care while you were pregnant or since you have had your baby, please add your comments here.

Was there anything else you meant to go back and complete later?

Please check you haven't missed any pages. If the survey has raised issues or questions of concern you may wish to contact your family doctor (GP) or health visitor.

Thank you very much for your help

Please return the questionnaire in the envelope provided or respond online. If you have any queries about the questionnaire or you would like to know more about the research please contact:

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