Questionnaire for the self-assessment of the hospital/health facilityfor the MAA Programme

1. **Basic Information**

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| 1. Name and address of the health facility: |
| 2. Name and designation of the administrator of the facility: |
| 3. Type of the hospital (tick all that apply): \* General Hospital \*Maternity Hospital \*Teaching Hospital \*Private Hospital \* Government Hospital |
| 4. Number of staff members in the maternity and newborn services: Doctors \_\_\_\_\_ Nurses \_\_\_\_ |
| 5. Number of dedicated breastfeeding counsellors providing counselling services to the pregnant andlactating women in your facility \_\_\_\_\_\_\_\_\_\_\_ |
| 6. Number of women attending the antenatal clinic in the hospital in last one months: \_\_\_\_\_\_\_\_\_\_\_\_ |
| 7. Number of deliveries in the facility during last one month: Total \_\_\_\_ Vaginal\_\_\_ Caesarean with GA Caesarean without GA  |
| 8. Number of newborn babies who were admitted to the neonatal unit during last one month: |
| 9. Number of infants discharged from the facility in last three months: Out of them: |
| a. Initiated breastfeeding within one hour of birth % |
| b. Discharged with exclusive breastfeeding % |
| c. Received feeds other than breastmilk % |

1. **Questions**

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| **S.****No.** | **Question** | **Response** |
| 1. | What activities are being implemented in your facility under the MAA programme? | *
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| 2. | Does your hospital have a written guideline for the 10 steps tosuccessful breastfeeding? | Yes/No |
| 3. | What proportion of staff working in the maternity and new-born services in the facility is trained in skilled counselling on breastfeeding underthe MAA programme? | * Doctors \_\_\_\_\_\_ (%) Nurses (%)
* Duration of the training: Doctors\_\_\_\_\_days;Nurses days
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| 4. | Does your facility have an ongoingmonitoring and data-management | Yes/No |

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|  | system on early initiation of breastfeeding and exclusivebreastfeeding at discharge? |  |
| 5. | a. What specific steps have you undertaken to ensure implementation of the IMS Act? | *
*
*
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| b. Has the staff received any trainingon the IMS Act? | Yes/No |
| c**.** Does your facility have display of posters etc. promoting infant formula, baby foods and feeding bottles bycompanies? | Yes/No |
| d. Have health workers in your facility (doctors/nurses/any other) received any sponsorship from the baby food and feeding equipment companies such as for research, conference,travel during last one year? | Yes/No |
| 6. | What proportion of mothers received skilled counselling on breastfeeding during the antenatal period in the lastone month in your facility? |  % |
| 7. | a. What practical assistance is provided in your facility at the time of birth for skin-to-skin contact and to initiate breastfeeding with in one hourof birth? | *
*
*
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| b. What practical assistance is provided in your facility to the mothers having caesarean births for skin-to-skin contact and earlyinitiation and exclusive breastfeeding? | *
*
*
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| c. What support is provided to the mothers with low-birth-weight babies (1800 – 2500 gms) in your facility to practice successful breastfeeding? | *
*
*
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| 8. | How many mothers having breastfeeding problems were provided skilled support in your facility in last one month? | * Engorgement of breast
* Inverted nipple\_\_\_\_\_\_\_\_\_\_\_\_\_
* Sore nipple\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Breast abscess
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|  |  | Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 9. | a. In what conditions infant formula was used in your facility during the last one month? | * Not enough milk
* Infant not satisfied after breastfeeds
* Infant cries often
* No milk comes when mother tries to express
* Infant suffering with Inborn Error od Metabolism like Galactosemia, Phenyl Ketonuria etc.
* Maternal medication (please specify)
* Maternal Illness (please specify)
 |
| b. What proportion of infants born in your hospital were given infant formula during the last one months inyour facility? |  % |
| c. What proportion of infants were given the pre-lacteal feeds e.g. milk, honey, ghutti etc. in your facility in thelast one month? |  % |
| 10. | a. Are feeding bottle, teats andpacifiers used in your facility? | Yes/No |
| b. In what conditions feeding bottle, teats and pacifiers are used? | *
*
*
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| c. Are the lactating mothers counselled in your facility about the risks of feeding bottles, teats andpacifiers? | Yes/No |
| 11. | What is the policy for rooming in of infants with their mothers in yourfacility? | * Normal Vaginal Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Caesarean Births
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| 12. | Does your facility provide follow-upsupport to mothers to sustain breastfeeding? | Yes/No; If yes, provide details about the schedule of follow-up visits  |