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 and  lactating 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? |  |
| 2. | Does your hospital have a written guideline for the 10 steps to  successful 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 under  the MAA programme? | * Doctors \_\_\_\_\_\_ (%) Nurses (%) * Duration of the training: Doctors\_\_\_\_\_days;Nurses days |
| 4. | Does your facility have an ongoing  monitoring and data-management | Yes/No |

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|  | system on early initiation of breastfeeding and exclusive  breastfeeding at discharge? |  |
| 5. | a. What specific steps have you undertaken to ensure implementation of the IMS Act? |  |
| b. Has the staff received any training  on the IMS Act? | Yes/No |
| c**.** Does your facility have display of posters etc. promoting infant formula, baby foods and feeding bottles by  companies? | 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 last  one 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 hour  of birth? |  |
| b. What practical assistance is provided in your facility to the mothers having caesarean births for skin-to-skin contact and early  initiation and exclusive breastfeeding? |  |
| c. What support is provided to the mothers with low-birth-weight babies (1800 – 2500 gms) in your facility to practice successful breastfeeding? |  |
| 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 in  your facility? | % |
| c. What proportion of infants were given the pre-lacteal feeds e.g. milk, honey, ghutti etc. in your facility in the  last one month? | % |
| 10. | a. Are feeding bottle, teats and  pacifiers used in your facility? | Yes/No |
| b. In what conditions feeding bottle, teats and pacifiers are used? |  |
| c. Are the lactating mothers counselled in your facility about the risks of feeding bottles, teats and  pacifiers? | Yes/No |
| 11. | What is the policy for rooming in of infants with their mothers in your  facility? | * Normal Vaginal Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Caesarean Births |
| 12. | Does your facility provide follow-up  support to mothers to sustain breastfeeding? | Yes/No; If yes, provide details about the schedule of follow-up visits |