

## Infant Feeding Maternal Discharge Survey

Many thanks for taking the time to complete this brief survey about your recent birth experience. Your responses will help us improve our care for mothers and infants.

| Section 1. Screening Questions   |   |
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| 1. Was your baby born before 37 weeks of gestational age?  | <input type="checkbox"/> Yes <b>(if yes, stop survey)</b><br><input type="checkbox"/> No  |
| 2. How old is your baby today?   | <input type="checkbox"/> 1-3 days old <input type="checkbox"/> 15-30 days old<br><input type="checkbox"/> 4-7 days old <input type="checkbox"/> Over a month <b>(if baby is over a month old, stop survey)</b><br><input type="checkbox"/> 8-14 days old                                      |
| 3. Did your baby ever receive breast milk (put to breast; expressed breast milk from a bottle, cup, spoon, syringe; or donor milk)?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No <b>(skip questions 6.a-c, 9, 10, 11)</b>  |
| Section 2. Hospital Care Questions   |   |
| 4. Did you visit this clinic or hospital for health checks during your pregnancy?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No <b>(skip to question 6)</b><br><input type="checkbox"/> I don't remember <b>(skip to question 6)</b>  |
| 5. When you visited this clinic or hospital for health checks during your pregnancy, did someone teach you about breastfeeding?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| 6. During your hospital stay, did a staff member help you or teach you ...   |   |
| a. ...how to position your baby for breastfeeding?<br><i>(Instructions: skip if baby was not breastfed)</i>  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| b. ...how to know that your baby is getting enough breastmilk?<br><i>(Instructions: skip if baby was not breastfed)</i>  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| c. ...how to express your breastmilk?<br><i>(Instructions: skip if baby was not breastfed)</i>   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| d. ...how to know when your baby is hungry?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| e. ...how to know when the baby is full?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| f. ...about the risks of using feeding bottles?<br><i>(Instructions: skip if a baby was not breastfed)</i>   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| 7. Was your baby placed on your bare chest or belly immediately after being born (without being weighed or examined first)?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No <b>(skip to question 9)</b><br><input type="checkbox"/> I don't remember <b>(skip to question 9)</b>  |
| 8. Did your baby stay on your bare chest or belly without being removed for at least one hour after being born?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| 9. Did your baby breastfeed in the first hour after being born?<br><i>(Instructions: skip if a baby was not breastfed)</i>   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| 10. Did <b>you</b> give your baby anything other than your breast milk (such as infant formula or water) during your stay at this hospital or clinic?<br><i>(Instructions: skip if a baby was not breastfed)</i> | <input type="checkbox"/> Yes (check all that apply)<br><input type="checkbox"/> Infant formula<br><input type="checkbox"/> Water with or without sugar in it<br><input type="checkbox"/> Some other food or drink<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember |

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|--|---|
| <p>11. Did <b>anyone else</b> give your baby anything other than breastmilk (such as infant formula or water) during your stay at this hospital or clinic?<br/><i>(Instructions: skip if a baby was not breastfed)</i></p>                                   | <input type="checkbox"/> Yes (check all that apply)<br><input type="checkbox"/> Infant formula<br><input type="checkbox"/> Water with or without sugar in it<br><input type="checkbox"/> Some other food or drink<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember |
| <p>12. Did anyone take your baby out of your room for any reason during your stay at this hospital or clinic?</p>  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| <p>a. If yes, please tell us why:</p>  |   |
| <p>13. Did your baby stay with you in your room for your whole hospital stay</p>   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| <p>a. If no, please tell us why:</p>   |   |
| <p>14. Did someone in this clinic or hospital tell you where you can get help with breastfeeding after you leave the hospital? (for example, support provided by health providers, community counselors, either in the hospital, community, or at home.)</p> | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> I don't remember  |
| <p><b>Section 3. Patient Experience Questions</b></p>  |   |
| <p>15. Did you feel the information you got during prenatal care about what to expect in the hospitals was:</p>  | <input type="checkbox"/> Not enough<br><input type="checkbox"/> Enough<br><input type="checkbox"/> Better than I expected<br><input type="checkbox"/> Too much!   |
| <p>16. Did you feel the amount of breastfeeding support you got in the hospital was:</p>   | <input type="checkbox"/> Not enough<br><input type="checkbox"/> Enough<br><input type="checkbox"/> Better than I expected<br><input type="checkbox"/> Too much!   |
| <p>17. If you had skin-to-skin care with your baby after birth, please tell us how it felt:</p>  | <input type="checkbox"/> I did not like it<br><input type="checkbox"/> It was OK<br><input type="checkbox"/> I liked it<br><input type="checkbox"/> I REALLY liked it<br><input type="checkbox"/> I did not get skin-to-skin  |
| <p>18. If you had your baby in the room with you all the time in the hospital, please tell us how it felt:</p>   | <input type="checkbox"/> I did not like it<br><input type="checkbox"/> It was OK<br><input type="checkbox"/> I liked it<br><input type="checkbox"/> I REALLY liked it<br><input type="checkbox"/> My baby was not in the room with me all the entire time                                     |
| <p>19. If you had a baby at this hospital before, please tell us if the care <b>this</b> time around was:</p>  | <input type="checkbox"/> Worse than last time<br><input type="checkbox"/> The same<br><input type="checkbox"/> Better this time<br><input type="checkbox"/> MUCH better this time   |
| <p>20. Please add anything else you would like here about your birth experience in this hospital:</p>  |   |

*Thank you for your participation. Your input will be useful to keep good infant feeding practices in our hospital.*