Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

IFPS-3: MONTH 2

The information you are being asked to provide is authorized to be collected under Section 301 of The Public Health Service Act (42 USC 241). Providing this information is voluntary. CDC will use this information in its study, *Feeding My Baby and Me (also known as the Infant Feeding Practices Study III)*, in order to learn more about the choices mothers make in feeding their babies and toddlers in the first 2 years of life. This information will support efforts to improve the health of our nation's children. This information will be shared with a contractor, Westat, with which CDC has entered into an agreement to assist with carrying out this study.

Public reporting burden of this collection of information varies from 2 to 24 minutes with an average of 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-***xxxx***)

DEMOGRAPHICS

A9. Are you currently {CHILD'S NAME} caregiver?

- Yes (GO TO A29)
- No

A10.Does {CHILD'S NAME} currently live with you?

- Yes
- No

[IF A9 AND A10 = NO, END SURVEY, MAY BE ELIGIBLE FOR FUTURE SURVEYS. SHOW SURVEY INELIGIBILITY SCREEN AND THEN END SURVEY.]

[START SURVEY INELIGIBILITY SCREEN]

We're sorry, you are not eligible to complete this survey if you are not currently the study child's caregiver and the child doesn't live with you. We will check back with you to see if you are eligible for study surveys in the future. Thank you.

[END SURVEY INELIGIBILITY SCREEN]

A29. Have you moved out of the United States?

- Yes
- No

FEEDING

Foods Your Baby Eats

[PROGRAMMER: LIST EACH REPETITION OF INSTRUCTIONS AND THE GRID THAT FOLLOWS THOSE INSTRUCTIONS ON A SEPARATE PAGE]

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Breast milk and infant formula	Feedings per day	Feedings per week
Breast milk at your breast		
Breast milk in a bottle/cup		
Infant formula		

[IF INFANT FORMULA ENDORSED IN FFQ] In the past week, about how many ounces of infant formula did your baby drink at each feeding?

- 1 to 2
- 3 to 4
- 5 to 6
- 7 to 8
- More than 8

In the past 7 days, how often was {CHILD'S NAME} fed each beverage listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the beverage once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the beverage less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the beverage at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Beverages	Feedings per day	Feedings per week
Water: include tap, bottled, or unflavored sparkling water		
100% pure fruit juice or 100% pure vegetable juice		
Regular soda or pop that contains sugar. Don't include diet soda or diet pop		
Sweetened fruit drinks such as Kool-Aid, lemonade, sweet tea, Hi-C, cranberry cocktail, Gatorade, or flavored milk (e.g., chocolate, strawberry, vanilla)		
Unsweetened cow's milk (includes milk added to foods such as cereals)		
Unsweetened other milk such as soy milk, rice milk, or goat milk.		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.

- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Grains	Feedings per day	Feedings per week
Baby cereal		
Infant snacks (includes baby puffs, melts, or teething biscuits)		

Cb1. Did {CHILD'S NAME} have any other foods in the past week?

- Yes
- No (GO TO C13)

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Grains	Feedings per day	Feedings per week
Hot or cold cereal (do not include baby cereal)		
Rice, pasta, breads (includes, rice, pasta, toast, rolls, bagels, cornbread, tortillas, bread in sandwiches, pancakes, waffles, crackers, etc.)		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Meats and Other Protein Foods	Feedings per day	Feedings per week
Meat (not processed): chicken, turkey, pork, beef, or lamb		
Processed meat: baby food meats, combination dinners, bacon, ham, lunch meats, hot dogs, etc.		
Fish or shellfish		
Eggs		
Beans: Refried beans, black beans, white beans, baked beans, beans in soup, pork and beans, or any other cooked dried beans. Don't include green beans.		
Peanut butter, other peanut foods, or nuts		
Soy foods: tofu, frozen soy desserts, etc.		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Fruits and Vegetables	Feedings per day	Feedings per week
Fruits: fresh, frozen, or canned, pureed baby food, or in squeezable pouches. Don't include juice.		
Potatoes: baked, boiled, or mashed potatoes, or sweet potatoes		
Fried potatoes including French fries, home fries, or hash browns		
Green leafy vegetables: spinach, kale, collards, lettuce, or other green leafy vegetables		
Other vegetables: fresh, frozen, or canned, or in squeezable pouches (other than green leafy or lettuce salads, potatoes, or cooked dried beans)		
Tomato sauces: Mexican-type salsa with tomato, spaghetti noodles with tomato sauce, or mixed into foods such as lasagna (do not include tomato sauce on pizza)		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Dairy	Feedings per day	Feedings per week
Cheese: all types (include cheese as a snack, on a sandwich, or in foods such as lasagna, quesadillas, or casseroles). Do not count cheese on pizza		
Other dairy products, such as pudding or yogurt. Don't include sugar free or plain kinds		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Sweets and Desserts	Feedings per day	Feedings per week
Ice cream or other frozen dairy desserts, such as frozen yogurt and sherbet. Don't include sugar free kinds		
Sugar free frozen dairy desserts or sugar free pudding, plain or sugar free yogurt, or other sugar free dairy products		
Sweet foods: candy, cookies, cake, doughnuts, muffins, pop-tarts, etc. Don't count frozen or sugar free desserts		

In the past 7 days, how often was {CHILD'S NAME} fed each food listed below? Include feedings by everyone who feeds the baby and include snack and night time feedings.

Fill in only one column for each item.

- If **{CHILD'S NAME}** was fed the food once a day or more, enter the number of feedings per day in the first column.
- If **{CHILD'S NAME}** was fed the food less than once a day, enter the number of feedings per week in the second column.
- If **{CHILD'S NAME}** was not fed the food at all during the past 7 days, fill in 0 in the second column.

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER LINE, EITHER FEEDINGS PER DAY OR FEEDINGS PER WEEK]

Snacks and Other Foods	Feedings per day	Feedings per week
Pizza: frozen pizza, fast food pizza, homemade pizza, or other pizza		
Snacks such as potato chips, corn chips, pretzels, or popcorn		

C13. [ASK ONLY IF BREAST MILK FROM BREAST AND BREAST MILK FROM BOTTLE/CUP ENDORSED IN FFQ] Babies might drink breast milk from the breast, a bottle, or a cup. Which of the following best describes how {CHILD'S NAME} was drinking breast milk in the past week.

- Mostly at the breast but some breast milk from a bottle or cup
- About half at the breast and half from a bottle or cup
- Some at the breast but most from a bottle or cup

C49. During the past week, how was your baby's bottle, and all bottle parts, usually cleaned before being used again?

- Rinsed with cold/lukewarm water only
- Washed with soap and water
- Washed in a dishwasher (does not include the heated drying cycle in the dishwasher, also called the sanitize cycle)
- Boiled or sterilized (e.g., using a steam-bag in the microwave or the heated drying cycle in the dishwasher, also called the sanitize cycle)
- Not cleaned between uses - used to feed without rinsing or washing
- I did not use a bottle in the past week (GO TO A25)

C50. During the past week, how often have you heated your baby's bottle of infant formula or breast milk in a microwave oven?

- Rarely or never
- Sometimes, but less than half the time
- About half the time
- Most of the time

A25. In the past month, did you ever add anything, such as water, to breast milk or formula to make it last longer? For formula, this means adding more water to formula than the instructions suggest.

- Yes
- No (GO TO E3)

A26. In the past month, how often did you add anything, such as water, to breast milk or formula to make it last longer? For formula, this means adding more water to formula than the instructions suggest.

- At least once per day
- Multiple times per week
- Once per week
- Less than once per week
- One time in the past month

Feeding Breast Milk

The following questions are about feeding your baby breast milk.

E3. [DO NOT ASK IF ANSWERED YES PREVIOUSLY OR BREAST MILK ENDORSED IN FFQ. CODE YES AND CONTINUE TO D14] Did you ever feed {CHILD'S NAME} breast milk, either from your breast or a bottle?

- Yes
- No (GO TO E22)

D14. How comfortable would you be in the following situations?

	Very comfortable	Somewhat comfortable	Neither comfortable nor uncomfortable	Somewhat uncomfortable	Very uncomfortable
Nursing your baby in in a public location that is not private (like a park, zoo, car, airport, or non private work setting)					
Pumping in a public location that is not private (like a park, zoo, car, airport, or non private work setting)					

C15. In the past month, did any of the following things happen?

	Yes	No
My baby had trouble sucking or latching on		
My baby wouldn't wake up or wasn't interested in nursing regularly enough		
My baby didn't gain enough weight or lost too much weight		
I didn't have enough milk		
I had breast problems (e.g., sore nipples, overfull, infection, clogged milk duct, etc.)		
I was sick or had to take medicine		
I had another problem		

E4. [DO NOT DISPLAY IF ANSWERED WITH DATE IN PREVIOUS SURVEY] How old was {FILL: HE/SHE} when {FILL: HE/SHE} was first fed directly at your breast? (Day 0 is the day your baby was born)

My baby first fed at my breast at___ days OR ___ weeks OR ___ months

OR

- My baby has never fed directly at my breast (GO TO E10)

E5. [ASK IF E4 FROM CURRENT OR PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Has {CHILD'S NAME} stopped directly feeding at your breast?

- Yes
- No (GO TO E10)

E6. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped feeding directly from your breast? Do not answer about pumped or expressed milk. You will be asked about that later. (Day 0 is the day your baby was born)

My baby completely stopped feeding at my breast at ___ days OR ___ weeks OR ___ months"

E7. What were the two most important reasons for your decision to stop feeding your baby directly at your breast?

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER COLUMN, DO NOT ALLOW BOTH COLUMNS CHECKED FOR SAME LINE]

	Most important reason	Second most important reason
My baby had trouble sucking or		

latching on		
I wanted or needed someone else to feed my baby		
Breast milk alone did not satisfy my baby		
I wanted my body back to myself		
I was sick or had to take medicine		
I could not breastfeed while working or going to school		
I was pregnant		
Other reason		

[PROGRAMMER: DISPLAY E10 AND E15 ON SAME SCREEN]

These next questions are about pumped or hand-expressed breast milk.

E10. [DO NOT DISPLAY IF ANSWERED WITH DATE IN PREVIOUS SURVEY] How old was {FILL: HE/SHE} when you first pumped your breast milk? (Day 0 is the day your baby was born)

I first pumped my breast milk at___ days OR ___ weeks OR ___ months

OR

- I have never pumped my breast milk

E15. [DO NOT DISPLAY IF ANSWERED WITH DATE IN PREVIOUS SURVEY] How old was {FILL: HE/SHE} when you first fed your baby pumped or hand-expressed breast milk? (Day 0 is the day your baby was born)

I first gave my baby pumped or hand-expressed breast milk at___ days OR ___ weeks OR ___ months

OR

- I have never given my baby pumped or hand-expressed breast milk

[IF E10 = NEVER PUMPED, SKIP TO E16]

C19. Are you currently pumping breast milk on a regular schedule?

- Yes
- No

C20. In the past week, how many times did you pump breast milk?

__ Times in past week

[IF C20 = 0, GO TO E11]

D17. What were the two most important reasons why you have you pumped or hand-expressed milk in the past week?

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER COLUMN, DO NOT ALLOW BOTH COLUMNS CHECKED FOR SAME LINE]

	Most important reason	Second most important reason
To maintain or increase my milk supply		
To get milk for someone else to feed to my baby when I needed to be away from my baby		
My nipples were too sore to nurse		
My baby and/or I had difficulty establishing latch		
To help other caregivers (e.g., family members) bond with my baby		
To help my baby learn how to use and/or accept a bottle		
To help estimate how much my baby was drinking		
I was sick or had to take medicine		

The next three questions refer to how often you rinse, wash, and sanitize your breast pump kit (not including tubing).

C24a. In the past week, how often did you rinse your pump kit (not including tubing)? This includes rinsing under running water without using soap.

- After each use
- After every 2-3 uses
- Less often than every 2 – 3 uses
- I did not rinse my pump kit this past week

C24b. In the past week, how often did you wash your pump kit (not including tubing)? This includes handwashing with soap and water or cleaning in a dishwasher. Please do not include washing in the dishwasher using the heated drying cycle (also called sanitize cycle). You will be asked about that later.

- After each use
- After every 2-3 uses
- Less often than every 2 – 3 uses
- I did not wash my pump kit this past week

C24c. In the past week, how often did you sanitize your pump kit (not including tubing)? This includes boiling, steaming (e.g., using a steam-bag in the microwave), or by washing in the dishwasher using the heated drying cycle (also called sanitize cycle).

- After each use
- After every 2-3 uses
- Less often than every 2-3 uses
- I did not sanitize my pump kit this past week

E11. [ASK IF E10 FROM CURRENT OR PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Have you stopped pumping or hand-expressing breast milk?

- Yes
- No (GO TO E16)

[IF E11 = VALID SKIP, SKIP TO E16]

E12. How old was {CHILD'S NAME} when you completely stopped pumping or hand-expressing breast milk? (Day 0 is the day your baby was born). Do not answer about feeding your baby your pumped breast milk. You will be asked about that later.

I completely stopped pumping or hand-expressing my breast milk at___ days OR ___ weeks OR ___ months

E13. What were the two most important reasons for your decision to stop pumping or hand-expressing breast milk?

[PROGRAMMER: ONLY ALLOW ONE RESPONSE PER COLUMN, DO NOT ALLOW BOTH COLUMNS CHECKED FOR SAME LINE]

	Most important reason	Second most important reason
Pumping milk no longer seemed worth the effort it required		
Too many challenges related to pumping at work or school		
Pumping supplies cost too much		
I was not getting enough pumped milk		
I had enough milk stored to reach my breastfeeding goal		
I was pregnant		
I was sick or had to take medicine		
Other reason		

E16. [ASK IF E15 FROM CURRENT OR PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Have you stopped feeding your baby pumped or expressed breast milk?

- Yes
- No (GO TO E22)

[IF E16 = VALID SKIP, GO TO E19]

E17. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped being fed any pumped or expressed breast milk? Do not answer about feeding directly at your breast. (Day 0 is the day your baby was born)

My baby completely stopped being fed pumped or expressed breast milk at___ days OR ___ weeks OR ___ months

E19. [IF E4 OR E15 HAVE DATE IN ANY SURVEY AND E5 ≠ NO AND E16 ≠ NO, ASK E19. ONCE ANSWERED, DO NOT ASK AGAIN IN FUTURE SURVEYS] Did you feed your baby breast milk (at the breast or pumped/expressed milk) as long as you wanted?

- Yes
- No

Feeding Formula

These next questions are about feeding your baby infant formula.

E22. [DO NOT ASK IF E22 = YES IN A PREVIOUS SURVEY; IF FORMULA ENDORSED IN FFQ CODE YES AND CONTINUE TO E23] Did you ever feed {CHILD'S NAME} infant formula?

- Yes
- No (GO TO C26)

E23. [DO NOT DISPLAY IF ANSWERED WITH DATE IN PREVIOUS SURVEY] How old was {FILL: HE/SHE} when {FILL: HE/SHE} was first fed infant formula? (Day 0 is the day your baby was born)

My baby was first fed infant formula at___ days OR ___ weeks OR ___ months

Solid foods

These next questions are about introducing your baby to solid foods.

C26. How old was {CHILD'S NAME} when {FILL: HE/SHE} was first fed solid foods? Please include any foods such as infant cereal, fruit, vegetables, meat or other foods, even if it was just a small amount fed from a spoon, a bottle or your hands. The first solid food means the first time your baby had any food other than breast milk or infant formula.

- ____ Weeks **[HAVE A DROP DOWN OPTION FOR LESS THAN ONE WEEK ALL OTHER RESPONSES ARE WRITE-IN]**
  [NOTE TO PROGRAMMER – DO NOT ALLOW FOR OPTIONS THAT ARE OLDER THAN CHILD'S AGE AT TIME OF SURVEY]
- I have not yet fed my baby solid foods (GO TO D20)

C27. What was the first solid food you fed {CHILD'S NAME}? The first solid food means the first time your baby had any food other than breast milk or infant formula. This can also include anything added to the bottle.

- Infant rice cereal
- Infant cereal (not rice)
- Fruits
- Vegetables
- Meats
- Other food
- I fed my baby several different foods mixed together

D20. [DO NOT DISPLAY IF ANSWERED WITH DATE IN C26] How old do you think {CHILD'S NAME} will be when you start introducing solid foods for the very first time? Solid foods are foods such as cereal, baby foods, or table food.

- 3 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months or older

HEALTH AND LIFESTYLE

A30. WIC is a nutrition and health program for Women, Infants, and Children. WIC benefits include food, checks or vouchers for food, health care referrals, and nutrition education. Did you ever get WIC food or vouchers for yourself or your baby?
Please select all that apply.

- Yes, during pregnancy, I got WIC food for myself.
- Yes, after I had my baby, I got WIC food for myself.
- Yes, my baby got WIC formula.
- No

H6. What kind of birth control are you or your spouse/partner using now?

Select all that apply.

- Hormonal IUD (Mirena®, Skyla®, Kyleena®, Liletta®)
- Implant (Nexplanon®)
- Shot (Depo-Provera®)
- Progestin-only pill (e.g. mini-pill)
- Combined contraception (e.g. combined pill, patch [OrthoEvra®] or vaginal ring [NuvaRing®])
- Non hormonal method (for example permanent sterilization [e.g., tubes tied, Essure®, vasectomy], copper [non-hormonal] IUD, condoms, not having sex at certain times [rhythm method or natural family planning], withdrawal [pulling out], diaphragm, cervical cap, sponge, not having sex, no method, not applicable [e.g. hysterectomy, same-sex partner])

H7. [IF H6 = ANY OF THE FIRST FIVE RESPONSES] When did you start this type of birth control?

I started my birth control at _____ days OR_____ weeks after my baby was born (day 0 is the day your baby was born).

H13. It is not easy being a new mother, and it is OK to feel unhappy at times. As you have recently had a new baby, we would like to know how you are feeling. Please select the answer which comes closest to how you have felt during the past week, not just how you are feeling today.

H13a. 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 so much now
- Not at all

H13b. 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

H13c. I have blamed myself unnecessarily when things went wrong.

- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

H13d. I have been anxious or worried for no good reason.

- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

H13e. I have felt scared or panicky for no good reason.

- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

H13f. Things have been getting to me

- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

H13g. I have been so unhappy that I have had difficulty sleeping.

- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

H13h. I have felt sad or miserable.

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

H13i. I have felt so unhappy that I have been crying.

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

H13j. The thought of harming myself has occurred to me.

- Yes, quite often
- Sometimes
- Hardly ever
- Never

PROGRAMMER IF H13J = YES OR SOMETIMES, SHOW REFERRAL SCREEN THAT INCLUDES INFORMATION FOR A HOTLINE. IF H13J = HARDLY EVER OR NEVER, GO TO H23.

[START REFERRAL SCREEN]

Being a mother of a newborn can be difficult. If you need someone to talk to, there is help available. The resources listed below can help you through a confidential phone conversation or internet chat for free, 24 hours per day, 7 days per week.

{LIST OF RESOURCES TO COME, clickable phone number and URL for chat such as National Suicide Prevention Lifeline or Kristin Brooks Hope Center}

If you click on the links above you will leave the survey and be connected with the hotline. We'll save your answers and your place on the survey and you can come back later to finish. If you want to talk with someone, but not right now, just click "NEXT" and we'll show these links again at the end of the survey.

[END REFERRAL SCREEN]

H23. Which of the following problems did your baby have during the past month? (Check Yes/No for each item)

	Yes	No
Fever		
Diarrhea or vomiting		
Ear infection		
Severe respiratory infection (e.g., pneumonia, bronchiolitis)		
Wheeze		
Eczema (atopic dermatitis)		
COVID-19		

C45. Which of the following was your baby given in vitamin or mineral drops at least 3 days a week during the past week? If your baby was given drops or pills that contained more than one of the items listed, please mark each of the separate items.

- Iron
- Vitamin D
- Other vitamins
- None of these **[PROGRAMMER: DO NOT ALLOW 'None of these' TO BE CHECKED ALONG WITH ANY OTHER OPTIONS]**

[PROGRAMMER: DISPLAY CONTACT INFORMATION SECTION. ONCE CONTACT INFORMATION SECTION IS COMPLETE, DISPLAY REFERRAL SCREEN]

[START REFERRAL SCREEN]

Being a mother of a newborn can be difficult. If you need someone to talk to, there is help available. The resources listed below can help you through a confidential phone conversation or internet chat for free, 24 hours per day, 7 days per week.

{LIST OF RESOURCES TO COME, clickable phone number and URL for chat such as National Suicide Prevention Lifeline or Kristin Brooks Hope Center}

If you click on the links above you will leave the survey and be connected with the hotline.

[END REFERRAL SCREEN]