

## IFPS-3: MONTH 3

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}'s 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.

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

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

**[IF >0 FOR INFANT FORMULA]** 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.

- o If {CHILD'S NAME} was fed the beverage once a day or more, enter the number of feedings per day in the first column.
- o If {CHILD'S NAME} was fed the beverage less than once a day, enter the number of feedings per week in the second column.
- o If {CHILD'S NAME} was not beverage 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]**

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.

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

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

- o If {CHILD'S NAME} was fed the food once a day or more, enter the number of feedings per day in the first column.
- o If {CHILD'S NAME} was fed the food less than once a day, enter the number of feedings per week in the second column.
- o 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]	Feedings per day	Feedings per week
<b>Fruits and Vegetables</b>		
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.

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

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

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

**C14. [ASK IF BREAST MILK FROM BOTTLE/CUP ENDORSED IN FFQ]** In the past week, if {CHILD'S NAME} started a bottle but did not finish it, what did you usually do with the remaining breast milk?

- I fed the remaining breast milk but only if it was within two hours of starting the bottle
- I fed the remaining breast milk but more than two hours after starting the bottle
- I threw any remaining breast milk away
- Not applicable, I did not feed my baby any breast milk from a bottle

**C97. [ASK IF BREAST MILK FROM BOTTLE/CUP ENDORSED IN FFQ]** How often does {CHILD'S NAME} drink all of his or her cup or bottle of pumped milk?

- Never
- Rarely
- Sometimes
- Often
- Always

**C98. [ASK IF INFANT FORMULA ENDORSED IN FFQ] How often does {CHILD'S NAME} drink all of his or her cup or bottle of formula?**

- Never
- Rarely
- Sometimes
- Often
- Always

### **Feeding Breast Milk**

These next questions are about feeding your baby breast milk.

**E5. [ASK IF E4 FROM 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



**E8. 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]**

	<b>Most important reason</b>	<b>Second most important reason</b>
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		
My baby lost interest in nursing or began to wean himself or herself		
I was pregnant		
Other reason		

**[PROGRAMMER: DISPLAY E10 AND E15 ON THE SAME SCREEN]**

**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

**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 {FILL: HE/SHE} 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 C16)

**[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? (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

**C16. In the past month, did you do any of the following actions to help you continue breastfeeding?**

	Yes	No
Took herbal teas or supplements to help boost milk supply, relieve pressure/engorgement, or other reasons		
Changed your diet in some way to help boost milk supply		
Took prescription medications to help boost milk supply		
Breastfed more frequently		
Pumped, or hand expressed, more frequently		
Changed routines or schedule to accommodate breastfeeding		

**[ONLY ASK D35 - D38 IF STILL BREASTFEEDING (E5 OR E16 = NO)]**

**D35. Shortly after {CHILD'S NAME} was born, you told us that you thought {FILL: HE/SHE} would be [FILL RESPONSE FROM D13, M1] months old when you would completely stop breastfeeding or feeding him or her pumped/expressed breast milk. Is that still what you think you will do?**

- Yes (GO TO D33)
- No

**D36. How old do you think {CHILD'S NAME} will be when you completely stop breastfeeding or feeding {FILL: HIM/HER} pumped/expressed breast milk?**

\_\_\_\_\_ Months (drop down)

**D37. [IF intention changed AND it INCREASED] Which reason best describes why you decided to breastfeed your baby longer? [Select one]**

- It was easier than I had thought it would be.
- I enjoy spending the time with my baby.
- I have a better understanding of the benefits to my baby's health.
- I have a better understanding of the benefits to my own health.
- My family encouraged me to breastfeed for longer.
- My healthcare provider encouraged me to breastfeed for longer.
- I changed jobs or stopped working so now can breastfeed longer than planned.
- Other reason
- No reason, I just wanted to continue

**D38. [IF intention changed AND it DECREASED] Which reason best describes why you decided to breastfeed your baby for a shorter amount of time? [Select one]**

- A healthcare provider says I should not breastfeed longer for medical reasons
- My family does not want me to breastfeed for any longer
- I am returning to work or school
- My baby has trouble sucking or latching on
- I want or need someone else to feed my baby
- Breast milk alone does not satisfy my baby
- I want my body back to myself
- I am sick or have to take medicine
- My baby has lost interest in nursing or is beginning to wean himself or herself
- I am pregnant
- Other reason
- No reason, I just don't think I'm going to breastfeed as long

## Feeding Formula

The next questions are about infant formula.

D33. Since you brought {CHILD'S NAME} home from the hospital or birth center, did a doctor or nurse tell you how to prepare infant formula?

- Yes
- No

D34. Since you brought {CHILD'S NAME} home from the hospital or birth center, did a doctor or nurse tell you how to store the prepared bottles of infant formula?

- Yes
- No

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

D8. [ASK ONLY IF BREAST MILK AND FORMULA ENDORSED IN FFQ] What were the two most important reasons for feeding your baby infant formula in addition to breastfeeding?

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

	Most important reason	Second most important reason
I believe that breast milk and formula together are the best for the baby		
I did not have enough breast milk		
I went back to work or school		
A health professional thought I should		

My baby had jaundice		
I was sick or had to take medicine		
Other reason		

**C6. In the past week, what type of infant formula is {CHILD'S NAME} usually fed?**

- Liquid Ready to feed (no water added)
- Liquid concentrate (water added)
- Powder from a can that makes more than one bottle (water added)
- Powder from single serving packs (water added)

**C8. [IF C6 ≠ LIQUID READY TO FEED] Was the water you used to mix the infant formula:**

- Boiled and cooled before adding infant formula
- Boiled and added to the infant formula then cooled
- Not applicable, I don't use boiled water

**C9. In the past week, if {CHILD'S NAME} started a bottle but did not finish it, what did you usually do with the remaining formula?**

- I fed the remaining formula but only if it was within one hour
- I fed the remaining formula but more than one hour afterwards
- I threw any remaining formula away

**C10. In the past week, how long were bottles of newly prepared infant formula usually kept at room temperature before feeding them to your baby?**

- I do not keep prepared formula bottles at room temperature
- Less than 1 hour
- 1 to 2 hours
- More than 2 hours
- I don't know

### **Solid Foods**

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

**C26. [ONCE ANSWERED WITH ANYTHING OTHER THAN "I HAVE NOT YET FED MY BABY SOLID FOODS," DO NOT ASK AGAIN] 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.

\_\_\_\_ Months **[HAVE A DROP DOWN OPTION FOR LESS THAN ONE MONTH 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 (SKIP TO D20)

**C27. [ONCE ANSWERED, DO NOT ASK AGAIN] 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

### **Feeding Practices and Beliefs**

The following two statements are things that parents may do. Please indicate how often you do each of the following:

**C71. I talk to {CHILD'S NAME} to encourage {FILL: HIM/HER} to drink {FILL: HIS/HER} formula or breast milk.**

- Never
- Seldom
- Half of the time
- Most of the time
- Always

**C79. I try to get {CHILD'S NAME} to finish {FILL: HIS/HER} breast milk or formula.**

- Never
- Seldom
- Half of the time

- Most of the time
- Always

Please indicate how much you agree or disagree with the following statement.

**C83. It is important for parents to decide how much an infant should eat.**

- Disagree
- Slightly disagree
- Neutral
- Slightly agree
- Agree

**Eating Behavior**

The following statements are about eating behaviors. For each statement, please select the response that most closely reflects {CHILD'S NAME}'s eating behavior.

	Never	Rarely	Sometimes	Often	Always
C91. If allowed to my baby would take too much milk.					
C92. My baby is always demanding a feed.					
C93. Even when my baby has just eaten well, s/he was happy to feed again if offered.					
C94. My baby got full up easily.					
C95. My baby got full before taking all the milk I though s/he should have.					
C96. My baby found it difficult to manage a complete feed.					

**HEALTH AND LIFESTYLE**

**H26a. How much did {CHILD'S NAME} weigh the last time {FILL: HE/SHE} was weighed at a doctor's visit?**

\_\_\_\_\_ pounds \_\_\_\_\_ ounces



**H26b. What was the date of those measurements?**

\_\_\_\_\_ month \_\_\_\_\_ day

**H26c. How long was {CHILD'S NAME} the last time {FILL: HE/SHE} was measured at a doctor's visit?**

\_\_\_\_\_ inches

**H26d. What was the date of those measurements?**

\_\_\_\_\_ month \_\_\_\_\_ day

**H4. On average, how many cigarettes do you smoke a day now?**

\_\_\_\_\_ CIGARETTES PER DAY

- Do not smoke

**H5. Not including yourself, how many people smoke inside your home most days? (Include both people living in your home and guests)**

- 0
- 1
- 2
- 3
- 4 or more

**H20. Are you currently pregnant?**

- Yes **[IF YES SKIP TO H25]**
- No

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

*Select all that apply.*

- Hormonal IUD (Mirena<sup>®</sup>, Skyla<sup>®</sup>, Kyleena<sup>®</sup>, Liletta<sup>®</sup>)
- Implant (Nexplanon<sup>®</sup>)
- Shot (Depo-Provera<sup>®</sup>)
- Progestin-only pill (e.g. mini-pill)
- Combined contraception (e.g. combined pill, patch [OrthoEvra<sup>®</sup>] or vaginal ring [NuvaRing<sup>®</sup>])
- Non hormonal method (for example permanent sterilization [e.g., tubes tied, Essure<sup>®</sup>, 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])

**H25. In the past three months, did {CHILD'S NAME} take any antibiotics?**

- Yes
- No
- Don't know

**H31. Where does {CHILD'S NAME} USUALLY go when {FILL: HE/SHE} needs routine preventive care, such as a physical examination or well-child check-up?**

- Doctor's office
- Hospital emergency room
- Hospital outpatient department
- Clinic or health center (such as a walk-in clinic or a community, free, or low-cost clinic)
- Retail store clinic or "minute clinic" (such as clinics in supermarkets or pharmacies)
- Some other place
- My child does not have a usual source of routine preventive care

**[PROGRAMMER: DISPLAY CONTACT INFORMATION SECTION]**