Form Approved
OMB No. 0920-1333
Exp. Date 4/30/2024

Feeding My Baby and Me: IFPS-III: MONTH 15

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.

DEMOGRAPHICS

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

- Yes (GO TO A29)
- No

[IF A9 = 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. 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

A20. What type of health insurance coverage does {CHILD'S NAME} have?

Select all that apply.

- Private (e.g., Aetna, Blue Cross/Blue Shield, Tricare)
- Public (e.g., Medicaid, S-CHIP, Indian Health Service)
- Other
- Don't know
- None, my child does not have health insurance coverage

FEEDING

Foods Your Child 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 child 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		
Toddler milk (includes follow up		

formula or toddler formulas)		

[IF INFANT FORMULA >0] In the past week, about how many ounces of infant formula did your child 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 child 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
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		

C55. How many times does {CHILD'S NAME} eat (such as breakfast, lunch, dinner, or snacks) on a normal day?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8 or more

C51a. Has {CHILD'S NAME} stopped drinking anything from a bottle?

- Yes
- No, my child is still drinking from a bottle (GO TO E5)
- My child never drank anything from a bottle (GO TO E5)

C51b. How old was {CHILD'S NAME} when {FILL: HE/SHE} stopped using a bottle?

Weeks____ Months _____ Years _____

<u>Feeding Breast Milk</u>

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 E11)

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 child was born)

My child 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 child 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
I wanted or needed someone else to feed my child		
Breast milk alone did not satisfy my child		
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 child lost interest in nursing or began to wean himself or herself		
I was pregnant		
Other reason		

E11. [ASK IF E10 FROM 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 child was born). Do not answer about feeding your child 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 PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Have you stopped feeding your child pumped or expressed breast milk?

- Yes
- No (GO TO E24)

[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 child was born)

My child 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 child breast milk (at the breast or pumped/expressed milk) as long as you wanted?

- Yes
- No

Feeding Formula

E24. [ASK IF E23 INCLUDES DATE FROM PREVIOUS SURVEY AND R HAS NOT ALREADY ANSWERED YES] Has {CHILD'S NAME} stopped being fed infant formula?

- Yes
- No (GO to G3)

E25. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped being fed infant formula? (Day 0 is the day your child was born)

My child completely stopped feeding infant formula at ___ days OR ___ weeks OR ___ months

E26. What were the two most important reasons for your decision to stop feeding {CHILD'S NAME} infant formula?

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

	Most important reason	Second most important reason
My child started drinking other milk(s) (such as cow's milk, soy milk, rice milk, or goat's milk)		
My child started drinking other drinks (such as water, juice, sweetened fruit drinks, or soda or pop)		
I fed my child my breast milk		
I fed my child breast milk from someone else		
My doctor told me to stop		
I thought it was time to be done		
Other reason		

EMPLOYMENT AND CHILD CARE

G3. Was {CHILD'S NAME} cared for by someone other than you or your partner on a regular schedule during the past month? That is, did someone else usually keep your child at least once a week for three or more hours at a time?

Include arrangements in which the exact day or time may change if the child care usually occurred at least once a week.

- Yes
- No (GO TO G3A)

G4. Where did your usual child care occur? (Please select one. If you have more than one, please select the one you use the most often)

- A daycare center
- An in-home daycare
- In a private home (this includes your own home)

G5. How many days in an average week was {CHILD'S NAME} cared for by your regularly scheduled child care provider(s)? (Include days your child was cared for by family members if they regularly provide child care while you are away from the child.)

_____ DAYS PER WEEK

G6. On an average day while {CHILD'S NAME} was with your child care provider, how many meals or snacks did {CHILD'S NAME} have?

Please include breast milk, formula, and all other foods, and include meals and snacks.

_____ Number PER DAY FED BABY

G36. [PROGRAMMER: ONLY DISPLAY IF G4 = A DAYCARE CENTER OR AN IN-HOME DAYCARE] Does your child care provider currently:

	Yes	No	Don't know
Serve a fruit or vegetable at every meal			
Have water for children to drink available at all times			
Give sugary drinks (e.g., juice, flavored milks, sweetened fruit drinks, soda or pop)			
Have active play time every day			

G8. Under your regular child care arrangements in the past month, who usually provided {CHILD'S NAME}'s food?

- You, the mother
- The child care provider
- Someone else

G3A. In the past month, was your regular childcare arrangement disrupted due to the COVID-19 pandemic?

- Yes
- No

G28. Are you currently attending school?

- Yes, full-time
- Yes, part-time
- No

G23. Are you currently working for pay?

- Yes, currently working for pay
- No, not currently working for pay (GO TO G20)

G23A. In the past month, have you been working from home?

- Yes, I only work at home
- Yes, I work both at home and outside the home
- No, I only work outside the home

G24. [ONCE ANSWERED, DO NOT ASK AGAIN] How old was {CHILD'S NAME} when you began working after your delivery?

_____ days or _____ weeks or _____ months

G25. How many hours per week did you usually work for pay at your job during the past month? (Answer for whatever time you have been working if less than 1 month. If you work at two or more jobs, answer for the total number of hours you work.)

- 1 to 9 hours per week
- 10 to 19 hours per week
- 20 to 29 hours per week
- 30 to 34 hours per week
- 35 to 40 hours per week
- More than 40 hours per week

G20. Thinking of work leave that you had available for maternity leave, how many weeks did you use? (Select the number of weeks of leave you used in each of the categories listed below. If you did not use parental leave, select 0 in all.)

[PROGRAMMER: FOR EACH RESPONSE CREATE DROP DOWN SELECTION, 0, LESS THAN 1, 1 TO 52, MORE THAN 52]

__ weeks of fully paid parental leave

__ weeks of fully paid sick leave/vacation time

__ weeks of partially paid leave

__ weeks of unpaid leave

- I did not take any leave

G21. [ASK IF A16 FROM PRENATAL INTERVIEW=NOW MARRIED OR DOMESTIC PARTNERSHIP] Thinking of work leave that your spouse/partner had available, how many weeks did your spouse/partner use? (Select the number of weeks of leave your spouse/partner used in each of the categories listed below. If your partner/spouse did not use parental leave, select 0 in all.)

[PROGRAMMER: FOR EACH RESPONSE CREATE DROP DOWN SELECTION, 0, LESS THAN 1, 1 TO 52, MORE THAN 52]

__ weeks of fully paid parental leave

__ weeks of fully paid sick leave/vacation time

__ weeks of partially paid leave

__ weeks of unpaid leave

- My spouse/partner did not take any leave

- I don't currently have a spouse/partner

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 month and year 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 month and year of those measurements?

_____ month _____ day

H30. Currently, would you describe {CHILD'S NAME} as overweight, normal weight or thin?

- Overweight
- Normal weight
- Thin

H24. Which of the following problems did your child have during the past month?

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

G26. How many days in the past month did you or another caregiver (e.g., the child's father) miss work because your child was sick?

_____ days

H10. What is your weight now?

_____

H20. Are you currently pregnant?

- Yes
- No

[PROGRAMMER: DISPLAY CONTACT INFORMATION SECTION]

CONTACT INFORMATION SCREEN

1-MONTH SURVEY AND ONWARDS:

Thank you very much for completing the survey! Please take a moment to review your information and update as needed.

We can provide you with a link for $X immediately after you complete this survey or mail you a check. Which would you prefer?

Preference for receiving the money for the survey:

O Check [PROGRAMMER: IF CHECK IS SELECTED BUT THERE IS NO ADDRESS, DISPLAY MESSAGE "Please enter your mailing address below"]

O Online gift card [PROGRAMMER: IF GIFT CARD IS SELECTED BUT THERE IS NO EMAIL ADDRESS, DISPLAY MESSAGE "Please enter your email address below"]

[PROGRAMMER: PRE-POPULATE ALL CONTACT INFORMATION THAT HAS BEEN PROVIDED ON PREVIOUS SURVEY(S). IF NO INFORMATION HAS BEEN PROVIDED, LEAVE BLANK]

Contact Information

Name*: _____

Cell Phone Number*: _____

Email address*: _____

*Would you **prefer** to receive study information through text or email or both?

Text Email Both Text and Email

*This information is required.

[PROGRAMMER: DISPLAY IF INFORMATION HAS BEEN PRE-POPULATED]

Is this information still correct?

Yes ☐

No ☐ [PROGRAMMER: IF NO, PROVIDE BLANK CONTACT INFORMATION FOR RESPONDENT TO UPDATE]

[PROGRAMMER: MAILING ADDRESS IS ONLY DISPLAYED IF CHECK IS INDICATED ABOVE AND NO MAILING ADDRESS HAS BEEN PROVIDED PREVIOUSLY]

Address 1: _____

Address 2: _____

Zip code: _____

[PROGRAMMER: PRE-POPULATE STATE AND CITY]

Contact Information of someone the study can contact in case we lose touch with you:

Please provide the name and contact information of another person who would always know how to contact you (such as your partner, parent, or friend). We will contact them only if we cannot reach you by email or text. Please let them know they have your permission to share your contact information with the study.

Name: _____

Relationship: Spouse/Partner/Parent/Sibling/Other Relative/Friend

Phone Number: _____

Email address: _____

[IF CHECK: Please look out for a check from Westat in 5 -7 business days IF VIRTUAL GIFT CARD: Please look out for an email or text with a link to your online gift card]. Your next survey will start [NEXT SURVEY START DATE]. We will send you a reminder on that day. Please make sure to update your contact information at this website at any time your phone number or email address changes. Thank you for your continued participation in the Feeding My Baby and Me Study.