

Feeding My Baby and Me: IFPS-III: Month 18

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 (0920-1333)

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

A4. Counting yourself, how many people live in your household? Include all members who live in your household for at least 9 months of the year.

_____ People < 17 years of age

_____ People 18 and older

A6. Which income range category represents the total combined income of all members of your household during the past 12 months? Please include any income from all sources (employment, pensions, social security, etc.).

- Less than \$5,000
- \$5,000 to \$7,499
- \$7,500 to \$9,999
- \$10,000 to \$12,499
- \$12,500 to \$14,999
- \$15,000 to \$19,999
- \$20,000 to \$24,999
- \$25,000 to \$29,999
- \$30,000 to \$34,999
- \$35,000 to \$39,999
- \$40,000 to \$49,999
- \$50,000 to \$59,999
- \$60,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$149,999
- \$150,000 or more

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.

- 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]

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 formulas or toddler formulas)		

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

- 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 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.

- 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.		

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]

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.

- 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		

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		

Feeding 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 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 {FILL: HE/SHE} 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 C66)

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		

Feeding Practices and Beliefs

These next questions are about beliefs you may have about your child and other toddlers.

How much do you agree or disagree with the following statements?

	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree
C66. {CHILD'S NAME} leaves food on {FILL: HIS/HER} plate at the end of meal.					
C67. {CHILD'S NAME} cannot eat a meal if {FILL: HE/SHE} has had a snack just before.					
C68. {CHILD'S NAME} is always asking for food.					
C69. If allowed to, {CHILD'S NAME} would eat too much.					
C84. It is important for parents to have rules for how much a toddler eats					
C85. A toddler should never eat fast food					

The following are statements that parents or children may do. Please indicate how often you or your child do the following:

	Never	Seldom	Half the time	Most of the time	Always
C70. {CHILD'S NAME} lets me know when {FILL: HE/SHE} is full					
C72. I talk to {CHILD'S NAME} to encourage {FILL: HIM/HER} to eat					
C81. I try to get {CHILD'S NAME} to finish {FILL: HIS/HER} food					
C82. I insist {CHILD'S NAME} re-tries new foods that were refused at the same meal					
C88. I allow {CHILD'S NAME} to watch TV while eating if {FILL: HE/SHE} wants					
C89. I allow {CHILD'S NAME} to eat fast food if {FILL: HE/SHE} wants					
C90. I allow {CHILD'S NAME} to drink sugared drinks/soda if {FILL: HE/SHE} wants					
C91. I allow {CHILD'S NAME} to eat desserts/sweets if {FILL: HE/SHE} wants					
C115. I let {CHILD'S NAME} decide how much to eat					
C116. I pay attention when {CHILD'S NAME} seems to be telling me that {FILL: HE/SHE} is full or hungry					
C117. I allow {CHILD'S NAME} to eat when {FILL: HE/SHE} is hungry					

The next questions are about your child's eating behavior. For each statement, please select the response that most closely reflects your child's eating behavior.

	Never	Rarely	Sometimes	Often	Always
C99. My child gets full up easily					
C100. My child gets full before {FILL: HIS/HER} meal is finished					
C101. Even if my child is full up, {FILL: HE/SHE} finds room to eat {FILL: HIS/HER} favorite food					
C102. My child enjoys tasting new foods					
C103. My child enjoys a wide variety of foods					
C104. My child decides that {FILL: HE/SHE} doesn't like food, even without tasting it					

HEALTH AND LIFESTYLE

C46. Which of the following was {CHILD'S NAME} given in vitamin or mineral drops [or pills] or chewables at least 3 days a week during the past week?

	Yes	No
Iron only vitamin		
Vitamin D only vitamin		
Multivitamin		
Other vitamins		

H24. Which of the following problems did {CHILD'S NAME} 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		

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])

[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:

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