

Feeding My Baby and Me: IFPS- III: MONTH 1

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

YOUR BABY'S BIRTH

B14. Did {CHILD'S NAME} have to stay in an intensive care unit immediately after birth?

- Yes, one day or less
- Yes, two days
- Yes, three days **[END SURVEY, INELIGIBLE]**
- Yes, more than three days **[END SURVEY, INELIGIBLE]**
- No

[IF INELIGIBLE START INELIGIBILITY SCREEN]

We're sorry, as we mentioned when you consented to be in the study, moms whose babies spend an extended time in intensive care are not eligible to continue with the study. Thank you for your participation, and our warmest wishes for a happy, healthy future for you and your baby. The incentive payment for this survey will be added to your virtual VISA card as a final thank you for your time.

[END INELIGIBILITY SCREEN, END SURVEY]

B1. Did you have any severe medical problems that prevented you from feeding {CHILD'S NAME} either breast milk or infant formula for 1 week or more following their birth?

- Yes **[END SURVEY, INELIGIBLE]**
- No

[IF INELIGIBLE START INELIGIBILITY SCREEN]

We're sorry, as we mentioned when you consented to be in the study, moms who have a severe medical problem that prevents them from feeding their newborns for 1 week or more are not eligible to continue with the study. Thank you for your participation, and our warmest wishes for a happy, healthy future for you and your baby. The incentive payment for this survey will be added to your virtual VISA card as a final thank you for your time.

[END INELIGIBILITY SCREEN, END SURVEY]

B39. What state is the hospital or birth center where you delivered your baby located?

[PROGRAMMER: SHOW PULL-DOWN WITH STATES AND TERRITORIES]

I did not deliver my baby in a hospital or birth center **(GO TO B9)**

B40. What county is the hospital or birth center where you delivered your baby located?

[PROGRAMMER: SHOW PULL-DOWN WITH COUNTY LIST FROM STATE SELECTED IN B39]

B41. What city is the hospital or birth center where you delivered your baby located?

[PROGRAMMER: SHOW PULL-DOWN WITH CITY LIST FROM STATE SELECTED IN B39]

B8. What is the name of the hospital or birth center where you delivered your baby?

_____ (Open-ended; write in name of hospital)

B9. How was your baby delivered?

- Vaginally and not induced
- Vaginally and induced
- A planned cesarean
- An unplanned or emergency cesarean

B10. What was the main pain medication you had during labor or delivery?

- General anesthesia (you were "put to sleep"); nitrous oxide (laughing gas)
- Other pain medication
- Epidural or spinal pain medications
- Don't know which pain medication
- No pain medication

[PROGRAMMER: DO NOT DISPLAY B12 AND B13 IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER; DISPLAY B12 AND B13 ON THE SAME SCREEN]

B12. How many hours were you in the hospital or birth center after your baby was born?

- Less than 24 hours (less than one day)
- 24-47 hours (At least 1 day but less than 2 days)
- 48-71 hours (At least 2 days but less than 3 days)
- 72-95 hours (At least 3 days but less than 4 days)
- More than 95 hours (4 days or more)

B13. How many hours was {CHILD'S NAME} in the hospital or birth center after {FILL: HE/SHE} was born?

- Less than 24 hours (less than one day)
- 24-47 hours (At least 1 day but less than 2 days)
- 48-71 hours (At least 2 days but less than 3 days)
- 72-95 hours (At least 3 days but less than 4 days)
- More than 95 hours (4 days or more)

Experience after Birth

B19. Holding your baby skin-to-skin means holding your baby's naked body against your skin with no clothing, blanket, or diaper between the two of you. About how long did you hold {CHILD'S NAME} skin-to-skin immediately after delivery? This is before {CHILD'S NAME} was given a bath or any other routine procedures were done.

- Less than 30 minutes
- 30 minutes to an hour
- An hour or more
- I did not hold my baby skin-to-skin right after delivery
- Don't know

B20. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] While you were in the hospital or birth center, did {CHILD'S NAME} stay in your room at least 23 hours per day (sometimes called "Rooming-in")?

- Yes
- No

[IF NO]- Did COVID-19 play a role in this decision?

- Yes
- No
- I don't know

B17. About how long after your delivery did you breastfeed or try to breastfeed {CHILD'S NAME} for the very first time?

- Less than 1 hour
- 1 to 2 hours

- 3 to 5 hours
- 6 hours or more
- I did not try to breastfeed

B31. How long did it take for your milk to come in?

- < 24 hours
- 24 - 47 hours
- 48 - 71 hours
- 72 - 95 hours
- 96 hours
- My milk did not come in

B25. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] While you were in the hospital or birth center, was {CHILD'S NAME} fed any of the following at any time? Please do not include any sugar water that may have occurred during a painful procedure.

	Yes	No	Don't know
Water			
Infant formula			
Sugar water			
Breast milk			

B28. [ASK ONLY IF B25 FORMULA = YES] Why was {CHILD'S NAME} fed infant formula in the hospital?

- I wanted my baby to be fed infant formula
- A nurse, doctor, or other staff recommended it

D6. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] While you were in the hospital or birth center, did a doctor or nurse tell you how to prepare infant formula?

- Yes
- No

D7. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] While you were in the hospital or birth center, did a doctor or nurse tell you how to store the prepared infant formula?

- Yes
- No

B21. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] While you were in the hospital, did you feed {CHILD'S NAME}...

- whenever he or she seemed hungry
- on a schedule or routine
- sometimes on a schedule AND sometimes when he or she seemed hungry

B18. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] While in the hospital or birth center, were you given information about:

	Yes	No	Don't know
Safe sleep practices for infant sleep during hospital stay (e.g., placed on their back and close to caregiver but not in same bed)			
Signs of neonatal jaundice or yellow coloring of skin			
Signs your baby is getting enough milk			
Appropriate urination (pee) and stooling (poop) frequency for infants			
Ways to prevent the spread of infectious illnesses, like COVID-19			

B26. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] While you were in the hospital or birth center, did any of the following people show you how or talk to you about breastfeeding?

	Yes	No
Doctor, nurse practitioner, midwife, staff nurse		
Lactation consultant		

B27. How helpful was the breastfeeding help you received?

PROGRAMMER: ONLY DISPLAY ITEMS SELECTED IN PREVIOUS Q

	Very helpful	Helpful	Somewhat helpful	A little helpful	Not very helpful
Doctor, nurse practitioner, midwife, staff nurse					
Lactation consultant					

B22. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] Before you went home from the hospital or birth center, were you given information about how to contact support groups, peer counselors or other medical or community health services if you had questions about breastfeeding your baby?

- Yes
- No
- Don't know

B30. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] When you left the hospital or birth center, what type of milk was {CHILD'S NAME} receiving?

Select all that apply.

- Breast milk
- Infant formula

B35. [PROGRAMMER: ONLY DISPLAY IF BREAST MILK IS SELECTED IN B30] In your opinion, were you and your baby breastfeeding well at hospital discharge?

- Yes
- No
- Don't know

B16. How old was your baby the first time he or she was given a pacifier?

_____ Hours

OR

_____ Days

OR

_____ Weeks

OR

- My baby has never been given a pacifier

B24. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] [PROGRAMMER: DO NOT DISPLAY IF B30 = ONLY INFANT FORMULA] After coming home from the hospital or birth center, what breastfeeding support did you receive from the hospital or birth center?

	Yes	No
In-person follow-up visits for lactation support		
Personalized phone calls to ask about breastfeeding (not automated calls)		
Video conference for lactation support		
Referral(s) to lactation providers in the community		
Printed breastfeeding information and resources		

B32. [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] [PROGRAMMER: DO NOT DISPLAY IF B30 = ONLY INFANT FORMULA] After coming home, did any of the following people help you with breastfeeding by showing you how or talking to you about breastfeeding?

	Yes	No
Health care professional (e.g., doctor, nurse, midwife)		
Lactation support provider (such as a certified lactation consultant)		
Peer counselor (such as a WIC counselor)		
Family member(s) or friend(s)		
Other		

FEEDING

Foods Your Baby Eats

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
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)		

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

- Yes
- No

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

Feeding Breast Milk

These next questions are about feeding your baby breast milk.

E3. [PROGRAMMER: DO NOT DISPLAY IF B25 BREAST MILK = YES OR BREAST MILK IS ENDORSED IN FFQ. CODE AS YES TO E3 AND CONTINUE TO B33] Did you ever feed {CHILD'S NAME} breast milk, either from your breast or a bottle?

- Yes
- No (GO TO D15)

B33. Did you have any of the following things happen during your first 2 weeks of breastfeeding?

	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 issues (e.g., sore nipples, overfull, infection, clogged milk duct, etc.)		
I was sick or had to take medicine		
I had another issue		

E4. 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 INCLUDES DATE] Has {CHILD'S NAME} stopped feeding directly 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 THE SAME SCREEN]

E10. 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. 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 INCLUDES DATE] 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 INCLUDES DATE] Have you stopped feeding your baby pumped or expressed breast milk?

- Yes
- No (GO TO D13)

[IF E16 = VALID SKIP, GO TO D13]

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

D13. [IF E5 or E16 = NO, ASK] How old do you think {CHILD'S NAME} will be when you completely stop breastfeeding or feeding him or her pumped/expressed breast milk?

___ months

[HAVE A DROP DOWN MENU FOR EACH MONTH, 1 MONTH - 24 MONTHS, AND MORE THAN 24 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

D15. [ASK IF E3 = NO] What were the two most important reasons for your decision not to breastfeed your baby?

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

	Most important reason	Second most important reason
A health professional said I should not breastfeed for medical reasons		
I believe that formula is as good or is better than breast milk		
I thought that breastfeeding would be too inconvenient		
I tried breastfeeding before and didn't like it or it didn't work out		
I planned to go back to work or school		
I wanted or needed someone else to feed my baby		
I was worried about giving my baby COVID-19		
Other reason		

Feeding Formula

These next questions are about feeding your baby infant formula.

E22. [DO NOT DISPLAY IF B25 = YES TO FORMULA OR FORMULA IS ENDORSED IN FFQ. CODE AS YES AND CONTINUE TO E23] Did you ever feed {CHILD'S NAME} infant formula?

- Yes
- No (GO TO B34)

E23. 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

B34. Did you receive free samples of infant formula:

	Yes	No
At hospital discharge (e.g., in a gift bag) [PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER]		
From my doctor's office		
In the mail		

HEALTH AND LIFESTYLE

H28. In the past month, has your baby been hospitalized for:

	Yes	No
Newborn jaundice		
Dehydration		

H9. How much weight did you gain during this pregnancy?

_____ Pounds

D10. During your pregnancy, did you receive information on any of the following topic areas for this baby from a health care provider such as a doctor or nurse?

	Yes	No	Don't know
Health benefits of breastfeeding for mom			
Health benefits of breastfeeding for baby			

H12a. Over the past two weeks have you ever felt down, depressed or hopeless?

- Yes
- No

H12b. Over the past two weeks have you felt little interest or pleasure in doing things?

- Yes
- 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).

H19. Have you:

	Yes	No	Don't know	Not applicable
Had lack of noticeable breast changes during pregnancy				
Had flat or inverted nipples				
Had previous breast surgery or had a previous breast biopsy				

H17. Has a doctor, nurse, or other health care worker ever told you that you had any of the following conditions during this pregnancy?

- Gestational diabetes
- Pre-eclampsia
- High blood pressure or hypertension
- Anemia

The next questions are about COVID-19.

During this pregnancy, were you ever tested for COVID-19? Please do not include any test you received when you went to the hospital or birth center to have your baby.

- Yes
- No

[IF YES] Did you ever receive a positive COVID-19 diagnosis?

- Yes
- No

[IF YES to positive diagnosis in pregnancy...] What trimester did you receive a positive COVID-19 diagnosis?

- First trimester
- Second trimester
- Third trimester

[PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] While you were in the hospital or birth center to have your baby, were you tested for COVID-19?

- Yes, and I tested positive
- Yes, and I tested negative
- Yes, but I do not know the result
- No, I was not tested
- I don't know if I was tested

[PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] While you were in the hospital or birth center, was your baby ever tested for COVID-19?

- Yes, and my baby tested positive
- Yes, and my baby ONLY tested negative
- Yes, but I do not know the result
- No, my baby was not tested
- I don't know if my baby was tested

[PROGRAMMER: DO NOT DISPLAY IF B39 = I DID NOT DELIVER MY BABY IN A HOSPITAL OR BIRTH CENTER] Many hospitals or birth centers have put in place some practices that could help with reducing the spread of infection, like COVID-19. While you were in the hospital or birth center, did any of the following things happen?

	Yes	No
Hospital limited the number of visitors		
I was encouraged to wash my hands before feeding or caring for my baby		
I was encouraged to wear a mask when I was feeding or caring for my baby		
Baby was kept 6 feet away from my bed when in my room		
Baby was kept in an incubator when in my room		

These final questions ask about characteristics and insurance coverage of [CHILD'S NAME]

A15a. Is {CHILD'S NAME} Latino or Hispanic?

- Yes
- No

A15b. What is {CHILD'S NAME} race?

Select all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

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

- 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

[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.