

Feeding My Baby and Me: IFPS-III: MONTH 10

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

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]

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 baby drink at each feeding?

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

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

Fill in only one column for each item.

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

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

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

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

Fill in only one column for each item.

- 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.		

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)		
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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]

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		

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

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

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

- Rinsed with water only
- Washed with soap and water
- Washed in a dishwasher
- Boiled or sterilized
- Not cleaned between uses - used to feed without rinsing or washing
- I did not use a bottle in the past week (GO TO E5)

C52. During the past week, how often was {CHILD'S NAME} put to bed with a bottle with anything other than water?

- At most bedtimes, including naps
- At most night bedtimes, but not naps
- At most naps, but not night bedtimes
- Only occasionally at bedtimes, including naps
- Never

C50. [ONLY DISPLAY IF BREAST MILK FROM BOTTLE OR INFANT FORMULA ENDORSED IN FFQ] During the past week, how often have you heated your baby's bottle of infant formula or breast milk in a microwave oven?

- Rarely or never
- Sometimes, but less than half the time
- About half the time
- Most of the time
- I did not feed my baby breast milk or infant formula from a bottle in the past week

Feeding Breast Milk

These next questions are about feeding your baby breast milk and pumping 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]

	Most important reason	Second most important reason
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 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 C14]

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

- Yes
- No

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

___ Times in past week

[IF C20 = 0, GO TO C14]

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

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

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

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

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

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

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

C14. [ASK IF BREAST MILK FROM BOTTLE 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

E11. [SKIP IF E10= NEVER PUMPED] [ASK IF E10 FROM CURRENT OR PREVIOUS SURVEY INCLUDES DATE AND R HAS NOT ALREADY ANSWERED YES] Have you stopped pumping or hand-expressing breast milk?

- Yes
- No (GO TO E16)

[IF E11 = VALID SKIP, SKIP TO E16]

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

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

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

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

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

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

- Yes
- No (GO TO E22)

[IF E16 = VALID SKIP, GO TO E19]

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

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

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

- Yes
- No

Feeding Formula

These next questions are about feeding your baby formula.

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

- Yes
- No (GO TO C26)

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

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

C9. [ASK IF FORMULA IS ENDORSED IN THE 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 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
- Not applicable, I did not feed my baby any infant formula from a bottle

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 C26)

E25. How old was {FILL: HE/SHE} when {FILL: HE/SHE} completely stopped being fed infant formula? (Day 0 is the day your baby was born) This means you are not planning to feed {CHILD'S NAME} infant formula again.

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

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 C64)

C27. [DO NOT DISPLAY IF ALREADY ANSWERED] 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

C28. When your baby first started eating solid food, did you do any of the following?

	Yes	No
Chose a specific food group first (such as vegetables, fruit, cereals, or meats)		
Introduced first foods that were pureed		
Introduced first foods that your baby could pick up		

D22. The following are statements about feeding babies once they have started eating solid foods. For each statement, choose the answer that most closely matches your opinion.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The earlier babies eat vegetables, the more likely they are to eat them when they are older.					
Babies who are introduced to a variety of foods (fruits, vegetables, grains, meats) will have healthier diets later in life.					
It may take more tries for babies to learn to like vegetables than other healthy food like fruits					

C29. In the past week, how often did you give {CHILD'S NAME} infant rice cereal?

- Never
- Rarely (once a week)
- Sometimes (2 to 3 times a week)
- Most of the time (4 or 5 times a week)
- Always (every day)

C57a. Have you ever fed {CHILD'S NAME} food in a store-bought or prepared at home squeezable pouch? This includes screw-top pouches and items like yogurt in a pouch.

- Yes
- No (GO TO C62)
- Not sure (GO TO C62)

C57b. In the past week, how often has {CHILD'S NAME} eaten a squeezable pouch?

- More than once a day
- Once a day
- A couple times in the past week
- Once in the past week
- Has not had a squeezable pouch in the past week

C62. In the past week, how often did {CHILD'S NAME} eat the same dinner (or the main meal of the day) as the rest of the family?

- Every day
- 5-6 days
- 3-4 days
- 1-2 days
- No days

C63. In the past week, how many times did {CHILD'S NAME} eat food from a restaurant (includes delivery or carry-out)? Include food eaten in any type of restaurant, such as a fast food, cafeteria, or table service restaurant.

- None, my baby did not eat any food from a restaurant
- 1 time
- 2 to 3 times
- 4 to 5 times
- 6 to 7 times
- 8 or more times

C64. In the past week, how many times did all or most of your family sit down for a meal together?

____ Times

OR

- Never

Please indicate how often the following statement is true for {CHILD'S NAME}.

C70. [CHILD'S NAME] lets me know when {FILL: HE/SHE} is full.

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

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

C80. When an infant cries, it usually means {FILL: HE/SHE} needs to be fed.

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

MILK SHARING

Milk sharing refers to getting breast milk for your baby from another lactating woman, or providing your own breast milk to another baby besides your own son or daughter. Breast milk obtained from another lactating woman is often referred to as "donor milk".

[PROGRAMMER: DISPLAY C41a AND C41b ON THE SAME SCREEN]

C41a. Have you ever donated or shared your own breast milk (e.g., to a milk bank or with an individual)?

- Yes
- No

C41b. Have you ever sold your own breast milk?

- Yes
- No

C42. [If YES to C41a] In the past month, how often have you donated or shared your own breast milk?

	Milk bank	Other source or person
Once in the past month		
Twice in the past month		
Three or four times in the past month		
More than four times in the past month		

C43. [If YES to C41b] In the past month, how often have you sold your own breast milk?

	Milk bank	Other source or person
Once in the past month		
Twice in the past month		
Three or four times in the past month		
More than four times in the past month		

D26. [IF YES TO C41a or C41b] Are any of the following reasons that you shared your breast milk?

	Yes	No
I had more breast milk stored than I need		
I produced too much breast milk		
I needed or wanted money from the sale of breast milk		
I wanted to help out others who need it		
A family member or friend asked me		

D27. [ALL ANSWER D27] The following questions are about informal milk sharing. By informal milk sharing, we mean milk sharing such as through friends, family, social media, or some other person or company. This does not include milk received from a milk bank or hospital. Please choose the answer that most closely matches your opinion.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I think it is acceptable for me to share my breast milk with someone I do not know.					
I think it is acceptable for mothers to share their breast milk with someone they do not know.					
I think it is acceptable for babies to receive breast milk from another mother.					

EMPLOYMENT

G15. Do you plan to work for pay during your baby's second year?

- Yes
- No (GO TO H26a)

G16. How many hours per week do you plan to work for pay during your baby's second year?

- 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

HEALTH & 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

H23. Which of the following problems did your baby 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		

H38. When {CHILD'S NAME} eats meals or snacks, how often is an electronic media device (e.g., TV, tablets, smart phone, etc.) on while {FILL: HE/SHE} is eating?

- Most of the time
- Much of the time
- Sometimes
- Occasionally
- Never

[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.