Follow Up Study of Infant Feeding Practices II (IFPS II)

Responses to OMB Comments of October 6, 2011

October 12, 2011

This memorandum is being sent with the following attachments: the articles in the Supplement to Pediatrics (October 2008) and the supporting statement from the IFPS II.

1. Please provide more specific information in the supporting statement about the uses for the information to be provided by the study.

How will FDA use the information – what, specifically, will it be used for?

Please provide more information about the associated initiatives, e.g., Office of Women's Health and Centers for Disease Control.

FDA Response:
We propose to remove the following sentence on page 4 of Part A of the Supporting Statement, *"FDA needs the information to provide a context for food allergy and nutrition policy considerations and to support consumer information and education programs."* We will replace it with the following paragraphs:

FDA, CDC, and OWH all plan to use the information to explore topics of concern to better understand where we might want to focus research in the future and also to help define the dimensions of future research on select topics. In addition, the results will be used to provide a background for understanding issues of importance to the agencies. The reasons each of these agencies need the data are described below.

Two particular topics of concern to FDA are food allergy and nutrition. Food allergy is a growing public health problem. Despite recent advances in diagnosis and management of food allergy, many unanswered questions remain regarding the increase in food allergies. Moreover, there is a need to understand the role that food allergen and other feeding exposures in early life play in the later development of allergic diseases including food allergy and asthma or other health conditions such as diabetes, obesity, and behavioral disorders. This study will contribute to our understanding of these various factors, which may aid in preventing the morbidity and mortality of food allergy. The Follow Up Study will also provide background that FDA needs to develop specific research to inform educational guidelines and strategies for consumers and also research related to safety and risk assessments of food allergenic ingredients.

The Follow Up Study will provide FDA an opportunity to compare and expand upon the results from the food allergy cohort observations identified in first IFPS II study in several ways. In particular, information from the Follow Up Study will help in understanding these factors in this cohort:

- If and how the prevalence of food allergy has changed in the original food allergy infant cohort and what factors may be associated with changed status.

- If it appears that the major food allergens identified by the Food Allergen Labeling and Consumer Protection Act of 2004 (FALCPA) - milk, eggs, soy, wheat, peanuts, tree nuts,

crustacea and fish - continue to be the most prevalent food allergens in children or if new and important food allergens are emerging in this population. The Follow Up Study may indicate the need for population based research in this area and will help to define the important dimensions of such a study if the agency decides that additional research is needed.

- Whether certain dietary and/or allergen avoidance practices in the first year of life increase or decrease the risk of food allergies at age six. An example of an important dietary exposure other than allergenic foods that has been linked to enhancing food allergies includes consumption of vitamins. Also, the positive or negative impact of food allergen avoidance in the first year of life on development of food allergies remains an unsettled national public health debate.

- Whether the development of food allergies early in life is associated with increased risk for development of asthma, childhood obesity, autoimmune diseases such as diabetes, or behavioral problems.

Current FDA consumer education initiatives on nutrition that relate to children include a school-based nutrition and food safety education program and an obesity prevention program that targets children just before the teenage years and focuses on use of the food label. Future possible initiatives have not been defined. The results of associations between diet quality of the children and other factors such as source of school lunch (e.g., participation in the school lunch program vs. bringing it from home) and the home food environment may help to identify information gaps and thereby contribute to an assessment of the need for additional research regarding the messages in the school-based program.

We propose to remove the following paragraph on page 4 of Part A of the Supporting Statement, *"The Office on Women's Health needs the information to evaluate the effects of early feeding patterns (including bottle feeding behaviors and duration) on oral health of children and to evaluate certain women's health issues that might be associated with infant feeding patterns, particularly overweight and obesity. Results from this study will help to inform the OWH breastfeeding, oral health, and girls' health initiatives.*"
We will replace it with the following paragraph:

The Office on Women's Health needs the information to explore the effects of early feeding patterns (including bottle feeding behaviors and duration) on oral health of children and to assess associations between certain women's health issues, particularly overweight and obesity, and infant feeding patterns. Results from this study will be used to evaluate the need for additional research on topics of concern related to OWH work on breastfeeding, oral health, and girls' health.

We propose to delete the last three lines from the following paragraph on page 4 of Part A of the Supporting Statement.

"In addition, CDC needs the information to evaluate possible effects of early feeding patterns on childhood overweight and obesity and on various types of childhood

development. Because the development of childhood obesity is influenced not only by infant feeding patterns, but also by many other factors, such as physical activity, TV/Screen time, maternal feeding styles, child's self-regulation of food intake, family meals or eating away from home, meal preparations, home healthy food environment, child care arrangement, school lunch, sleeping patterns, consumptions of high energy dense food, fruits and vegetable, and sugar sweet beverages, etc., CDC needs the data on this information to develop strategic public health efforts to prevent and control childhood obesity and chronic diseases."

We propose to replace the deleted lines as shown below as the last three lines of the otherwise same paragraph:

> In addition, CDC needs the information to evaluate possible effects of early feeding patterns on childhood overweight and obesity and on various types of childhood development. Because the development of childhood obesity is influenced not only by infant feeding patterns, but also by many other factors, such as physical activity, TV/Screen time, maternal feeding styles, child's self-regulation of food intake, family meals or eating away from home, meal preparations, home healthy food environment, child care arrangements, school lunch, sleeping patterns, consumption of high energy dense food, fruits and vegetables, and sugar sweet beverages, etc., CDC needs these data to contribute to understand the potentially modifiable risk factors for developing childhood obesity which will contribute to developing strategic public health efforts to prevent and control childhood obesity and chronic diseases.

We propose to remove the following sentences on page 6 of Part A of the Supporting Statement, *"The information will be used to provide a context for policy development and to inform consumer education activities. Other agencies, including OWH and CDC, will use the information similarly, that is, for policy development context, consumer education activities, and designing targeted interventions."* We will replace them with the following sentence:

FDA and the other involved agencies recognize that this data collection will serve the purposes of a research study and will not be appropriate to use as a basis for policy or consumer education initiatives.

2. Please provide more specific information in the supporting statement about future uses of this information.

FDA Response:
We propose to add the following sentences to the Supporting Statement, Part A, in section 2.

The agencies have not developed plans for future use of the data after the issues described in this supporting statement are addressed. Future use will depend on what other agency issues arise that are relevant to the data and how much staff time is available for further analysis. We will maintain our awareness that the data cannot be used as population estimates or as the major support for policy or consumer education initiatives.

3. Please provide more information about plans for publication.

FDA Response:
We propose to delete the following paragraphs from the Supporting Statement, Part A, in section 16, page 13-14.

> *"The Agency anticipates disseminating the results of the study after the data analysis is completed, reviewed, and cleared. Final results of the study will be summarized for publication in a peer-reviewed scientific journal. The planned schedule for project activities is shown in Table 2.*
>
> *Activities associated with the outcomes of this research will primarily consist of written and oral presentations. Journal manuscripts and oral and/or poster presentations at professional meetings will be planned to disseminate the information to the public, including professionals, academics, and industry and consumer organizations. The dialogues will help to improve the effectiveness of the agency's education initiatives in promoting and protecting the public health."*

We propose to add the following paragraph to the Supporting Statement, Part A, in section 16, page 13-14.

Because we expect to publish results in professional journals, a number of articles (not only one study summary) will have to be published on focused topics. The first topics that will be analyzed are those of most importance to the agency at the time the data become available, probably those relating to food allergy for FDA, obesity for CDC, and oral health for OWH. Scientists from other agencies involved will choose topics depending on their priorities. Generally, results are presented at professional meetings before they are published. The annual meeting of the American Public Health Association is often chosen for presentations because it reaches a variety of health care professionals, industry professionals, government scientists, and academic scientists. The purpose of the presentations and articles will be to share the research findings and to engage in discussions with other researchers doing related work in order to establish a stronger foundation for future research. The planned schedule for project activities is shown in Table 2.

4. Please provide a description of the cognitive interviews.

FDA Response:
We propose to add the following paragraphs to the Supporting Statement, Part A, in section 12.

During the questionnaire development phase, cognitive interviews were conducted with six respondents to test the new and modified questions. Although many of the questions are from previous data collection instruments, the total questionnaire will present the questions in a different context from the original, and for many questions, the form of collection will be changed from an in-person interview to a written questionnaire or a telephone interview.

Therefore, a pilot study of 91 mail and 9 telephone respondents will be conducted to test the questionnaire after OMB approves the data collection. It is expected that the pilot test will refine some of the questions but not result in substantial changes in the questionnaire. The materials for the pilot study are included in the Appendices showing each specific material for the main study, except that the debriefing questionnaire is shown in Appendix I.

The cognitive interviews tested the questions about the child's diet, food environment, and mother's control of the child's eating. They also tested the questions on exposures to pets and chemicals used in the home, mother and child's activity levels, other mother characteristics (e.g., subsequent pregnancies, employment), child care, school characteristics, child's height and weight, oral hygiene and oral health, child health, food allergy, and child's sleeping patterns. We did not test any sets of questions that we could not change, for example, the Strengths and Difficulties Questionnaire and the Home Environment scale. Because of the length of the questionnaire, we divided the questionnaire into two parts, each of which was asked of six respondents. None of the same questions was asked of both sets of respondents.

Respondents were mothers from the consumer opinion panel that the pilot sample will be selected from and that the sample for the infant part of the study was selected from. Using panel administrative data, the contractor identified mothers who worked and who had a 6 year-old child. We requested working mothers because we thought they would have more challenges reporting their child's diet than mothers who did not work. All interviews were conducted by telephone. The Project Officer conducted the interviews in the company of another FDA scientist also assigned to the project. The interviews were recorded and the responses, including responses to probe questions, were transcribed. The interview team identified questions that were confusing to the mothers, hard to answer, or misinterpreted. Respondents were probed to ascertain their understanding of the questions, to find other terms they used for concepts in the questions, and to determine if the question covered their situation. The questions were tested on two respondents, modified, tested on another two respondents, modified again, and tested on a third set of two respondents.

We asked how easy or hard it was for respondents to remember over the 12 month reference period, whether they used different terms for any of the key words in the questions, whether the response options fit their situation, and other details. Changes included re-wording questions, changing response options, and changing the order of questions. As one example of a revision, we changed the reference period for days missed from school from the past 12 months to the past school year because respondents told us that it was hard to remember for the part of the previous school year that fit into the past 12 months.

For an example of re-wording, the two sets of questions about Individualized Education Programs below show the wording in the first set of interviews and then the final wording in the Pilot Questionnaire after the third round of cognitive interviews. We changed the question and explanatory note and added one additional response option.

Round 1

1. Does your 6-year-old have a health problem, condition, or disability for which he/she has a written intervention plan at school called an Individualized Education Program or IEP?

EXPLANATORY NOTE: Some children have difficulty in school because of a health problem, condition, or disability. These children may receive services from a program called Special Education and have a written intervention plan called an Individualized Education Program or IEP. Services on an IEP might include special instruction; speech or language therapy; vision and hearing services; psychological services; health services; social work services; family counseling and support; transportation; or other services needed to support the child's educational performance.

Yes..... ☐ No..... ☐ →**(GO TO SECTION B)** Don't Know..... ☐

2. Why does your 6-year-old have an Individualized Education Program or IEP? **(PLEASE "X" ALL REASONS THAT APPLY).**

Speech or language therapy..... ☐
Occupational therapy or other type of therapy for help with handwriting or other motor skills..... ☐
Physical therapy..... ☐
Special instruction or help in one or more school subjects such as reading or math..... ☐
Special services because of a problem with vision or hearing..... ☐
Psychological services or counseling because of a problem with emotions, behavior, or socialization..... ☐
Special support because of a chronic health condition ..... ☐
Other reason..... ☐

Pilot Questionnaire

1. During this school year, has a special plan been developed at school to provide your 6-year-old with extra help or support such as a special needs program or an Individualized Education Program (IEP)?

EXPLANATORY NOTE: Some children have difficulty in school because of a health problem, condition, or disability. These children may receive services from a program called Special Education and have a written intervention plan called an Individualized Education Program (IEP).

Yes..... ☐ No..... ☐ Don't know..... ☐

2. During this school year, has your 6-year-old received any of the following services? **(PLEASE "X" ALL THAT APPLY)**

Speech or language therapy..... ☐
Occupational therapy or other type of therapy for help with handwriting or other motor skills..... ☐
Physical therapy..... ☐
Special instruction or help in one or more school subjects such as reading or math..... ☐
Special services because of a problem with vision or hearing..... ☐
Psychological services or counseling because of a problem with emotions, behavior, or socialization..... ☐
Behavioral support, such as a behavior management plan or individual support in the classroom by an assistant..... ☐
Special support because of a chronic health condition ..... ☐
Other (please specify) _____..... ☐
None of these ..... ☐

The reason for the change was that we found mothers focused on the first part of the sentence in Round 1, and answered about the child's problems whether or not they resulted in an IEP. We found that mothers thought of this type of support as a program for "special needs." One mother interviewed mentioned the additional type of support we added. Also, some children received services outside of school, and for that reason we changed the second question in the set. The

purpose of the question is to indicate child development problems, not school services, and the final version seems to achieve this purpose.

Below is an example of a question for which we changed the question and response options to include all situations reported by respondents:

Round 1

1. Does your 6-year-old take daily medications to manage his/her asthma?

Yes..... ☐ No..... ☐

Pilot Questionnaire

1. Does your 6-year-old take daily medications either year-round or seasonally to manage his or her asthma?

Yes, year-round..... ☐ Yes, seasonally..... ☐ No ..... ☐

An example of changing the order of the questions comes from the food frequency and details about the child's diet. Initially, we began the section on diet with the food frequency chart (D-13 on the Pilot Questionnaire). However, we found that mothers recalled foods that they wanted to add to the chart after they read the following questions about type of milk, bread, etc, that the child eats. We realized that asking the specific questions first helps the mother to begin thinking about the child's usual diet and makes it easier to answer the food frequency chart. Now the specific questions have been placed before the food frequency chart as questions D-3 through D-12.

5. Please provide information in the supporting statement Part A about the purpose/goal of the pilot study.

FDA Response:
We propose to add the following sentences to the Supporting Statement, Part A, in section 12.

The purpose of the pilot study is to test the total questionnaire with respondents like those who will answer the main study questionnaire and to evaluate certain elements of the study design. We will examine these factors by analyzing the answers to the pilot test, analyzing responses to the debriefing questionnaire, evaluating the telephone interviews, and analyzing response rates from groups sent the two different levels of incentive.

6. Please add to Part B the methods to be used in the pilot study.

FDA Response:
The Supporting Statement, Part B, section 4, currently ends with the first paragraph below (italicized). We propose to retain this paragraph and add the following three paragraphs to this section:

During the questionnaire development phase, cognitive interviews were conducted with six respondents to test the new and modified questions. Although many of the questions are from previous data collection instruments, the total questionnaire will present the questions in a

different context from the original, and for many questions, the form of collection will be changed from an in-person interview to a written questionnaire or a telephone interview. Therefore, a pilot study of 91 mail and 9 telephone respondents will be conducted to test the questionnaire after OMB approves the data collection. It is expected that the pilot test will refine some of the questions but not result in substantial changes in the questionnaire. The materials for the pilot study are included in the Appendices showing each specific material for the main study, except that the debriefing questionnaire is shown in Appendix I.

The method for the pilot test will be similar to that of the main study with a few exceptions because of the different sample and different purpose. The contractor will select the sample to match the IFPS II sample on the demographic characteristics of race, income, education, region, household size, and age plus 6 years (because the IFPS II sample will be contacted six years after the prenatal questionnaire, on which we asked age). The contractor will identify 250 female panel members that match the above demographic characteristics and that have a 6-year-old child (because the IFPS II sample will be contacted when the target child is 6 years old). A low response rate has been assumed for the pilot study because it is urgent to obtain the target sample size of 100 completed questionnaires in a short period of time.

A prenotification letter (Appendix B) will be sent to the selected sample. Half of the sample will be offered an incentive of $10 value in points and half will be offered $15 in points value so that we can test whether a higher incentive yields a higher response rate. The panel administrators recommended the two different points values based on the length of the survey. A few weeks after the prenotification letter, the sample will be sent an introduction letter (Appendix C) along with the pilot questionnaire (Appendix D) and the debriefing questionnaire (Appendix I). Note that the estimated burden for the pilot study is greater than for the main study because we are asking them to complete the debriefing questionnaire in addition to the study questionnaire. Two weeks after the questionnaire mailing, a post card reminder (Appendix F) will be sent to all sample members. A week later, nine sample members who have not responded will be contacted for a telephone interview to collect the same information that was requested in the mailed questionnaire, using the telephone introduction shown in Appendix H. These mailings and the telephone interview timing are like those proposed for the main study except that in the main study, we will have in addition a second mailing of the questionnaire.

The unedited data from the pilot study will be made into a SAS data base and analyzed for amount of item non-response, inconsistent responses between and within questions, incorrect skips, and multiple responses given to questions that request only one response. The responses to the debriefing questionnaires will be read and coded manually.

7. Please add to Part B the criteria to be used for modifying the study once you have completed the pilot.

FDA Response:
We propose to add the following paragraphs to the Supporting Statement, Part B, in section 4.

We will obtain the following information from analyzing the answers to the pilot test:

- whether the skip instructions are clear (by analyzing those who should have skipped compared with those who did skip each question)
- whether any questions generate a large amount of non-response (by reviewing the number of missing responses for each question)
- whether different questions that ask similar information result in inconsistent responses (by checking the responses of such questions against each other)
- whether questions with multiple responses have inconsistent responses or have a written response in the "other" category that is the same as one of the listed responses
- whether any response options are given by either no one or everyone
- whether items that we believe should have only one answer receive multiple responses.

If we find that any skip instructions are not clear, we will consider using larger or bolder font for the instructions, rearranging questions to minimize the number of questions to be skipped or the location of the place to begin after a skip, or work with the contractor to identify other possible remedies.

If any questions receive a large amount of non-response, we will examine the characteristics of the non-responders to determine whether the question might not apply to their situation; we will examine the placement of the item (for example, was it the beginning of continuing after a skip, or did it have other such placement characteristics that might cause nonresponse?); we will examine cognitive interview responses to the question to determine whether they indicate a lack of clarity that we had not addressed. The remedy we decide on will depend on what we determine to be the cause of the non-response.

If similar questions generate inconsistent responses, we will evaluate whether respondents might misinterpret one of the questions by reviewing the context of the two questions and by examining the characteristics of the respondents with inconsistent responses; we will examine cognitive interview responses to the question to determine whether they indicate a lack of clarity or possible multiple interpretations that we had not addressed. The remedy may be a rewording of one of the items or a rearrangement of one of the questions. We will use similar procedures if responses within a multiple response question are inconsistent (for example, the respondent chooses an option and also chooses "none of these").

If some response options are chosen by no one, we will evaluate whether the option is likely to be needed in a larger sample. If experts agree that it probably will have a very low or zero frequency in the main sample, we will delete the response option. Because more white space is better in a written questionnaire, there is a cost to keeping options that are not needed. However, if the item measures a low incident condition of importance, we will keep it. If some questions are answered the same by everyone, we will evaluate the need for the question in the main study. If the characteristic is obvious and not likely to vary, we will delete the question.

If some items that we thought should have only one answer receive multiple answers, we will evaluate the combinations of responses chosen and the characteristics of the respondents

who give the response to determine whether the question needs to be revised to a "mark all that apply" type of response or if it should be clarified or be given additional response options.

We will obtain the following information from the debriefing questionnaire sent with the pilot questionnaire. Most of this information was obtained from the respondents to the cognitive interviews, but we want to know for a larger number of mothers:

- Range of length of time it takes respondents to answer the total questionnaire (self-reported in response to a specific question on the debriefing questionnaire)
- whether most mothers in this sample have a scale for measuring a person's weight at home and what they did about answering the child's weight question if they did not have a scale
- what percent of mothers in the pilot sample had difficulty with the instructions for measuring height
- what percent of mothers found it hard to remember over the 12 month reference period
- what kinds of situations mothers have that cause any questions to be hard to answer.

If we find that the questionnaire takes longer than the 20 minutes on average that we expect, we will consider the following possible actions: Increase the response burden estimates we have given in the supporting statement; increase the incentive; delete some questions to shorten the questionnaire. If we believe that we must shorten the questionnaire, we will consider deleting items with these characteristics: request details about some low prevalence conditions, have no variation in the pilot data; ask for lower priority information.

If we find that some mothers do not have a scale and that those who did not own a scale also did not have access to a scale (for example, at a friend's or relative's home), we will first evaluate whether the level of missing data that will be caused by this lack is acceptable. If the number missing a scale is too large, we will consider the possibility of adding money to the contract to fund obtaining permission from the mothers and then contacting their health care providers about the child's weight. This option will require additional review by FDA's Research Involving Human Subjects Committee. Because all six of the respondents to the cognitive interviews had scales, we expect that nearly all mothers will have a scale.

If mothers have difficulty with the instructions for measuring height, we will simplify the instructions and then test the new instructions with several mothers whom we will obtain from the panel in the same manner as the cognitive interviews. Because none of the six respondents to the cognitive interviews had difficulty with the instructions, we believe that nearly all mothers will be able to follow them easily.

If mothers indicate that that they had difficulty remembering over the 12 month reference period or write in other problems with some questions, we will evaluate the respondent characteristics, the reason for the difficulty, if given, and the details of the mother's special situation, if given. We will determine how likely it is that the difficulty applies to many other mothers and whether we can clarify the question without changing it substantially before

changing the item. The mothers in the cognitive interviews were able to recall information over the reference period.

We will compare response rates between the two groups that receive the different incentive amounts to see if the larger incentive leads to a higher response rate for this type of respondent (by comparing response rates of the groups that receive the $10 and the $15 incentive). With a sample size of 50 in each group, and assuming an overall 80 percent response rate, we will be able to detect a significant difference of 23% or greater at $p<.05$ and 80 percent power. If the two incentive levels yield a similar response rate, we will use the lower amount for the main study.

The telephone interview part of the pilot test will show us how long the questionnaire takes when administered orally, give an indication of whether respondents react favorably to being called about a questionnaire they received in the mail but did not complete in writing, and show whether any of the questions need to be re-worded in order to obtain the information orally. For example, some of the multiple response questions may be better understood if each response is answered. We will ask the telephone interviewers to give their general impressions of how well each interview went and whether they recognized any particular problems. However, their training is for consistent administration of a questionnaire, not for probe questions as one would do in a cognitive interview, and therefore, we will not ask them to follow up with any questions in addition to those in the questionnaire. An additional reason not to add questions to the telephone interview is that we want to test the length of the oral administration of the questionnaire. Because we are looking for areas between the two types of data collection that may have large differences, we believe that we can obtain the information we need from a small number of telephone respondents.

8. Please add to Part B the basis for assuming the stated response rate. Please add a discussion of why you estimate that you will get the response rates stated in section 3.

FDA Response:
We propose to add the following paragraphs to the Supporting Statement, Part B, in section 3:

Our estimate that we will be able to find contact information for 90% of the respondents to the IFPS II is based on several factors. First, the IFPS II sample was relatively stable in their residence, given that they were on a consumer opinion panel and that a very large percentage of them answered numerous questionnaires by mail when their child was an infant. It is likely that most will continue to be residentially stable and therefore easier to trace than some elements of the US population. Second, the panel administration has contact information for all of them that was current about five years ago because the IFPS II continued through the child's first birthday. In some instances, the panel will also have names of other family members.

A description of the tracing procedures follows. Drawing upon Experian/MSG's in-house Business and Household databases, its GENESYS system provides sample/list enhancement services specifically focused on the needs of researchers. Computerized forward and reverse matching appends phone numbers, addresses, and demographic information to lists. We plan to use Experian/MSG's Enhanced Match, which, on average yields 10-15% more

matches. To conduct the Enhanced Matching, MSG uses 4 databases to append addresses and phone numbers. The first database is the TARGUS database. TARGUS has hundreds of data sources and a unique membership in the U.S. Telecommunications Network. The database is updated several times daily. Any records that do not return a match are run against the 3 consumer databases MSG has in-house including: InfoUSA, Experian, and Acxiom to locate a match. These databases are compiled from various sources including white page listings, public information, and other proprietary sources.

As an additional step, Synovate will verify the mailing address for each sample member by performing a look-up of name and address records with the National Change of Address (NCOA) files. ZIP codes will be updated on existing addresses, and street name designations will be brought into compliance with Postal Service requirements, increasing the deliverability and thereby increasing the contact rate. We will also obtain and append telephone numbers for sample members, where available.

We have several reasons for assuming that this study will have a response rate of 80 percent. The first reason is that these same people had high response rates in the infant part of the sample, which occurred during a time that most mothers find challenging. The response rates were 82.9% for the birth screener, 76.9% for the neonatal (first month) questionnaire, and 83.1% for the month 2 questionnaire. In the IFPS II, 76.6 percent of respondents answered at least seven of the total twelve questionnaires. We believe that many respondents will be more inclined to respond because they were part of the earlier study, i.e., because they have already committed time to the study. They all have experience answering the type of questionnaire we will send and doing so by mail. In addition, the current response rate for telephone surveys in the panel is relatively high and will be able to obtain data from many of those who do not answer by mail.

This vendor's current average panel response rate for mail studies is about 40% without an incentive and its response rate for telephone studies is about 80%. The contractor estimated a higher than average mail response rate (60%) because we are offering an incentive, because respondents should find this survey more interesting than average, and because of the past experience respondents have with this study. They estimated a lower than average telephone response rate [(513/1024) = 50%] because the questionnaire is longer than most they administer and because they will be calling respondents who were unable or unwilling to answer by mail.

The incentive offered for this study, either $10 or $15, is about average for a 20 minute survey. The incentive usually offered depends on the survey topic and the expected respondent interest in the subject. For this study, interest is expected to be high and therefore the incentive will be adequate even for the respondents that take a little longer to complete it.

8. Please provide more detail about the power analysis and move it from Part B, section 2, to Part B, section 1. Please also add a list of health outcomes and an analysis of in which of these health outcomes you have the power to detect realistic differences between groups.

FDA Response:
We have moved the following sentences to Part B, section 1.

Data analysis will be conducted using SAS 9.1 statistical software. A statistical power analysis based on Casagrande, 1978 and Fleiss 1981 via the calculations at the website http://department.obg.cuhk.edu.hk/researchsupport/Sample_size_Comp2Prop.asp

indicates that if we test with 95 percent confidence, we will have 80 percent power to detect differences in two groups of 2.5 to 4 percent with about 900 respondents in each group when the overall prevalence of an outcome is 10 percent or less, which is likely to be the case for a number of health outcomes. We will have 80 percent power to detect a difference of 5 percent between two groups of about 1,000 respondents each when the overall prevalence of the outcome is 22.5 percent.

We propose to add the following text to Part B, section 1:

Specific information used for the power analysis is listed below. Because power depends in part on how many respondents are in each of the groups compared, we have first listed the percentage in various feeding characteristic groups, as found in the IFPS II.

Feeding characteristic	Prevalence In IFPS II (%)	Number in each dichotomous group in the Follow Up Study based on total sample size of 2051
Fed cow milk at 10-1/2 months	17	349/1702
Fed other allergenic foods at 10-1/2 months	30	615/1436
Exclusively breastfed at 3 months	36	738/1313
Fed infant expressed milk	60	1231/820
Breastfed at least 6 m	50	1025/1026
Fed breast milk as 100% of milk feeds at month 9	27	554/1497
Put to bed with a bottle (10-1/2 m)	20	410/1641
Fed less than 1 daily serving of either fruit or vegetable in late infancy	15	308/1743

The table below shows the minimal detectable difference between select groups for various outcomes. The two feeding characteristics chosen for display are the one with half of the sample in each group (breastfed at least six months) and the one with the greatest difference in the size of the groups (fed less than 1 daily serving of fruit or vegetable in late infancy). The minimal difference for the other feeding characteristics will lie between these two. References for the prevalence estimates are given below the table.

Outcome	Prevalence in children (%)	Minimum detectable difference	
		Breastfed at	Fed <1 daily

		least 6 months	fruit or vegetable
Food allergy, parent-reported symptoms	35 (a)	6	9
Food allergy, diagnosed	6 (a)	4	4
Asthma	6 (b)	4	4
Atopy	15 (a)	5	6.5
Childhood obesity	19 (c)	5	6.5
Inadequate intake of fruit	74 (e)	5.5	8
Poor psychosocial development (Parent reports at least some difficulties on the Strengths and Difficulties Questionnaire	45 (d)	6.5	9

a. Lee, LA and Burks, AW. Food allergies: prevalence, molecular characterization, and treatment/prevention strategies. *Annu Rev Nutr*. 2006;26:539-565.

b. Ip S, Chung M, Raman G et al. Breastfeeding and maternal and infant health outcomes in developed countries. *Evid Rep Technol Assess (Full Rep)* 2007;1-186.

c. Ogden, CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of overweight and obesity in the United States, 1999-2004. *JAMA*. 2006;295(13):1549-1555.

d. Kramer MS, Fombonne E, Igumnov S et al. Effects of prolonged and exclusive breastfeeding on child behavior and maternal adjustment: evidence from a large, randomized trial. *Pediatrics* 2008;121:E435-E440.

e. Lorson, BA, Melgar-Quinonez, HR, Taylor, CA. Correlates of fruit and vegetable intakes in US children. *J Am Diet Assoc*. 2009;109:474-478.