



## ***Draft Report: Feeding in the First Year of Life***

H. Crawley. Comments on draft report, September 2017.

Thank you for the opportunity to submit comments related to the scientific content of the draft report *Feeding in the First Year of Life*. I commend SMCN on an elegant summary of the extensive data review. A few thoughts are highlighted below on additional data that might be considered. However, newer data highlighted is likely to consolidate, rather than change, conclusions so might be considered only for completeness. Several additions are also suggested.

1. Inclusion of conclusions from the January 2016 The Lancet breastfeeding series in the introduction/policy context is welcomed to widen the narrative on benefits and importance of breastfeeding for infants, mothers and society.
2. Infant formula, or just the term formula (p123), is mentioned in the report in several places. Would it be possible to use the consistent term 'infant formula' when referring to the breastmilk substitute recommended for non/partially breastfed infants in the first year of life and to define this in the glossary p129 as Infant formula (not formula, infant formula):

Infant Formula	A breastmilk substitute suitable for use in the first year of life which meets the regulatory, compositional and labelling standards for infant formula.
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I am not sure why it is suggested this can be manufactured to Codex standards. Infant formula has a specific name and definition and we need to be clear that this is not a 'catch all' name for breastmilk substitutes, some of which are defined by other regulations.

It would also be useful to define breastmilk substitute. On p125 the term 'alternative breast milk substitutes' is used but this should be breastmilk substitute and defined in glossary on p127. It is important that all BMS are not considered 'infant formula.'

3. A study published in 2016 looking at choices of infant formula in Ireland (Smith et al, 2016) suggested that a substantial proportion of families choose non whey based infant formula in the first months of an infant's life (e.g. hungry baby formula), use a milk which is a 'food for special medical purpose' (e.g. 'comfort' formula) and a follow on formula after 6 months of age. The draft report currently highlights that in the 2010 Infant Feeding Survey 57% of mothers were predominantly giving their infant follow on formula at stage 3 (8-9m, average age 38 weeks), but comment is not made that this is not in line with current Government policy in paragraph 415.

This also has relevance to discussions on protein intake and infant body weight since hungry baby formula, most follow on formula and many BMS marketed as foods for

special medical purposes have higher protein contents compared to whey based infant formula. Further findings from the European Childhood Obesity Project (CHOP) continue to support links between protein intake and adiposity e.g. Gruszfeld et al (2016). A systematic review published in 2016 (Patro-Golab et al, 2016) however highlights inconclusive evidence from other studies and the need for more research as the CHOP study remained the only RCT that assessed long term outcomes (and some methodological limitations are noted in this study).

An additional research recommendation (p125) could be further work on choice of breastmilk substitutes and potential health and wellbeing consequences of these choices. We currently have little data on what impact self-selection of BMS, including some FSMP products widely used without medical supervision by families may have on later health, and food choice outcomes.

4. Paragraph 35 on p12 could usefully mention the NICE maternal and child nutrition Quality Standards (QS98, 2015)

<https://www.nice.org.uk/guidance/gs98/resources/maternal-and-child-nutrition-pdf-2098975759045>.

5. In paragraph 483 there is mention of gluten but this does not appear in a conclusion sentence. The COT review conclusion is supported by reviews of evidence (and recommendations for ESPGHAN) by Szajewska et al (2016) and by Silano et al (2016). A systematic review by Pinto-Sanchez et al (2016) however suggested earlier introduction is associated with reduced risk of coeliac disease development and this has caused some confusion. A statement on gluten introduction in the report conclusions would be welcomed by practitioners.

6. The COT review references the systematic review by Boyle et al (2016) but does not highlight the lack of evidence for any benefit of the use of partially hydrolysed formula in the prevention of allergy. As this is again something that is confusing for practitioners who are exposed to marketing of formula making claims that this is the case, it would be helpful to highlight this in a conclusion sentence.

7. A number of papers from cross-sectional studies have been published since 2016 relating to age of introduction of solids and body weight. Papoutsou et al 2017 reporting on the IDEFICS study suggested that later introduction 6m+ was related to increased weight, but not early introduction (<4m), but early feeding reports need consideration. The large (3000 babies +) HealthNuts study in Australia (Sun et al, 2016) reported that both earlier and later introduction (<5m, >7m) was associated with higher BMI.

8. Further publications from the BLISS study do not change conclusions on BLW, but could be considered for completeness: Fandugo et al (2016), Morrison et al (2016), Taylor et al, (2017), As could the review by Brown et al (2017).

9. The section on maternal/caregiver feeding practices (p82) only deals with baby led weaning and does not mention literature on other caregiver practices which can particularly impact on over- nutrition. (e.g. as usefully summarised by Hodges et al, 2013) The lack of discussion of responsive complementary feeding (with links to responsive breastfeeding) feels like an omission in the report.

10. There is no mention of vegetarian or vegan/plant based diets for infants. The evidence for safety and outcome is limited but it might be timely to suggest more

research is needed to support public health guidance in this area. As dietary choices become increasingly diverse in the population, clarity over any risks would be welcomed by practitioners.

The following points are drafting points, but I have included them as they may be of interest to the secretariat:

1. Paragraph 40 highlights commonly allergenic foods, but it could usefully say in the last sentence 'it is advised that *these* commonly allergenic foods' to make clear it is those listed.
2. 'Sugar' and 'sugary foods' are used in several places without definition of free sugars – e.g. paragraph 41. This might be considered to ensure clarity over those foods and drinks that restriction is suggested for among infants. A footnote to define free sugars and foods and drinks that these contain could be considered.
3. Paragraph 52. Is the word 'intensity' the right word for how you breastfeed? Perhaps frequency is what is meant here.
4. 196 – there is a word missing in the second sentence.
5. Paragraph 350 says '*Texture should be progressed from smooth to lumpy and more complex textures throughout the first months of complementary feeding, though there is insufficient evidence to give objective guidance on the speed of progression of solid food textures*'

This does suggest that it is still necessary to start with smooth foods despite the emphasis on individual child development and perhaps the word 'should' could be qualified and the wording considered in light of the discussions on texture progression.

## References:

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