

# sacn

Scientific Advisory Committee on Nutrition

## **Feeding in the First Year of Life – consultation responses**

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## **Procedure**

The draft report on Feeding in the First Year of Life was published for an eight week consultation on 19 July 2017, closing on 13 September 2017. Interested parties were invited to submit comments relating to the scientific content of the draft report and to alert the Committee to any evidence that it may have missed.

Twenty nine responses were received from a variety of interested parties.

SACN wishes to note that each of the consultation comments received was very carefully considered by the committee. Where consultation comments were similar, the committee's responses were standardised purely in order to ensure consistency. Comments relating to risk management issues were outside the scope of this report and have therefore not been responded to.

SACN would like to thank all those who responded to consultation; their input is much appreciated.

## **Respondents**

Comments were received from the following organisations and individuals:

1. Becker, Genevieve (Registered Dietitian and International Board Certified Lactation Consultant)
2. Bernabé, Eduardo (Reader in Dental Public Health, King's College London Dental Institute)
3. Breastfeeding Network
4. British Association for the Study of Community Dentistry (BASCD)
5. British Dental Association
6. British Dietetic Association Paediatric and Food Allergy Specialist Groups (BDA-PFASG)
7. British Society of Paediatric Dentistry
8. British Specialist Nutrition Association Ltd (BSNA)
9. Brown, Rosemary (Infant Feeding Coordinator, Whittington Health NHS Trust, Islington)
10. Coulthard, Helen and Harris, Gillian (Division of Psychology, De Montfort University)
11. Crawley, Helen (First Steps Nutrition Trust)
12. Dalzell, Janet (Infant Nutrition Coordinator) and Richards, Derek (Dental Public Health Consultant.)
13. Ella's Kitchen
14. GP Infant Feeding Network UK
15. HENRY
16. Hetherington, Marion (Professor of Biopsychology, University of Leeds) and Fildes, Alison (University Academic Fellow, School of Psychology, University of Leeds)
17. Infant Feeding Support UK
18. Johnston, Steven (Senior Dental Officer, NHS Orkney)
19. La Leche League GB
20. More, Judy (Freelance Paediatric Dietitian and Registered Nutritionist)
21. Nestle Nutrition
22. Norris, Sarah (Maternity Nurse)
23. Pearson-Glaze, Philippa (International Board Certified Lactation Consultant)
24. Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group
25. Royal College of Midwives
26. Royal College of Paediatrics and Child Health (RCPCH)
27. Rugg-Gunn, Andrew (Professor Emeritus, Newcastle University).
28. Stirton, Ruth (Lecturer in Healthcare Law, Sussex Law School, University of Sussex)
29. World Breastfeeding Trends Initiative (WBTi)

## General comments

**Table 1.1: General comments on the report**

Organisation/ Individual	Comments	Reply from SACN
British Dietetic Association Paediatric and Food Allergy Specialist Groups (BDA – PFASG)	<p>The BDA welcomes this report, which gives a clear health promotion line to promote breastfeeding, and identified the need to support continuation of breastfeeding through the first year. We also strongly support the call for the reinstatement of the infant feeding surveys, which we considered essential.</p> <p>However, we remain concerned that the document appears to be biased toward reiterating or supporting the view that breastfeeding should be exclusive to around 6 months. We do not believe it has critically reviewed and appropriately recognised the more recent evidence that there is no harm in the earlier introduction of solids.</p> <p>We have made a number of general comments and then more specific comments relating to individual chapters.</p>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on ‘Infant feeding, growth and health’ and ‘Infant feeding, body composition and health’.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on ‘Risks of allergic and autoimmune disease’).</p>
BDA - PFASG	<p><u>Non-breastfed babies</u></p> <p>Consideration needs to be given to the appropriate age for introduction of solid foods to mixed and formula fed infants as well as those exclusively or predominantly breastfed. The report considers complementary feeding only in relation to the breast fed infant. However, based on the breastfeeding rates reported from the last UK infant feeding survey (2010), most infants will receive some infant formula during the first six months of life. Therefore complementary feeding recommendations cannot</p>	<p>Thank you for your comments.</p> <p>SACN was of the view that its recommendations on the timing of introduction of solid foods were applicable to all infants, regardless of mode of feeding.</p> <p>SACN used methods in line with the SACN Framework for the</p>

Organisation/ Individual	Comments	Reply from SACN
	be focused only on breastfed infants.	<p>Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN noted the limited available evidence on the introduction of solid foods to exclusively formula fed and mixed fed infants which hindered consideration of this issue. They further highlighted the lack of clarity regarding how 'breastfeeding' and infant feeding patterns were defined in the study populations.</p> <p>As a result, SACN added a research recommendation on the need to examine the timing of introduction of solid foods and health outcomes in exclusively formula fed and mixed fed infants.</p>
BDA - PFASG	<p><u>Promotion of breastfeeding</u></p> <p>Breastfeeding could be more strongly promoted as the method of choice for all infants. While most (~80%) mothers initiate breastfeeding in the UK, this proportion rapidly declines until only half of mothers are breastfeeding at all by the time their infant is 6 weeks old and only a third by 6 months. Exclusive breastfeeding rates are low with only 1% of mothers doing this by 6 months. The benefits of breastfeeding could be highlighted and recommendations updated on the basis of new information e.g. from the recent Lancet series.<sup>1</sup></p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN considered the Lancet Breastfeeding Series (2016) (Victoria et al, 2016) and has included a reference to this in the updated report (see chapter on 'UK infant feeding practice').</p> <p>The risks associated with not breastfeeding infants are outlined in the chapter on 'Infant feeding, growth and health'.</p> <p>The promotion of breastfeeding falls under risk management and is therefore not in SACN's remit. Consequently, it is outside the scope of this report. However, SACN has added a recommendation stating that greater focus should be given to reducing breastfeeding attrition rates and supporting women who make the informed choice to breastfeed.</p>

Organisation/ Individual	Comments	Reply from SACN
BDA - PFASG	Support for qualitative research to assess mothers attitudes to breastfeeding and identify barriers and facilitators to this would be highly recommended.	<p>Thank you for your comments.</p> <p>Maternal attitudes to breastfeeding and the identification of barriers and facilitators to breastfeeding are outside the terms of reference of this report.</p> <p>However, SACN has added a recommendation stating that greater focus should be given to reducing breastfeeding attrition rates and supporting women who make the informed choice to breastfeed.</p>
BDA - PFASG	<p><u>Exclusive breastfeeding to around six months</u></p> <p>Evidence to support the recommendation to exclusively breastfeed for the first six months of life is not strong as stated in the report. Whilst several observational studies have reported exclusive breastfeeding to 6 months to be safe for most infants others have shown no harm in introducing solids between 4 and 6 months. RCT data in particular does not strongly support exclusive breastfeeding to 6 months (Cohen et al., 1994). A study in Honduras reported superior iron status in infants introduced to solids between 4 and 6 months compared with those introduced at around 6 months This was later confirmed in an RCT from Iceland (Jonsdottir et al., 2012).</p>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on 'Infant feeding, growth and health' and 'Infant feeding, body composition and health'.</p> <p>The studies by Dewey et al (1998) and Jonsdottir et al (2012) have been considered by SACN (see the chapter on 'Micronutrients'). The findings from these studies did not change the overall conclusions of the 'Feeding in the first year of life' report.</p>

Organisation/ Individual	Comments	Reply from SACN
BDA - PFASG	In view of this, rather than setting hard goals that may be difficult to attain for many mothers, eg to breastfeed exclusively for 6 months, a more relaxed approach to infant feeding guidance eg encouraging to breastfeed for as long as possible, may encourage more mothers to continue for longer.	<p>Thank you for your comments.</p> <p>SACN considered that the need for flexibility in advice is addressed by the wording “around 6 months.”</p> <p>SACN is of the view that the findings from the totality of evidence support current UK policy to recommend exclusive breastfeeding for around the first 6 months of life.</p> <p>SACN noted that data from the Infant Feeding Survey 2010 (McAndrew et al, 2012) indicated that following the change in policy in 2003 to recommending exclusive breastfeeding for around the first 6 months of life, there had been a five-fold increase in the number of mothers introducing solid foods between 4 and 6 months, compared with when the policy recommendation was 4 to 6 months exclusive breastfeeding, when a high percentage of mothers introduced solid foods before 4 months.</p> <p>SACN also recognised the importance of encouraging continued breastfeeding to 1 year of age and beyond, alongside solid foods, for both infant and maternal health outcomes. Text has been amended to further emphasise this point in the report.</p>
Becker G	Excellent report	Thank you for your comment.
Breastfeeding Network	This is very welcome. There are currently many conflicting and undermining messages	Thank you for your comment.
Brown R	First of all, thank you very much for this monumental piece of work, which is so crucial and helpful for those of us involved in guiding parents day by day with feeding their children, as well as training staff. I work as Infant Feeding Coordinator for an inner London borough and have been very involved in training staff and preparing resources for staff and parents about starting babies on solid foods. Having	Thank you for your comments.

Organisation/ Individual	Comments	Reply from SACN
	<p>an up-to-date and robust review of all the evidence is so important.</p> <p>The question of what kind of complementary foods are given when starting on solids is a very significant bone of contention between health professionals/academics, as well as being a great source of confusion for parents. It also has enormous political and economic undertones, with the baby food industry understandably very keen to maintain their market of largely pureed foods.</p>	
British Dental Association	The BDA welcomes this detailed evidence review by SACN. We are pleased to note the inclusion of oral health as a key consideration for general health and wellbeing, and the recognition of the important bi-directional relationship between infant feeding and oral health.	Thank you for your comments.
British Specialist Nutrition Association (BSNA)	<p>We welcome the acknowledgement in the report that the age of introduction of complementary foods should remain the same as current practice. While we understand the importance of recommending an age before which complementary feeding should not begin (in this case, 4 months), we would emphasise the importance of using the term ‘around 6 months of age’ in acknowledging that the introduction of complementary foods before 6 months is common practice in the UK(Lennox et al 2013; McAndrew et al 2012). Maintaining some flexibility in the advice provided will be beneficial in permitting an individual approach to the introduction of complementary foods in line with the natural variability in nutritional requirements and the neurodevelopmental readiness of infants at around 6 months of age (Carruth and Skinner, 2002; Fewtrell et al 2017) Furthermore, such flexibility goes some way towards ensuring that the UK position is not contradictory to that of other European groups (EFSA, 2009).</p>	<p>Thank you for your comments.</p> <p>SACN considered that the need for flexibility in advice is addressed by the wording “around 6 months.”</p> <p>SACN is of the view that the findings from the totality of evidence support current UK policy to recommend exclusive breastfeeding for around the first 6 months of life.</p> <p>SACN noted that data from the Infant Feeding Survey 2010 (McAndrew et al, 2012) indicated that following the change in policy in 2003 to recommending exclusive breastfeeding for around the first 6 months of life, there had been a five-fold increase in the number of mothers introducing solid foods between 4 and 6 months, compared with when the policy recommendation was 4 to 6 months exclusive breastfeeding, when a high percentage of mothers introduced solid foods before 4 months.</p>
British Society of Paediatric Dentistry.	Thank you for drafting a comprehensive and evidence-based report which highlights the importance of children's oral health. Whilst welcoming this report, we would be interested to see a follow up publication looking at infant feeding post 12 months.	<p>Thank you for your comments.</p> <p>Work on a review of ‘Feeding children aged 12-60 months’ will start in earnest once this report has been published.</p>



Organisation/ Individual	Comments	Reply from SACN
Crawley H	<p>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.</p> <p>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.</p>	<p>Thank you for your comments.</p> <p>SACN considered the Lancet Breastfeeding Series (2016) (Victora et al, 2016) and has included a reference to this in the updated report (see chapter on 'UK infant feeding practice').</p>
Dalzell J , Richards D	General Comments- Does not adhere to 0-12 months throughout document	<p>Thank you for your comments.</p> <p>The report has been checked for consistency and amended where required.</p>
Ella's kitchen	We welcome any new report on infant feeding, particularly one that examines the evidence supporting parental feeding practices that may improve an infant's developing relationship with food. The report is an impressive body of work synthesising many of the major studies in this area and is an important contribution to childhood wellbeing.	Thank you for your comments.
Hetherington M, Fildes A	Thank you for the opportunity to comment on the SACN draft report 'Feeding in the First Year of Life' and the interpretation of the scientific evidence presented within it. We welcome this report and are particularly encouraged to see the inclusion of Chapter 8 'Eating and feeding of solid foods' which discusses the behavioural aspects of complementary feeding.	Thank you for your comments.
HENRY	<p>HENRY is an early years charity dedicated to supporting children to get the best possible start in life. We focus particularly on the prevention and management of early child obesity of which infant feeding is a critical element. We are very pleased to see the committee looking at this area. In particular, we:</p> <p>Agree with the proposed recommendations for exclusive breastfeeding in the first 6 months and agree with the committee that more should be done to support mother in the UK to achieve this.</p> <p>Agree with the committee that the Government should reintroduce the Infant Feeding Survey, or some other means of accurately tracking trends in infant feeding in the UK, as policy recommendations are very difficult to make in the absence of this data.</p>	Thank you for your comments.

Organisation/ Individual	Comments	Reply from SACN
	<p>Agree with the need for further research across the areas recommended by the committee. Particularly in the area of the impact if responsiveness in feeding across the first year of life and the impact of Baby Led Weaning.</p>	
GP Infant Feeding Network	<p>This is an excellent appraisal of current evidence – and is also a comprehensive summary of knowledge required for all health professionals.</p> <p>We welcome a re-iteration of the strong evidence base demonstrating the multiple health benefits of breastfeeding for both infant and mother. This summary highlights the need for policy development to promote exclusive breastfeeding until 6 months and continued breastfeeding throughout the first year to 2 years and beyond in line with WHO policy. The presentation of evidence on micronutrients and risks of early weaning is particularly welcome.</p> <p>We would urge all organisations to take note and for this to be incorporated into educational frameworks as well as when considering creating environmental and public health guidance. The potential projected benefits for the long term health of the population, and therefore the economic viability of the NHS and other associated public services makes supporting a breastfeeding friendly policy essential. It cannot be over-emphasised that these are benefits which have life-long impact and raising public awareness of risk reduction in cancer, cardiovascular disease and obesity is vital.</p> <p>This will be a valuable resource to be used in conjunction with other materials supporting breastfeeding.</p>	Thank you for your comments.
La Leche League GB	General note, there is no consistency between use of breastmilk (50 occurrences) or breast milk (85 occurrences).	<p>Thank you for your comment.</p> <p>SACN agreed that ‘breast milk’ should be used consistently throughout the report. The report has been amended where required.</p>
Pearson-Glaze P	General note, there is no consistency between use of breastmilk (50 occurrences) or breast milk (85 occurrences).	<p>Thank you for your comment.</p> <p>SACN agreed that ‘breast milk’ should be used consistently throughout the report. The report has been amended where required.</p>

Organisation/ Individual	Comments	Reply from SACN
Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group	This extensive review takes a comprehensive approach to formulating recommendations aimed at improving population and individual's health in the first year of life.	Thank you for your comment.
RCPCH	<p>RCPCH updated its position statement on breastfeeding in August 2017  <a href="http://www.rcpch.ac.uk/system/files/protected/news/WEBSITE%20FINAL%20Breastfeeding%20Position%20Statement%20280717_0.pdf">http://www.rcpch.ac.uk/system/files/protected/news/WEBSITE%20FINAL%20Breastfeeding%20Position%20Statement%20280717_0.pdf</a></p> <p>As can be seen from this statement, RCPCH agrees that recent data from the most robust series of meta-analyses to date, with comprehensive assessment of study quality and sources of potential bias, indicate that breastfeeding is likely to be causally related to reduced risk of gastro-intestinal, respiratory and ear infections and reduced need for hospitalisation for infections, in all settings. This protection is seen whilst the infant is receiving breast-milk, and is greater with exclusive than with partial breastfeeding. The protective benefits are large and the evidence consistent and biologically plausible.</p> <p>RCPCH strongly supports breastfeeding, the promotion of breastfeeding, the provision of advice and support for women, and national policies, practices, and legislation that are conducive to breastfeeding. We also note that whilst breastfeeding is a natural process, mothers may require support, knowledge and education. With such support, the expectation is that most women will be able to breastfeed.</p> <p>RCPCH is working with a wide range of organisations to consider how breastfeeding rates in the UK can be increased.</p>	Thank you for your comments.
RCPCH	The report is called 'Feeding in the first year of life', but the terms of reference are more focussed on complementary feeding, and the health and economic benefits of breastfeeding per se (or the adverse consequences of not breastfeeding) are not covered in a comprehensive way. A review of the scientific evidence on this topic from a series of systematic reviews and meta-analyses (recently summarised by Victora et al 2016 in the Lancet series) would enable current recommendations and advice to parents on breastfeeding to be updated to reflect recent developments. In addition the issue of the appropriate age for introduction of solids in formula-fed infants is not specifically discussed, even to highlight the	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p>

Organisation/ Individual	Comments	Reply from SACN
	lack of good quality evidence. This is important given that the majority of British infants are currently receiving at least some formula by 4-6 months.	<p>SACN noted that limitations of the available evidence hindered consideration of the issue of timing of introduction of solid foods to non-breastfed babies. In particular:</p> <ul style="list-style-type: none"> <li>• the limited available evidence on the introduction of solid foods to exclusively formula fed and mixed fed infants</li> <li>• the lack of clarity regarding how 'breastfeeding' and infant feeding patterns were defined in the study populations.</li> </ul> <p>SACN reviewed the wording and made amendments to the text relating to breastfeeding and age of introduction of solid foods, where appropriate.</p> <p>SACN has added a research recommendation on the need to examine the timing of introduction of solid foods and health outcomes in exclusively formula fed and mixed fed infants, as well as exclusively breastfed infants.</p> <p>SACN considered the Lancet Breastfeeding Series (2016) (Victora et al, 2016) and has included a reference to this in the updated report (see chapter on 'UK infant feeding practice').</p>
RCPCH	The report structure should be reconsidered in order to reduce repetition and a summary of the recommendations should be included.	<p>Thank you for your comments.</p> <p>The report has been edited for clarity and consistency and to minimise repetition. An executive summary has been added.</p>
RCPCH	The description of the methodological approach used to identify relevant studies is imprecise and inadequate.	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p>

Organisation/ Individual	Comments	Reply from SACN
RCPCH	There are frequent statements along the lines of ‘a study shows,’ or ‘studies show’ without references and this is unsatisfactory, for example in paragraphs 510, 511 and 514.	<p>Thank you for your comment.</p> <p>The report has been proof read in detail to ensure references are included as necessary. As with other SACN reports, references are not included in concluding statements.</p>
RCPCH	Given the increasing popularity of vegetarian and vegan diets, it would be helpful for the Committee to consider their role in complementary feeding in order to formulate recommendations and provide advice.	<p>Thank you for your comment.</p> <p>The formulation of recommendations and provision of advice are the responsibility of risk managers. SACN has recommended that risk managers consider how to develop and communicate advice on the role of vegetarian and vegan diets during complementary feeding.</p> <p>SACN has added a research recommendation on the need to examine the potential impact of different dietary patterns (such as vegetarian or vegan diets) on infant immediate and long term health outcomes.</p>
WBTi	<p>More of the recent research on the impact of breastfeeding on infant and maternal health collected in Acta paediatric 2015 Special issue could have been included: Acta Paediatrica Special Issue: Impact of Breastfeeding on Maternal and Child Health. December 2015 Volume 104, Issue Supplement S467 Pages 1–134. <a href="http://onlinelibrary.wiley.com/doi/10.1111/apa.2015.104.issue-S467/issuetoc">http://onlinelibrary.wiley.com/doi/10.1111/apa.2015.104.issue-S467/issuetoc</a></p>	<p>Thank you for highlighting this evidence.</p> <p>SACN has considered the references included in the Acta Paediatrica Special Issue.</p> <p>In line with the approach set out in the ‘Methodology’ chapter, SACN only considered newly available evidence where the findings might influence the conclusions of the ‘Feeding in the first year of life’ report.</p> <p>Text has been added on the association between breastfeeding and neurodevelopmental outcomes (see chapter on ‘Infant feeding, growth and health’).</p>

## Specific comments by chapter

**Table 2.1: Specific comments on Chapter 1. Introduction (Paragraphs 1–15)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	BDA - PFASG	The wider role of complementary feeding could be addressed i.e. developmental as well as nutritional factors	Thank you for your comment.  The developmental aspects of complementary feeding are outside SACN's remit and have therefore not been covered in this report.
General	BDA - PFASG	A risk benefit analysis concerning the introduction of allergenic foods is needed in light of new evidence from RCTs since previous reports	Thank you for your comment.  A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen's egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group's statement was provided in the draft report. For information, the statement is available here: <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a>
General	BDA - PFASG	Micronutrient status, in particular iron, should also be considered. Complementary feeding is needed not only to accustom the infant to solid foods but has an important role in bridging the gap in nutrient provision from breast or formula milk	Thank you for your comments.  Micronutrient status, including iron, is covered in the 'Micronutrients' chapter of the report.
General	BDA - PFASG	Evidence for the optimal duration of breastfeeding to protect against infections in developing countries is strong but not so convincing for developed countries such as the UK. Most studies have compared shorter versus longer durations rather than specifically comparing 4-6 with 6 months of exclusive breastfeeding. Therefore the optimal duration is unknown.	Thank you for your comment.  SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			<p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on ‘Infant feeding, growth and health’ and ‘Infant feeding, body composition and health’.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on ‘Risks of allergic and autoimmune disease’).</p> <p>SACN is of the view that the findings from the totality of evidence support current UK policy to recommend exclusive breastfeeding for around the first 6 months of life.</p>
1	Breastfeeding Network	<p><i>There has been no comprehensive risk assessment of infant and young child feeding in the UK since the Committee on Medical Aspects of Food Policy (COMA) published its report ‘Weaning and The Weaning Diet’ in 1994.</i></p> <p>This is very welcome. There are currently many conflicting and undermining messages.</p>	Thank you for your comment.
2	RCPCH	<p>Recommendations by international expert committees: The report on complementary feeding by EFSA (2009) could be cited here Also the ESPGHAN Position paper on complementary feeding (Fewtrell et al 2017)</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN considered the reports listed and has included reference to these in the updated report.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
4 (ToR)	RCPCH	<p>The terms of reference of the report states that ‘breastfeeding is the physiological norm, based on the fact that 80% of infants are at least initially breastfed’. Whilst footnote 2 explains ‘incidence of breastfeeding is defined as the proportion of babies who were breastfed initially. This includes all babies who were put to the breast at all, even if this was on one occasion only. It also includes giving expressed breastmilk to the baby,’ this definition ignores the reality of breastfeeding rates in the UK in terms of how long the activity is sustained for. By 6-8 weeks a much smaller percentage of babies are receiving any breastmilk (43.2% in England ,38.9% in Scotland ). Whilst the RCPCH is working to improve breastfeeding rates, these figures show that breastfeeding is not the norm in reality in the UK and the terms of reference of the report should be amended to reflect the norms currently observable. RCPCH believes that a more evidence-based, pragmatic, less dogmatic approach is preferable, focussing on breastfeeding per se rather than on exclusively breastfeeding for a particular period of time, particularly when the evidence supporting the latter in the UK context is not strong.</p>	<p>Thank you for your comments.</p> <p>SACN has amended the text to improve clarity regarding breastfeeding figures.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN considered that the need for flexibility in advice is addressed by the wording “around 6 months.”</p> <p>SACN is of the view that the findings from the totality of evidence support current UK policy to recommend exclusive breastfeeding for around the first 6 months of life.</p> <p>SACN noted that data from the Infant Feeding Survey 2010 (McAndrew et al, 2012) indicated that following the change in policy in 2003 to recommending exclusive breastfeeding for around the first 6 months of life, there had been a five-fold increase in the number of mothers introducing solid foods between 4 and 6 months, compared with when the policy recommendation was 4 to 6 months exclusive breastfeeding, when a high percentage of mothers introduced solid foods before 4 months.</p> <p>SACN also recognised the importance of encouraging continued breastfeeding to 1 year of age and beyond, alongside solid foods, for both infant and maternal health outcomes. Text has been amended to further emphasise this point in the report.</p>
4 (ToR)	RCPCH	<p>It would be helpful to include the definition of ‘complementary feeding’ used in this report early on in the document, to make it clear whether this includes ‘anything except milk (breast milk or formula)’ or ‘anything except breast milk’.</p>	<p>Thank you for your comments.</p> <p>The definition of complementary feeding used in the report has been included in the glossary and highlighted in bold in the introductory section of the report.</p>



Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
6	RCPCH	<p>The report states ‘breastfeeding is the physiological norm and in the UK 80% of babies are breastfed initially’. A reference is required for this figure. The RCPCH agrees with the first element of the statement but disputes the accuracy of the 80% figure when applied to the whole of infancy. The percentage of babies receiving breastmilk at 6-8 weeks is substantially lower than the initiation rate (43.2% in England and 38.9% in Scotland) which indicates that breastfeeding is not the norm in practice after the first few days/ weeks of infancy.</p>	<p>Thank you for your comment.</p> <p>SACN has reviewed the text to include the reference to the Infant Feeding Survey 2010 (McAndrew et al 2012) and further details on UK infant feeding practice from the survey findings have been included.</p>
6	RCPCH	<p>It is stated that ‘the role, timing and type of complementary food can only be considered within the context of their potential benefits balanced against the risk of displacing breast milk’. This is not accurate, since the purpose of a complementary food is to ‘complement’ the nutrients provided from breast milk at a point where they cannot alone support growth and development. From a nutritional perspective, the issue is to identify the age at which this occurs, and to identify the nutrient gaps which need to be filled by the complementary foods which will differ for breast versus formula-fed infants. Complementary foods are also required for behavioural and developmental reasons, so that infants progress onto the family diet.</p> <p>The emphasis on the need to balance risks and benefits when drawing conclusions highlights the importance of considering the whole range of relevant outcomes – including allergy and coeliac disease. The decision to keep the detailed consideration of evidence on the age at introduction of allergenic foods or gluten to separate documents which are not part of the current consultation, with only a summary in the current report, is therefore unsatisfactory.</p>	<p>Thank you for your comments.</p> <p>The definition of complementary feeding used in the report has been included in the glossary and highlighted in bold in the introductory section of report.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on ‘Infant feeding, growth and health’ and ‘Infant feeding, body composition and health’.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on ‘Risks of allergic and autoimmune disease’).</p> <p>Both the FSA-commissioned systematic review on the timing of introduction of allergenic foods to the infant diet (Boyle et al, 2016a) and accompanying COT statement (COT 2016b) highlighted that</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			<p>findings on the timing of introduction of foods containing peanut and hen's egg into the infant diet in relation to the risk of developing peanut and hen's egg allergy respectively, might impact current government advice and required further consideration.</p> <p>A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen's egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group's statement was provided in the draft report. For information, the statement is available here:  <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>SACN has updated the text in the chapter 'Risks of allergic and autoimmune disease' to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease. These reviews included consideration of gluten, and infant formulae containing hydrolysed cows' milk protein. The FSA-commissioned reviews were evaluated by COT (COT, 2016a; COT, 2016b; COT, 2017) and have also been published in the peer reviewed literature (Boyle et al., 2016b; Ierodiakonou et al., 2016; Garcia-Larsen et al., 2018).</p> <p>SACN has also added further background on the development of current recommendations, including those on gluten.</p>
8	RCPCH	Growth is not the only outcome of importance related to nutritional adequacy; micronutrient status, especially iron status, is also important.	<p>Thank you for your comment.</p> <p>The range of outcomes considered in the report are outlined in the 'Methodology' chapter. This has been reviewed and updated for clarity.</p> <p>In addition, SACN updated the 'Micronutrients' chapter to highlight the link between micronutrient status and other health outcomes.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
12	Breastfeeding Network	<p>'Accordingly the report also set out to summarise evidence from the field of behavioural psychology on food acceptance in the early years.'</p> <p>The inclusion of behavioural psychology is welcome. Waiting till around 6 months before introducing solid food makes it more likely that babies are active in the process of learning new tastes and textures and the experience ought to be quicker and more enjoyable for all involved. This is often forgotten.</p>	Thank you for your comments.
14	RCPCH	<p>Paragraph 14. The introduction of gluten should be mentioned here or elsewhere. Along with the introduction of allergenic foods, this is one of the few areas for which the evidence base has improved in recent years with the publication of 2 large RCTs in the NEJM.</p>	<p>Thank you for your comment.</p> <p>SACN has updated the text in the chapter 'Risks of allergic and autoimmune disease' to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease. These reviews included consideration of gluten. The FSA-commissioned reviews were evaluated by COT (COT 2016a, 2016b, 2017) and have also been published in the peer reviewed literature (Boyle et al, 2016b; Ierodiakonou et al, 2016; Garcia-Larsen et al, 2018).</p> <p>SACN has also added further background on the development of current recommendations, including those on gluten.</p>

**Table 2.2: Specific comments on Chapter 2. Policy background (Paragraphs 16-41)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
23	Dalzell J, Richards D	Prior to Healthy Start the withdrawal of infant formula sales from health centres took place	Thank you for your comment.
25	RCPCH	The systematic review and meta-analysis by Kramer & Kakuma plus the update from 2012 (Kramer & Kakuma , 2012) which, along with a separate paper on nutritional adequacy and developmental readiness (Butte et al, 2002), formed the basis of the WHO recommendation, could be included here. This section could also mention the EFSA opinion of 2009.	Thank you for your comment.  This section is specifically concerned with the WHO recommendations. SACN considered the current text to be sufficient and therefore did not amend.
31	RCPCH	It is not correct to state that the purpose of introducing foods other than breast milk is to 'diversify the diet whilst breastfeeding continues'. Whilst dietary diversification is one aspect, the main purpose of complementary foods in a breast fed infant is to complement the nutrients provided from breast milk at the point they can no longer support the infant's requirements for growth and development.	Thank you for your comment.  The definition of complementary feeding used in the report has been included in the glossary and highlighted in bold in the introductory section of report.  Accompanying text on the purpose of introducing solid foods has also been amended.
31	BDA - PFASG	This states that more than one definition of complementary foods exists. It needs to be made clear at this point what definition is used in the report.	Thank you for your comment.  The definition of complementary feeding used in the report has been included in the glossary and highlighted in bold in the introductory section of report.
35	Crawley H	Could usefully mention the NICE maternal and child nutrition Quality Standards (QS98, 2015) <a href="https://www.nice.org.uk/guidance/qs98/resources/maternal-and-child-nutrition-pdf-2098975759045">https://www.nice.org.uk/guidance/qs98/resources/maternal-and-child-nutrition-pdf-2098975759045</a> .	Thank you for your comment.  SACN has not included a reference to the quality standard as the NICE guideline PH11, on which it is based, is already referenced (NICE, 2014).

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
35	Dalzell J, Richards D	Is there a Scottish equivalent?	Thank you for your comment. SACN provides advice across the UK and has clarified the text in this respect.
38	La Leche League GB	It would be useful to include SACN's opinion on studies that suggest if mothers take a high enough dose of vitamin D then this will provide enough vitamin D in their breast milk. eg to address the ideas in these articles <a href="https://www.vitamindcouncil.org/vitamin-d-during-pregnancy-and-breastfeeding/#">https://www.vitamindcouncil.org/vitamin-d-during-pregnancy-and-breastfeeding/#</a> <a href="http://blogs.creighton.edu/heaney/2014/06/05/vitamin-d-and-the-nursing-mother/">http://blogs.creighton.edu/heaney/2014/06/05/vitamin-d-and-the-nursing-mother/</a>	Thank you for your comment.  Vitamin D was considered in a recent SACN risk assessment, Vitamin D and Health, 2016 (SACN, 2016) and findings from this report are included in the 'Micronutrients' chapter.
40	Crawley H	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.	Thank you for your comment.  SACN has amended the text as suggested to improve clarity. Please note that this text has been moved to the chapter on 'Risks of allergic and autoimmune disease'.
41	Crawley H	'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.	Thank you for your comment.  SACN has added the definition of free sugars to the glossary and the text has been reviewed to ensure that the correct terms are used.
41	Breastfeeding Network	The sugar reduction plan is welcome however much could be achieved by avoiding very sweet foods in the first place and encouraging family / or savoury first foods.	Thank you for your comment.

**Table 2.3: Specific comments on Chapter 3. Methodology (Paragraphs 42-60)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
52	Crawley H	Is the word ‘intensity’ the right word for how you breastfeed? Perhaps frequency is what is meant here.	<p>Thank you for your comment.</p> <p>SACN has replaced “intensity of breastfeeding” with “degree of exclusivity of breastfeeding” to improve clarity.</p> <p>A definition of breastfeeding intensity has been added to the glossary.</p>
56	Dalzell J, Richards D	There is no evidence that heavier infants or hungrier may be more demanding. There is strong evidence that if a mother responsively breastfeeds she will produce enough milk for her baby.	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN has amended the text to improve clarity.</p>
57	Royal College of Midwives	<p><u>Socio-economic influences on breastfeeding</u></p> <p>The prevalence of breastfeeding has profound implications for the health of both mother and baby. As it can give rise to health inequality of generations, it is a government priority at the forefront of the public health policy agenda.</p> <p>The RCM recognises that socio-economic and other complex factors can have a considerable influence on breastfeeding rates. We acknowledge the reference given to this in paragraph 57, but believe it to be of such relevance to a scientific enquiry on feeding in the first year of life as to warrant more attention from the Committee, inclusion within the body of the report and to feature amongst the Committee’s recommendations – where it is sadly absent.</p> <p>Explanations as to why breastfeeding rates in the UK compare unfavourably with other developed nations are multiple and varied. The prevalence of</p>	<p>Thank you for your comments.</p> <p>SACN noted that socio-demographic factors, such as smoking, parental education, socioeconomic status and family size, are highlighted as confounders for infant feeding patterns in the ‘Methodology’ and ‘Conclusions and recommendations’ chapters.</p> <p>The socio-economic factors influencing breastfeeding rates, and other barriers and facilitators to breastfeeding, fall under risk management. Consequently, they are not in SACN’s remit and therefore are not considered in this report. However, SACN recognise that these are important issues and has added a recommendation stating that greater focus should be given to reducing breastfeeding attrition rates and supporting women who make the informed choice to breastfeed.</p>

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		<p>breastfeeding is especially low among very young mothers and disadvantaged socio-economic groups. Data from the 2010 Infant Feeding Survey showed that 46% of mothers in the most deprived areas were breastfeeding, compared with 65% in least deprived areas.</p> <p>Financial pressures may result in mothers returning to the workforce before they are ready to stop breastfeeding and cultural intolerance of breastfeeding mothers in the workplace is clearly unhelpful. Recent welfare reforms have seen an upsurge in the number of families dependent on food bank subsidy and there is likely to be a negative impact on breastfeeding with increased food poverty. More research into this is clearly needed.</p> <p>Societal attitudes may lead to women feeling uncomfortable about breastfeeding in public, under pressure to supplement to achieve weight gain and to be in doubt about their own milk production. The RCM works hard to promote breastfeeding acceptance across communities and would encourage the Committee to make recommendations which will do likewise.</p> <p>Public Health England commissioned survey of 500 mothers (March 2107) showed that more than half were concerned that breastfeeding could mean that they wouldn't be able to tell if their baby was getting too much or not enough milk.</p> <p>Nearly 3 in 10 worried that breastfeeding could mean their baby might not be getting the right nutrients, indicating why mothers may stop breastfeeding at an early point.</p> <p>Healthy Start food and vitamin vouchers support low income families across the UK, and their uptake can be patchy. The RCM believes that consistent advice about micronutrients (Chapter 7) must be given to all mothers in relation to supplements and dietary requirements in pregnancy and while breastfeeding.</p> <p>High quality and ongoing support by midwives, maternity support workers and other health professionals is crucial, if the aspiration to improve breastfeeding rates in the UK is to succeed.</p>	

**Table 2.4: Specific comments on Chapter 4. Infant feeding, growth and health (Paragraphs 61-127)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	BDA - PFASG	<p>Breastfeeding and Health Outcomes</p> <ul style="list-style-type: none"> <li>The introduction of infant formula, rather than CF, has been associated with an increased likelihood of hospital admission in the UK(Quigley et al 2009).</li> </ul>	<p>Thank you for your comment and for highlighting this evidence.</p> <p>SACN has reviewed this text and made amendments where necessary to improve clarity.</p>
General	BDA - PFASG	<p>The report does not fully address the benefits of exclusive breastfeeding to 6 months against the risks of not introducing allergenic foods alongside breastfeeding.</p>	<p>Thank you for your comment.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on ‘Infant feeding, growth and health’ and ‘Infant feeding, body composition and health’.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on ‘Risks of allergic and autoimmune disease’).</p> <p>Both the FSA-commissioned systematic review on the timing of introduction of allergenic foods to the infant diet (Boyle et al, 2016a) and accompanying COT statement (COT 2016b) highlighted that findings on the timing of introduction of foods containing peanut and hen’s egg into the infant diet in relation to the risk of developing peanut and hen’s egg allergy</p>

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>



Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			<p>respectively, might impact current government advice and required further consideration.</p> <p>SACN has updated the chapter on ‘Risks of allergic and autoimmune disease’ to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease. The FSA-commissioned reviews were evaluated by COT (COT 2016a; COT, 2016b; COT, 2017) and have also been published in the peer reviewed literature (Boyle et al, 2016b; Ierodiakonou et al, 2016; Garcia-Larsen et al, 2018).</p> <p>A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen’s egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group’s statement was provided in the draft report. For information, the statement is available here:  <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a>.</p> <p>This chapter has been reviewed and updated for clarity throughout.</p>
General	Breastfeeding Network	One of the greatest achievements of ‘around 6 months’ is that the anxiety caused by the 4-6 months guidance has evaporated. We no longer get distressed calls from mothers reaching the 6 months mark fearing their baby will not learn to eat.	Thank you for your comment.
General	Dalzell J, Richards D	Chapter 4: Infant feeding growth and health(Horta et al 2015a; Horta et al 2015b; Sankar et al2015, Giugliani et al 2015; Lodge et al 2015)	<p>Thank you for highlighting this evidence.</p> <p>SACN has considered the references listed and text has been added on the association between breastfeeding and neurodevelopmental outcomes (see chapter on ‘Infant feeding, growth and health’).</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	Infant Feeding Support UK	<p>Furthermore, it is critical to understand whether the increases in breastfeeding rates that would be required to achieve the savings described in SACN’s report on p30 can actually be achieved; how this can be achieved, and how much it would cost to achieve this. The modelling conducted by Renfrew et al (2012) and Pohkrel et al (2014) does not establish what it would cost to achieve the increase in rates required, or whether the type of interventions advocated will deliver the necessary improvement in rates. More recently, a systematic review of cost-effectiveness studies failed to identify any breastfeeding promotion studies which could be used to calculate “return on investment” ( Masters et al 2017)</p> <p>If more mothers are encouraged to breastfeed then it follows that the incidence of breastfeeding related morbidities such as thrush, mastitis, subclinical mastitis, cracked nipples, D-MER and other associated conditions are also likely to increase, and this should also be considered in any cost analysis.</p> <p>With regards to helping mother breastfeed for longer, two recent randomized studies have sought to identify how such mothers might be helped (Flaherman et al 2013; Straňák et al 2016)</p>	<p>Thank you for your comments.</p> <p>SACN has removed reference to potential cost savings associated with breastfeeding as consideration of cost effectiveness is outside the committee’s remit.</p> <p>The promotion of breastfeeding and encouraging women to breastfeed for longer fall under risk management and are therefore not in SACN’s remit. Consequently, it is outside the scope of this report. However, SACN has added a recommendation stating that greater focus should be given to reducing breastfeeding attrition rates and supporting women who make the informed choice to breastfeed.</p>
General	Infant Feeding Support UK	<p>As a general comment, we would caution definitive conclusions regarding causation based on observational studies. As the SACN report states ‘in relation to infant feeding, it is necessary to use additional evidence from observational cohort studies, although the latter cannot be used to infer causation’. Furthermore, any claims should be backed up with suitable scientific references; for example, the report states that “some limited evidence suggests that formula-fed and breastfed infants differ in their ability to regulate milk intake; formula fed infants may not do so until they are over six weeks of age’, yet provides no evidence for this claim.</p>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>The report has been reviewed to ensure that the conclusions accurately reflect the type and strength of the evidence considered and that references are included as necessary. In keeping with the style of SACN reports, concluding statements are not supported by citations.</p> <p>In relation to this specific example, reference support is provided in the associated text found in the section on ‘Feeding and regulation of intake’.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	RCPCH	The default position of the report is that infants should be exclusively breastfed for 6 months and that earlier introduction of complementary foods must be justified by proving benefits outweigh the 'risk' of displacing breastmilk. However the few higher quality RCTs (randomised) studies demonstrated no negative effects where infants were randomised to start complementary foods at 4 v 6 months (and in fact, better iron status was found in the earlier introduction groups in two trials).	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on 'Infant feeding, growth and health' and 'Infant feeding, body composition and health'.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on 'Risks of allergic and autoimmune disease').</p>
General	WBTi	Magnetic imaging resonance studies found that babies who are formula fed have less white matter as their brains develop - even at 2 years of age(Deoni et al 2013)	<p>Thank you for your comment.</p> <p>SACN considered that the relevance of this outcome measure to later health is unclear and this has therefore not been examined further.</p>
62	RCPCH	RCPCH is not aware of evidence to support the statement that healthy infants are capable of absorbing sufficient amounts of micronutrients from complementary foods 'by six months' as opposed to 'by 4 or 5 months'. Indeed, the fact that infants have for many years thrived whilst receiving other foods considerably earlier than 6 months would suggest that this capability is achieved before 6 months.	<p>Thank you for your comments.</p> <p>SACN has amended the text to better describe the gradual maturational changes to gastrointestinal function that occur over the first months of life. In particular, "by 6 months" has been removed to address the point raised.</p>
73	RCPCH	The report states a number of times that 6 months is the age when infants are developmentally ready for complementary foods. Chapter 4 outlines the gastrointestinal, renal and neurological development of infants and provides the evidence for this statement, however the evidence is not	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		appraised and many nuances in the included text (e.g. ‘within populations there are considerable inter-individual variation in the attainment of skills,’ - paragraph 73, and ‘20% reached out for food as early as four to five months,’ paragraph 75) are not translated into the conclusion.	<p>approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN is of the view that the findings from the totality of evidence support current UK policy to recommend exclusive breastfeeding for around the first 6 months of life.</p> <p>SACN considered that the need for flexibility in advice is addressed by the wording “around 6 months” and has reviewed the report to ensure that where appropriate, the term “around 6 months” is used.</p> <p>Text has been amended to address the point raised regarding variations in developmental readiness.</p>
74	Breastfeeding Network	Chewing is important and is learnt independently to swallowing purees – so early introduction just means a two stage process.	Thank you for your comment.
79	RCPCH	If the mean age at introducing complimentary food was 5.4 months then it would be more accurate to state this rather than generalising to ‘around 6 months’ or indeed ‘around 5 months’, which is closer to the mean average.	<p>Thank you for your comment.</p> <p>SACN has amended this paragraph to better reflect the duration of breastfeeding of infants in the WHO Multicentre Growth Reference Study (WHO MGRS, 2006a, 2006b), on which the growth standards were based.</p>
79	BDA - PFASG	With respect to the WHO growth standards, the mean age at introduction of CF was 5.4 months but has been reported as around 6 months. The mean age at CF could equally be reported as around 5 months perhaps reflecting more accurately what is actually done.	<p>Thank you for your comment.</p> <p>SACN has amended this paragraph to better reflect the duration of breastfeeding of infants in the WHO Multicentre Growth Reference Study (WHO MGRS, 2006a, 2006b), on which the growth standards were based.</p>
81	Breastfeeding Network	The gap in the growth charts during the first two weeks has a sound basis however the uncertainty about the best evidence for infant feeding plans by gradations of % weight loss, allows for significant variations in care. For example there is a popular hypothesis that large volumes of fluid via an epidural, while the mother is in labour, can lead to rapid weight loss in the first few days. This has not been tested adequately yet can delay	<p>Thank you for your comments.</p> <p>While the committee recognises that this is potentially an important issue, it is outside the terms of reference of the report.</p> <p>Furthermore, SACN considered that evidence had not been provided to support these points.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		interventions to increase milk transfer for vulnerable infants. The growth charts, particularly the de-emphasising of the 50th centile have helped parents understand their babies growth. If possible it would help to reiterate that babies should not have breastfeeds restricted if they are on the top centiles.	
83	RCPCH	'Exclusive breastfeeding during the first half of infancy' implies up to 6 months. The supporting evidence is not that specific. 'First months of infancy' would be more appropriate.	Thank you for your comment.  SACN has amended the text to more accurately reflect the contribution of breast milk to the infant's developing immune system.
83	WBTi	Breastmilk oligosacharides have anti-microbial properties <a href="http://pubs.acs.org/doi/abs/10.1021/acsinfecdis.7b00064">http://pubs.acs.org/doi/abs/10.1021/acsinfecdis.7b00064</a> (Ackerman et al 2017)	Thank you for highlighting this evidence.  SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.  SACN noted that this is an in vitro study and therefore does not meet the inclusion criteria for consideration in the report.
85	Breastfeeding Network	Freedom from infections is important for child and careers, particularly for mothers returning to work.	Thank you for your comment.
85-102	RCPCH	We agree that the evidence for a protective effect of breastfeeding per se against infectious outcomes is convincing, certainly over the first 6 months. Few studies have investigated the impact of longer periods of breastfeeding in higher income settings, although the recent analysis from the Norwegian Mother and Baby cohort suggested that the risk of hospitalisation for infection was similar for infants with any breastfeeding for 6-11 v >12months (Størdalet al 2017).	Thank you for your comments and for highlighting this evidence.  SACN noted that this evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'.

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
85-102	RCPCH	<p>Fewer studies have specifically addressed the effect of exclusive breastfeeding duration or the age at introduction of solid foods on infectious disease in high income settings, and the findings are difficult to compare due to differences in definitions and categorization of breast-feeding/ exclusive breastfeeding, classification and definitions of infection, and methods of ascertainment for both exposure and outcome variables. We agree that collectively these observational studies suggest that more prolonged exclusive breastfeeding may protect against infection and hospitalization for infection in infants in high-income settings with access to clean water supplies and safe complementary foods, such as the UK. It should be noted however, that most of these studies are looking at 'longer' versus 'shorter' durations of exclusive breastfeeding rather than 6 months v 4-6 months specifically, because in many cohorts only a relatively small proportion of mothers exclusive breastfeeding for 6 months. The following additional relevant studies could be cited in this section and the table at Appendix 1 contains a summary of their main findings: (Chantry et 2006; Rebhan et al 2009; Ladomenou et al 2010; Li et al 2014; Størdal et al 2017)</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN has considered the evidence highlighted and agreed that the findings do not change the conclusions of the 'Feeding in the first year of life' report. Therefore the evidence has not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p>
85-102	RCPCH	<p>RCPCH think it is important to emphasise the findings from the UK Millennium Birth Cohort Study (Quigley 2009), in which it was shown that it was the introduction of infant formula, not solid foods, that predicted an increased likelihood of hospital admission. As summarised in the SACN report appendix, (table 4.1), but not currently mentioned in the text, the monthly risk of hospitalization was not significantly higher in those who had received solids compared with those not on solids (for diarrhoea, adjusted OR 1.39, 95% CI 0.75–2.59; for lower respiratory tract infection, adjusted OR 1.14, 95% CI 0.76–1.70), and the risk did not vary significantly according to the age of starting solids. Thus, it appeared to be the introduction of formula feeding alongside breastfeeding that was problematic.</p> <p>More recently, the EAT RCT, in which the median duration of exclusive breastfeeding was 16 weeks in the intervention group and 24 weeks in the control group, reported that, whilst parent-reported upper respiratory tract infection in the 4-to-6 month period was significantly higher in the</p>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN considered Quigley et al (2009) and added further detail on the findings from this study.</p> <p>To note that the EAT Study was considered by the joint SACN/COT working group as part of its benefit-risk assessment on the timing of introduction of peanut and hen's egg into the infant diet, findings from which are included in the chapter on 'Risks of allergic and autoimmune disease'.</p> <p>SACN considered findings from the EAT Study and the SACN/COT statement, and noted the increased risk of upper respiratory tract infections in the intervention group of the EAT Study.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		<p>intervention group, there was no significant difference for parent-reported lower respiratory tract infection, bronchiolitis, or other infections, nor in parent-reported diarrhoea between groups (mean [SE] days affected between 4 and 6 months 0.62 [0.06] for the intervention group vs 0.66 [0.08] for controls, P=0.7). Infants in the intervention group in this study consumed most of their complementary foods as solid foods and the use of infant formula was low with only 10.5% consuming &gt;300 mL/day by 6 months (Perkin 2016 (NEJM and JACI)). Thus these findings are consistent with the results from the Millennium Birth Cohort Study in suggesting that the introduction of solids alongside breast-feeding may not result in an increase in infection risk, with the exception of upper respiratory tract infection. These findings have potential practical importance for breastfeeding mothers and could also be mentioned as a topic for future research.</p>	<p>For information, the joint SACN/COT statement is available here: <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a>.</p>
103	Becker G	<p>In relation to point 103 and the Kramer review (2012), you may wish to include the more up to date review:</p> <p>Smith HA, Becker GE. Early additional food and fluids for healthy breastfed full-term infants. Cochrane Database of Systematic Reviews 2016, Issue 8. Art. No.: CD006462. DOI: 10.1002/14651858.CD006462.pub4</p> <p>This is the update of Becker GE, Remington T. Early additional food and fluids for healthy breastfed full-term infants. Cochrane Database of Systematic Reviews 2014 (update of 2011 review), Issue 11. Art. No.: CD006462. DOI: 10.1002/14651858.CD006462.pub3.</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN has considered the evidence highlighted and agreed that the findings do not change the conclusions of the 'Feeding in the first year of life' report. Therefore the evidence has not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p>
105	RCPCH	<p>In addition to the RCT by Cohen et al in Honduras, there are data on iron status from the Icelandic RCT comparing 4 v 6 months exclusive breastfeeding; and observational data from the US and Germany. (Jonsdottir et al 2012; Dube et al 2010a; Dube et al 2010b; Chantry et al 2007)</p> <p>In the Icelandic study, infants randomised to receive complementary foods from 4 months had significantly higher serum ferritin at age 6 months than those still exclusive breastfeeding, across the range of serum ferritin.</p>	<p>Thank you for your comment and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN considered the evidence and has added text relating to Jonsdottir et al (2012) to the 'Micronutrients' chapter.</p> <p>SACN has considered the other highlighted papers and agreed that the</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		<p>Although all infants had serum ferritin within the expected range for age in this population, the finding is consistent with higher iron stores in those who received complementary foods from 4 months which would be considered a positive rather than a negative outcome, even though the later significance of this for iron status and anaemia was not tested in the trial. It is also consistent with the findings from the Cohen RCT in Honduras and with observational data suggesting that infants with more prolonged EBF who are not supplemented are at greater risk of iron deficiency later in infancy. It is possible that these results would differ if the studies were repeated in a population where systematic delayed clamping of the umbilical cord is practiced. However, currently no such studies are available to our knowledge.</p>	<p>findings do not change the conclusions of the 'Feeding in the first year of life' report. Therefore the evidence has not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p>
106	RCPCH	<p>It is not clear why these studies on infectious outcomes are in a section separate from the ones discussed previously. All of the studies in some way address the introduction of solid foods or formula at different ages before 6 months of age.</p>	<p>Thank you for your comment.</p> <p>SACN has reviewed this text and made amendments where necessary to improve clarity.</p>
107	RCPCH	<p>It is not clear how the statement 'exclusive breastfeeding during the first 6 months of life, as opposed to the first four with mixed feeding thereafter, is advantageous for infant health and does not adversely affect infant growth' follows from the data presented and discussed earlier in the chapter. Furthermore, without the additional consideration of allergenic foods and gluten, it is not possible to consider the full balance of risks and benefits for infant health.</p>	<p>Thank you for your comment.</p> <p>SACN has updated the chapter on 'Risks of allergic and autoimmune disease' to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease . These reviews included consideration of gluten. The FSA-commissioned reviews were evaluated by COT (COT 2016a; COT, 2016b; COT 2017) and have also been published in the peer reviewed literature (Boyle et al, 2016b; Ierodiakonou et al, 2016; Garcia-Larsen et al, 2018).</p> <p>Both the FSA-commissioned systematic review on the timing of introduction of allergenic foods to the infant diet (Boyle et al, 2016a) and accompanying COT statement (COT 2016b) highlighted that findings on the timing of introduction of foods containing peanut and hen's egg into the infant diet in relation to the risk of developing peanut and hen's egg allergy respectively, might impact current government advice and required further consideration.</p>



Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			<p>A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen's egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group's statement was provided in the draft report. For information, the statement is available here: <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>SACN has also added further background on the development of current recommendations, including those on gluten to the report.</p>
108	RCPCH	The recently published study from the Norwegian Mother and Baby cohort is relevant here and suggested that the risk of hospitalisation for infection was similar for infants with any breastfeeding for 6-11 v >12mo (Størdal et al 2017).	<p>Thank you for highlighting this evidence.</p> <p>SACN noted that this evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'</p>
111	WBTi	Breastfeeding offers protection against endometriosis <a href="https://www.bmj.com/content/358/bmj.i3778">https://www.bmj.com/content/358/bmj.i3778</a> (Farland et al 2017)	<p>Thank you for highlighting this evidence.</p> <p>SACN considered the evidence and has added text relating to breastfeeding and endometriosis to the chapter on 'Infant feeding, growth and health'.</p>
111	WBTi	Infant and Maternal health: (Chowdhury et al 2015) Chowdhury R, Sinha B, Sankar MJ, Taneja S, Bhandari N, Rollins N, et al. Breastfeeding and maternal health outcomes: a systematic review and meta-analysis. Acta Paediatr 2015; 104 (Suppl. 467): 96–113.	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN has considered the evidence highlighted and agreed that the findings do not change the conclusions of the 'Feeding in the first year of life' report. Therefore the evidence has not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p>
120	RCPCH	It is really not possible from the available data to make a statement that 'on average, infants attain neurological maturity to participate in diversification of the diet through active acceptance of solid foods at around six months of age' as opposed to 4 or 5 months of age. It also depends on what type of foods are to be provided (puree v semi-solid for	<p>Thank you for your comment.</p> <p>SACN reviewed this text and edited the sentence to omit "on average".</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		example), and what is meant by ‘active acceptance’ or ‘participation’. It would be preferable either to avoid citing a single age, or to acknowledge that the age at which the necessary skills are obtained depends on the type of food, method of feeding to be employed etc.	
122	Pearson-Glaze P	It would be useful if this paragraph could also refer to catch up growth after faltering growth as a reason for climbing centiles, see below next section 158-159.	Thank you for your comment.  SACN has clarified the text on catch up growth during infancy to include the scenario of catch-up following postnatal growth faltering.
122	La Leche League GB	This paragraph doesn’t refer to catch up growth, see below next section 158-159.	Thank you for your comment.  SACN has clarified the text on catch up growth during infancy to include the scenario of catch-up following postnatal growth faltering.
123-125	Crawley H	<p>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):</p> <p><u>Infant Formula</u> A breastmilk substitute suitable for use in the first year of life which meets the regulatory, compositional and labelling standards for infant formula.</p> <p>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.</p> <p>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.’</p>	Thank you for your comment.  SACN agreed that “infant formula” should be used consistently throughout the report unless the source text specifically refers to “breast milk substitutes” and the report has been edited for consistency to this effect. The glossary has been updated to include breast milk substitutes.

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
123-125	Crawley H	<p>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.</p> <p>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).</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN has considered the literature on infant formula with a high protein content, in relation to infant weight gain (and/or childhood BMI). Text has been added to the chapter on 'Infant feeding, body composition and health' based on studies by: Koletzko et al, 2009; Weber et al, 2014; Inostroza et al, 2014; and Ziegler et al, 2015.</p>
127	Royal College of Midwives	<p><u>Cost &amp; benefit</u></p> <p>Conclusions (Paragraph 127) states: 'Increasing the prevalence of breastfeeding would be expected to yield significant health service cost savings through reduction in the risk of common infections and risk of breast cancer in the mother'.</p> <p>The RCM agrees with this forecast, which is consistent with the available evidence, and advocates the front-loading of resources into service provision to secure these long-term gains.</p>	<p>Thank you for your comments.</p> <p>SACN has removed reference to potential cost savings associated with breastfeeding as assessment of cost effectiveness is outside the committee's remit.</p>

**Table 2.5: Specific comments on Chapter 5. Energy requirements (Paragraphs 128-157)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	BDA - PFASG	<p>Evidence to support that 6 months of exclusive breastfeeding is able to meet energy requirement for most infants is lacking (Reilly et al). Findings of previous research may not be generalizable (Neilson et al).</p> <ul style="list-style-type: none"> <li>• Complementary feeding does displace breastmilk. However, growth of infants introduced to CF at 4-6 or 6 months has not been reported to differ significantly in studies.</li> <li>• The role of responsive feeding in the prevention of childhood overweight and obesity could be considered here. A large number of observational studies support this.</li> <li>• Animal protein is more strongly associated than plant protein (Voortman et al 2016; Gunther et al 2007)</li> </ul>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on 'Infant feeding, growth and health' and 'Infant feeding, body composition and health'.</p> <p>SACN considered the generalisability of the findings and were of the view that the existing text was appropriate and did not require amendment.</p> <p>SACN has added text on the role of responsive feeding to the chapter on 'Eating and feeding in the first year of life'.</p> <p>SACN noted that the quality of the infant diet, including the impact of different types of protein on body composition, had been considered in the chapter on 'Infant feeding, body composition and health'.</p>
135	RCPCH	<p>The hypothesis raised in the cited papers was that there was insufficient evidence to be certain that exclusive breastfeeding for 6 months would meet the energy requirements of all healthy term infants. The same authors then conducted the study cited in Paragraph 138 (Nielsen et al) to investigate this hypothesis further. In that observational study, it was</p>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been</p>

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		<p>shown that milk intake increased significantly between 15 and 25 weeks in mothers who chose to and were successful in exclusively breastfeeding their infant for 6 months, without evidence of 'strain' in the breastfeeding process, and without compromising infant growth. Whilst this demonstrates that mothers who exclusive breast feed for 6 months adapt physiologically to provide sufficient breast milk, these mothers were a highly selected minority and certainly not representative of all mothers in the study population in Glasgow. Hence, the same questions about generalisability of findings applies to this study, as is the case with all data used to establish the adequacy of exclusive breastfeeding for 6 months. Namely, all data come from a minority of the population and should be generalised to the whole population with some caution.</p>	<p>amended for clarity.</p> <p>SACN considered the generalisability of the findings and were of the view that the existing text was appropriate and did not require amendment.</p>
142	Breastfeeding Network	<p>Feeding and regulation of intake: Newborn breastfed infants may be able to regulate intake to meet their needs however the work of Dr Jack Newman suggests that babies appear sleepy and stop feeding when the flow slows and not necessarily when they are full.</p>	<p>Thank you for your comment.</p> <p>A full reference would be required for SACN to consider this evidence.</p>
146	Nestle Nutrition	<p>Para 146 states:</p> <p><i>The extent to which the caregiver responsiveness modifies the infant self-regulation of intake is currently unclear. The observational studies available in this area are cross-sectional thus the direction of causality is unclear. The methodology adopted to measure caregiver responsiveness has also been inconsistent.</i></p> <p>Comment: A 2016 randomized clinical trial investigating the effect of a responsive parenting intervention on infant weight gain between birth and 28 weeks and overweight status at age 1 year has been shown to reduce rapid weight gain during the first 6 months after birth and overweight status at age 1 year. (Savage et al 2016) .</p>	<p>Thank you for your comment and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN has considered this evidence and expanded the text on caregiver responsiveness as appropriate (see chapter on 'Eating and feeding in the first year of life').</p>
146	RCPCH	<p>The recent systematic review by Redsell et al considered RCTs that aim to reduce the risk, either directly or indirectly, of overweight and obesity in infancy and early childhood. It concluded that the most promising obesity prevention interventions for children younger than 2 years of age are those that focus on diet and responsive feeding, including education for</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		carers on recognising infant hunger and satiety cues and non-food management of infant behaviour.(Redsell et al 2016)	SACN has considered the paper by Redsell et al (2016) and added text on the findings from the systematic review.
149	RCPCH	Follow-up data from the Icelandic RCT also suggest that there was no effect of the intervention on anthropometric measurements up to pre-school age (Jonsdottir et al 2014) or developmental screening tests over the same period (Jonsdottir et al 2013).	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN has considered the paper by Jonsdottir et al (2014) and agreed that the findings do not change the conclusions of the 'Feeding in the first year of life' report. Therefore the evidence has not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p> <p>SACN noted that Jonsdottir et al (2013) might be of relevance when they start the review of 'Feeding children aged 12-60 months'.</p>
153	RCPCH	It is important to add that this finding was in self-selected mother-infant dyads who successfully undertook exclusive breastfeeding for 6 months, and generalisability to the wider population is uncertain.	<p>Thank you for your comment.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN considered the generalisability of the findings and were of the view that the existing text was appropriate and did not amend.</p>
154	RCPCH	<p>It is inappropriate to say that the intervention 'compromised' breast milk intake; that is a subjective assessment.</p> <p>Objectively, the intervention decreased milk intake by a small amount without affecting total energy intake or growth, and overall there were no adverse effects of the intervention on any measured outcome. In fact, the only potentially 'beneficial' effect seen in the trial – on iron status (serum ferritin) - was seen in the intervention group who had solids introduced alongside breastfeeding from 4 months rather than in the 6 months exclusive breastfeeding group.</p>	<p>Thank you for your comment.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN's conclusions are based on the committee's interpretation of the evidence. SACN considered the comments and agreed to review and amend the text where necessary.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
157, 486, 506	More J	<p>These refer to risks of displacing breastmilk from the diet. If complementary feeding is recommended more clearly as anytime between 4 &amp; 6 months of age a small displacement of breastmilk in this time frame would not significantly increase any risks for those being exclusively breastfed up until this age. In the Wells study in Iceland in 2012 introducing complementary feeding in the 4-6 month period only displaced 9% of daily breastmilk intake with no reported consequences in anthropometry or body composition.</p>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks. This included the findings from Wells et al (2012).</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on 'Infant feeding, growth and health' and 'Infant feeding, body composition and health'.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on 'Risks of allergic and autoimmune disease').</p>
157	RCPCH	<p>This is similarly inaccurate. There have not been a 'succession' of RCTs showing that giving complementary feeding to breast fed infants before 6 months is associated with other negative health outcomes. It is objectively true that complementary foods will replace an equivalent amount of breast milk with no effect on anthropometric outcomes, but the 'negative' outcomes, if any, have actually been found in groups of infants exclusive breastfeeding for 6 months: poorer iron status in the Honduras RCT, lower serum ferritin in the Icelandic RCT, with no reported effect on infectious diseases in any of the trials, including the recent EAT RCT. If negative outcomes are mentioned in this way, they should be specified and the references cited.</p>	<p>Thank you for your comments.</p> <p>The studies by Dewey et al (1998) and Jonsdottir et al (2012) have been considered by SACN (see the chapter on 'Micronutrients'). In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks. The findings from these studies did not change the overall conclusions of the 'Feeding in the first year of life' report.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on 'Infant feeding, growth and health' and 'Infant feeding, body composition and health'.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			<p>considered (see chapter on ‘Risks of allergic and autoimmune disease’).</p> <p>To note that the EAT Study (Perkin et al 2016) was considered by the joint SACN/COT working group as part of its benefit-risk assessment on the timing of introduction of peanut and hen’s egg into the infant diet, findings from which are included in the chapter on ‘Risks of allergic and autoimmune disease’. For information, the statement is available here: <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>SACN considered findings from the EAT Study, and the SACN/COT statement, and noted the increased risk of upper respiratory tract infections in the intervention group of the EAT Study.</p> <p>SACN has reviewed and amended the text where necessary to improve clarity. SACN has reviewed this text and made amendments where necessary to improve clarity.</p>



**Table 2.6: Specific comments on Chapter 6. Infant feeding, body composition and health (Paragraphs 158-197)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	Crawley H	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.	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN considered that the evidence highlighted did not change the conclusions of the report. Therefore the evidence has not been added to the report, in line with the approach outlined in the 'Methodology' chapter.</p>
158	Nestle Nutrition	<p>Paragraph 158 states: <i>Systematic reviews of observational studies have indicated that rapid weight gain in infancy (displayed as upward crossing of centiles) is associated with an increased risk of later obesity in childhood and adulthood....</i></p> <p>Comment: We suggest adding: 'regardless of whether the infant is breastfed or formula-fed'. (Dennison et al 2006)</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>Dennison et al (2006) was included in the meta-analysis by Druet et al (2012) which was considered by SACN. Therefore the evidence has not been added to the report, in line with the approach outlined in the 'Methodology' chapter.</p>
158	Nestle Nutrition	We suggest that policy and guidelines need to focus on growth monitoring of infants, regardless of feeding method, with defined interventions, in order to reduce the risk of obesity (Redsell et al 2011)	<p>Thank you for your comments and for highlighting the paper by Redsell et al (2011).</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN agreed not to consider this additional reference as this topic is outside SACN's remit. Please note that policy development and other aspects of risk management are outside the remit of SACN.</p>

<sup>1</sup> Paragraph numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
158	Nestle Nutrition	<p>A systematic review concludes that the most promising obesity prevention interventions for children under 2 years of age are those that focus on diet and responsive feeding. (Redsell et al 2016)</p>	<p>Thank you for your comment and for highlighting the paper by Redsell et al (2016).</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN considered this additional reference and amended the text where appropriate.</p>
158	Nestle Nutrition	<p>Comment: Suggest addition to paragraph 158: The mechanism behind rapid postnatal weight gain is unclear, however possible explanations include behavioural, social and hormonal factors as well as differences in milk macronutrient composition. Evidence from The Early Nutrition Programming Project, (Koletzko et al 2009). implicates protein as a growth-enhancing nutrient and suggested that higher protein intakes increase plasma and tissue levels of insulin-releasing amino acids, and thence of insulin and insulin- like growth factor 1 (IGF-1), thereby increasing weight gain and adipogenic activity. The Koletzko follow-up study shows that BMI differences at age 2 years persisted to age 6 years. (Weber et al 2014; Kirchberg et al 2015)</p> <p>A recent paper, investigating breast milk macronutrient composition and the relationship with growth in infancy, reported associations between high breast milk % protein and BMI at age 12 months. (Prentice et al 2016).A systematic review published in 2016 concluded that whey-predominant infant formula with a lower protein content (1.8g/100kcal) that more closely resembles that of breast milk, supports healthy growth comparable to the WHO growth standards. (Alexander et al 2016)</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN agreed to consider the literature on infant formula with a high protein content, in relation to infant weight gain (and/or childhood BMI). Text has been added to the chapter on 'Infant feeding, body composition and health' based on studies by: Koletzko et al, 2009; Weber et al, 2014; Inostroza et al, 2014; and Ziegler et al, 2015.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
158	Nestle Nutrition	Comment: Advice regarding use of a low protein formula may be useful in mixed, or formula-fed infants, improving the metabolic health of such infants by reducing excessive protein consumption. Another systematic review from 2016 concluded that there is some evidence that avoiding excess protein intake could reduce the risk of obesity in infants and young children 0-24 months, (Woo Baidal et al2016)	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN agreed to consider the literature on protein content of infant formula in relation to infant weight gain (and/or childhood BMI). Text has been added to the chapter on ‘Infant feeding, body composition and health’ based on findings from: Koletzko et al, 2009; Weber et al, 2014; Inostroza et al, 2014; and Ziegler et al, 2015.</p>
158-159	La Leche League GB	I feel it would be useful if these paragraphs could encompass the scenario of catch up gain for term, breastfed babies with faltering growth. I would welcome clarification that underweight breastfed babies who may be as much as 30% underweight need to show catch up gain and that upward crossing of centiles is desirable for these babies. Parents who are anxious about introducing formula for their exclusively breastfed—but seriously underweight—babies might be confused about weighing up risks of obesity with stunted growth in later life after reading this report.	<p>Thank you for your comments.</p> <p>Text on catch up growth during infancy has been clarified to include the scenario of catch-up following postnatal growth faltering (see chapter on ‘Infant feeding, body composition and health’).</p>
158-159	La Leche League GB	I would like clarification on the health risks of sustained undernutrition for these young babies and the importance of restoring their nutritional status.	<p>Thank you for your comment.</p> <p>In keeping with SACN’s remit only healthy term infants have been considered and therefore the health risks associated with sustained undernutrition were not in the terms of reference of this report.</p>
158-159	Pearson-Glaze P	I feel it would be useful if the following two paragraphs could encompass the scenario of catch up gain for term, breastfed babies with faltering growth. I would welcome clarification that underweight breastfed babies who may be as much as 30% underweight need to show catch up gain and that upward crossing of centiles is desirable for these babies. Parents who are anxious about introducing formula for their exclusively breastfed—but seriously underweight—babies might be confused about weighing up risks of obesity if there is rapid catch up gain, or with stunted growth if there isn’t good catch up after reading this report.	<p>Thank you for your comments.</p> <p>Text on catch up growth during infancy has been clarified to include the scenario of catch-up following postnatal growth faltering.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
158-159	Pearson-Glaze P	I would also like clarification on the health risks of sustained undernutrition for these young babies and the importance of restoring their nutritional status.	<p>Thank you for your comment.</p> <p>In keeping with SACN's remit only healthy term infants have been considered and therefore the health risks associated with sustained undernutrition were not in the terms of reference of this report.</p>
161-163	RCPCH	The additional systematic review by Daniels et al could also be cited (Daniels et al 2015), although the conclusions are similar to those in the reviews by Moorcroft and by Pearce	<p>Thank you for this comment and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN considered that the evidence highlighted did not change the conclusions of the report. Therefore the evidence has not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p>
164	Brown R	'One American RCT has reported findings from a study in which....were randomised to receive to solid foods from three to four months or six months' – 'to' is not needed.	<p>Thank you for your comments.</p> <p>SACN has amended the text as suggested.</p>
165 (and 196 of conclusions).	RCPCH	The Icelandic RCT has also reported growth data beyond infancy, using data from the computerised child health records system up to pre-school age, showing no effect of 4 v 6mo exclusive breastfeeding on the anthropometric outcomes (Jonsdottir et al 2014).	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report.</p> <p>SACN has considered the evidence highlighted and agreed that the findings do not change the conclusions of the 'Feeding in the first year of life' report. Therefore the evidence has not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on 'Infant feeding, growth and health' and 'Infant feeding, body composition and health'.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
176-180	RCPCH	<p>Quality of the complementary feeding diet:            Additional references which could be considered relating to protein intake during complementary feeding (from milk and solid foods):            (Hornell et al 2013; Pimpin et al 2016; Inostroza et al 2014; Ziegler et al 2015)</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN agreed to consider the literature on protein content of infant formula in relation to infant weight gain (and/or childhood BMI). Text has been added to the chapter on 'Infant feeding, body composition and health' based on findings from: Koletzko et al (2009); Inostroza et al (2014); and Ziegler et al (2015).</p> <p>With regards to dietary protein intake, SACN has considered the evidence highlighted and agreed that the findings do not change the conclusions of the 'Feeding in the first year of life' report. Therefore the evidence has not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p> <p>SACN further noted that the papers by Hornell et al (2013) and Pimpin et al (2016) might be of relevance when they start the review of 'Feeding children aged 12-60 months'.</p>
196	Crawley H	There is a word missing in the second sentence.	<p>Thank you for your comment.</p> <p>SACN has reviewed the text and amended this for clarity.</p>

**Table 2.7: Specific comments on Chapter 7. Micronutrients (Paragraphs 198-262)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation /Individual	Comments	Reply from SACN
220	Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group	Advice on infant feeding needs to stress that iron rich foods can be given <u>when complementary feeding begins</u> . As stated in this SACN report, if a mother’s iron status wasn’t optimal during pregnancy or she had risk factors such as obesity (6.5% pregnant women in Wales have a BMI above 35), the infant’s iron stores may not be adequate to last until around 6 months.	Thank you for your comment.  SACN has reviewed the text in line with your comment.  SACN has added a recommendation that “A wide range of solid foods, including iron-containing foods, should be introduced in an age-appropriate form from around 6 months of age”.
221	Nestle Nutrition	Iron status in infancy – from six to twelve months Follow-on formulae contributes the largest proportion (31%) of dietary iron from 7-11 months in the UK (DNSIYC). The report should acknowledge this fact and support the recommendation of iron-fortified milks considering this significant contribution to iron intakes that they make.	Thank you for your comments.  SACN has reviewed the text in line with your comment, and added text on the contribution of iron to the diet in both the ‘Micronutrients’ chapter and the chapter on ‘UK infant feeding practice’.
222	More J	The recommendation for dietary diversity from 6 months of age is made to guarantee an adequate iron intake. This is at odds with recommending complementary feeding to commence ‘around 6 months of age’ as ‘around six months’ can be interpreted to be as late 7-8 months. I have seen parents in my clinic who do not begin complementary feeding until after 7 months of age.  To ensure iron intakes especially for those already with low iron status at 6 months of age, it would be preferable to recommend commencing complementary feeding ‘by six months but not before 4 months’. This has the advantage of allowing parents to decide when their infant is ready for beginning complementary feeding and advising against those beginning very late.	Thank you for your comments.  SACN considered that the need for flexibility in advice is addressed by the wording “around 6 months.”  SACN is of the view that the findings from the totality of evidence support current UK policy to recommend exclusive breastfeeding for around the first 6 months of life.  The importance of introducing iron-containing foods from a diverse diet when complementary feeding commences at around 6 months has been highlighted in the ‘Micronutrients’ chapter.  SACN has added a recommendation that “A wide range of solid foods, including iron-containing foods, should be introduced in an age-appropriate form from around 6 months of age.”

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation /Individual	Comments	Reply from SACN
256	RCPCH	<p>Whilst we agree that Exclusive breast feeding (EBF) provides sufficient iron in the first 6 months for healthy, term, AGA infants with adequate iron stores and delayed clamping of the umbilical cord, the same cannot be said for the many infants who do not meet one or more of these criteria. Hence some flexibility is required since some of these infants may benefit from earlier introduction of iron-rich foods to complement the supply from breast milk.</p>	<p>Thank you for your comments.</p> <p>SACN considered that the need for flexibility in advice is addressed by the wording “around 6 months.”</p> <p>SACN is of the view that the findings from the totality of evidence support current UK policy to recommend exclusive breastfeeding for around the first 6 months of life.</p> <p>The importance of introducing iron-containing foods from a diverse diet when complementary feeding commences at around 6 months has been highlighted in the ‘Micronutrients’ chapter.</p> <p>SACN has added a recommendation that “A wide range of solid foods, including iron-containing foods, should be introduced in an age-appropriate form from around 6 months of age.”</p>
259	RCPCH	<p>Regarding the possible adverse effects of supplemental iron, especially in iron- replete infants, there are two other potentially relevant references (Krebs et al 2013)</p> <p>Data from this pilot study conducted within a larger RCT suggested that iron supplements may have adverse effects on the microbiome, raising the hypothesis that providing additional iron in a form which is not easily absorbed could promote dysbiosis.</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN considered that the microbiome evidence was at a very early, hypothetical stage and therefore of limited relevance to the current report. Consequently, the evidence suggested has not been added to the report.</p>
259	RCPCH	<p>(Lozoff et al 2012) This was a follow-up of 473 children at age 10 years from a RCT in which 835 healthy Chilean infants with birth weights &gt; 3 kg and no IDA at 6 months were randomized to high iron (12 mg/L) or low iron (2.3 mg/L) formula from 6-12 months. It showed a trend towards a lower IQ in the iron fortified group (91.5 vs 93.3, p=0.06) and the iron fortified group had significantly lower scores for spatial memory (86.8 vs 91.4, p=0.02) and visual-motor integration (97.2 vs 99.8, p=0.046). There was also a significant interaction between initial Hb at 6 months and the intervention effects on all developmental outcomes; children with higher</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN has added text from the study by Lozoff et al (2012) to the ‘Micronutrients’ chapter.</p>

Paragraph number <sup>1</sup>	Organisation /Individual	Comments	Reply from SACN
		6-month hemoglobin concentrations (> 128 g/L) showed poorer developmental outcomes if they received iron-fortified formula, whereas those with low initial hemoglobin levels (<105 g/L) showed better outcome with iron fortified formula. This adds to concerns that providing additional iron to iron-replete infants could have adverse effects.	



**Table 2.8: Specific comments on Chapter 8. Eating and feeding of solid foods (Paragraphs 263-351)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
General	BDA - PFASG	The authors of this document eloquently discuss all of the studies by Manella who identified a window of opportunity for the introduction of protein hydrolysate formula (PHF), ie earlier exposure for a longer duration was associated with greater acceptance in formula fed infants. However, the conclusion of the SACN does not include this. It is important that the conclusion reflects the data that for PHF there is a window of taste acceptance that may be earlier than 6 months. This may go against the recommendation of exclusive breast feeding for 6 months, but is an evidence-based practical fact that is important for HCPs working in allergy.	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>In keeping with SACN’s remit, only healthy infants were considered. Clinical advice for infants under medical supervision is not in SACN’s remit and therefore recommendations are not made as part of this report.</p>
General	BDA - PFASG	Protein is a particular concern. A growing body of evidence reports that energy from protein increases significantly during CF and exceeds recommendations. High protein intake in infancy has been associated with increased risk of obesity in many observational studies (Hornell et al 2013; Pimpin et al 2016; Voortman et al 2016). A causal relationship is reported from several RCTs in infants.(Weber et al 2014; Gunther et al 2007)	<p>Thank you for your comments and highlighting this evidence.</p> <p>SACN noted that the quality of the infant diet, including the impact of different types of protein on body composition, had been considered in the chapter on ‘Infant feeding, body composition and health’.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN agreed to consider the literature on infant formula with a high protein content, in relation to infant weight gain (and/or childhood BMI). Text has been added to the chapter on ‘Infant feeding, body composition and health’ based on studies by: Koletzko et al, 2009; Weber et al, 2014; Inostroza et al, 2014; and Ziegler et al, 2015.</p>

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
			SACN further noted that the papers by Hornell et al (2013) and Pimpin et al (2016) might be of relevance when they start the review of 'Feeding children aged 12-60 months'.
General	Hetherington M, Fildes A	<p>We welcome this report and are particularly encouraged to see the inclusion of Chapter 8 'Eating and feeding of solid foods' which discusses the behavioural aspects of complementary feeding.</p> <p>While the report generally provides a comprehensive overview of the current evidence base, we propose that the importance of introducing a variety of vegetables during the early complementary feeding period warrants discussion. The current report tends to group fruits and vegetables together, despite acknowledging the difference between infants' acceptance of sweet versus more bitter foods. We suggest that a 'vegetables first' approach (Chambers et al, 2016) during complementary feeding should be mentioned in this report since there is sufficient evidence to indicate this approach can help to establish liking and acceptance of vegetables when it matters most, namely in the early stages of complementary feeding.</p> <p>As children generally prefer sweet fruits to more bitter tasting vegetables it may be beneficial to delay introducing fruits and instead offer vegetables as first foods. Two experimental studies cited by the report (Barends et al, 2013 and Fildes et al, 2015) demonstrated, in the Netherlands and the UK, that exposure to vegetables at the start of weaning, while delaying introduction of fruits, facilitated vegetable acceptance without negatively impacting on fruit preference.</p> <p>These studies also suggest, along with previous evidence (Birch et al., 1998), that the impact of repeated exposure to fruit does not generalise to other foods, for example repeated exposure to fruit does not lead to increased liking for vegetables. This is an important point to make when emphasising the need for repeated exposure to a variety of flavours during the complementary feeding period, for later food acceptance. Variety in itself, without specific exposure to vegetables, may not be sufficient to increase acceptance of these commonly rejected but important, nutrient-dense foods. Thus, vegetables first and in a variety is proposed to encourage acceptance of vegetables from the</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN is aware of the highlighted evidence, and has considered many of the studies in its report, but is of the view that there is insufficient evidence to support recommending the introduction of vegetables specifically as the first food in an infant's diet. SACN has added text on the follow up study by Maier-Noth et al (2016) to the chapter on 'Eating and feeding of solid foods'.</p> <p>SACN concluded that the findings from the other highlighted studies (Garcia et al, 2013 and 2015; Caton et al, 2011; Fildes et al, 2015; Mallan et al, 2016; Freeman et al, 2000) do not change the conclusions of the 'Feeding in the first year of life' report. Therefore the evidence has not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p> <p>SACN further highlighted the lack of evidence on complementary feeding practices and longer term outcomes, such as food preferences in childhood, and stressed the need for longer term follow up.</p> <p>SACN has added a research recommendation on the need to distinguish between exposure to fruit or vegetables, characterise the dominant sensory attributes of the foods (taste, texture) and how they were processed.</p>

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
		<p>early stages of complementary feeding. (Chambers et al, 2016).</p> <p>Evidence highlighted: (Barends et al 2013; Birch et al 1998; Caton et al 2011; Freeman et al 2000; Garcia et al 2013; Garcia et al 2015; Maier-Noth et al 2016; Mallan et al 2016)</p>	
General	Hetherington M, Fildes A	<p>In the report it is stated that data from DNSIYC suggests <i>‘Baby rice and pureed fruit or vegetables were the most common first foods consumed by infants (65% and 21%, respectively)’</i> but it is not clear what proportion of children received fruit compared to vegetables as first foods. Data from the Euro growth study (Freeman et al., 2000) suggested the most common first foods given to UK infants were fruits and baby rice. Vegetables are offered less frequently and often combined with sweet-tasting fruits to mask the underlying distinctive vegetable flavour. Commercial baby foods are frequently sweet-tasting. A study by Garcia and colleagues (2013) found almost two-thirds (65%) of foods aimed at the early stage of complementary feeding (i.e. from 4 months) were sweet foods. A second study by the same author (Garcia et al., 2015) reported that the fruit and vegetable content of UK commercial baby foods predominantly comprised fruits and relatively sweet vegetables (e.g. carrot rather than broccoli). In an effort to encourage their children to eat them, parents may also try to hide vegetables in dishes or mix them with other more liked foods (Caton et al. 2011). While these approaches may increase infants’ intake of these vegetables in the short-term, combining vegetables with fruits, or even mixing more bitter tasting vegetables with sweeter ones is unlikely to encourage preferences for bitter-tasting vegetables or other non-sweet foods in the longer term. As a result infants may not experience the benefits of single vegetable flavour exposure and could fail to acquire liking for these foods. We propose that the report make the clear distinction between fruits (which tend to be sweet and readily accepted) and vegetables, particularly dark green or bitter-flavoured varieties, when discussing the benefits of repeated exposure and variety during early complementary feeding.</p> <p>The suggested benefits of exposure to a variety of vegetables for later acceptance of these foods has been discussed in the report. However we would like to highlight some more recent evidence, published after 2015. A</p>	<p>Thank you for your comments and for highlighting this evidence,</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN is aware of the highlighted evidence, and has considered many of the studies in its report, but is of the view that there is insufficient evidence to support recommending the introduction of vegetables specifically as the first food in an infant’s diet. SACN has added text on the follow up study by Maier-Noth et al (2016) to the chapter on ‘Eating and feeding of solid foods’.</p> <p>SACN concluded that the findings from the other highlighted studies (Garcia et al, 2013 and 2015; Caton et al, 2011; Fildes et al, 2015; Mallan et al, 2016; Freeman et al, 2000) do not change the conclusions of the ‘Feeding in the first year of life’ report. Therefore the evidence has not been added to the report, in line with the approach set out in the ‘Methodology’ chapter.</p> <p>SACN further highlighted the lack of evidence on complementary feeding practices and longer term outcomes, such as food preferences in childhood, and stressed the need for longer term follow up.</p> <p>SACN has added a research recommendation on the need Distinguish between exposure to fruit or vegetables, characterise the dominant sensory attributes of the foods (taste, texture) and how they were processed.</p>

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
		<p>recent observational study from Australia found that not only did children who had tried a greater number of vegetables before the age of 14 months like a wider range of vegetables and eat more of them at three years of age, these children were also found to display less fussy eating behaviour at three years (Mallan et al., 2016). Another recent study reported that French children exposed to a high level of vegetable variety during complementary feeding had higher intakes of, and greater liking for vegetables at 6 years of age (Maier-North et al., 2016). These findings indicate that exposure to a variety of vegetables from the start of weaning may impact on children’s vegetable acceptance and diet quality with long lasting effects.</p> <p>We commend the authors for a thorough review of the literature relating to the issue of a ‘sensitive window’ for the introduction of complementary foods. While we agree there is insufficient evidence to support a narrow ‘critical window’ for the acceptance of solid foods, the report does present evidence highlighting the importance of introducing a variety of foods early in the complementary feeding process, and specifically the need to offer children a variety of vegetables.</p> <p>In summary, we propose that following the consultation process the following changes are made to the report:</p> <p>a)Vegetables first and in variety is recommended based on the current, available observational and experimental evidence of the benefits to children of early, repeated and varied exposure</p> <p>b)Vegetables are identified separately from fruits where possible, to make the point that fruits are generally favoured, and given their sweet taste require less experience to be liked than vegetables</p> <p>Evidence highlighted: (Barends et al 2013; Birch et al 1998; Caton et al 2011;Chambers et al 2016; Fildes et al 2015; Freeman et al 2000; Garcia et al 2013; Garcia et al 2015; Maier-Noth et al 2016; Mallan et al 2016)</p>	

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
274	Ella's kitchen	<p>Overt versus covert parental control</p> <p>We suggest that a distinction is made between overt and covert restrictions on unhealthy foods, given that covert control may have beneficial effects on health.</p> <p>Point 274 deals with restricting palatable or unhealthy foods and highlights the risk that such practices may later increase the child's preference for the restricted food with negative impacts on eating behaviour and health. It would be advisable to distinguish between overt and covert restriction. Covert control, in which less healthy foods and drinks are restricted without the child's knowledge, has been shown, in the case of energy-dense snacks and sugar-sweetened beverages, to be associated with lower BMI (standardised for age and sex) and increased fruit intake (Rodenburg et al, 2014). It may therefore be of practical importance for parents to understand that covert control may have beneficial effects on health, whereas overt control may not.</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN noted that this issue and evidence might be of relevance when they start the review of 'Feeding children aged 12-60 months'.</p>
274	Coulthard H, Harris G	<p>The report mentions the feeding strategies that parents adopt and how they may influence acceptance. However we feel the report would benefit from including a recent study that examined early acceptance of solids in infants. There is evidence that the inherent characteristics of the child may influence acceptance, and this may vary with the age of the child (Coulthard, Harris &amp; Fogel, 2016). The quality of this paper meets the criteria for this review as, although it is a cross sectional study published in 2016, it does add unique and critical evidence to the data. It was found that infants who were weaned at the later age and had high sensory (tactile) sensitivity ate less of the carrot test food (<math>p &lt; 0.001</math>). Infants who were weaned early within the 4-6 month period ate similar amounts of the new taste food regardless of tactile responsivity. This finding suggests that there might be a sensitive period for the introduction of complementary foods for some infants who are highly reactive to sensory stimuli.</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN agreed that the findings from the study by Coulthard et al (2016) do not change the conclusions of the 'Feeding in the first year of life' report that there is insufficient evidence to support the view that there is a "critical window" for the acceptance of solid foods before 6 months of age.</p> <p>This study has therefore not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p>

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
280	Ella's Kitchen	<p>Paragraph 280 highlights the fact that observational data is prone to confounding and hence, the evidence in favour of a sensitive window of opportunity for introducing commonly rejected foods like vegetables has been questioned by SACN. It is interesting to note that many observational studies are used to support the practice (which SACN recommends) of repeated exposure to foods to promote their acceptance by infants and also to support the observation that breast fed infants more readily accept new foods vs formula-fed infants.</p> <p>Few experimental studies are reported in support of the existence of the sensitive window, beyond those comparing the introduction of protein hydrolysed infant formula at various ages during infancy. While it is clearly very difficult to obtain experimental data in such a young population group, the observational evidence extends beyond those studies cited. For example, a recent study of 4779 infant participants of the large Generation R cohort in Holland demonstrated that an earlier introduction of vegetables was associated with less fussy eating behaviour at age 4 years using the food fussiness scale of the Children's Eating Behaviour Questionnaire (de Barse et al, 2017).</p> <p>The experimental work of Barends et al (2013, 2014) has been cited in support of the repeated exposure approach to introducing new foods but these data additionally support the introduction of vegetables first in the complementary feeding process, offered both frequently and in variety, to promote acceptance, with the outcome of increased vegetable consumption (versus the fruit first groups) tracking into early childhood (12 months of age). This study suggests that offering vegetables early in the complementary feeding period, before more readily accepted sweet foods like fruit or cereals could be beneficial to long term eating behaviour. While those effects were attenuated at age 23 months, potentially due to children entering the neophobic phase and also due to the unfamiliar clinical setting and texture of food offered, observational data do suggest that eating habits formed in early infancy track into later childhood (Coulthard et al, 2014). It is worth noting that the majority of the studies on the repeat exposure effect have been conducted using vegetables, suggesting that vegetables require more effort before they are accepted by infants. This would imply that specific recommendations on the introduction of vegetables would be beneficial.</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>Findings from observational studies on the impact of repeated exposure on food acceptance are supported by two experimental studies.</p> <p>SACN considered the available evidence in detail and believe there is insufficient evidence to support the view that there is a "critical window" for the acceptance of solid foods before 6 months of age.</p> <p>SACN noted that the study by de Barse et al (2017) might be of relevance when they start the review of 'Feeding children aged 12-60 months'.</p>

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
280	Ella's Kitchen	<p>The randomised controlled trial conducted by Fildes et al, 2015, is cited to support the recommendation that introducing a variety of foods to infants during complementary feeding may help promote the acceptance of new foods. However, this study also suggests, in the UK specifically, where a vegetables-first approach to weaning is not common practice, that offering a variety of single vegetables, repeated every five days, for the first 15 days of weaning, can lead to better acceptance of vegetables in infants. Moreover, the work of Hetherington et al, 2015, again supports this vegetables-first approach by introducing the taste of vegetables in a step-by-step approach, first mixed with milk, then baby rice and finally alone to promote initial acceptance.</p> <p>Together, these findings, along with the proceedings of a roundtable of leading UK complementary feeding experts (Chambers et al, 2016) support the recommendation that infants be introduced to vegetables early in the weaning period, when showing appropriate signs of readiness and not before 17 weeks, in a way that does not displace breastmilk from the diet. This 'tiny tastes' approach bridges the gap between milk feeding and the introduction of solid foods by facilitating the smooth transition from milk to foods that are an important part of a healthy, balanced diet i.e. vegetables. The approach is already practised in other European countries, such as France, Sweden and Holland (Schwartz et al. 2013; Swedish National Food Agency 2012; Netherlands Nutrition Center 2016).</p> <p>SACN concludes that complementary feeding should start at around 6 months of age and that earlier introduction of food may risk displacing breastmilk from the diet. However, there is no evidence to suggest that familiarising infants with the flavour of food i.e. vegetables, during the 4-6 month window is detrimental to health. In acknowledgement of the fact that many parents do choose to wean their children before the age of 6 months (Lennox et al 2013) it would be beneficial to provide advice on the type of foods, textures and quantities offered i.e. small tastes of vegetable purees, in variety. Moreover, if we uncouple the evidence on the sensitive window of opportunity from age of introduction of solid foods, it would still be advisable, given the evidence from Barends (2013, 2014), Hetherington (2015), Fildes (2015) and de Barse (2017) to recommend that weaning begin with a variety of vegetables being introduced before fruit or cereal but alongside iron-rich foods in order to</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN considered the highlighted evidence in detail but is of the view that there is insufficient evidence to support recommending the introduction of vegetables specifically as the first food in an infant's diet. SACN has added text on the follow up study by Maier-Noth et al (2016) to the chapter on 'Eating and feeding of solid foods'.</p> <p>Proceedings from the roundtable (Chambers et al, 2016) do not meet the inclusion criteria and this has therefore not been added to the report, in line with the approach set out in the 'Methodology' chapter.</p> <p>SACN further highlighted the lack of evidence on complementary feeding practices and longer term outcomes, such as food preferences in childhood, and stressed the need for longer term follow up.</p> <p>SACN has added a research recommendation on the need to distinguish between exposure to fruit or vegetables, characterise the dominant sensory attributes of the foods (taste, texture) and how they were processed.</p> <p>SACN considered that the need for flexibility in advice is addressed by the wording "by around 6 months."</p> <p>Please note that the formulation of recommendations and provision of advice (for example, on the types of food, texture and quantities of food offered during complementary feeding) are the responsibility of risk managers and are outside the remit of SACN.</p>

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
		increase early acceptance of these commonly rejected foods. We would recommend further reference of the benefits to this vegetables-first approach within the “new food acceptance” section, as well as in the conclusions section.	
343-346	Crawley H	The section on maternal/caregiver feeding practices 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.	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN has added text on caregiver responsive feeding to the chapter on ‘Eating and feeding of solid foods’ based on studies by Redsell et al (2016) and Hohman et al (2017).</p>
346	Brown R	I am sure you are aware, but, just in case, I am listing some of the BLISS papers that have come out recently that don’t seem to be in the report’s reference list: Fangupo et al 2016; Morison et al 2016; Taylor et al 2017.	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN is aware of the BLISS publications and has updated the text related to ‘baby-led weaning’ to reflect findings from the BLISS trial.</p>
346	Crawley H	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).	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN is aware of the BLISS publications and has updated the text related to ‘baby-led weaning’ to reflect findings from the BLISS trial.</p>



Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
347	British Specialist Nutrition Association (BSNA)	<p>We welcome discussion in the report of the behavioural, social and environmental influences of social food acceptance. This is an area in which the commercial infant feeding sector has invested resource and championed the need for research.</p> <p>It is encouraging to see the inclusion of clear recommendations for offering variety and repeated exposure during complementary feeding, in keeping with the experimental evidence that these techniques are effective at promoting acceptance (Barends et al 2013; Barends et al 2014; Fildes et al 2015; Hetherington et al 2015).</p> <p>However, in relation to the conclusion drawn [347] we believe it is important to differentiate between ‘sensitive’ and ‘critical’ period, and acknowledge expert opinion that the early complementary feeding period does represent a ‘window of opportunity’ where there is a need to capitalise on an infant’s willingness to try new foods at the start of complementary feeding.</p> <p>A British Nutrition Foundation expert panel consider that the 4-6 months period can be an appropriate time to introduce small tastes of age appropriate foods, that do not compromise breast milk intake, but support ‘food acclimatisation’(Chambers, 2016).</p> <p>Furthermore, it would be pragmatic of the report to acknowledge that most infants in the UK are introduced to complementary foods below 6 months (Lennox et al 2013; McAndrew et al 2012), and as such, should include practical messages on the appropriate type, texture and amount of food for first complementary feeding in order to support parents who are introducing complementary foods below 6 months of age.</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter. Proceedings from the roundtable (Chambers et al, 2016) do not meet the inclusion criteria and have not been added to the report.</p> <p>SACN considered the available evidence in detail and believe there is insufficient evidence to support the view that there is a “critical window” for the acceptance of complementary foods before 6 months of age.</p> <p>SACN considered that the need for flexibility in advice is addressed by the wording “around 6 months.”</p> <p>Please note that the formulation of recommendations and provision of advice (for example, on the types of food, texture and quantities of food offered during complementary feeding) are the responsibility of risk managers and outside the remit of SACN.</p>
347	RCPCH	<p>This conclusion does not seem to follow from the results of experimental studies with extensively hydrolysed protein formulas summarized in Paragraphs 285-288 in which earlier (and longer) exposure to the formula was associated with greater acceptance of this flavour later on, albeit in formula-fed infants. The remaining data on timing of exposure to different flavours is observational and therefore presumably should be considered of lower quality. Additionally, few of the studies include infants exposed to different flavours</p>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p>

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
		specifically from 6 months since mothers have generally introduced them earlier.	<p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>SACN considered the available evidence in detail and believe that there is insufficient robust evidence to support the view that there is a “critical window” for the acceptance of solid foods before 6 months of age.</p>
350	Brown, R	<p>Re: <i>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.</i></p> <p>This sentence gives the impression that smooth textures, which could be interpreted as purees, should be given before offering any finger foods. This would seem to conflict with evidence such as that most babies at around 6 months are able to feed themselves (Wright et al 2011). It is also is different from present DH advice which encourages offering finger foods from 6 months along with softer and/or mashed foods. To avoid confusion it would be really important to be more specific about what is meant by ‘smooth’ and also if a progression is being advised, rather than offering both soft and/or mashed foods on a spoon along with finger foods from the beginning when starting at around 6 months. Obviously if a baby is started earlier on solid foods, they will need food pureed, not having acquired the skills to cope with anything else.</p>	<p>Thank you for your comments.</p> <p>In response to the comments received through public consultation, SACN has reviewed its conclusions and recommendations and updated these where appropriate.</p> <p>Please note that the formulation of recommendations and provision of advice (for example, on the types of food, texture and quantities of food offered during complementary feeding) are the responsibility of risk managers and outside the remit of SACN.</p>
350	Crawley H	<p>Re: <i>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.</i></p> <p>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.</p>	<p>Thank you for your comments.</p> <p>In response to the comments received through public consultation, SACN has reviewed its conclusions and recommendations and updated these where appropriate.</p> <p>Please note that the formulation of recommendations and provision of advice (for example, on the types of food, texture and quantities of food offered during complementary feeding) are the responsibility of risk managers and outside the remit of SACN.</p>

Paragraph number <sup>1</sup>	Organisation/individual	Comments	Reply from SACN
351	Brown R	<p><i>There is insufficient evidence at present to conclude that the BLW approach to complementary feeding achieves better infant outcomes than traditional feeding practices. This approach has not been tested in an RCT.</i></p> <p>I recognise that the BLISS study is still in progress, (though they have started to publish some results, which would be good to include) and we still need more RCT evidence for BLW approaches. However, I feel it is crucial to point out at the same time that we have NO RCTs and very little, if any, robust evidence about benefits, outcomes or suitability of ‘traditional feeding practices’. Often it is assumed by both health professionals and the public that we have, and so BLW or other baby-led approaches are viewed suspiciously, as if it has been proven that traditional practices work and are helpful. If this is not clarified, those with a vested interest in maintaining traditional practices will use this sentence to justify that approach, without robust evidence.</p>	<p>Thank you for your comments.</p> <p>SACN is aware of the BLISS publications and has updated the text related to ‘baby-led weaning’ to reflect findings from the BLISS trial.</p>
Conclusions	Ella’s kitchen	<p>The sensitive window for the introduction of complementary foods and the vegetables-first approach</p> <ul style="list-style-type: none"> <li>- We suggest that the report’s conclusion on the concept of the window of opportunity is amended to reflect the totality of evidence that shows that acceptance of bitter flavours such as vegetables is higher during the early stages of weaning - including if this begins at six months.</li> <li>- We suggest that specific recommendations about the benefits and practicalities of starting weaning with vegetables is included in the final report, given the considerable experimental evidence which supports the benefits of this practice.</li> </ul>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN’s conclusions are based on the committee’s interpretation of the evidence.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>SACN considered the available evidence in detail and believe there is insufficient robust evidence to support the view that there is a “critical window” for the acceptance of solid foods before 6 months of age.</p> <p>SACN is also of the view that there is insufficient evidence to support recommending the introduction of vegetables specifically as the first food in an infant’s diet.</p>

**Table 2.9: Specific comments on Chapter 9. Oral health (Paragraphs 352-399)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	Bernabe E	I would like to call your attention to a recent publication on breastfeeding and dental caries among Scottish children. The publication is attached for your perusal (Bernabe et al 2017). This is the only longitudinal study to date including multiple assessments for tooth decay, to the point where caries trajectories from age 1 to 4 years were explored as the outcome. The analysis shows that breastfeeding duration was not associated with caries trajectories, after accounting for multiple confounders. It thus challenges conclusion 1 in chapter 9. In all, we believe that even if there are no actual benefits of breastfeeding on preventing decay in baby teeth, we should strongly encourage the practice	Thank you for your comments and for highlighting this evidence.  SACN noted that this issue and evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'.
General	Breastfeeding Network	Oral health and incidence of caries is of great concern. More consideration on this topic is welcome. We would like to see work on the role of illnesses in pregnancy while the enamel is developing, antibiotics and dummies have been flagged up as possible factors. S398 considered breastfeeding in association with caries in older breastfed children, however the mechanism is not clear as breastmilk is usually delivered to the back of the infants mouth so unlikely to pool on front teeth. May also reflect additional milk given by bottle before bed.	Thank you for your comments.  Consideration of the role of illnesses during pregnancy and its effect on oral health is not in the scope of this report. SACN noted that evidence on dummy use may be of relevance when they start the review of 'Feeding children aged 12-60 months'.
General	British Society of Paediatric Dentistry	Please could the committee consider inclusion of the following recently published article: Peres et al 2017.	Thank you for highlighting this evidence.  SACN noted that this evidence may be considered when they start the review of 'Feeding children aged 12-60 months'.
General	British Society of Paediatric Dentistry	The BSPD position statement on infant feeding will not be limited to the first year of life and is due for publication October 2017.	Thank you for your comment and for highlighting this publication.

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	British Society of Paediatric Dentistry	There is one section with some typos- para 74, P21, the sentence beginning 'Munching can occur...' doesn't seem to make sense.	Thank you for your comment.  The report has been amended to improve clarity.
General	British Society of Paediatric Dentistry	Finally, it would have been great to have a mention of Dental Check by One, especially since the paper so comprehensively covers the other key preventive messages: <a href="http://bspd.co.uk/Dental-Check-by-One-">http://bspd.co.uk/Dental-Check-by-One-</a>	Thank you for your comments and for highlighting this publication.  This has been added to the section highlighting guidance provided in the 4 countries of the UK.
General	Dalzell J, Richards D	A very good summary of the available evidence in relation to dental disease in the first year of life in particular in relation to breastfeeding and dental caries. The breastfeeding and caries evidence rightly focuses on the one of the most recent systematic reviews providing a good discussion of the evidence. Two newer reviews and a cohort study are now also available that also support the general conclusion in relation to the chapters conclusions on breastfeeding and caries: Cui et al 2017; Peres et al 2017; Avila et al 2015.	Thank you for your comments and for highlighting this evidence.  SACN noted that this issue and evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'.
General	La Leche League GB	Possible additional references could include:  Association Between Infant Breastfeeding and Early Childhood Caries in the United States <a href="http://pediatrics.aappublications.org/content/120/4/e944?sso=1&amp;so_redirect_count=1&amp;nfstatus=401&amp;nftoken=00000000-0000-0000-0000-000000000000&amp;nfstatusdescription=ERROR%3a+No+local+token">http://pediatrics.aappublications.org/content/120/4/e944?sso=1&amp;so_redirect_count=1&amp;nfstatus=401&amp;nftoken=00000000-0000-0000-0000-000000000000&amp;nfstatusdescription=ERROR%3a+No+local+token</a> (Iida et al 2007)	Thank you for highlighting this evidence.  The subjects of this study were 2 to 5 years old and were therefore outside the scope of the current SACN report.  SACN noted that this evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'.
General	La Leche League GB	Investigation of the role of human breast milk in caries development <a href="http://www.aapd.org/assets/1/25/Erickson-21-02.pdf">http://www.aapd.org/assets/1/25/Erickson-21-02.pdf</a> (Erickson & Mazhari 1999) Breastfeeding and early childhood caries: a critical review <a href="http://www.iped.com.br/conteudo/04-80-S199/ing.pdf">http://www.iped.com.br/conteudo/04-80-S199/ing.pdf</a> (Ribeiro & Ribeiro 2004)	Thank you for highlighting this evidence.  SACN noted that this evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'.

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	Pearson-Glaze P	Possible additional references could include Association Between Infant Breastfeeding and Early Childhood Caries in the United States <a href="http://pediatrics.aappublications.org/content/120/4/e944?sso=1&amp;so_redirect_count=1&amp;nfstatus=401&amp;nftoken=00000000-0000-0000-0000-000000000000&amp;nfstatusdescription=ERROR%3a+No+local+token">http://pediatrics.aappublications.org/content/120/4/e944?sso=1&amp;so_redirect_count=1&amp;nfstatus=401&amp;nftoken=00000000-0000-0000-0000-000000000000&amp;nfstatusdescription=ERROR%3a+No+local+token</a> (Iida et 2007)	Thank you for highlighting this evidence.  The subjects of this study were 2 to 5 years old and were therefore outside the scope of the current SACN report. SACN noted that this evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'.
General	Pearson-Glaze P	Investigation of the role of human breast milk in caries development <a href="http://www.aapd.org/assets/1/25/Erickson-21-02.pdf">http://www.aapd.org/assets/1/25/Erickson-21-02.pdf</a> (Erickson & Mazhari 1999)  Breastfeeding and early childhood caries: a critical review <a href="http://www.jpeds.com.br/conteudo/04-80-S199/ing.pdf">http://www.jpeds.com.br/conteudo/04-80-S199/ing.pdf</a> (Riberio & Ribeiro 2004)	Thank you for highlighting this evidence.  SACN noted that this evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'.
General	Rugg-Gunn A	I welcome this report and the inclusion of the chapter on oral health. Importance of oral health is correctly emphasised.  I wish to draw your attention to three issues: a recent publication on breast feeding; vitamin D; and fluoride.  I draw your attention to the following article recently published in Pediatrics (Peres et al 2017). The study was a well-controlled birth cohort study. [Your paragraphs 372-380]  Lastly, I think in paragraph 375, the name 'Parera' is mis-spelt.	Thank you for your comments and for highlighting this evidence.  SACN noted that the impact of prolonged breastfeeding may be of relevance when they start the review of 'Feeding children aged 12-60 months'.  The report has been proof read and the typo highlighted has been corrected.
General	Rugg-Gunn A	[paragraphs 363-4] Vitamin D has been studied since the first article by May Mellanby in 1918. Vitamin D status both of the mother in pregnancy and of the infant influences the occurrence of enamel hypoplasia and dental caries. There are two aspects: raising an inadequate intake to adequate, and supplemental vitamin D in the presence of adequate intake. It is likely that there is more than one mechanism for effect: including the well-known effect on calcification while teeth are forming; post-eruptive	Thank you for highlighting this evidence.  The subjects of this study were older than 12 months and were therefore outside the scope of the current SACN report. SACN noted that this evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'.

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		immunological effects. The first article (a systematic review) reports substantial effect size. (Hujoel 2013; Schroth et al 2013; Schroth et al 2014)	SACN agreed that the impact of maternal and infant vitamin D status on the risk of dental caries in children aged over 12 months should be considered in its review of 'Feeding children aged 12-60 months'.
364	Rugg-Gunn A	<p>Paragraph 364: The use of a fluoride-containing toothpaste is rightly emphasised in paragraph 359. I would like to see mention of the caries preventive effect of water fluoridation (there are PHE references to its effectiveness and promotion in the UK). Water fluoridation has a pre-eruptive effect (while teeth are forming, i.e. from birth) as well as a topical, intra-oral, post-eruptive effect (on teeth as soon as they erupt). Both are relevant to this report. The post-eruptive effects are very well documented (by PHE) but I give you three references to the pre-eruptive effect: (Groeneveld et al 1990; Singh et al 2003; Cho et al 2014)</p> <p>I would comment [paragraph 363], in case you consider it, that fluoride has no worthwhile pre-natal effect on the child's dental health.</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN agreed to consider the benefits of water fluoridation on oral health and text has been added based on a recent Cochrane review by Iheozor-Ejiofor et al (2015):</p> <ul style="list-style-type: none"> <li>Iheozor-Ejiofor Z, Worthington HV, Walsh T, O'Malley L, Clarkson JE, Macey R, Alam R, Tugwell P, Welch V, et al. (2015) Water fluoridation for the prevention of dental caries. Cochrane Database Syst Rev. (6):CD010856.</li> </ul>
353	British Association for the Study of Community Dentistry	The aetiology of early childhood caries(ECC )is complex and the disease progresses more rapidly than in the permanent dentition. The American Academy of Pediatric Dentistry (AAPD) defines ECC as the presence of one or more decayed (non-cavitated or cavitated lesions), missing (due to caries), or filled tooth surfaces in any primary tooth in a child 71 months of age or younger. In children younger than 3 years of age, any sign of smooth-surface caries is indicative of severe early childhood caries (S-ECC). Reinforcing that ECC is often severe would add strength to this point that might otherwise be overlooked.	<p>Thank you for your comments.</p> <p>SACN has checked the definition and amended the text accordingly.</p>
354	British Association for the Study of Community Dentistry	The severity of the impact of dental caries could be made more strongly here. For example, children who have experienced multiple tooth loss can have problems eating due to their reduced ability to chew thus limiting their nutritional intake, and for some speech development can be effected.	<p>Thank you for your comment.</p> <p>SACN agreed that it may be relevant to consider this issue in its review of 'Feeding children aged 12-60 months'.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
354	British Dental Association	It is worth noting that childhood dental decay also places a substantial strain on GP services and A&E departments (Cope et al 2016; Currie et al 2017). Furthermore, recent surveys by the BDA have shown that a quarter of parents are unaware that children are entitled to free NHS dental care ( <a href="https://www.bda.org/news-centre/press-releases/Documents/a-tax-on-teeth.pdf">https://www.bda.org/news-centre/press-releases/Documents/a-tax-on-teeth.pdf</a> ); this is likely to contribute to the pressure on non-dental health professionals and also to the socio-economic inequalities in children's oral health.	Thank you for your comments and for highlighting this evidence.  The subjects of this study were older than 12 months and were therefore outside the scope of the current SACN report. SACN noted that this issue and evidence may be of relevance when they start the review of 'Feeding children aged 12-60 months'.
358	British Dental Association	Poor oral hygiene practices may also be a factor.	Thank you for your comment.  SACN has added text on the association between delayed commencement of tooth brushing and/or lack of access to fluoride toothpaste (or use of low fluoride toothpaste) and dental decay, referencing Public Health England's 'Delivering Better Oral Health: An evidence-based toolkit for prevention (Third Edition)' (PHE, 2014).
359	BDA - PFASG	Advice on oral health is needed to include reducing consumption of free (non-milk) sugars and appropriate cleaning once the first teeth appear.	Thank you for your comment.  SACN considers that this advice is clearly stated in the report.
359-360	Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group	It is positive to read that key complementary feeding messages around introducing a cup, offering low salt and sugar options to infants and giving a variety of tastes and textures remain unchanged and a key part of guidance. It is important that message around introducing cups states around 6 months as some families may introduce one earlier, again for valid reasons such as a breastfeeding mother returning to work.	Thank you for your comments.  SACN considered that the need for flexibility in advice is addressed by the wording "around 6 months." SACN has reviewed the report to ensure that where appropriate, the term "around 6 months" is used.
359-360	Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group	From one year of age feeding from a bottle should be discontinued rather than discouraged. It would be helpful to state that breast milk, infant formula or water are the only drinks recommended for this age group.	Thank you for your comment.  The text reflects guidance from NICE guideline PH11 (NICE, 2014) and therefore cannot be amended.



Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
361	British Association for the Study of Community Dentistry	In addition to the points made about free-flow cups and speech development. Use of a valved cup also enables drinks to be consumed over a longer period because of minimal risk of spilling. This potentially prolongs exposure of children's teeth to cariogenic liquid.	Thank you for your comment.  The text is a direct quote from NICE guideline PH11 (NICE, 2014) and therefore cannot be amended.
363	British Dental Association	New evidence suggests that maternal smoking during pregnancy could also affect tooth development (Al-Ani et al 2017)	Thank for your comment and for highlighting this evidence.  While smoking is mentioned as a potential confounder of infant feeding patterns in the 'Methodology' chapter, a detailed consideration of the impact of maternal smoking on infant health outcomes is not in the remit of this report and has not been further considered.
365	British Dental Association	Some babies are routinely bottle fed with expressed breast milk; we would urge SACN to clarify the distinction between the mode of delivery (breast or bottle) and the type of milk provided (breast milk or formula).	Thank you for your comment.  SACN has amended the text to clarify the difference between mode of delivery and mode of feeding.
365	Johnston S	Could this paragraph be reworded to make it clearer that vaginal delivery and breast feeding leads to beneficial effects?  This section otherwise appears to be very comprehensive and clear.	Thank you for your comment.  SACN has reviewed the text and amended this for clarity.
367	British Dental Association	As noted in paragraph 367, there is evidence that constituents of breast milk inhibit growth and adhesion of cariogenic bacteria; this seems likely to be independent of the mode of delivery. It may be the case that further research is needed to separate the effects of the variables.	Thank you for your comment.  SACN has added a research recommendation on the need for studies to describe the mode of delivery of feeds and drinks, for example, breast fed compared with expressed breast milk taken from a bottle, and the use of free flow cups.
369	British Dental Association	Is there evidence to support the suggestion that formula-fed infants might be more likely to be given sugar-sweetened beverages in a bottle than those who are breastfed, or those fed expressed breast milk in a bottle?	Thank you for your comment.  SACN noted that consideration of this issue may be of relevance when they start the review of 'Feeding children aged 12-60 months'.

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
374	British Association for the Study of Community Dentistry	Clarity to this paragraph could be added if it was stated if the children in the study were exclusively breast-fed, or combination fed <i>i.e.</i> breast and bottle. This distinction aids readers interpretation of the evidence cited.	Thank you for your comment.  SACN has reviewed the evidence and details on mode of feeding and type of milk are not provided.
381-389	British Dental Association	As above, the distinction between mode of feeding and type of milk needs to be clarified. Are mixed-fed infants more likely than those purely bottle-fed to receive expressed breast milk rather than formula?	Thank you for comment.  SACN has reviewed the evidence and details on mode of feeding and type of milk are not provided.
395	British Association for the Study of Community Dentistry	Clarity to this paragraph could be added if the age, or an age range of the children included was stated and over what period of time their feeding practices continued. If this is not possible due to the information in individual papers, perhaps a note of caution could be added for readers. For example 'ever breastfed' could be as short as a week, which would be minimally protective in terms of malocclusion, including anterior open bite.	Thank you for comment.  SACN has reviewed the evidence and details on mode of feeding and type of milk are not provided.
Conclusions	RCPCH Conclusions	In practical terms, RCPCH suggest that it would be helpful to have a conclusion/recommendation on the importance of tooth-brushing with a fluoride paste from the time the first tooth erupts, regardless of mode of feeding.	Thank you for your comment.  SACN recognises the importance of tooth brushing and has reproduced current government advice for oral health improvement in the report, however, this issue is outside SACN's remit and SACN is therefore unable to provide a conclusion or recommendation on this.

**Table 2.10 Specific comments on Chapter 10. UK infant feeding practice (Paragraphs 400-465)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
162	RCPCH	The low prevalence of iron deficiency anaemia found in DNSIYC is likely to reflect the high use of infant formula and follow-on formula in the second six months. The impact of higher breastfeeding prevalence and reduced use of formulas during this period is uncertain but this should be an area for future research assuming measures to increase breastfeeding duration in the UK are successful.	Thank you for your comment.  Text on the contributors of iron in the infant diet can be found in the chapter on 'UK infant feeding practice'.

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

**Table 2.11: Specific comments on Chapter 11. Risks of chemical toxicity in relation to the infant diet (Paragraphs 466-473)<sup>1</sup>**

Page number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
Table 11.1 (page 107)	La Leche League GB	<p>Caffeine recommendation is 200mg per day. Seems a bit low compared to other resources. Reference?</p> <p>Alcohol recommendation 1 or 2 units once or twice a week... seems quite conservative compared to other resources? Reference?</p>	<p>Thank you for your comments.</p> <p>The figures provided are consistent with advice on NHS Choices, which reflect COT overarching statement (COT, 2012). Available at: <a href="https://cot.food.gov.uk/sites/default/files/cot/cotstatementoverarch201203.pdf">https://cot.food.gov.uk/sites/default/files/cot/cotstatementoverarch201203.pdf</a></p>
Table 11.1 (page 107)	Pearson-Glaze P	<p>Caffeine recommendation is 200mg per day. Is there a reference, this seems on the low side to some other resources?</p> <p>Alcohol recommendation 1 or 2 units once or twice a week. Is there a reference, this seems quite conservative compared to some other resources?</p>	<p>Thank you for your comments.</p> <p>The figures provided are consistent with advice on NHS Choices, which reflect COT overarching statement (COT, 2012). Available at: <a href="https://cot.food.gov.uk/sites/default/files/cot/cotstatementoverarch201203.pdf">https://cot.food.gov.uk/sites/default/files/cot/cotstatementoverarch201203.pdf</a></p>

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

**Table 2.12: Specific comments on Chapter 12. Risks of allergic and autoimmune disease to the infant diet (Paragraphs 475-487)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	BDA - PFASG	<p>Comments on peanuts and egg are as below in the commissioned section on this specific topic</p> <p>The authors have included this statement: “Based on evidence relating to the consequences of reduced breast milk feeding, on the basis that complementary foods displace breast milk, introduction of complementary foods including peanut and hen’s egg earlier than around six months of age presents risks that are not outweighed by any potential benefit.” This statement is unclear as the EAT study (commissioned by FSA) reported that breast feeding rates in the intervention group were higher than the UK average and did not differ from the control group. Suggest this is reworded to reflect that whilst some displacement of energy/nutrients from breastmilk occurs evidence (from limited studies) indicates that breast feeding is maintained when solids are commenced.</p>	<p>Thank you for your comments.</p> <p>SACN has updated the text in the chapter on ‘Risks of allergic and autoimmune disease’ to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease. These reviews included consideration of gluten. More information about the review methodology is available in Boyle et al (Boyle et al, 2016a). The FSA-commissioned systematic reviews were evaluated by COT (COT, 2016a; COT, 2016b; COT, 2017) and published in the peer-reviewed literature (Boyle et al, 2016b; Ierodiakonou et al, 2016; Garcia-Larsen et al, 2018).</p> <p>Both the FSA-commissioned systematic review on the timing of introduction of allergenic foods to the infant diet (Boyle et al, 2016a) and accompanying COT statement (COT, 2016b) highlighted that findings on the timing of introduction of foods containing peanut and hen’s egg into the infant diet in relation to the risk of developing peanut and hen’s egg allergy respectively, might impact current government advice and required further consideration.</p> <p>A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen’s egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group’s statement was provided in the draft report. For information, the statement is available here:  <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>The EAT Study was considered by the joint SACN/COT working group as part of its benefit-risk assessment on the timing of introduction of peanut and hen’s egg into the infant diet, findings from which are included in the chapter on ‘Risks of allergic and autoimmune disease’.</p>

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			<p>SACN has also added further background on the development of the current recommendations, including those on gluten.</p> <p>This chapter has been reviewed and updated for clarity throughout.</p>
General	BDA - PFASG	<p>In addition, it is unclear what “risks” the report refers to? In the EAT study no harm was associated with the early introduction (from 3-4 months) of peanut and egg and children continued with breast feeding. Therefore, this statement does not reflect the study findings. Whilst breast feeding has a clear advantage for developing countries with regard to infections, the EAT study did not find an increased risk with earlier introduction except for URTI.</p>	<p>Thank you for your comments.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on ‘Infant feeding, growth and health’ and ‘Infant feeding, body composition and health’.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on ‘Risks of allergic and autoimmune disease’). The chapter ‘Risks of allergic and autoimmune disease’ has been updated to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease. These reviews included consideration of gluten. More information about the review methodology is available in Boyle et al (Boyle et al, 2016a). The FSA-commissioned systematic reviews were evaluated by COT (COT, 2016a; COT, 2016b; COT, 2017) and published in the peer-reviewed literature (Boyle et al, 2016b; Ierodiakonou et al, 2016; Garcia-Larsen et al, 2018).</p> <p>A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen’s egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group’s statement was provided in the draft report. For information, the statement is available here:  <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>The EAT Study was considered by the joint SACN/COT working group as part of its benefit-risk assessment on the timing of introduction of peanut and hen’s egg into the infant diet, findings from which are included in the chapter on ‘Risks of allergic and autoimmune disease’.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			SACN considered findings from the EAT Study and the SACN/COT statement, and noted the increased risk of upper respiratory tract infections in the intervention group of the EAT Study.
General	British Specialist Nutrition Association (BSNA)	<p>At present, the advice provided by commercial infant food providers on allergen introduction reflects the current position of the Department of Health (<a href="http://www.nhs.uk/conditions/pregnancy-and-baby/pages/solid-foods-weaning.aspx">http://www.nhs.uk/conditions/pregnancy-and-baby/pages/solid-foods-weaning.aspx</a> <a href="http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/food-allergies-in-children.aspx">http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/food-allergies-in-children.aspx</a> );to avoid the introduction of allergenic foods before 6 months of age. This advice has recently been challenged by clinical practitioners as contradictory to the evidence base and recent updates in European guidance (Fewtrell et al 2017)</p> <p>In light of this, we welcome efforts by SACN and COT (SACN-COT 2017)(to review the evidence relating to the development of food allergy, atopic and auto-immune disease. However, we wish to highlight that the conclusions and recommendations drawn in this report [531,532,543,544] are ambiguous and open to interpretation. We would urge SACN to give consideration to how statements might be interpreted and translated into practical and consistent advice for parents and to amend the conclusions accordingly.</p> <p>In particular, we urge the panel to consider whether:</p> <p>Recommendations for hen’s egg and peanut will be extended, such that all allergenic foods need not be differentiated from other sources of complementary foods.</p>	<p>Thank you for your comments.</p> <p>In response to the comments received through public consultation, SACN has reviewed its conclusions and recommendations and updated these where appropriate.</p> <p>Please note that the formulation of recommendations and provision of advice are the responsibility of risk managers and outside SACN’s remit.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	British Specialist Nutrition Association (BSNA)	In particular, we urge the panel to consider whether:  Current advice to introduce allergens one at a time is still appropriate. ( <a href="http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/food-allergies-in-children.aspx">http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/food-allergies-in-children.aspx</a> )	Thank you for your comment.  Existing UK guidance on the introduction of allergenic foods into the infant diet has been added to this chapter.
General	British Specialist Nutrition Association (BSNA)	We acknowledge that the report is restricted to the risk assessment only of healthy term infants. However, it remains unclear whether this will include infants at high risk of atopy or whether the panel would acknowledge and support that specific recommendations for the population may be appropriate.	Thank you for your comment.  In keeping with SACN's terms of reference, only healthy term infants are considered. SACN is unable to provide advice on the management of clinical conditions, including autoimmune diseases.
General	Crawley H	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.	Thank you for your comment.  SACN has updated the text in the chapter on 'Risks of allergic and autoimmune disease' to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease, including the review on infant formulae containing hydrolysed cows' milk protein.
General	La Leche League GB	This chapter has no mention of formula as a source of allergy and autoimmune disease. Could Maureen Minchin's book <i>Milk Matters Infant Feeding and Immune Disorder</i> or the harms of formula be referred to? Autoimmune disease is not really covered and this chapter is weak compared to others.	Thank you for your comment and for highlighting this evidence.  In keeping with SACN's terms of reference, only healthy term infants are considered. SACN is unable to provide advice on clinical conditions, including autoimmune diseases.  The FSA-commissioned systematic review on the timing of introduction of allergenic foods to the infant diet (Boyle et al, 2016b) and accompanying COT statement (COT, 2016a) explored the evidence on infant formulae containing hydrolysed cows' milk protein and their potential role in reducing the risk of infants and young children developing atopic and autoimmune disease. Standard infant formula was not considered.



Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	Pearson-Glaze P	<p>This chapter has no mention of formula as a source of allergy and autoimmune disease. References in Maureen Minchin’s book <i>Milk Matters Infant Feeding and Immune Disorder</i> may be useful. Autoimmune disease is not really covered and this chapter seemed weak compared to others.</p>	<p>Thank you for your comment and for highlighting this evidence.</p> <p>In keeping with SACN’s terms of reference, only healthy term infants are considered. SACN is unable to provide advice on management of clinical conditions, including autoimmune diseases.</p> <p>An FSA-commissioned systematic review on the timing of introduction of allergenic foods to the infant diet (Boyle et al, 2016b) and accompanying COT statement (COT, 2016a) explored the evidence on infant formulae containing hydrolysed cows’ milk protein and their potential role in reducing the risk of infants and young children developing atopic and autoimmune disease. Standard infant formula was not considered.</p>
General	Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group	<p>It would be helpful to reference the European perspective provided by the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) Committee on Nutrition (Fewtrell et al 2017) here and to give the rationale for differences between the guidance documents. Clear, evidence based guidance is needed on the introduction of allergens for both professionals and families. In practice, families continue to be given unhelpful advice that infants given solids before 6 months should only be given single fruits and vegetables until they are 6 months old. The advice given on the introduction of allergen foods is inconsistent. The ESPGHAN committee recommend that allergenic foods including hen’s eggs and peanuts (in an appropriate form) will no longer be separated from other complementary foods.</p> <p>Furthermore, infants at high risk of peanut allergy (those with severe eczema, egg allergy, or both as defined in the LEAP study) should have peanut introduced (e.g. as smooth peanut butter) between 4 and 11 months, following evaluation by an appropriately trained professional. Clarity is needed regarding gluten and cow’s milk as these need not be differentiated from other complementary foods.</p> <p>We are aware of three reviews on the topic of early introduction of complementary foods that were published after the end of 2015.</p>	<p>Thank you for your comments and for highlighting this evidence.</p> <p>SACN has considered the evidence highlighted and agreed that the findings do not change the conclusions of the ‘Feeding in the first year of life’ report. Therefore the evidence has not been added to the report, in line with the approach set out in the ‘Methodology’ chapter.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on ‘Infant feeding, growth and health’ and ‘Infant feeding, body composition and health’.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on ‘Risks of allergic and autoimmune disease’). The chapter on ‘Risks of allergic and autoimmune disease’ has been updated to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease. More information about the review methodology is available in Boyle et al (Boyle et al, 2016a). The FSA-commissioned systematic reviews were evaluated by COT (COT, 2016a; COT, 2016b; COT, 2017) and published in the peer-reviewed literature (Boyle et al, 2016b; Ierodiakonou et al,</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		<p>These are;            “Modifying the infant’s diet to prevent food allergy”(Grimshaw et al 2017).This is a review of current evidence of prevention of food allergy as part of broad range approach bringing together expertise on food allergy research (iFAAM). Among other dietary manipulations, they review the timing of introduction of allergenic foods into the infant’s diet. They conclude that "avoidance strategies are ineffective in the prevention of food allergies".            "However before recommendations are updated it is important to understand how best to introduce preventive intervention in a community context, particularly as there may be significant numbers of children sensitised by the time they are weaned".</p> <p>“Prevention of food allergy” (Du Toit et al2016)            This is a review of preventive strategies of IgE mediated food allergy through dietary manipulations, focused on recent interventional studies.            About early food introduction they conclude that “it is clear that the paradigm has shifted from recommending avoidance of common food allergens in infancy, to consideration of early consumption strategies to prevent allergy development”.</p> <p>"Can early allergen exposure prevent food allergy“ ArchDisChild July 2016;101:802.            This is a brief internal peer review on the topic (including EAT and LEAP studies). They conclude that early introduction was protective against development of allergy, safe and dose-dependent for peanut and egg. Because of the difference between the ITT and PP analysis, “if official guidance changes to encourage early introduction of (at least) peanut and egg, which it probably should, then parents will need advice on how to prepare these foods and present them to 3-month-olds in a way that they will easily accept”.</p>	<p>2016; Garcia-Larsen et al, 2018).</p> <p>A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen’s egg into the infant diet, and the risk of developing allergy to these foods. As part of this assessment, the working group considered the findings from the EAT and LEAP studies in detail.</p> <p>A link to the working group’s statement was provided in the draft report. For information, the statement is available here:  <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>Please note that the formulation of recommendations and provision of advice are the responsibility of risk managers and are outside the remit of SACN.</p> <p>In keeping with SACN’s terms of reference, only healthy term infants are considered. SACN is unable to provide advice on the management of clinical conditions, including autoimmune diseases.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	RCPCH	The consultation does not include the accompanying SACN/COT report on the introduction of allergenic foods and the introduction of gluten is not covered. It is therefore not possible for stakeholders to critically review and discuss the evidence on those topics and this hinders a full risk-benefit consideration of the optimal age (or range of ages) for introducing complementary foods.	<p>Thank you for your comment.</p> <p>SACN has updated the text in the chapter ‘Risks of allergic and autoimmune disease’ to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease. These reviews included consideration of gluten. More information about the review methodology is available in Boyle et al (Boyle et al, 2016a). The FSA-commissioned systematic reviews were evaluated by COT (COT, 2016a; COT, 2016b; COT, 2017) and published in the peer-reviewed literature (Boyle et al, 2016b; Ierodiakonou et al, 2016; Garcia-Larsen et al, 2018).</p> <p>Both the FSA-commissioned review (Boyle et al, 2016a) and accompanying COT statement (2016b) highlighted that findings on the timing of introduction of foods containing peanut and hen’s egg into the infant diet in relation to the risk of developing peanut and hen’s egg allergy respectively, might impact current government advice and required further consideration.</p> <p>A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen’s egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group’s statement was provided in the draft report. For information, the statement is available here:  <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>SACN has also added further background on the development of the current recommendations, including those on gluten.</p> <p>This chapter has been reviewed and updated for clarity throughout.</p>
483	Crawley H	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.	<p>Thank you for your comment.</p> <p>SACN has updated the text in the chapter ‘Risks of allergic and autoimmune disease’ to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease. These reviews included consideration of gluten. More information about the review methodology is available in Boyle et al (Boyle et al, 2016a). The FSA-</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			<p>commissioned systematic reviews were evaluated by COT (COT, 2016a; COT, 2016b; COT, 2017) and published in the peer-reviewed literature (Boyle et al, 2016b; Ierodiakonou et al, 2016; Garcia-Larsen et al, 2018).</p> <p>Both the FSA-commissioned review (Boyle et al, 2016a) and accompanying COT statement (COT, 2016b) highlighted that findings on the timing of introduction of foods containing peanut and hen's egg into the infant diet in relation to the risk of developing peanut and hen's egg allergy respectively, might impact current government advice and required further consideration.</p> <p>A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen's egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group's statement was provided in the draft report. For information, the statement is available here:  <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>SACN has also added further background on the development of the current recommendations, including those on gluten.</p> <p>This chapter has been reviewed and updated for clarity throughout.</p>
485 & 486	RCPCH	<p>It is impossible to respond adequately to these statements without the opportunity to comment on the scientific assessment on which they are based. It is stated that 'based on the consequences of reduced breast milk feeding, on the basis that complementary foods displace breast milk, introduction of complementary foods including peanut and hen's egg earlier than around six months of age presents risks that are not outweighed by any potential benefit'. It is not clear which risks are referred to here. In the EAT study itself, there were no apparent risks associated with the introduction of allergenic foods from 3-4 months, including for all types of infection apart from URTI. Furthermore, the statement</p>	<p>Thank you for your comment.</p> <p>SACN has updated the text in the chapter 'Risks of allergic and autoimmune disease' to include further details on the Food Standards Agency (FSA) commissioned systematic reviews examining the influence of infant diet on the development of food allergy, and atopic and autoimmune disease. These reviews included consideration of gluten. The FSA-commissioned systematic review (Boyle et al 2016a) included findings from Vriezinga et al (2014). It is not in SACN's remit to comment on why the other two papers highlighted were not included in the systematic review.</p> <p>The FSA-commissioned reviews were evaluated by COT (COT, 2016a; COT, 2016b; COT, 2017). Both the FSA-commissioned review (Boyle et al 2016a) and</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		<p>assumes that nutritionally significant amounts of allergenic foods would be consumed, whereas the beneficial effects of introducing such foods for immune tolerance may be afforded by relatively small quantities which have minimal impact on breast milk intake. Indeed, published data from the EAT study suggested minimal impact on breastfeeding duration since rates in the intervention group were significantly above expected for the UK, and were not significantly different from those in the control group. RCPCH would like a clearer explanation of the risks which were considered in formulating this statement, and an opportunity to respond to them. Without such an opportunity, we suggest it is impossible to conduct a comprehensive assessment.</p> <p>There is also no specific mention of the issue of gluten introduction during complementary feeding. Two large RCTs conducted in European infants have shown that the introduction of gluten at different ages after 4 months does not influence the subsequent development of coeliac disease. Breastfeeding also had no impact on this outcome. These studies have led to the revision of guidelines on introducing gluten which now suggest that it can be introduced at any time between 4 and 11 months of age.(Vriezinga et al 2014; Lionetti et al 2014; Szajewska et al 2016)</p>	<p>accompanying COT statement (2016b) highlighted that findings on the timing of introduction of foods containing peanut and hen’s egg into the infant diet in relation to the risk of developing peanut and hen’s egg allergy respectively, might impact current government advice and required further consideration.</p> <p>A joint SACN/COT working group was established to undertake a benefit-risk assessment relating to the timing of introduction of peanut and hen’s egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group’s statement was provided in the draft report. For information, the statement is available here:  <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>SACN has also added further background on the development of the current recommendations, including those on gluten.</p> <p>This chapter has been reviewed and updated for clarity throughout.</p>

**Table 2.13: Specific comments on Chapter 131. Conclusions and recommendations (Paragraphs 488-545) (Page 115-124)**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group	<p>The dietetic profession is fully in support of encouraging and supporting women and their families to breastfeed for as long as they wish to. There needs to be continued strict guidance on the marketing on infant formula milks to health professionals so that they are equipped to give accurate and impartial advice to families considering use of an infant formula milk.</p> <p>We agree that further research is required around responsive feeding and the ability to self-regulate appetite and weight gain. This will assist professionals when supporting families to help reduce the risk of becoming overweight before they start school (as many as 1 in 5 children in Wales are overweight by the time they are 5 years of age, PHW 2017).</p> <p>We support the recommendation to re-instate the Infant Feeding Survey every 5 years. This provided local practitioners with invaluable information and insight into the infant feeding choices of families and helped to inform practice.</p>	Thank you for your comments.
General	BDA-PFASG	<p>Current evidence does not support that exclusive breastfeeding to 6 months is the physiological norm for all infants. Research has found that some infants will need complementary foods before this. Responsive feeding is key here as infants will signal developmental and nutritional needs to their mother.</p> <p>It is unclear where evidence reviewed for the report strengthens the recommendation to breastfeed exclusively to 6 months. Recent evidence from RCTs supports that there is no harm in introducing allergenic foods from 4 months.</p> <p>Suggest that current recommendations should reflect this by stating</p>	<p>Thank you for your comments.</p> <p>SACN considered that the need for flexibility in advice is addressed by the wording “around 6 months.” Text on the role of responsive feeding to the chapter on ‘Eating and feeding in the first year of life’.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN is of the view that the findings from the totality of evidence</p>

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		that mothers should be supported to exclusively breastfeed for the first 6 months. No infant should be introduced to CF before 4 months but all should be given these by 6 months of age	<p>support current UK policy to recommend exclusive breastfeeding for around the first 6 months of life.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on 'Infant feeding, growth and health' and 'Infant feeding, body composition and health'. Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on 'Risks of allergic and autoimmune disease').</p> <p>SACN's conclusions on these issues are reflected in the text.</p>
General	BDA-PFASG	Standard and follow on formulas could account for the low prevalence of ID reported in the DNSIYC	Thank you for your comments. Iron status during infancy has been considered in detail in the 'Micronutrients' chapter, while dietary intakes of iron and iron status in UK infants have been considered in the chapter on 'UK infant feeding practice'.
490	RCPCH	Breastfeeding is certainly the physiological norm at birth but there is no evidence that the physiological norm for the duration of exclusive breastfeeding is six months in all infants. It is more likely biologically and physiologically that the optimal period for exclusive breastfeeding is variable between infants. Hence the assertion that the potential benefits of introducing any complementary food before six months must be balanced against the risk of displacing breast milk is not a reasonable starting point for the analysis. It is also important to consider behavioural aspects and the possibility that infants may indicate or 'signal' to their mother that they are ready for other foods – either from a nutritional or developmental perspective	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN's conclusions are based on the committee's interpretation of the evidence.</p>
506	RCPCH	The 'best estimates' indicating that breast milk production increases between 4 and 6 months and that this would meet the increasing energy demands of the growing infant are all from studies in (highly) selected mother-infant dyads who chose this behaviour and are	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
		<p>successful. The statement should be qualified to this effect and the issue of generalizability mentioned.</p> <p>It is not accurate that a ‘succession of randomised trials has shown that giving complementary foods to breast fed infant before 6 months compromises breast milk intake without increasing total energy intake or increasing weight gain and is associated with other negative health outcomes’. There have been 4 RCTs; two in Honduras, one in Iceland and one in the UK (EAT). The studies did suggest that some breast milk is displaced by complementary foods without influencing energy intake or infant growth (or growth in early childhood in the Iceland study) but we are not aware of negative health effects. In fact, in both the Honduras and Iceland trials, infants with earlier introduction actually had better iron status.</p>	<p>the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on ‘Infant feeding, growth and health’ and ‘Infant feeding, body composition and health’.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on ‘Risks of allergic and autoimmune disease’).</p> <p>The studies by Dewey et al (1998) and Jonsdottir et al (2012), and the findings from the EAT study, have been considered by SACN (see the chapters on ‘Micronutrients’ and ‘Risks of allergic and autoimmune disease’). The findings from these studies did not change the overall conclusions of the ‘Feeding in the first year of life’ report. SACN’s conclusions on this issue are reflected in the text.</p>
507	RCPCH	This statement is not substantiated by evidence – see Paragraph 120.	<p>Thank you for your comment.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the ‘Methodology’ chapter, which has been amended for clarity.</p> <p>SACN’s conclusions are based on the committee’s interpretation of the evidence. In keeping with the style of SACN reports, references are not included in the conclusions.</p>



Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
512.	RCPCH	This statement ignores the findings of the research with extensively hydrolysed protein formulas by Menella et al. See Paragraph 347.	<p>Thank you for your comment and for highlighting this evidence.</p> <p>SACN considered the evidence from Mennella et al (2004) on the introduction of protein hydrolysate formula in detail in the chapter on 'Eating and feeding of solid foods'.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p>
520	RCPCH	It seems likely that the relatively low prevalence of IDA in DNSIYC reflects the widespread use of infant formulas and follow-on formulas between 6 and 12 months.	Thank you for your comment.
533.	RCPCH	We cannot agree that the evidence presented (and other evidence so far not included) justifies the statement that 'the evidence reviewed for the report strengthens current guidance to breastfeed exclusively for around the first six months of the infant's life'. Recent evidence from RCTs demonstrates no adverse effects from introducing complementary foods, including gluten and allergenic foods, from 4 months, with better iron status in two trials. The evidence is not sufficient for such a dogmatic statement, and suggests the need for a greater degree of flexibility. RCPCH believes that mothers should be supported to exclusively breast feed their infant for up to 6 months, that complementary foods should not be introduced to any infant before 4 months, and that all infants require complementary foods by 6 months. We favour a greater focus on supporting breastfeeding initiation and maintenance given strong evidence for beneficial effects on infant and maternal health, than on a goal for exclusive breastfeeding which many mothers find unrealistic and for which the evidence is much weaker.	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN's conclusions are based on the committee's interpretation of the evidence.</p> <p>SACN considered that the need for flexibility in advice is addressed by the wording "around 6 months."</p> <p>The studies by Dewey et al (1998) and Jonsdottir et al (2012) have been considered by SACN (see the chapter on 'Micronutrients'). The findings from these studies did not change the overall conclusions of the 'Feeding in the first year of life' report.</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			<p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on 'Infant feeding, growth and health' health' and 'Infant feeding, body composition and health'.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on 'Risks of allergic and autoimmune disease').</p> <p>SACN's conclusions on this issue are reflected in the text.</p>
535 & 536	More J	<p>The recommendation for complementary feeding to be introduced at around 6 months of age but not before 4 months is a vague recommendation and is currently interpreted and passed on by some healthcare professionals as 'do not being complementary feeding before 6 months of age'. This adds considerable anxiety and a feeling of guilt to parents who perceive that their infant is ready to begin complementary feeding earlier than 6 months, at 4 or 5 months of age. It also reinforces the concept that infants develop their various skills at different rates and any skill development is not tied strictly to one specific calendar date.</p> <p>A clearer recommendation for healthcare professionals and parents to understand and in which to have confidence, would be to begin complementary feeding by 6 months but not before 4 months or more simply begin anytime between 4 and 6 months of age.</p> <p>The WHO growth charts by which infant growth is now assessed are based on infants who were exclusively breastfed and introduced to complementary feeding in the 4-6 month age range.</p>	<p>Thank you for your comments.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN's conclusions are based on the committee's interpretation of the evidence.</p> <p>SACN considers the need for flexibility in advice is addressed in the wording "around 6 months".</p> <p>In deriving its conclusions, SACN thoroughly considered the available evidence on infant feeding patterns and short and long term health outcomes, taking into account the totality of benefits and risks.</p> <p>Evidence regarding the impact on health outcomes associated with introducing solid foods before around 6 months of age has been considered in the chapters on 'Infant feeding, growth and health' and 'Infant feeding, body composition and health'.</p> <p>Evidence on the timing of introduction of allergenic foods into the infant diet and risks of developing atopic and autoimmune disease was also considered (see chapter on 'Risks of allergic and autoimmune disease').</p> <p>SACN's conclusions on this issue are reflected in the text.</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
542.	RCPCH	This recommendation could also emphasise the importance of regular tooth brushing with fluoride toothpaste once the first tooth erupts.	<p>Thank you for your comment.</p> <p>SACN's remit covers nutritional/dietary aspects of oral health. Therefore, while the committee recognises the importance of tooth brushing and has reproduced current advice in the report, this issue is outside SACN's remit and SACN is therefore unable to provide a conclusion or recommendation on this.</p>
543.	RCPCH	RCPCH suggests this recommendation should emphasise that peanut and hen's egg should not be introduced before 4 months, and after that these foods should be treated in the same way as other complementary foods.	<p>Thank you for your comment.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN's conclusions are based on the committee's interpretation of the evidence presented in the chapter on 'Risks of allergic and autoimmune disease' and in the joint SACN/COT benefit-risk assessment relating to the timing of introduction of peanut and hen's egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group's statement was provided in the draft report. For information, the statement is available here: <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p>
544	RCPCH	What is the evidence for the recommendation that exposure to allergenic foods must continue after initial exposure to avoid the risk of sensitization and food allergy? The follow-up of subjects from the LEAP trial showed no increase in sensitization or allergy after a 1 year period of peanut avoidance in the intervention group. To our knowledge, this issue was not investigated in the other published trials.	<p>Thank you for your comment.</p> <p>SACN used methods in line with the SACN Framework for the Evaluation of Evidence to critically review the evidence throughout the report. The approach employed is set out in the 'Methodology' chapter, which has been amended for clarity.</p> <p>SACN's conclusions are based on the committee's interpretation of the evidence presented in the chapter on 'Risks of allergic and autoimmune disease' and in the joint SACN/COT benefit-risk</p>

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
			<p>assessment relating to the timing of introduction of peanut and hen's egg into the infant diet, and the risk of developing allergy to these foods. A link to the working group's statement was provided in the draft report. For information, the statement is available here: <a href="https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet">https://www.gov.uk/government/publications/SACN/COT-statement-on-the-introduction-of-peanut-and-hens-egg-into-the-infant-diet</a></p> <p>As part of this assessment, the working group considered the findings from the LEAP study in detail.</p>
545	RCPCH	RCPCH strongly supports the reintroduction of the five yearly Infant Feeding Survey to allow tracking of secular trends and changes in practice consequent to new recommendations.	<p>Thank you for your comment.</p> <p>SACN has added a research recommendation on the need to address gaps in the evidence on infant feeding practices in the absence of national monitoring of current practice. This includes evidence gaps on the prevalence and duration of breastfeeding, use of nutritional supplements, and use of foods other than breast milk in infancy.</p> <p>SACN noted that the questions and definitions previously adopted in the five yearly IFS should be used in order to allow tracking of secular trends and changes in practice consequent to new recommendations and guidance.</p>

**Table 2.14: Specific comments on Research Recommendations (Paragraphs 546-558)<sup>1</sup>**

Paragraph number <sup>1</sup>	Organisation/ Individual	Comments	Reply from SACN
General	Crawley H	An additional research recommendation 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.	Thank you for your comment.  The composition of infant formulae and factors influencing consumer choice of these products are outside the scope of this report.
546	Royal College of Midwives	<p>The RCM is grateful to the Scientific Advisory Committee on Nutrition for the comprehensive and detailed work, as set out in the draft report, and welcomes the opportunity to respond to this consultation.</p> <p>Our contribution will focus on the areas of policy, practice and research, as encompassed in Terms of Reference, Section 4d.</p> <p><b>Definitions</b></p> <p>The UK has one of the lowest rates of breastfeeding in Europe and one which declines very rapidly in the first few weeks of life. Analysis shows that in England in 2015/16 rates dropped from over three quarters of women initially breastfeeding to just 43.2% at 6-8 weeks (The Lancet Breastfeeding series paper 1, data sources and estimates: countries without standardized surveys 2016).</p> <p>The RCM notes that the incidence of breastfeeding is currently defined as the proportion of babies who were breastfed initially. This includes all babies who were put to the breast at all, even if this was on one occasion only.(Terms of Reference, Point 6) The proportion given is 80% of UK infants are now at least initially breastfed and the RCM would question whether this is an accurate and meaningful figure.</p> <p>There is now the routine practice of placing babies skin to skin</p>	<p>Thank you for your comment.</p> <p>SACN has considered the Lancet Breastfeeding Series (2016) (Victoria et al, 2016) and included a reference to this in the updated report (see chapter on 'UK infant feeding practice').</p> <p>SACN has added a recommendation stating that greater focus should be given to reducing breastfeeding attrition rates and supporting women who make the informed choice to breastfeed.</p> <p>SACN has also added a research recommendations regarding the need to:</p> <ul style="list-style-type: none"> <li>• establish valid measures of the successful establishment of breastfeeding that go beyond simple initiation at birth.</li> <li>• measure the exclusivity, intensity and duration of breastfeeding as precisely as possible. Definitions adopted should be fully explained in publications.</li> </ul>

<sup>1</sup> References to chapters and paragraphs/page numbers refer to those in the draft report which went out for public consultation: <https://www.gov.uk/government/consultations/feeding-in-the-first-year-of-life-draft-sacn-report>

		<p>within one hour of delivery with support and encouragement for mothers to breastfeed, which is in line with NICE guidance. This does mean that many babies may be recorded as having initially breastfed, without it ever becoming fully established, or even being the intended method of feeding.</p> <p>Research Recommendation (Paragraph 546) states: “The intensity and duration for breastfeeding should be measured as precisely as possible in all studies, preferably by application of standard WHO definitions of breast milk exposure and a prospective study design”.</p> <p>The RCM agrees that a consistent, measurable and reliable baseline for marking breastfeeding initiation is important and recommends that an interval be identified some hours after birth at which to record this observation.</p> <p>Our intention would not be to diminish the importance of breastmilk exposure at birth in any way, but to give a more accurate starting point from which to determine duration of breastfeeding.</p>	
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## Out of scope comments

**Table 3.1: Comments relating to risk management or outside SACN remit (for information)**

Organisation/Individual	Comments
Breastfeeding Network	<p>Communication of SACN evidence: Start for Life leaflets were a useful way to get accurate evidence-based information from SACN reports to parents. Families should have access to hard copies of leaflets with pdf's available on the website. It makes no sense to remove both options. The text about bottle-feeding on the website is hard to follow. Please consider a recommendation to reprint the bottle-feeding leaflet in particular. <a href="https://www.gov.uk/government/publications/start4life-updated-guide-to-bottle-feeding/start4life-guide-to-bottle-feeding">https://www.gov.uk/government/publications/start4life-updated-guide-to-bottle-feeding/start4life-guide-to-bottle-feeding</a></p> <p>Industry sponsored education has resulted in a whispering campaign that the age of introduction of solid food is to be reduced. This has caused so much confusion amongst parents and ought to be a warning about the need to stick with the evidence.</p>
Breastfeeding Network	<p>Missing:- Infant feeding in emergencies- power-cuts and flooding can happen in the UK, please consider the guidance that was on the Department of Health website, update it as necessary and republish. It included details about choosing bottled water and boiling all water before preparing feeds except when no option.</p>
Infant Feeding Support UK	<p>We welcome the opportunity to give input to SACN consultation 'Feeding in the first year of life'. Here we note some evidence pertaining to the SACN inclusion criteria, which we would suggest be considered in relation to the SACN's goals, along with brief comments.</p> <p>We note the SACN's overall recommendations for exclusive breastfeeding for the first six months' of a baby's life; on the basis of some randomized and further observational evidence from developed country settings, showing reductions in the risk of acute upper respiratory tract infections, diarrhoea, and otitis media, with exclusive breastfeeding as compared to partial or no breastfeeding. All three outcomes are, as noted by SACN, contributors at a national level to infant morbidity.</p> <p>However, as noted by SACN substantial proportions of women stop breastfeeding early during their baby's life. Evidence from the Infant Feeding Survey 2010 (cited by SACN) and from the global research literature suggests one major reason is insufficient milk supply. (Li et al 2008; Otoo et al 2008; Newby &amp; Davis et al 2016)</p> <p>Estimates of the actual incidence of insufficient milk supply or delayed onset of lactogenesis II range from 22% to 44%. (Dewey et al 2003; Nommsen-Rivers et al 2010;)</p> <p>The risks of insufficient milk supply include malnutrition to the baby, hypoglycaemia, hyperbilirubinemia and/or hypernatremia. (Samayam et al 2015)</p> <p>We are concerned to note that the document contains no mention of the potentially life-changing and threatening complications caused by hypoglycaemia, hyperbilirubinemia and/or hypernatremia. (Boskabadi et al 2017)</p>

Organisation/Individual	Comments
	<p>The outcomes of such feeding related complications should be considered in any cost:benefit analyses, particularly in relation to SACN's comment that increased breastfeeding rates would produce cost-savings for the UK health service.</p>
Norris S	<p>With 25 years real, front line experience as a Maternity Nurse in The UK, I am seeing daily the negative impact that the current 'exclusive breastfeed at all costs' agenda is having on the physical health of babies and on the mental health of the mothers.</p> <p>I am seeing an increase in feeding related exhaustion and anxiety, and have seen first-hand how the ubiquitous, relentless pressure towards exclusive breastfeeding and the guilt involved is contributing to PND in vulnerable parents. When I speak to many mental health professionals they are voicing the same concerns, so I was dismayed on reading the SACN Report to see no mention anywhere of Maternal Mental Health.</p> <p>There has been a recent surge in negative publicity relating to mental health provision deficiencies plus concerns raised about the adverse effects of breastfeeding pressure.</p> <p>Surely this is significant enough to warrant investigation and data collection as part of a responsible approach to monitoring the safety of the current guidelines? At the very least the financial aspect of diagnosing, hospitalisation, mother and baby units, and ongoing psychiatric care for mothers affected in this way should be explored and added to any equation relating to the financial benefits to the NHS of long term exclusive breastfeeding.</p> <p>I also think there should be some research in to the amount of money being spent on breastfeeding promotion campaigns and BFHI accreditation bearing in mind your own research shows that though breastfeeding initiation rates have increased slightly, the number of women discontinuing breastfeeding by 6 weeks is unchanged since 1990.</p> <p>This would indicate that current guidelines and policies are actually having no positive effect, and could benefit from close scrutiny and re appraisal before more money is spent in the same way</p>
Norris S	<p>I would like to draw your attention to a glaring omission that not only skews the financial argument for breastfeeding, but also raises serious safety issues about the safety and advisability of the current focus on exclusive breastfeeding.</p> <p>The Fed Is Best Foundation has been raising awareness about the dangers of exclusive breastfeeding, as it is being implemented currently in US hospitals, due to the serious potential risk to the baby's health from Hyperbilirubinemia, Hyponatremia, and Hypoglycemia. They have tens of thousands of stories from women whose babies have suffered in this way including many cases of accidental starvation, brain damage, developmental delay, and even a death and also amassed a wealth of up to date scientific and medical data.</p> <p>As the UK representative of this charity I am concerned about the situation here in the UK, but I am also a fierce supporter of our NHS and do not want to see it brought in to disrepute.</p> <p>I too am collecting personal stories, but I have also attempted to collect firm data for the UK using the Freedom of Information Act, and the results are alarming in more than one way.</p> <p>I approached 34 hospitals around the UK (not the biggest London ones) and for term babies under 4 weeks of age I requested readmission rates, and number for babies diagnosed with hyperbilirubinemia, hyponatremia, and hypoglycaemia for</p>



Organisation/Individual	Comments
	<p>2015.</p> <p>Out of the 26 that responded I was horrified to see the casual and piecemeal approach to data collection, with 1 major hospital not routinely recording ANY of my fields of enquiry, 3 not recording 1 or more of the fields, 1 replied that the data was only recorded in patients records so would take too long to collate, and 1 stating that it had no codes for the data.</p> <p>This would indicate a review of the procedure for efficient, accessible and consistent data collection in NHS hospitals is needed as a matter of urgency in order to be able to accurately monitor the results and the safety of the current and planned feeding recommendations.</p> <p>The usable data I did manage to collect showed</p> <p>Readmissions – 6877</p> <p>Hyperbilirubinemia – 29739</p> <p>Hypernatremia – 485</p> <p>Hypoglycemia – 2276</p> <p>Whilst there may be other underlying causes for these conditions it is widely accepted that they are commonly the result of feeding difficulties, primarily as a result of failed or inadequate breastfeeding. Therefore, I would suggest that this needs to be the subject of urgent data collection and medical review in order to safeguard baby's health.</p> <p>Many of these feeding problems could be prevented with judicious temporary supplementation. This has been suggested to actually support and prolong breastfeeding so further research in to this area could be very beneficial to all concerned.</p> <p>I would also suggest that to say breastfeeding could save the NHS £'s is wildly inaccurate because it does not take in to account the cost of these feeding related readmissions and initial treatment, the cost of further monitoring and treatment in the community, the cost of lifetime care for the most damaged babies, and the litigation costs and compensation paid out by the NHS e.g. £235.4m used to settle 60 claims of negligence where hospital staff failed to detect hypoglycaemia resulting in complications, and the deaths of 2 babies.</p> <p>I think it would also be medically responsible to make a direct comparison between the number of babies admitted to hospital for gastro intestinal and upper respiratory infections (522 respiratory infections and 173 gastro intestinal infections per 10,000) against the thousands being readmitted and treated for failed breastfeeding related problems, and also compare the financial costs incurred, both long and short term because the resulting data could have a significant influence over present and future recommendations regarding exclusive breastfeeding. It occurs to me when looking at these figures it is possible that in trying to solve one problem, these guidelines have actually created a much greater one?</p> <p>I also think it is a matter of urgency to review the scientific validity of some of the current advice being given to breastfeeding parents relating to newborn stomach size, acceptable, safe weight loss, signs of dehydration, and the calorific requirements of a newborn compared with calorific content of colostrum and breastmilk in the quantities being produced by the mother. These are all either under taught to healthcare professionals, or are inaccurate and out of date and</p>

Organisation/Individual	Comments
	<p>may leave the NHS vulnerable to further litigation.</p> <p>With the recent public scandal regarding the ‘natural birth’ movement where ideology was allowed to hold sway over substantiated scientific and medical evidence and which led to deaths and damage, I believe it is vital in future that the NHS be above reproach in this area.</p>
Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group	<p>Breastfeeding, growth and health and complementary feeding.</p> <p>We fully support the message “introduce solid foods at around 6 months” for healthy term infants and the promotion of breastfeeding. However, the 2010 Infant Feeding Survey showed that only 1% of families were able to or chose to follow the guidance to exclusively breastfeed their baby until around 6 months. Guidance and information for families should take into account individual preferences and the valid reasons many parents have to introduce solids earlier (not before 17 weeks) e.g. returning to work, cultural factors. Families need to be fully supported regardless of their infant feeding choices.</p>
Pearson-Glaze P	<p>I would also like clarification on the health risks of sustained undernutrition for these young babies and the importance of restoring their nutritional status.</p>
Royal College of Midwives	<p>Peer Support</p> <p>The RCM’s report Pressure Points: The case for better postnatal care (2014) is based on surveys of midwives, maternity support workers, student midwives and mothers. Through this research, we consistently found that many mothers gave up breastfeeding before they wanted to because of a lack of support and information from health professionals.</p> <p>Professional and peer support is a critical factor and investment is needed in structured and high quality programmes. Support for breastfeeding mothers has been shown to increase the length of time women continue to breastfeed. Our evidence showed that that when support was offered to women, the duration and exclusivity of breastfeeding is increased. Effective support was found to be appropriate input from a trained personnel during antenatal or postnatal care, and ongoing scheduled visits, so that women can predict when support will be available. It should be tailored to the setting and the needs of the specific population group.</p> <p>The RCM is aware that many specialist breastfeeding jobs have been down-graded or closed, which has an inevitable impact on the level of service mothers can expect to receive in the early weeks of their babies’ lives. We are aware of the financial constraints operating across the public sector, however to ensure adequate support for breastfeeding mothers, it is necessary to invest in high quality service provision.</p>
Dalzell J, Richards D	<p>The feedgood website does not support the entire MIN framework, only the infant feeding part.</p>
Dalzell J, Richards D	<p>A Scottish commentary was produced on NICE PH11</p>
BDA - PFASG	<p>There is no provision of the vitamin D supplements that are recommended. Their lack of availability at this time should be a policy consideration.</p>
BDA - PFASG	<p>The focus is mainly on when CF is introduced rather than what and how much is given.</p>

Organisation/Individual	Comments																																			
BDA - PFASG	Breastfeeding support organisations (e.g. La Leche League, NCT) have reported a high demand from mothers for support to breastfeed and highlight the lack of provision by the NHS. Steps to redress this could help improve breastfeeding rates in the UK and therefore nutrition in the first year of life. Actions to support sustainable breastfeeding are urgently needed in the UK including educational interventions and increased provision of breastfeeding facilities in the workplace and public spaces.																																			
BDA - PFASG	We further support a joined up approach to supporting mothers to breastfeed. All HCPs working with mothers should be up-skilled and able to provide appropriate advice and support. Understanding early growth and weight fluctuations in the very early post-natal period is central to avoid unnecessary 'top up' formula feeding. Practical support to breastfeed is key and increased provision of lactation counselors is highly desirable. The aim should be to encourage all mothers to initiate breastfeeding and maintain any breastfeeding for the longest period possible. The strong available evidence on the protective effect of breastfeeding on child and maternal health should be used to encourage this.																																			
More J	Paragraph 37: A claim is made that current policy is to recommend 20mg vitamin C each day for infants. There is no scientific document that has proposed a universal recommendation for vitamin C supplements since infant formula has been fortified with vitamin C to a similar level in breastmilk. I suspect this recommendation has been erroneously imported into advice by current agencies and NHS choices because vitamin C is present in the Healthy Start vitamin drops for children. Vitamins A & D were recommended in the 1994 COMA report 45 Weaning and the Weaning Diet but not vitamin C. Vitamin C was added to the Welfare Food vitamins, which became the Healthy Start vitamins, because low income groups have been shown to have lower intakes of vitamin C. The 2002 COMA report Scientific Review of the Welfare Food Scheme 51 reinforced this reason for including vitamin C in the free vitamin drops for low income families. The Diet and Nutrition Survey of Infants and Young Children did not show vitamin C deficiency in infants as noted in paragraph 448 of this draft report. Hence there is no justification for currently recommending all infants take a vitamin C supplement.																																			
More J	<p>Paragraphs 38, 261, 243 Five hundred millilitres of any brand of infant formula provides much less than the Safe Intake of 8.5-10micrograms of vitamin D: Vitamin D fortification of different brands in the UK:</p> <table border="1" data-bbox="502 1541 1326 1917"> <thead> <tr> <th data-bbox="502 1541 639 1608">Brand</th> <th colspan="4" data-bbox="639 1541 1326 1570">Vitamin D content in infant formula</th> </tr> <tr> <th data-bbox="502 1570 639 1608"></th> <th data-bbox="639 1570 807 1608">mcg/100mLs</th> <th data-bbox="807 1570 975 1608">mcg/500mLs</th> <th data-bbox="975 1570 1142 1608">mcg/800mLs</th> <th data-bbox="1142 1570 1326 1608">mcg/1100mLs</th> </tr> </thead> <tbody> <tr> <td data-bbox="502 1608 639 1637">SMA PRO</td> <td data-bbox="639 1608 807 1637">0.9</td> <td data-bbox="807 1608 975 1637">4.5</td> <td data-bbox="975 1608 1142 1637">7.2</td> <td data-bbox="1142 1608 1326 1637">9.9</td> </tr> <tr> <td data-bbox="502 1637 639 1742">Aptamil 1<sup>st</sup>/ Profutura</td> <td data-bbox="639 1637 807 1742">1.2</td> <td data-bbox="807 1637 975 1742">6</td> <td data-bbox="975 1637 1142 1742">9.6</td> <td data-bbox="1142 1637 1326 1742">13.2</td> </tr> <tr> <td data-bbox="502 1742 639 1809">Cow &amp; Gate 1<sup>st</sup></td> <td data-bbox="639 1742 807 1809">1.2</td> <td data-bbox="807 1742 975 1809">6</td> <td data-bbox="975 1742 1142 1809">9.6</td> <td data-bbox="1142 1742 1326 1809">13.2</td> </tr> <tr> <td data-bbox="502 1809 639 1877">Hipp Organic</td> <td data-bbox="639 1809 807 1877">1.2</td> <td data-bbox="807 1809 975 1877">6</td> <td data-bbox="975 1809 1142 1877">9.6</td> <td data-bbox="1142 1809 1326 1877">13.2</td> </tr> <tr> <td data-bbox="502 1877 639 1917">Kendamil</td> <td data-bbox="639 1877 807 1917">0.8</td> <td data-bbox="807 1877 975 1917">4.0</td> <td data-bbox="975 1877 1142 1917">6.4</td> <td data-bbox="1142 1877 1326 1917">9.6</td> </tr> </tbody> </table> <p data-bbox="502 1951 1398 2000">As commercial infant foods are not fortified with vitamin D it is unlikely that there would be other significant sources of vitamin D in foods offered in the</p>	Brand	Vitamin D content in infant formula					mcg/100mLs	mcg/500mLs	mcg/800mLs	mcg/1100mLs	SMA PRO	0.9	4.5	7.2	9.9	Aptamil 1 <sup>st</sup> / Profutura	1.2	6	9.6	13.2	Cow & Gate 1 <sup>st</sup>	1.2	6	9.6	13.2	Hipp Organic	1.2	6	9.6	13.2	Kendamil	0.8	4.0	6.4	9.6
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Organisation/Individual	Comments
	<p>complementary feeding period. Hence infant formula would be the most significant source of vitamin D throughout infancy. From the table above it would seem wise to recommend a higher intake of formula than 500mLs before recommending discontinuing the vitamin D supplement. It would be preferable to give a simpler message on vitamin D supplementation such as 'all infants to being a supplement at birth and continue throughout childhood'. A simple and consistent public health message is more likely to be remembered and passed on by healthcare professionals and more likely to be remembered and implemented by parents and carers.</p> <p>The European upper intake level of vitamin D for infants is 25mcg/day and 50mcg/day for children 1-10 years. The Institute of Medicine considers it to be double that at 50mcg/day for infants and 100mcg/day for older children. Hence there would be no risk for infants who drink up to 1100mLs /day of infant formula and in addition take a supplement of 8.5-10mcg/day. Few infants would drink this volume and this would not continue for long:</p> <ul style="list-style-type: none"> <li>• A 50<sup>th</sup> centile boy not receiving complementary feeding at 6 months would weigh 7.4kg and with an energy requirement at 84kcal/kg /day (SACN 2011 Dietary Reference Values for Energy), he would need to drink 920mLs formula milk/day to provide 620kcal/day but as complementary feeding progressed, the daily volume of formula consumed would decrease.</li> <li>• a 98<sup>th</sup> centile boy not receiving complementary feeding at 6 months would weigh 10kg and with an energy requirement at 84kcal/kg /day (SACN 2011 Dietary Reference Values for Energy), he would need to drink 1270mLs formula milk/day to provide 8400kcal/day. In fact large, male infants are usually weaned earlier than 6 months (Wright al. 2004) so it is unlikely any infants would consume more than 15mcg vitamin D/day from formula. If they did it would be for a very short period as the daily volume of formula decreased with the introduction of complementary foods.</li> </ul> <p>From 2020 when the European Infant Formula regulations change, all brands will be required to fortify to slightly higher levels between 2-3 mcg vitamin D/100Kcal ( 1.3-1.95mcg/100mLs). Infant formula fortified at these levels will provide 6.5 – 9.75 mcg vitamin D/500mLs. I would suggest that PHE work with the different companies now so that a similar level of vitamin D fortification occurs in all brands sold in the UK. The lower level of fortification would be preferable so that the message on vitamin D supplementation could be as suggested above and exactly the same for both breastfed and formula fed infants.</p>
Infant Feeding Support UK	<p>It has long been assumed that in seeking to achieve exclusive breastfeeding (as per SACN's recommendations), all supplementation must be avoided. This assumption has been driven by observational evidence indicating associations between use of supplementation and greater likelihood of stopping breastfeeding, or lower likelihood of achieving exclusive breastfeeding later on. However, the two trials noted above suggest that this assumption is false and likely a result of confounding, and that mothers whose babies have experienced moderate weight loss may benefit from being advised to 'top up' with small amounts of formula. A further trial, planned to recruit 328 infants, is currently ongoing and is anticipated</p>

Organisation/Individual	Comments
	<p>to complete primary outcome data collection in Dec 2017:  <a href="https://clinicaltrials.gov/show/NCT02313181">https://clinicaltrials.gov/show/NCT02313181</a>.            Together, these studies indicate that caution should be advised regarding the direct promotion to mothers to exclusively breastfeed at all costs, and to avoid all formula; some mother/baby pairs will benefit from limited formula introduction and this may even assist with the establishment of breastfeeding.</p> <p>Further studies indicate that negative emotional consequences are common for mothers who are feeding their babies formula. These researchers note limitations but conclude: “current approach to infant feeding promotion and support in higher income countries may be paradoxically related to significant issues with emotional wellbeing” (Fallon et al 2017).</p> <p>Given this work we would urge SACN to consider ensuring that messages directly targeted towards families are sufficiently flexible to permit them to safely and adequately feed their babies, without negative stigma, and acknowledging that not all parents can or choose to breastfeed fully for the first six months of their baby’s life.</p>
Breastfeeding Network	<p>Caregiver control and responsiveness and Formula fed infants may not regulate milk intake until over six weeks.</p> <ul style="list-style-type: none"> <li>• Please consider portion size of formula / expressed breast milk by bottle as the recommendations on the tins have not changed from 30 years ago when the aim was to feed large volumes at well spaced intervals. More physiologically sized portions, fed in response to the baby sounds kinder yet the companies say they have to state large portions as described by COMA.</li> </ul>
BDA - PFASG	<ul style="list-style-type: none"> <li>• Advice on specific foods and amounts to be provided is currently lacking in UK government advice (i.e. NHS choices website). In particular iron rich foods are not advised until 8-9 months of age when they can be safely given earlier. Whilst some infants may be replete in iron up to 6 months of age this is variable and others may benefit from earlier introduction of iron-rich foods. A review of this is needed.</li> <li>• Vitamin D continues to be a problem nutrient for infants and young children according to the last UK infant feeding survey and the Diet and Nutrition Study in Infants in Young Children DNSIYC. Uptake of supplements should be addressed and how this can be improved. Iron Deficiency Anaemia</li> <li>• IDA was reported to be low prevalence in the DNSIYC. However, this may reflect intake of iron fortified formulas. Extended duration of breastfeeding would reduce formula intake so may impact on iron status.</li> </ul>
Royal College of Midwives	<p>Healthy Start food and vitamin vouchers support low income families across the UK, and their uptake can be patchy. The RCM believes that consistent advice about micronutrients (Chapter 7) must be given to all mothers in relation to supplements and dietary requirements in pregnancy and while breastfeeding.</p>
Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group	<p><i>‘infants fed infant formula should not be given a vitamin D supplement until they are having less than 500mls of infant formula’</i> – we are aware that the vitamin D content of some infant formula does not meet the recommended 8.5-10 micrograms in 500ml of formula. For example Cow and Gate (1) per 500mls has 6 micrograms and SMA (1) per 500mls has 4.5 micrograms. We would therefore</p>

Organisation/Individual	Comments
	<p>welcome clarification.</p> <p>More needs to be done at government level to promote the vitamin D messages outlined in this and previous SACN report. This message is still poorly understood by some health professionals and the general public. As acknowledged in this report, uptake of vitamins for 0-4 years olds remains low.</p> <p>We are aware that Healthy Start children’s vitamins require reformulation to meet the recommended daily Safe Intake of 8.5-10µg vitamin D. In view of concerns that some infants may exceed the tolerable upper limit for vitamin A this may be an opportunity to review the vitamin A content.</p>
RCPCH	<p>Iron: RCPCH suggest it would be relevant to consider the effectiveness of different sources of iron to inform recommendations. This is particularly relevant to populations for whom meat is not acceptable, including vegetarian and vegan families. Given the current popularity of plant-based diets, it would be helpful to have an opinion on the role of such diets during the complementary feeding period.</p>
Crawley H	<p>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.</p>
Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group	<p>Whilst it may not fit within this section, we would welcome the inclusion of the recommendation that honey should not be introduced before 12 months of age unless the heat-resistant spores of Clostridium botulinum have been inactivated by adequate high-pressure and high-temperature treatment, as used in industry (Tanzi &amp; Gabay 2002) since the consumption of honey has been repeatedly associated with infant botulism.</p>
British Specialist Nutrition Association (BSNA)	<p>Recommendations need to be strengthened to support the continued offering of allergenic foods, following initial exposure, in order to prevent sensitisation (SCAN-COT 2017)</p>
Stirton R	<p>The importance of recognising the social and political context surrounding infant feeding</p> <p>This submission focuses on the implications of policy making in this area. Work by Lisa Smyth explores the impact on women of target-driven health-promotion messages. She shows that:  ...breastfeeding promotion itself has become an important part of these wider contexts, in ways which can produce resentment, prolonged ill health, depression and anxiety, and consequently damage rather than enhance the relationship between mother and baby.  (Smyth,2012)</p> <p>The SACN terms of reference were to consider the scientific evidence underpinning recommendations around infant and young child feeding, and “to make recommendations for policy...”. Given the complex social and political context in this field, it is fundamental to rely on a broad understanding of “science” which includes the social sciences. Making effective policy recommendations presupposes an understanding of the mechanisms of behaviour</p>

Organisation/Individual	Comments
	<p>change. These mechanisms are well understood in the social sciences. (Sieber 1981, Sieber 1995 )</p> <p>Sam Sieber’s work explores the counterproductive effects that occur when policy interventions fail to take into account the environment in which they take place. The simple conclusion that the science supports exclusive breastfeeding, therefore the policy recommendation is to “reduce attrition rates” fails to take into account the impact on women of the policy itself. It fails to take into account the possibility that women stop breastfeeding, at least in part, because of the policy’s “target-driven”(Sieber 1981, Sieber 1995) approach. This was shown to be a specific problem in relation to infant feeding in Smyth’s work, and in work by Elizabeth Murphy in 2004 (Murphy 2004) and Ellie Lee in 2007 (Lee 2007). If the aim of the SACN is to make recommendations that will result in more women in the UK breastfeeding, then it is important that those recommendations will help women to initiate and continue breastfeeding. The recommendations must go beyond the assumption that women will respond to being told that science says they must breastfeed their babies. The recommendations must be informed by social science research on behaviour modification, and must recognise and deal sensitively with the complex social and political context surround infant feeding choices.</p> <p>In the following, I highlight some of my respondents’ experiences of the rhetoric around infant feeding and the support system available to them. Quotes are taken from stories from participants in My Infant Feeding Journey. Names have been changed where participants have requested anonymity.</p> <p><u>1 “Attrition rates” and the rhetoric of infant feeding</u></p> <p>The rhetoric surrounding infant feeding is highly problematic. Words which may appear objective to non-mothers can have a negative impact on individual women, and may further trigger a great deal of hurt and resentment, and potentially mental health issues (Woollard &amp; Porter, 2017; Smyth 2012)</p> <p>In this case, the use of the phrase “attrition rates” carries significant negative connotations and squarely places the blame on the mother for stopping breastfeeding. It implies that it is the mother’s responsibility to continue to breastfeed, and that she has failed when she stops breastfeeding and changes to another method of infant feeding.</p> <p>There are particular problems with the “breast is best” rhetoric. This is not restricted to the specific phrase. It is applicable to all the phrasing which implies that breast is best. Whether intended by the author or not, this particular phraseology causes feelings of being judged in mothers who were not able to breastfeed. This further compounds the feelings of guilt and shame about their experiences, which also stay with some women for very long periods of time. At the least intrusive, Kirsty explained that:</p> <p>I have never felt able to tell anyone that actually I didn’t want to breast feed — society, the media, family, friends and professionals all support breast is best meaning my concerns made me ashamed.</p> <p>The problem for Kirsty was that the “breast is best” rhetoric meant she felt unable to discuss her concerns with midwives antenatally. These concerns were also in the context of difficulties conceiving and ultimately a complex and traumatic birth. At the very least she would have been better prepared for the experience of breastfeeding if she had been able to work through her concerns before she was thrust into the reality of establishing feeding after an emergency c-section with a baby in SCBU.</p>

Organisation/Individual	Comments
	<p>Both Paula and Megan highlight a different problem of the “breast is best” rhetoric: It seems to me that it is utterly absurd and frankly CRUEL to put women under SO much pressure to breastfeed (“Breast is best. Breast is best.”) and then to effectively withdraw all support from them when they try to. Midwives just aren’t expert enough in, many cases. And if the mothers fail? Well, we’re repeatedly told by the media that you only have yourself to blame if your child develops allergies, obesity, low intelligence and even leukaemia. [Paula]</p> <p>There seems to be a huge discrepancy between the emphasis on breastfeeding within both antenatal and postnatal provision, as an actually morally valuable ‘decision’, versus the lack of the actual level of personalised, free support within the NHS, that is in fact required to enable so many of those who want to breastfeed to do so. The gap between these two things seems to transform by default into blame, ultimately, on the mother – who has ‘decided’ to formula feed (morally reprehensible); who has ‘failed’ to work hard enough to get the breast established (lazy, selfish). [Megan]</p> <p>This problem is not only limited to the rhetoric. There is a feedback circle from the rhetoric heard antenatally to the experiences of support after birth. The majority of my respondents wanted to breastfeed. They were motivated to breastfeed. But when the crunch time came, in the “post-natal fug” [Kirsty]</p> <p>Many were not able to access the support necessary to help them establish and continue their breastfeeding journey. The problem with telling women that “breast is best” is that this is perceived to be pressuring them to breastfeed (whether intended to or not), and it is coupled with an inadequate support system which sets them up to fail.</p> <p><u>2 The problem of support</u></p> <p>Every one of my respondents had difficulties at early stage in their infant feeding journey. This included women who had breastfed before, and women who had a relatively uncomplicated breastfeeding journey. Everyone initiated breastfeeding, and they asked for help to deal with latching difficulties, or pain, or cracked nipples, for example. What followed in most cases was a confusing mess of different advice from different people with varying success. In some cases, the mother received the right support from the right person at the right time. This transformed her feeding experience from one of pain to one of joy. Megan’s experience is telling:</p> <p>It was towards the end of the first week post birth, and in the midst of all this, that I saw a wonderful community midwife who was giving us one of the standard post-partum home visit check-ups (I remember him particularly because he was the only male midwife I saw) who recommended that I try and get an appointment with one of his colleagues who ran supporting sessions on breastfeeding, 1-2-1, at a children’s centre which was around a 20 minute bus ride away.</p> <p>He gave me her number, and I left a message. She phoned me back a day or so later and gave me an appointment for a few days hence. I am fairly sure my daughter was about two weeks old at that first appointment. The midwife sat with me and my partner for nearly an hour, in a consulting room upstairs at the children’s centre, where she held her regular clinic, and we worked on the latch. She told me my baby’s palate was quite deep, and pointed out that my breasts naturally pointed slightly outwards – which none of the many other midwives I’d had fleeting support from had had the time or, I think, the specific training to spot. Both of these features required, she suggested, a particular shift in the angle I should hold the baby at, and in the technique for latching her on. She gave me practical advice on what foods to eat to boost milk supply – a bowl of pasta every</p>



Organisation/Individual	Comments
	<p>day, she said, for rapidly absorbed carbs, and fenugreek supplements (tested in the US apparently though not proven through UK based research as yet). She told me to express on both breasts in between every feed, to stimulate the milk production further, and enable me to take a break from breast feeding when nipples were sore, when I could use the expressed milk instead if I wanted to. My partner and I refer to this midwife now as an ‘angel’ (and we are both fundamentally atheists, but if ever we met one, she was it). She saw us for about an hour at a time, every other day, for two weeks. During this period, I figured out the latch. My milk supply shot up. I was still mix feeding – but there appeared to be no issue with nipple confusion, after all the horror stories I had imbibed in previous months. I was reducing the amount of formula we were using, and the number of feeds that were on the bottle, and getting the breast feeding established.</p> <p>After two weeks she signed us off, and from that point on our feeding experience was pretty great.</p> <p>Once she was able to find it, Megan received good support from someone who was properly trained, and was able to spend time working with Megan and giving personalised support. This ‘angel’ saved Megan’s breastfeeding journey. Other women did not get this experience. Instead, they were seen by a series of health professionals who were not able to offer advice beyond “well the latch looks fine, keep going” [Paula]. Some women report comments and practices by health professionals that directly damaged their feeding relationships.</p> <p>They kept me and him overnight, back on the ward where he’d been born where the midwives came in to ‘observe’ us feeding (not great for oxytocin) and would say things like “how you must feel ... being back here two weeks later ... I can’t imagine how bad you must feel”. [Paula]</p> <p>On the second night the health care assistant queried the fact I was trying to breast feed at all given that Toby was now five days old and I hadn’t managed it, she also stated that she had two other mothers to help during the night so could not be long. [Kirsty]</p> <p>These negative comments from health professionals are not limited to the newborn phase:</p> <p>At his one year check I was told that he was malnourished because he was having too much milk and not enough food — he wasn’t but for a while I would sit feeding him in the night with tears streaming down my face because I thought I was doing to wrong thing by the professionals but I knew I was doing the right thing for my baby. [Kirsty] The power that health professionals have in relation to infant feeding is tremendous. Issues surrounding feeding stay with women for a long time. Kirsty’s son is around 3 now, and:</p> <p>I went to the Dr last week to ask for blood tests for excessive tiredness and aching in my bones – she asked if I had breast fed, I simply said no and she then proceeded to tell me how good breast feeding is and that it helps the body recover from pregnancy. I’m pretty sure that ship has sailed but thanks for making me feel like a failure again!</p> <p>The issue around support is that it must be done sensitively. Women are often extremely fragile after giving birth, they are not properly prepared for the experience of breastfeeding, and those that want to breastfeed have to fight for the support they need to help them. Doing all of this during the immediate post-natal phase makes it particularly challenging. As Kirsty’s story also shows, there is a danger that women who do not want to breastfeed feel unable to discuss this with healthcare professionals because of the way that breastfeeding is talked about in healthcare practice. It is essential that women feel able to have calm, dispassionate conversations with healthcare professionals about their infant feeding choices, without the fear of judgement.</p> <p>This submission so far gives a rather bleak picture of infant feeding experiences in</p>

Organisation/Individual	Comments
	<p>the UK context.</p> <p>Of course it is not awful and bleak for every woman. There are many examples of women who went through horrendous difficulties, and came out the other side. There are also stories from women who I had relatively straightforward experiences of establishing breastfeeding. Paula writes:</p> <p>I fed my daughter to 15 months. From about 6 months on it became a dreamy, gorgeous experience. Tired? Hungry? Sad? Bump her head? Whatever - my magical boobs could cure it! It had been worth the very literal blood, sweat and tears.</p> <p>It is important therefore that we do not ignore the joy that mothers experience, but it is essential to recognise that many women do not reach the joyful phase because they are unsupported during the “blood, sweat and tears” around establishing breastfeeding. This lack of support is a policy decision in its own right, and it has a devastating impact on mothers and babies in the UK.</p> <p><u>Conclusion and additional recommendations</u></p> <p>Making policy recommendations in this area is a complex and sensitive business. The adherence to the “target-driven health-promotion”<sup>7</sup> approach is damaging to the ultimate goal of providing that mothers and babies are looked after in the way that most enhances their wellbeing. The impact of the current social and political context of infant feeding in the UK may make it difficult to convincingly argue that exclusive breastfeeding is best for the mother and baby, notwithstanding the scientific evidence in favour of exclusive breastfeeding. This is an uncomfortable point to make. If the SACN want to make recommendations that will increase the numbers of babies being breastfed in the UK, then the recommendations must move beyond the target-driven approach. They must be grounded in the extensive social science research on changing behaviour and take into account the social and political context in which women are being told to breastfeed.</p> <p>I have two recommendations for the final report into this area, which I think will strengthen the overall tenor of the conclusions.</p> <ol style="list-style-type: none"> <li>1. Include a statement that the social and political context around infant feeding in the UK has a dramatic impact on women’s experiences in this area. This evidence was not explicitly considered by the SACN, but that future recommendations must use a broader concept of science and take this literature into account.</li> <li>2. Make a recommendation directly to Public Health England, and the Department of Health that a wide ranging enquiry should be made into women’s experiences of infant feeding policy in the UK, and that the terms of reference for that enquiry include making recommendations for new policy, which should be informed by the huge social science literature on regulating human behaviour.</li> </ol>
Breastfeeding Network	The Infant Feeding Survey: Agree, should be reinstated, if necessary on a 10 year cycle, however 5 yearly is preferred for key points.

## Evidence highlighted in the consultation

**Table 4.1: Evidence raised for the attention of SACN by organisation/individual**

Evidence	Organisations/ individual
Ackerman, D.L., Doster, R.S., Weitkamp, J.H., Aronoff, D.M., Gaddy, J.A. and Townsend, S.D., 2017. Human Milk Oligosaccharides Exhibit Antimicrobial and Antibiofilm Properties against Group B Streptococcus. <i>ACS infectious diseases</i> , 3(8), pp.595-605.	WBTi
Acta Paediatrica Special Issue: Impact of Breastfeeding on Maternal and Child Health. December 2015 Volume 104, Issue Supplement S467 Pages 1–134. <a href="http://onlinelibrary.wiley.com/doi/10.1111/apa.2015.104.issue-S467/issuetoc">http://onlinelibrary.wiley.com/doi/10.1111/apa.2015.104.issue-S467/issuetoc</a>	WBTi
Al-Ani, A.H., Antoun, J.S., Thomson, W.M., Merriman, T.R. and Farella, M., 2017. Maternal Smoking during Pregnancy Is Associated with Offspring Hypodontia. <i>Journal of dental research</i> , 96(9), pp.1014-1019.	British Dental Association
Alexander, D.D., Yan, J., Bylsma, L.C., Northington, R.S., Grathwohl, D., Steenhout, P., Erdmann, P., Spivey-Krobath, E. and Haschke, F., 2016. Growth of infants consuming whey-predominant term infant formulas with a protein content of 1.8 g/100 kcal: a multicenter pooled analysis of individual participant data, 2. <i>The American journal of clinical nutrition</i> , 104(4), pp.1083-1092.	Nestle Nutrition
Avila, W.M., Pordeus, I.A., Paiva, S.M. and Martins, C.C., 2015. Breast and bottle feeding as risk factors for dental caries: a systematic review and meta-analysis. <i>PLoS One</i> , 10(11), p.e0142922.	Dalzell J, Richards D
Barends, C., de Vries, J., Mojet, J. and de Graaf, C., 2013. Effects of repeated exposure to either vegetables or fruits on infant's vegetable and fruit acceptance at the beginning of weaning. <i>Food quality and preference</i> , 29(2), pp.157-165.	BSNA Ella's Kitchen Hetherington M, Fildes A
Barends, C., de Vries, J.H., Mojet, J. and de Graaf, C., 2014. Effects of starting weaning exclusively with vegetables on vegetable intake at the age of 12 and 23 months. <i>Appetite</i> , 81, pp.193-199.	BSNA Ella's Kitchen
Bernabé, E., MacRitchie, H., Longbottom, C., Pitts, N.B. and Sabbah, W., 2017. Birth weight, breastfeeding, maternal smoking and caries trajectories. <i>Journal of dental research</i> , 96(2), pp.171-178.	Bernabé E
Birch, L.L., Gunder, L., Grimm-Thomas, K. and Laing, D.G., 1998. Infants' consumption of a new food enhances acceptance of similar foods. <i>Appetite</i> , 30(3), pp.283-295.	Hetherington M, Fildes A
Boskabadi, H., Akhondian, J., Afarideh, M., Maamouri, G., Bagheri, S., Parizadeh, S.M., Mobarhan, M.G., Mohammadi, S. and Frens, G.A., 2017. Long-term neurodevelopmental outcome of neonates with hypernatremic dehydration. <i>Breastfeeding Medicine</i> , 12(3), pp.163-168.	Infant Feeding Support UK

Evidence	Organisations/ individual
British Society of Paediatric Dentistry position statement on infant feeding – Published January 2018 <a href="https://www.bspd.co.uk/Portals/0/BSPD%20statement%20on%20Infant%20feeding%20Jan%202018i.pdf">https://www.bspd.co.uk/Portals/0/BSPD%20statement%20on%20Infant%20feeding%20Jan%202018i.pdf</a>	British Society of Paediatric Dentistry
Brown, A., Jones, S.W. and Rowan, H., 2017. Baby-led weaning: the evidence to date. Current nutrition reports, 6(2), pp.148-156.	Crawley H
Butte, N.F., Lopez-Alarcon, M.G. and Garza, C., 2002. Nutrient adequacy of exclusive breastfeeding for the term infant during the first six months of life. Geneva: World Health Organization.	RCPCH
Caton, S.J., Ahern, S.M. and Hetherington, M.M., 2011. Vegetables by stealth. An exploratory study investigating the introduction of vegetables in the weaning period. Appetite, 57(3), pp.816-825.	Hetherington M, Fildes A
Chambers, L., 2016. Complementary feeding: Vegetables first, frequently and in variety. Nutrition Bulletin, 41(2), pp.142-146.	BSNA Hetherington, M, Fildes A Ella's Kitchen
Chambers, L., Hetherington, M., Cooke, L., Coulthard, H., Fewtrell, M., Emmett, P., Lowdon, J., Blissett, J., Lanigan, J., Baseley, C. and Stanner, S., 2016. Reaching consensus on a 'vegetables first' approach to complementary feeding. Nutrition Bulletin, 41(3), pp.270-276.	BSNA Hetherington, M, Fildes A Ella's Kitchen
Chantry, C.J., Howard, C.R. and Auinger, P., 2006. Full breastfeeding duration and associated decrease in respiratory tract infection in US children. Pediatrics, 117(2), pp.425-432.	RCPCH
Chantry, C.J., Howard, C.R. and Auinger, P., 2007. Full breastfeeding duration and risk for iron deficiency in US infants. Breastfeeding Medicine, 2(2), pp.63-73.	RCPCH
Cho, H.J., Jin, B.H., Park, D.Y., Jung, S.H., Lee, H.S., Paik, D.I. and Bae, K.H., 2014. Systemic effect of water fluoridation on dental caries prevalence. Community dentistry and oral epidemiology, 42(4), pp.341-348.	Rugg-Gunn A
Chowdhury, R., Sinha, B., Sankar, M.J., Taneja, S., Bhandari, N., Rollins, N., Bahl, R. and Martines, J., 2015. Breastfeeding and maternal health outcomes: a systematic review and meta-analysis. Acta Paediatrica, 104(S467), pp.96-113.	WBTi
Cohen, R.J., Brown, K.H., Dewey, K.G., Canahuati, J. and Rivera, L.L., 1994. Effects of age of introduction of complementary foods on infant breast milk intake, total energy intake, and growth: a randomised intervention study in Honduras. The Lancet, 344(8918), pp.288-293.	BDA - PFASG
Cope, A.L., Chestnutt, I.G., Wood, F. and Francis, N.A., 2016. Dental consultations in UK general practice and antibiotic prescribing rates: a retrospective cohort study. Br J Gen Pract, 66(646), pp.e329-e336.	British Dental Association

Evidence	Organisations/ individual
Coulthard, H., Harris, G. and Fogel, A., 2016. Association between tactile over-responsivity and vegetable consumption early in the introduction of solid foods and its variation with age. <i>Maternal &amp; child nutrition</i> , 12(4), pp.848-859.	Coulthard H, Harris G
Coulthard, H., Harris, G. and Fogel, A., 2014. Exposure to vegetable variety in infants weaned at different ages. <i>Appetite</i> , 78, pp.89-94.	Ella's Kitchen
Cui L, Li X, Tian Y, Bao J, Wang L, Xu D, Zhao B, Li W, 2017. Breastfeeding and early childhood caries: a meta-analysis of observational studies. <i>Asia Pac J Clin Nutr</i> ;26(5):867-880. doi: 10.6133/apjcn.082016.09. PubMed PMID: 28802297.	Dalzell J, Richards D
Currie, C.C., Stone, S.J., Connolly, J. and Durham, J., 2017. Dental pain in the medical emergency department: a cross-sectional study. <i>Journal of oral rehabilitation</i> , 44(2), pp.105-111.	British Dental Association
Daniels, L., Mallan, K.M., Fildes, A. and Wilson, J., 2015. The timing of solid introduction in an 'obesogenic' environment: a narrative review of the evidence and methodological issues. <i>Australian and New Zealand journal of public health</i> , 39(4), pp.366-373.	RCPCH
de Barse, L.M., Jansen, P.W., Edelson-Fries, L.R., Jaddoe, V.W., Franco, O.H., Tiemeier, H. and Steenweg-de Graaff, J., 2017. Infant feeding and child fussy eating: The Generation R Study. <i>Appetite</i> , 114, pp.374-381.	Ella's Kitchen
Deoni, S.C., Dean III, D.C., Piryatinsky, I., O'muircheartaigh, J., Waskiewicz, N., Lehman, K., Han, M. and Dirks, H., 2013. Breastfeeding and early white matter development: a cross-sectional study. <i>Neuroimage</i> , 82, pp.77-86.	WBTi
Dewey, K.G., Nommsen-Rivers, L.A., Heinig, M.J. and Cohen, R.J., 2003. Risk factors for suboptimal infant breastfeeding behavior, delayed onset of lactation, and excess neonatal weight loss. <i>Pediatrics</i> , 112(3), pp.607-619.	Infant Feeding Support UK
Lennox, A., Sommerville, J., Ong, K., Henderson, H. and Allen, R., 2013. Diet and nutrition survey of infants and young children, 2011. A survey carried out on behalf of the Department of Health and Food Standards Agency. Available at: <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/139572/DNSIYC_UK_report_ALL_chapters_DH_V10.0.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/139572/DNSIYC_UK_report_ALL_chapters_DH_V10.0.pdf</a> (Accessed June 2018)	Ella's Kitchen
Dennison, B.A., Edmunds, L.S., Stratton, H.H. and Pruzek, R.M., 2006. Rapid infant weight gain predicts childhood overweight. <i>Obesity</i> , 14(3), pp.491-499.	Nestle Nutrition
Dube, K., Schwartz, J., Mueller, M.J., Kalhoff, H. and Kersting, M., 2010a. Iron intake and iron status in breastfed infants during the first year of life. <i>Clinical Nutrition</i> , 29(6), pp.773-778.	RCPCH
Dube, K., Schwartz, J., Mueller, M.J., Kalhoff, H. and Kersting, M., 2010b. Complementary food with low (8%) or high (12%) meat content as source of dietary iron: a double-blinded randomized controlled trial. <i>European journal of nutrition</i> , 49(1), pp.11-18.	RCPCH

Evidence	Organisations/ individual
du Toit, G., Tsakok, T., Lack, S. and Lack, G., 2016. Prevention of food allergy. <i>Journal of Allergy and Clinical Immunology</i> , 137(4), pp.998-1010.	Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group
EFSA Panel on Dietetic Products, Nutrition and Allergies (NDA), 2009. Scientific Opinion on the appropriate age for introduction of complementary feeding of infants. <i>EFSA Journal</i> , 7(12), p.1423.	BSNA RCPCH
Erickson, P.R. and Mazhari, E., 1999. Investigation of the role of human breast milk in caries development. <i>Pediatric Dentistry</i> , 21, pp.86-90.	La Leche League Pearson-Glaze P
Fallon, V., Komninou, S., Bennett, K.M., Halford, J.C. and Harrold, J.A., 2017. The emotional and practical experiences of formula-feeding mothers. <i>Maternal &amp; child nutrition</i> , 13(4).	Infant Feeding Support UK
Fangupo, L.J., Heath, A.L.M., Williams, S.M., Williams, L.W.E., Morison, B.J., Fleming, E.A., Taylor, B.J., Wheeler, B.J. and Taylor, R.W., 2016. A baby-led approach to eating solids and risk of choking. <i>Pediatrics</i> , p.e20160772.	Brown R, Crawley H
Farland, L.V., Eliassen, A.H., Tamimi, R.M., Spiegelman, D., Michels, K.B. and Missmer, S.A., 2017. History of breast feeding and risk of incident endometriosis: prospective cohort study. <i>bmj</i> , 358, p.j3778.	WBTi
Fewtrell, M., Bronsky, J., Campoy, C., Domellöf, M., Embleton, N., Mis, N.F., Hojsak, I., Hulst, J.M., Indrio, F., Lapillonne, A. and Molgaard, C., 2017. Complementary feeding: a position paper by the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) Committee on Nutrition. <i>Journal of pediatric gastroenterology and nutrition</i> , 64(1), pp.119-132.	BSNA Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group RCPCH
Fildes, A., Lopes, C., Moreira, P., Moschonis, G., Oliveira, A., Mavrogianni, C., Manios, Y., Beeken, R., Wardle, J. and Cooke, L., 2015. An exploratory trial of parental advice for increasing vegetable acceptance in infancy. <i>British Journal of Nutrition</i> , 114(2), pp.328-336.	BSNA Ella's Kitchen Hetherington M, Fildes A
Flaherman, V.J., Aby, J., Burgos, A.E., Lee, K.A., Cabana, M.D. and Newman, T.B., 2013. Effect of early limited formula on duration and exclusivity of breastfeeding in at-risk infants: an RCT. <i>Pediatrics</i> , 131(6), pp.1059-1065.	Infant Feeding Support UK
Freeman, V., van't Hof, M., Haschke, F. and Euro-Growth Study Group, 2000. Patterns of milk and food intake in infants from birth to age 36 months: the Euro-growth study. <i>Journal of pediatric gastroenterology and nutrition</i> , 31, pp.S76-S85.	Hetherington M, Fildes A

Evidence	Organisations/ individual
Garcia, A.L., Raza, S., Parrett, A. and Wright, C.M., 2013. Nutritional content of infant commercial weaning foods in the UK. Archives of disease in childhood, 98(10), pp.793-797.	Hetherington M, Fildes A
Garcia, A.L., McLean, K. and Wright, C.M., 2015. Types of fruits and vegetables used in commercial baby foods and their contribution to sugar content. Maternal & child nutrition, 12(4), pp.838-847.	Hetherington M, Fildes A
Giugliani, E.R., Horta, B.L., Loret de Mola, C., Lisboa, B.O. and Victora, C.G., 2015. Effect of breastfeeding promotion interventions on child growth: a systematic review and meta-analysis. Acta Paediatrica, 104(S467), pp.20-29.	Dalzell J and Richards D
Grabosky, P.N., 1995. Counterproductive regulation. International journal of the Sociology of Law, 23(4), pp.347-369.	Stirton R
Grimshaw, K., Logan, K., O'donovan, S., Kiely, M., Patient, K., Van Bilsen, J., Beyer, K., Campbell, D.E., Garcia-Larsen, V., Grabenhenrich, L., Lack, G., Mills, C., Wal, JM., and Roberts, G., 2017. Modifying the infant's diet to prevent food allergy. Archives of disease in childhood;102:179-186.	Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group
Groeneveld, A., Van Eck, A.A.M.J. and Dirks, O.B., 1990. Fluoride in caries prevention: is the effect pre-or post-eruptive?. Journal of dental research, 69(2_suppl), pp.751-755.	Rugg-Gunn A
Gruszfeld, D., Weber, M., Gradowska, K., Socha, P., Grote, V., Xhonneux, A., Dain, E., Verduci, E., Riva, E., Closa-Monasterolo, R. and Escribano, J., 2016. Association of early protein intake and pre-peritoneal fat at five years of age: Follow-up of a randomized clinical trial. Nutrition, Metabolism and Cardiovascular Diseases, 26(9), pp.824-832.	Crawley H
Günther, A.L., Remer, T., Kroke, A. and Buyken, A.E., 2007. Early protein intake and later obesity risk: which protein sources at which time points throughout infancy and childhood are important for body mass index and body fat percentage at 7 y of age?-. The American journal of clinical nutrition, 86(6), pp.1765-1772.	BDA - PFASG
Heaney RP (2014) Blog: ' Vitamin D and the nursing mother'. Available at: <a href="http://blogs.creighton.edu/heaney/2014/06/05/vitamin-d-and-the-nursing-mother/">http://blogs.creighton.edu/heaney/2014/06/05/vitamin-d-and-the-nursing-mother/</a>	La Leche League Pearson-Glaze P
Hetherington, M.M., Schwartz, C., Madrelle, J., Croden, F., Nekitsing, C., Vereijken, C.M. and Weenen, H., 2015. A step-by-step introduction to vegetables at the beginning of complementary feeding. The effects of early and repeated exposure. Appetite, 84, pp.280-290.	BSNA Ella's Kitchen
Hodges, E.A., Johnson, S.L., Hughes, S.O., Hopkinson, J.M., Butte, N.F. and Fisher, J.O., 2013. Development of the responsiveness to child feeding cues scale. Appetite, 65, pp.210-219.	Crawley H

Evidence	Organisations/ individual
Hörnell, A., Lagström, H., Lande, B. and Thorsdottir, I., 2013. Protein intake from 0 to 18 years of age and its relation to health: a systematic literature review for the 5th Nordic Nutrition Recommendations. <i>Food &amp; nutrition research</i> , 57(1), p.21083.	BDA - PFASG RCPCH
Horta, B.L., Loret de Mola, C. and Victora, C.G., 2015a. Breastfeeding and intelligence: a systematic review and meta-analysis. <i>Acta paediatrica</i> , 104(S467), pp.14-19.	Dalzell J, Richards D
Horta, B.L., Loret de Mola, C. and Victora, C.G., 2015b. Long-term consequences of breastfeeding on cholesterol, obesity, systolic blood pressure and type 2 diabetes: a systematic review and meta-analysis. <i>Acta Paediatrica</i> , 104(S467), pp.30-37.	Dalzell J, Richards D
Hujoel, P.P., 2013. Vitamin D and dental caries in controlled clinical trials: systematic review and meta-analysis. <i>Nutrition reviews</i> , 71(2), pp.88-97.	Rugg-Gunn A
Inostroza, J., Haschke, F., Steenhout, P., Grathwohl, D., Nelson, S.E. and Ziegler, E.E., 2014. Low-protein formula slows weight gain in infants of overweight mothers. <i>Journal of pediatric gastroenterology and nutrition</i> , 59(1), p.70.	BDA - PFASG RCPCH
Iida, H., Auinger, P., Billings, R.J. and Weitzman, M., 2007. Association between infant breastfeeding and early childhood caries in the United States. <i>Pediatrics</i> , 120(4), pp.e944-e952.	La Leche League Pearson-Glaze P
Jonsdottir, O.H., Thorsdottir, I., Hibberd, P.L., Fewtrell, M.S., Wells, J.C., Palsson, G.I., Lucas, A., Gunnlaugsson, G. and Kleinman, R.E., 2012. Timing of the introduction of complementary foods in infancy: a randomized controlled trial. <i>Pediatrics</i> , 130(6), pp.1038-1045.	BDA - PFASG
Jonsdottir, O.H., Kleinman, R.E., Wells, J.C., Fewtrell, M.S., Hibberd, P.L., Gunnlaugsson, G. and Thorsdottir, I., 2014. Exclusive breastfeeding for 4 versus 6 months and growth in early childhood. <i>Acta Paediatrica</i> , 103(1), pp.105-111.	RCPCH
Jonsdottir, O.H., Thorsdottir, I., Gunnlaugsson, G., Fewtrell, M.S., Hibberd, P.L. and Kleinman, R.E., 2013. Exclusive breastfeeding and developmental and behavioral status in early childhood. <i>Nutrients</i> , 5(11), pp.4414-4428.	RCPCH
Kirchberg, F.F., Harder, U., Weber, M., Grote, V., Demmelmaier, H., Peissner, W., Rzehak, P., Xhonneux, A., Carlier, C., Ferre, N. and Escribano, J., 2015. Dietary protein intake affects amino acid and acylcarnitine metabolism in infants aged 6 months. <i>The Journal of Clinical Endocrinology &amp; Metabolism</i> , 100(1), pp.149-158.	Nestle Nutrition
Koletzko, B., Monasterolo, R.C. and von Kries, R., 2009. Lower protein in infant formula is associated with lower weight up to age 2 y: a randomized clinical trial, <i>The American Journal of Clinical Nutrition</i> , 89 (6),pp1836–1845, <a href="https://doi.org/10.3945/ajcn.2008.27091">https://doi.org/10.3945/ajcn.2008.27091</a>	Nestle Nutrition
Kramer, M.S. and Kakuma, R., 2012. Optimal duration of exclusive breastfeeding. <i>Cochrane Database of Systematic Reviews</i> , Issue 8. Art. No.: CD003517. DOI: 10.1002/14651858.CD003517.pub2.	RCPCH



Evidence	Organisations/ individual
Krebs, N.F., Sherlock, L.G., Westcott, J., Culbertson, D., Hambidge, K.M., Feazel, L.M., Robertson, C.E. and Frank, D.N., 2013. Effects of different complementary feeding regimens on iron status and enteric microbiota in breastfed infants. <i>The Journal of pediatrics</i> , 163(2), pp.416-423.	RCPCH
Ladomenou, F., Moschandreas, J., Kafatos, A., Tselentis, Y. and Galanakis, E., 2010. Protective effect of exclusive breastfeeding against infections during infancy: a prospective study. <i>Archives of disease in childhood</i> , 95(12), pp.1004-1008.	RCPCH
[The] Lancet breastfeeding series - <a href="http://www.thelancet.com/series/breastfeeding">http://www.thelancet.com/series/breastfeeding</a>	Crawley H Royal College of Midwives
Lee, E., 2007. Health, morality, and infant feeding: British mothers' experiences of formula milk use in the early weeks. <i>Sociology of health &amp; illness</i> , 29(7), pp.1075-1090.	Stirton R
Lennox, A., Sommerville, J., Ong, K., Henderson, H. and Allen, R., 2013. Diet and nutrition survey of infants and young children, 2011. A survey carried out on behalf of the Department of Health and Food Standards Agency. Available at: <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/139572/DNSIYC_UK_report_ALL_chapters_DH_V10.0.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/139572/DNSIYC_UK_report_ALL_chapters_DH_V10.0.pdf</a>	BSNA Ella's kitchen
Li, R., Dee, D., Li, C.M., Hoffman, H.J. and Grummer-Strawn, L.M., 2014. Breastfeeding and risk of infections at 6 years. <i>Pediatrics</i> , 134(Supplement 1), pp.S13-S20.	RCPCH
Li, R., Fein, S.B., Chen, J. and Grummer-Strawn, L.M., 2008. Why mothers stop breastfeeding: mothers' self-reported reasons for stopping during the first year. <i>Pediatrics</i> , 122(Supplement 2), pp.S69-S76.	Infant Feeding Support UK
Lionetti, E., Castellaneta, S., Francavilla, R., Pulvirenti, A., Tonutti, E., Amarri, S., Barbato, M., Barbera, C., Barera, G., Bellantoni, A. and Castellano, E., 2014. Introduction of gluten, HLA status, and the risk of celiac disease in children. <i>New England Journal of Medicine</i> , 371(14), pp.1295-1303.	RCPCH
Lodge, C.J., Tan, D.J., Lau, M.X.Z., Dai, X., Tham, R., Lowe, A.J., Bowatte, G., Allen, K.J. and Dharmage, S.C., 2015. Breastfeeding and asthma and allergies: a systematic review and meta-analysis. <i>Acta Paediatrica</i> , 104, pp.38-53.	Dalzell J, Richards D
Lozoff, B., Castillo, M., Clark, K.M. and Smith, J.B., 2012. Iron-fortified vs low-iron infant formula: developmental outcome at 10 years. <i>Archives of Pediatrics &amp; adolescent medicine</i> , 166(3), pp.208-215.	RCPCH
Maier-Nöth, A., Schaal, B., Leathwood, P. and Issanchou, S., 2016. The lasting influences of early food-related variety experience: a longitudinal study of vegetable acceptance from 5 months to 6 years in two populations. <i>PLoS One</i> , 11(3), p.e0151356.	Hetherington M, Fildes A
Mallan, K.M., Fildes, A., Magarey, A.M. and Daniels, L.A., 2016. The relationship between number of fruits, vegetables, and noncore foods tried at age 14 months and food preferences, dietary intake patterns, fussy eating behavior, and weight status at age 3.7 years. <i>Journal of the Academy of Nutrition and Dietetics</i> , 116(4), pp.630-637.	Hetherington M,Fildes A

Evidence	Organisations/ individual
Masters, R., Anwar, E., Collins, B., Cookson, R. and Capewell, S., 2017. Return on investment of public health interventions: a systematic review. <i>J Epidemiol Community Health</i> , 71(8), pp.827-834.	Infant Feeding Support UK
Minchin, M., 2015. Milk matters: infant feeding and immune disorder. Milk Matters Pty Limited.	La Leche League, Pearson-Glaze P
McAndrew, F., Thompson, J., Fellows, L., Large, A., Speed, M. and Renfrew, M.J., 2012. Infant feeding survey 2010. Leeds: Health and Social Care Information Centre. Available at: <a href="http://content.digital.nhs.uk/catalogue/PUB08694/Infant-Feeding-Survey-2010-Consolidated-Report.pdf">http://content.digital.nhs.uk/catalogue/PUB08694/Infant-Feeding-Survey-2010-Consolidated-Report.pdf</a>	BSNA
Morison, B.J., Taylor, R.W., Haszard, J.J., Schramm, C.J., Erickson, L.W., Fangupo, L.J., Fleming, E.A., Luciano, A. and Heath, A.L.M., 2016. How different are baby-led weaning and conventional complementary feeding? A cross-sectional study of infants aged 6–8 months. <i>BMJ open</i> , 6(5), p.e010665.	Brown R Crawley H
Murphy, E., 2004. Anticipatory accounts. <i>Symbolic Interaction</i> , 27(2), pp.129-154.	Stirton R
Netherlands Nutrition Center (2016) <a href="http://www.voedingscentrum.nl/eerstehapjes">http://www.voedingscentrum.nl/eerstehapjes</a>	Ella's Kitchen
Newby, R.M. and Davies, P.S.W., 2016. Why do women stop breast-feeding? Results from a contemporary prospective study in a cohort of Australian women. <i>European journal of clinical nutrition</i> , 70(12), p.1428-1432	Infant Feeding Support Network
NHS Choices. Food allergies in babies. Available at: <a href="http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/food-allergies-in-children.aspx">http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/food-allergies-in-children.aspx</a>	BSNA
NICE maternal and child nutrition Quality Standards (QS98, 2015) <a href="https://www.nice.org.uk/guidance/qs98/resources/maternal-and-child-nutrition-pdf-2098975759045">https://www.nice.org.uk/guidance/qs98/resources/maternal-and-child-nutrition-pdf-2098975759045</a>	Crawley H
Nommsen-Rivers, L.A., Chantry, C.J., Peerson, J.M., Cohen, R.J. and Dewey, K.G., 2010. Delayed onset of lactogenesis among first-time mothers is related to maternal obesity and factors associated with ineffective breastfeeding-. <i>The American journal of clinical nutrition</i> , 92(3), pp.574-584.	Infant Feeding Support UK
Otoo, G.E., Lartey, A.A. and Pérez-Escamilla, R., 2009. Perceived incentives and barriers to exclusive breastfeeding among periurban Ghanaian women. <i>Journal of Human Lactation</i> , 25(1), pp.34-41.	Infant Feeding Support UK
Papoutsou, S., Savva, S.C., Hunsberger, M., Jilani, H., Michels, N., Ahrens, W., Tornaritis, M., Veidebaum, T., Molnár, D., Siani, A. and Moreno, L.A., 2018. Timing of solid food introduction and association with later childhood overweight and obesity: The IDEFICS study. <i>Maternal &amp; child nutrition</i> , 14(1), p.e12471.	Crawley H

Evidence	Organisations/ individual
Patro-Gołąb, B., Zalewski, B.M., Kouwenhoven, S.M., Karaś, J., Koletzko, B., Bernard van Goudoever, J. and Szajewska, H., 2016. Protein Concentration in Milk Formula, Growth, and Later Risk of Obesity: A Systematic Review–3. <i>The Journal of nutrition</i> , 146(3), pp.551-564.	Crawley H
Peres, K.G., Nascimento, G.G., Peres, M.A., Mittinty, M.N., Demarco, F.F., Santos, I.S., Matijasevich, A. and Barros, A.J., 2017. Impact of prolonged breastfeeding on dental caries: a population-based birth cohort study. <i>Pediatrics</i> , 140(1), p.e20162943.	British Society of Paediatric Dentistry Dalzell J, Richards D Rugg-Gunn R
Perkin, M.R., Logan, K., Marrs, T., Radulovic, S., Craven, J., Flohr, C., Lack, G., Young, L., Offord, V., DeSousa, M. and Cullen, J., 2016. Enquiring About Tolerance (EAT) study: feasibility of an early allergenic food introduction regimen. <i>Journal of Allergy and Clinical Immunology</i> , 137(5), pp.1477-1486.	RCPCH
Perkin, M.R., Logan, K., Tseng, A., Raji, B., Ayis, S., Peacock, J., Brough, H., Marrs, T., Radulovic, S., Craven, J. and Flohr, C., 2016. Randomized trial of introduction of allergenic foods in breast-fed infants. <i>New England Journal of Medicine</i> , 374(18), pp.1733-1743.	RCPCH
Pimpin, L., Jebb, S., Johnson, L., Wardle, J. and Ambrosini, G.L., 2016. Dietary protein intake is associated with body mass index and weight up to 5 y of age in a prospective cohort of twins, 2. <i>The American journal of clinical nutrition</i> , 103(2), pp.389-397.	BDA - PFASG RCPCH
Pinto-Sánchez, M.I., Verdu, E.F., Liu, E., Bercik, P., Green, P.H., Murray, J.A., Guandalini, S. and Moayyedi, P., 2016. Gluten introduction to infant feeding and risk of celiac disease: systematic review and meta-analysis. <i>The Journal of pediatrics</i> , 168, pp.132-143.	Crawley H
Prentice, P., Ong, K.K., Schoemaker, M.H., van Tol, E.A., Vervoort, J., Hughes, I.A., Acerini, C.L. and Dunger, D.B., 2016. Breast milk nutrient content and infancy growth. <i>Acta Paediatrica</i> , 105(6), pp.641-647.	Nestle Nutrition
Quigley MA, Kelly YJ, Sacker A., 2009. Infant feeding, solid foods and hospitalisation in the first 8 months after birth. <i>Archives of Disease in Childhood</i> 2009;94:148-150.	BDA – PFASG
RCPCH Position statement: breastfeeding in the UK <a href="http://www.rcpch.ac.uk/system/files/protected/news/WEBSITE%20FINAL%20Breastfeeding%20Position%20Statement%20280717_0.pdf">http://www.rcpch.ac.uk/system/files/protected/news/WEBSITE%20FINAL%20Breastfeeding%20Position%20Statement%20280717_0.pdf</a>	RCPCH
Rebhan, B., Kohlhuber, M., Schwegler, U., Fromme, H., Abou-Dakn, M. and Koletzko, B.V., 2009. Breastfeeding duration and exclusivity associated with infants' health and growth: data from a prospective cohort study in Bavaria, Germany. <i>Acta paediatrica</i> , 98(6), pp.974-980.	RCPCH
Ribeiro, N.M. and Ribeiro, M.A., 2004. Breastfeeding and early childhood caries: a critical review. <i>Jornal de pediatria</i> , 80(5), pp.s199-s210.	La Leche League, Pearson-Glaze P

Evidence	Organisations/ individual
Redsell, S.A., Atkinson, P.J., Nathan, D., Siriwardena, A.N., Swift, J.A. and Glazebrook, C., 2011. Preventing childhood obesity during infancy in UK primary care: a mixed-methods study of HCPs' knowledge, beliefs and practice. <i>BMC Family Practice</i> , 12(1), p.54.	Nestle Nutrition
Redsell, S.A., Edmonds, B., Swift, J.A., Siriwardena, A.N., Weng, S., Nathan, D. and Glazebrook, C., 2016. Systematic review of randomised controlled trials of interventions that aim to reduce the risk, either directly or indirectly, of overweight and obesity in infancy and early childhood. <i>Maternal &amp; child nutrition</i> , 12(1), pp.24-38.	RCPCH Nestle Nutrition
Rodenburg, G., Kremers, S.P., Oenema, A. and van de Mheen, D., 2014. Associations of parental feeding styles with child snacking behaviour and weight in the context of general parenting. <i>Public Health Nutrition</i> , 17(5), pp.960-969.	Ella's Kitchen
Samayam, P., Ranganathan, P.K., Kotari, U.D. and Balasundaram, R., 2015. Study of asymptomatic hypoglycemia in full term exclusively breastfed neonates in first 48 hours of life. <i>Journal of clinical and diagnostic research: JCDR</i> , 9(9), p.SC07-SC10.	Infant Feeding Support UK
Sankar, M.J., Sinha, B., Chowdhury, R., Bhandari, N., Taneja, S., Martines, J. and Bahl, R., 2015. Optimal breastfeeding practices and infant and child mortality: a systematic review and meta-analysis. <i>Acta paediatrica</i> , 104, pp.3-13.	Dalzell J, Richards D
Savage, J.S., Birch, L.L., Marini, M., Anzman-Frasca, S. and Paul, I.M., 2016. Effect of the INSIGHT responsive parenting intervention on rapid infant weight gain and overweight status at age 1 year: a randomized clinical trial. <i>JAMA pediatrics</i> , 170(8), pp.742-749.	Nestle Nutrition
Scientific Advisory Committee on Nutrition, 2011. Dietary reference values for energy. Available at: <a href="https://www.gov.uk/government/publications/sacn-dietary-reference-values-for-energy">https://www.gov.uk/government/publications/sacn-dietary-reference-values-for-energy</a>	More J
Schroth, R.J., Levi, J.A., Sellers, E.A., Friel, J., Kliwer, E. and Moffatt, M.E., 2013. Vitamin D status of children with severe early childhood caries: a case-control study. <i>BMC pediatrics</i> , 13(1), p.174.	Rugg-Gunn A
Schroth RJ, Lavelle C, Tate R, Bruce S, Bilings RJ, Moffatt MEK. 2014. Prenatal Vitamin D and Dental Caries in Infants. <i>Pediatrics</i> ; 133(5): e1277-1284.	Rugg-Gunn A
Schwartz, C., Madrelle, J., Vereijken, C.M.J.L., Weenen, H., Nicklaus, S. and Hetherington, M.M., 2013. Complementary feeding and "donner les bases du goût"(providing the foundation of taste). A qualitative approach to understand weaning practices, attitudes and experiences by French mothers. <i>Appetite</i> , 71, pp.321-331.	Ella's Kitchen
Scientific Advisory Committee on Nutrition (SACN) and Committee on Toxicity (COT) Joint Working Group Report. 2017. Assessing the health benefits and risks of the introduction of peanut and hen's egg into the infant diet before six months of age in the UK; 2017. Available at: <a href="https://cot.food.gov.uk/cotwg/joint-sacn/cot-working-group-on-the-timing-of-introduction-of-allergenic-foods-into-the-infant-diet/sacn/cot-working-group-report">https://cot.food.gov.uk/cotwg/joint-sacn/cot-working-group-on-the-timing-of-introduction-of-allergenic-foods-into-the-infant-diet/sacn/cot-working-group-report</a>	BSNA
Sieber, S., 1981. <i>Fatal Remedies: The Ironies of Social Intervention (International Cryogenics Monograph Series)</i> /Sam Sieber. New York City: Springer.	Stirton R

Evidence	Organisations/ individual
Singh, K.A., Spencer, A.J. and Armfield, J.M., 2003. Relative effects of pre-and posteruption water fluoride on caries experience of permanent first molars. <i>Journal of public health dentistry</i> , 63(1), pp.11-19.	Rugg-Gunn A
Smith HA, Becker GE.2016. Early additional food and fluids for healthy breastfed full-term infants. <i>Cochrane Database of Systematic Reviews</i> , Issue 8. Art. No.: CD006462. DOI: 10.1002/14651858.CD006462.pub4. This is the update of Becker GE, Remington T. 2014. Early additional food and fluids for healthy breastfed full-term infants. <i>Cochrane Database of Systematic Reviews</i> (update of 2011 review), Issue 11. Art. No.: CD006462. DOI: 10.1002/14651858.CD006462.pub3.	Becker G
Smith, H.A., Hourihane, J.O.B., Kenny, L.C., Kiely, M., Leahy-Warren, P. and Murray, D.M., 2016. Infant formula feeding practices in a prospective population based study. <i>BMC pediatrics</i> , 16(1), p.205.	Crawley H
Smyth, L., 2012. The social politics of breastfeeding: Norms, situations and policy implications. <i>Ethics and Social Welfare</i> , 6(2), pp.182-194.	Stirton R
Silano, M., Agostoni, C., Sanz, Y. and Guandalini, S., 2016. Infant feeding and risk of developing celiac disease: a systematic review. <i>BMJ open</i> , 6(1), p.e009163.	Crawley H
Størðal, K., Lundeby, K.M., Brantsæter, A.L., Haugen, M., Nakstad, B., Lund-Blix, N.A. and Stene, L.C., 2017. Breast-feeding and infant hospitalization for infections: large cohort and sibling analysis. <i>Journal of pediatric gastroenterology and nutrition</i> , 65(2), pp.225-231.	RCPCH
Straňák, Z., Feyereislova, S., Černá, M., Kollárová, J. and Feyereisl, J., 2016. Limited Amount of formula may facilitate breastfeeding: randomized, controlled trial to compare standard clinical practice versus limited supplemental Feeding. <i>PLoS One</i> , 11(2), p.e0150053.	Infant Feeding Support UK
Sun, C., Foskey, R.J., Allen, K.J., Dharmage, S.C., Koplín, J.J., Ponsonby, A.L., Lowe, A.J., Matheson, M.C., Tang, M.L., Gurrin, L. and Wake, M., 2016. The impact of timing of introduction of solids on infant body mass index. <i>The Journal of pediatrics</i> , 179, pp.104-110.	Crawley H
Swedish National Food Agency (2012) Good food for infants under one year. <a href="https://www.livsmedelsverket.se/globalassets/matvanor-halsa-miljo/kostrad-matvanor/spadbarn/good-food-for-infants-under-one-year-livsmedelsverket.pdf">https://www.livsmedelsverket.se/globalassets/matvanor-halsa-miljo/kostrad-matvanor/spadbarn/good-food-for-infants-under-one-year-livsmedelsverket.pdf</a> (Accessed August 2017)	Ella's Kitchen
Szajewska, H., Shamir, R., Mearin, L., Ribes-Koninckx, C., Catassi, C., Domellöf, M., Fewtrell, M.S., Husby, S., Papadopoulou, A., Vandenplas, Y. and Castillejo, G., 2016. Gluten introduction and the risk of coeliac disease: a position paper by the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition. <i>Journal of pediatric gastroenterology and nutrition</i> , 62(3), pp.507-513.	Crawley H RCPCH

Evidence	Organisations/ individual
Tanzi, M.G. and Gabay, M.P., 2002. Association between honey consumption and infant botulism. <i>Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy</i> , 22(11), pp.1479-1483.	Public Health Dietitians in Wales Network and Wales Dietetic Leadership and Advisory Group
Taylor, R.W., Williams, S.M., Fangupo, L.J., Wheeler, B.J., Taylor, B.J., Daniels, L., Fleming, E.A., McArthur, J., Morison, B., Erickson, L.W. and Davies, R.S., 2017. Effect of a baby-led approach to complementary feeding on infant growth and overweight: a randomized clinical trial. <i>JAMA pediatrics</i> , 171(9), pp.838-846.	Brown R Crawley H
Victora, C.G., Bahl, R., Barros, A.J., França, G.V., Horton, S., Krasevec, J., Murch, S., Sankar, M.J., Walker, N. and Rollins, N.C., 2016. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. <i>The Lancet</i> , 387(10017), pp.475-490.	BDA – PFASG RCPCH
Vitamin D Council <a href="https://www.vitamindcouncil.org/vitamin-d-during-pregnancy-and-breastfeeding/#">https://www.vitamindcouncil.org/vitamin-d-during-pregnancy-and-breastfeeding/#</a>	La Leche League Pearson-Glaze P
Voortman, T., Braun, K.V.E., Kiefte-de Jong, J.C., Jaddoe, V.W.V., Franco, O.H. and van den Hooven, E.H., 2016. Protein intake in early childhood and body composition at the age of 6 years: the Generation R Study. <i>International Journal of Obesity</i> , 40(6):1018-1025.	BDA - PFASG
Vriezinga, S.L., Auricchio, R., Bravi, E., Castillejo, G., Chmielewska, A., Crespo Escobar, P., Kolaček, S., Koletzko, S., Korponay-Szabo, I.R., Mummert, E. and Polanco, I., 2014. Randomized feeding intervention in infants at high risk for celiac disease. <i>New England Journal of Medicine</i> , 371(14), pp.1304-1315.	RCPCH
Weber, M., Grote, V., Closa-Monasterolo, R., Escribano, J., Langhendries, J.P., Dain, E., Giovannini, M., Verduci, E., Gruszfeld, D., Socha, P. and Koletzko, B., 2014. Lower protein content in infant formula reduces BMI and obesity risk at school age: follow-up of a randomized trial–. <i>The American journal of clinical nutrition</i> , 99(5), pp.1041-1051.	BDA - PFASG Nestle Nutrition
Woo Baidal, J.A., Locks, L.M., Cheng, E.R., Blake-Lamb, T.L., Perkins, M.E. and Taveras, E.M., 2016. Risk factors for childhood obesity in the first 1,000 days: a systematic review. <i>American journal of preventive medicine</i> , 50(6), pp.761-779.	Nestle Nutrition
Woollard, F. and Porter, L., 2017. Breastfeeding and defeasible duties to benefit. <i>Journal of medical ethics</i> , pp.515-518.	Stirton R
Wright, C.M., Cameron, K., Tsiaka, M. and Parkinson, K.N., 2011. Is baby-led weaning feasible? When do babies first reach out for and eat finger foods?. <i>Maternal &amp; child nutrition</i> , 7(1), pp.27-33.	Brown R
Wright, C.M., Parkinson, K.N. and Drewett, R.F., 2004. Why are babies weaned early? Data from a prospective population based cohort study. <i>Archives of disease in childhood</i> , 89(9), pp.813-816.	More J

Evidence	Organisations/ individual
Ziegler, E.E., Fields, D.A., Chernausek, S.D., Steenhout, P., Grathwohl, D., Jeter, J.M., Nelson, S.E. and Haschke, F., 2015. Adequacy of infant formula with protein content of 1.6 g/100 kcal for infants between 3 and 12 months. Journal of pediatric gastroenterology and nutrition, 61(5), pp.596-603.	RCPCH
<a href="https://www.bda.org/news-centre/press-releases/Documents/a-tax-on-teeth.pdf">https://www.bda.org/news-centre/press-releases/Documents/a-tax-on-teeth.pdf</a>	British Dental Association
Education Pack from 'The Fed is Best Foundation' ( <a href="https://fedisbest.org/">https://fedisbest.org/</a> ): The Fed is Best Foundation believes that babies should never go hungry and mothers should be supported in choosing clinically safe feeding options for their babies. Whether breast milk, formula, or a combination of both – #FedIsBest. The paper details a number of cases where exclusively breastfed newborn babies have become dehydrated, jaundiced and developed severe hypoglycaemia due to insufficient breast milk intake, resulting in brain injury and neurological disabilities. The author/group advocate increased monitoring and supplementation to prevent adverse neurological conditions in all exclusively breastfed newborn babies.	Norris S

## **References included in SACN's responses to comments**

Boyle RJ, Garcia-Larsen V, Ierodiakonou D, Leonardi-Bee J, Reeves T, Trivella M, Chivinge J, Robinson Z, Geoghegan N, et al. (2016a) Systematic review of scientific published literature on infant feeding and development of atopic and autoimmune disease: Review B: Timing of introduction of allergenic foods to the infant diet [online]. Available at: [www.food.gov.uk/sites/default/files/fs305005breport.pdf](http://www.food.gov.uk/sites/default/files/fs305005breport.pdf) [Accessed April 2018].

Boyle RJ, Ierodiakonou D, Khan T, Chivinge J, Robinson Z, Geoghegan N, Jarrold K, Afxentiou T, Reeves T, et al. (2016b) Hydrolysed formula and risk of allergic or autoimmune disease: systematic review and meta-analysis. *BMJ* 352, i974.

Caton, S.J., Ahern, S.M. and Hetherington, M.M., (2011) Vegetables by stealth. An exploratory study investigating the introduction of vegetables in the weaning period. *Appetite*, 57(3), pp.816-825.

Chambers, L., Hetherington, M., Cooke, L., Coulthard, H., Fewtrell, M., Emmett, P., Lowdon, J., Blissett, J., Lanigan, J., Baseley, C. and Stanner, S., (2016) Reaching consensus on a 'vegetables first' approach to complementary feeding. *Nutrition Bulletin*, 41(3), pp.270-276.

COT (2012) Overarching statement on risks of chemical toxicity and allergic disease in relation to infant diet [online]. Available at: <https://cot.food.gov.uk/sites/default/files/cot/cotstatementoverarch201203.pdf> [Accessed April 2018]

COT (2016a) Statement on the role of hydrolysed cows' milk formulae in influencing the development of atopic outcomes and autoimmune disease [online]. Available at: <https://cot.food.gov.uk/sites/default/files/finalstatement-hydrolysedformula.pdf> [Accessed April 2018].

COT (2016b) Statement on the timing of introduction of allergenic foods to the infant diet and influence on the risk of development of atopic outcomes and autoimmune disease [online]. Available at: [https://cot.food.gov.uk/sites/default/files/finalstatementontiming.doc\\_1.pdf](https://cot.food.gov.uk/sites/default/files/finalstatementontiming.doc_1.pdf) [Accessed April 2018].

COT (2017) Statement on maternal and infant dietary exposures and risk of development of atopic outcomes and autoimmune disease [online]. Available at: <https://cot.food.gov.uk/sites/default/files/maternal-infant-exposure.pdf> [Accessed April 2018].

Coulthard, H., Harris, G. and Fogel, A., (2016) Association between tactile over-responsivity and vegetable consumption early in the introduction of solid foods and its variation with age. *Maternal & child nutrition*, 12(4), pp.848-859.

de Barse, L.M., Jansen, P.W., Edelson-Fries, L.R., Jaddoe, V.W., Franco, O.H., Tiemeier, H. and Steenweg-de Graaff, J., (2017) Infant feeding and child fussy eating: The Generation R Study. *Appetite*, 114, pp.374-381.

Dennison, B.A., Edmunds, L.S., Stratton, H.H. and Pruzek, R.M., (2006) Rapid infant weight gain predicts childhood overweight. *Obesity*, 14(3), pp.491-499.

Dewey KG, Cohen RJ, Rivera LL & Brown KH (1998) Effects of age of introduction of complementary foods on iron status of breast-fed infants in Honduras. *Am J Clin Nutr* 67, 878-884.

Druet C, Stettler N, Sharp S, Simmons RK, Cooper C, Smith GD, Ekelund U, Levy-Marchal C, Jarvelin MR, et al. (2012) Prediction of childhood obesity by infancy weight gain: an individual-level meta-analysis. *Paediatr Perinat Epidemiol* 26, 19-26.



- Fildes A, Lopes C, Moreira P, Moschonis G, Oliveira A, Mavrogianni C, Manios Y, Beeken R, Wardle J, et al. (2015) An exploratory trial of parental advice for increasing vegetable acceptance in infancy. *Br J Nutr* 114, 328-336.
- Freeman, V., van't Hof, M., Haschke, F. and Euro-Growth Study Group, (2000) Patterns of milk and food intake in infants from birth to age 36 months: the Euro-growth study. *Journal of pediatric gastroenterology and nutrition*, 31, pp.S76-S85.
- Garcia, A.L., Raza, S., Parrett, A. and Wright, C.M., (2013) Nutritional content of infant commercial weaning foods in the UK. *Archives of disease in childhood*, 98(10), pp.793-797.
- Garcia, A.L., McLean, K. and Wright, C.M., (2015) Types of fruits and vegetables used in commercial baby foods and their contribution to sugar content. *Maternal & child nutrition*, 12(4), pp.838-847.
- Garcia-Larsen, V., Ierodiakonou, D., Jarrold, K., Cunha, S., Chivinge, J., Robinson, Z., et al (2018) Diet during pregnancy and infancy and risk of allergic or autoimmune disease: A systematic review and meta-analysis. *PLoS Med.* 15(2):e1002507.
- Hohman EE, Paul IM, Birch LL & Savage JS (2017) INSIGHT responsive parenting intervention is associated with healthier patterns of dietary exposures in infants. *Obesity* 25, 185-191.
- Hörnell, A., Lagström, H., Lande, B. and Thorsdottir, I.,(2013) Protein intake from 0 to 18 years of age and its relation to health: a systematic literature review for the 5th Nordic Nutrition Recommendations. *Food & nutrition research*, 57(1), p.21083.
- Ierodiakonou D, Garcia-Larsen V, Logan A, Groome A, Cunha S, Chivinge J, Robinson Z, Geoghegan N, Jarrold K, et al. (2016) Timing of Allergenic Food Introduction to the Infant Diet and Risk of Allergic or Autoimmune Disease: A Systematic Review and Meta-analysis. *JAMA* 316, 1181-1192.
- Iheozor-Ejiofor Z, Worthington HV, Walsh T, O'Malley L, Clarkson JE, Macey R, Alam R, Tugwell P, Welch V, et al. (2015) Water fluoridation for the prevention of dental caries. *Cochrane Database Syst Rev.* (6):CD010856.
- Inostroza J, Haschke F, Steenhout P, Grathwohl D, Nelson SE & Ziegler EE (2014) Low-protein formula slows weight gain in infants of overweight mothers. *J Pediatr Gastroenterol Nutr* 59, 70.
- Jonsdottir OH, Thorsdottir I, Hibberd PL, Fewtrell MS, Wells JC, Palsson GI, Lucas A, Gunnlaugsson G & Kleinman RE (2012) Timing of the introduction of complementary foods in infancy: a randomized controlled trial. *Pediatrics* 130, 1038-1045.
- Jonsdottir, O.H., Kleinman, R.E., Wells, J.C., Fewtrell, M.S., Hibberd, P.L., Gunnlaugsson, G. and Thorsdottir, I., (2014) Exclusive breastfeeding for 4 versus 6 months and growth in early childhood. *Acta Paediatrica*, 103(1), pp.105-111.
- Jonsdottir, O.H., Thorsdottir, I., Gunnlaugsson, G., Fewtrell, M.S., Hibberd, P.L. and Kleinman, R.E., (2013) Exclusive breastfeeding and developmental and behavioral status in early childhood. *Nutrients*, 5(11), pp.4414-4428.
- Koletzko B, von KR, Closa R, Escribano J, Scaglioni S, Giovannini M, Beyer J, Demmelmair H, Gruszfeld D, et al. (2009) Lower protein in infant formula is associated with lower weight up to age 2 y: a randomized clinical trial. *Am J Clin Nutr* 89, 1836-1845.
- Lozoff B, Castillo M, Clark KM & Smith JB (2012) Iron-fortified vs low-iron infant formula: developmental outcome at 10 years. *Arch Pediatr Adolesc Med* 166, 208-215.

Maier-Nöth A, Schaal B, Leathwood P & Issanchou S (2016) The lasting influences of early food-related variety experience: a longitudinal study of vegetable acceptance from 5 months to 6 years in two populations. *PLoS One* 11, e0151356.

Mallan, K.M., Fildes, A., Magarey, A.M. and Daniels, L.A., (2016) The relationship between number of fruits, vegetables, and noncore foods tried at age 14 months and food preferences, dietary intake patterns, fussy eating behavior, and weight status at age 3.7 years. *Journal of the Academy of Nutrition and Dietetics*, 116(4), pp.630-637.

McAndrew, F., Thompson, J., Fellows, L., Large, A., Speed, M. and Renfrew, M.J., (2012) Infant feeding survey 2010. Leeds: Health and Social Care Information Centre. Available at: <http://content.digital.nhs.uk/catalogue/PUB08694/Infant-Feeding-Survey-2010-Consolidated-Report.pdf> [Accessed April 2018].

Mennella JA, Griffin CE & Beauchamp GK (2004) Flavor programming during infancy. *Pediatrics* 113, 840-845.

NICE (2014) Maternal and child nutrition. NICE public health guideline 11. London..

Perkin MR, Logan K, Tseng A, Raji B, Ayis S, Peacock J, Brough H, Marrs T, Radulovic S, Craven J, Flohr C, Lack G; EAT Study Team. (2016) Randomized Trial of Introduction of Allergenic Foods in Breast-Fed Infants. *New England Journal of Medicine*; 374: 1733-1743

PHE (2014) Delivering Better Oral Health: An evidence-based toolkit for prevention (Third Edition) [online]. Available at: [www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention](http://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention) [Accessed June 2018].

Pimpin, L., Jebb, S., Johnson, L., Wardle, J. and Ambrosini, G.L., (2016) Dietary protein intake is associated with body mass index and weight up to 5 y of age in a prospective cohort of twins, 2. *The American journal of clinical nutrition*, 103(2), pp.389-397.

Quigley MA, Kelly YJ & Sacker A (2009) Infant feeding, solid foods and hospitalisation in the first 8 months after birth. *Arch.Dis.Child* 94, 148-150.

Redsell SA, Edmonds B, Swift JA, Siriwardena AN, Weng S, Nathan D & Glazebrook C (2016) Systematic review of randomised controlled trials of interventions that aim to reduce the risk, either directly or indirectly, of overweight and obesity in infancy and early childhood. *Matern Child Nutr* 12, 24-38.

Redsell, S.A., Atkinson, P.J., Nathan, D., Siriwardena, A.N., Swift, J.A. and Glazebrook, C., (2011) Preventing childhood obesity during infancy in UK primary care: a mixed-methods study of HCPs' knowledge, beliefs and practice. *BMC Family Practice*, 12(1), p.54.

SACN (2016) Vitamin D and health. Available from: [www.gov.uk/government/publications/sacn-vitamin-d-and-health-report](http://www.gov.uk/government/publications/sacn-vitamin-d-and-health-report)

Victora CG, Bahl R, Barros AJD, França GVA, Horton S, Krasevec J, Murch S, Sankar MJ, Walker N, et al. (2016) Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet* 387, 475-490.

Vriezinga, S.L., Auricchio, R., Bravi, E., Castillejo, G., Chmielewska, A., Crespo Escobar, P., Kolaček, S., Koletzko, S., Korponay-Szabo, I.R., Mummert, E. and Polanco, I., (2014) Randomized feeding intervention in infants at high risk for celiac disease. *New England Journal of Medicine*, 371(14), pp.1304-1315.

Weber M, Grote V, Closa-Monasterolo R, Escribano J, Langhendries JP, Dain E, Giovannini M, Verduci E, Gruszfeld D, et al. (2014) Lower protein content in infant formula reduces BMI and obesity risk at school age: follow-up of a randomized trial. *Am J Clin Nutr* 99, 1041-1051.

Wells JC, Jonsdottir OH, Hibberd PL, Fewtrell MS, Thorsdottir I, Eaton S, Lucas A, Gunnlaugsson G & Kleinman RE (2012) Randomized controlled trial of 4 compared with 6 mo of exclusive breastfeeding in Iceland: differences in breast-milk intake by stable-isotope probe. *Am J Clin Nutr* 96, 73-79.

WHO MGRS (2006a) Enrolment and baseline characteristics in the WHO Multicentre Growth Reference Study. *Acta Paediatr* 95, 7-15.

WHO MGRS (2006b) WHO Child Growth Standards: Length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age: Methods and development. Geneva.

Ziegler EE, Fields DA, Chernausk SD, Steenhout P, Grathwohl D, Jeter JM, Nelson SE & Haschke F (2015) Adequacy of infant formula with protein content of 1.6 g/100 kcal for infants between 3 and 12 months. *J Pediatr Gastroenterol Nutr* 61, 596-6