Response to Nutrition For Healthy Term Infants: Six to 24 Months
June 2013
Submitted by: The Ontario Society of Nutrition Professionals in Public Health (OSNPPH)

General Comments:

1. The terms used to describe the various ages and stages in the document needs clarification.
   - Age and age **range** for the terms "young children", "infants", and "older infants" need to be defined at the beginning of the document (e.g. is older infants 6+ months or 9 months +?).
   - Terms should be consistently used throughout the document (e.g., "older infant").
   - It seems that up to 12 months is infant and 12 to 24 months is young child, ie, Page 19 says…**by one year** of age, **young children**… and on page 19 it says "Based on the average intake in the **second year**, nearly 2/3 of a **young child's"**

2. The evidence used throughout the document should be graded, so the reader clearly understands when principles/recommendations are based on strong evidence or when it is based on expert opinion. We would recommend a grading method similar to the Dietitians of Canada – Practice Evidence-Based Nutrition (PEN), the Registered Nurses Association of Ontario RNAO Best Practice Guidelines)

3. While we recognize the importance and value of continued breastfeeding, the focus of 6 to 24 month olds is to develop competent and healthy eating skills and habits. Therefore to set the appropriate tone and improve the flow of the document, we suggest the reordering of the principles and recommendations as follows:
   - Breastfeeding is an important….
   - Iron-rich complementary…
   - Complementary feeding begins….
   - Responsive feeding promotes…
   - Young children can begin….
   - Food for infant and ……
   - Recommendations on the use….

4. The document needs to provide guidance or recommendations for those infants and young children who are receiving a combination of breastmilk and formula or breastmilk and cow's milk/soy beverage.
   - We suggest the following question in the "In practice" section – "What is the advice about parents who are offering a combination of breastmilk and infant formula or cow's milk (or soy beverage)?"

- We suggest the following answer to the proposed question "If parents or caregivers are offering a combination of breastmilk and infant formula or cow's milk (or soy beverage), inform them that infant formula or cow's milk (or soy beverage) intake may be less then guidelines. For example, if a young child is breastfeeding several times per day, there is little or no need for cow's milk (or soy beverage) as 'milk' needs can be met by breastmilk alone. Parents and caregivers should know that the recommended 500-750 mL (2-3 cups) of milk for young children includes breastmilk as part of the total intake (recognizing that breastmilk isn't measured).

5. The vitamin D information should be included as a principle. The issue of vitamin D is of importance to all infants and young children in Canada and should not be relegated to a question in the in practice section.
   - There is no information for the mother who is breastfeeding (past the first year) and not offering other milk sources
   - The advice given is that parents should offer children vitamin D rich foods, including cow milk every day. There is no advice here regarding vitamin D intake in the young child (over one year of age) who is breastfeeding and drinking little or no other milk
   - Would consider if evidence from the recent study would support the recommendation of 2 cups of milk per day. Need to provide guidance for parents who choose not to serve cow's milk or for those young children receiving breastmilk as their primary milk source in the second year of life. (Maguire JL et al., The Relationship Between Cow's Milk and Stores of Vitamin D and Iron in Early Childhood Pediatrics 2013;131:e144–e151)
   - Recommend the following: a principle on vitamin D be included in the statement that includes the recommendations made from the Canadian Academy of Health Sciences Expert Advisory Committee for Calcium and Vitamin D (released January 2013) http://www.cahs-acss.ca/pt-widget/notices/cahs-expert-advisory-committee-report_jan31-2013/. The recommendation should include a statement that supplementation should continue until the young child is consuming 400 IU of vitamin D through the diet (through milk or other sources).

6. The term 'feeding cues' should be clearly defined due to the following: while '**how much'** an infant or young child eats is clear, the '**when'** to eat differs between breastmilk and formula/milk/food for young children (12 months and older). Best practice using the Division of Responsibility for young children on '**when'** to eat is not on demand but rather based on a predictable schedule/routine. Reference: Satter, E. (2000). Child of Mine. Feeding with Love and Good Sense. Bulder, Colorado: Full Publishing Company; Ellyn Satter Institute: http://ellynsatterinstitute.org/index.php.

7. Further consideration on topic layout is advised due to the following:
   - Information is located in unexpected locations (e.g., aspartame is in the "At what age should parents and caregivers offer other liquids to a breastfed child" section)
   - Key information on topics are located in several locations e.g., "juice" is discussed under four headings:
     1) At what age should parents and caregivers offer other liquids to a breastfed child?
     2) How can parents and caregivers reduce the risk of early childhood caries?
     3) Open cup
     4) Fruit juices and sweetened beverages

- We suggest that if a topic is discussed under various headings, then hyperlink these sections so it is easier to locate the information

8. Type of Milk offered:
   - The document discusses other milk sources than breastmilk for ages 9 months and older. It isn't clear throughout the document what type of milk is appropriate at the different age ranges
   - There is contradictory messaging regarding full fat soy beverage (in the principles it indicates not to offer until after age 2, but in the "In Practice" section, it indicates that they can be offered.
   - In the In Practice section, more clarity should be provided to ensure that if lower fat (2%) cow milk is offered, it should only be offered in the second year of life (and not between 9-12 months of age).
   - We recommend inserting a chart, such as below, in the "In practice" section under the question "At what age can children transition from whole cow milk to low fat milk (such as skim, 1% or 2% cow milk)?"

<u>Acceptable milk sources for infants and young children</u>

Age Range	Acceptable *	Not Acceptable
9-12 months	Breastmilk Whole homogenized milk (3.25% milk fat)	Soy beverages Lower fat milk 2% or 1% Non fat milk 0% (skim) Other plant based beverages
12-24 months	Breastmilk Whole homogenized cow milk (3.25%) Lower fat (2%) cow milk Full fat soy beverage	low fat cow milk (1%) Non fat cow milk 0% (skim) Other plant based beverages

* Lower fat and/or soy beverages are only acceptable if the child is growing well and eating a wide variety and an adequate quantity of foods.

The following chart provides recommendations specific to the principles and recommendations from the draft statement.

<table>
<tr><th>Principles and recommendations</th><th>Sub Statements and Rationale</th><th>Comment</th></tr>
<tr><td rowspan="3">Breastfeeding is an important source of nutrition for older infants and young children as complementary foods are introduced.</td><td></td><td>• It is the breastmilk that has the nutrients. Suggest changing the wording to “Breastmilk is a source if important nutrients for older infants and young children as complementary foods are introduced.”</td></tr>
<tr><td>Support sustained breastfeeding for up to two years or beyond, as long as mother and child want to continue.</td><td>• Pleased to see the inclusion of the following statement: “as long as the mother and child want to” continue”
• The statement “no evidence of a risk to child’s health or nutrition with longer breastfeeding durations” is inaccurate. Recent research indicates that prolonged breastfeeding may increase the risk for iron deficiency. Association Between Total Duration of Breastfeeding and Iron Deficiency, Maguire, et al. Pediatrics peds.2012-2465 (Target Kids Study)</td></tr>
<tr><td>Rationale
In the second year, <u>breastfeeding</u> continues to make an important nutritional contribution to the young child (WHO, 2009; PAHO, 2003; Michaelsen, Weaver, Branca & Robertson, 2003).
<u>The decision to continue breastfeeding is a personal one</u>

<u>Continued breastfeeding has been associated with a number of positive infant and maternal health outcomes</u>. Longer breastfeeding durations, in addition to a wide range of other determinants, may have a protective effect against overweight and obesity (Arenz, Rückerl, Koletzko & von Kries,</td><td>• Would suggest using “breastmilk” instead of “breastfeeding” when discussing the nutrition contribution of breastfeeding
• Pleased to see the inclusion of the statement regarding breastfeeding being a personal one
• The paragraph about positive infant and maternal health outcomes does not include duration as part of the discussion. The ‘duration’ of breastfeeding is a key part of any discussion about the health outcomes of breastfeeding. We recommend that the specific length of duration for each of the outcomes should be stated. Some of the positive outcomes shown in DC-PEN are shown below as an example of how this information could be shown in this document.
• We recommend using a table/chart to highlight this information in a clear and concise manner (see below)

<table><tr><th>Breastfeeding Duration</th><th>Positive health outcome for infant</th><th>Positive health outcome for mother</th></tr><tr><td><6 months</td><td>Associated with decreased risk of</td><td></td></tr></table></td></tr>
</table>

<table>
<tr><th>Principles and recommendations</th><th>Sub Statements and Rationale</th><th>Comment</th></tr>
<tr><td></td><td>2004; Scott, Ng & Cobiac, 2012; von Kries et al., 1999). Breastfeeding provides the infant and young child with immune factors during the first and second years (Goldman, Goldblum & Garza, 1983; Goldman, Garza, Nichols & Goldblum, 1982). Longer durations of breastfeeding appear to protect against infectious illnesses, particularly gastrointestinal and respiratory infections (Fisk et al., 2011). Consistent findings have shown a decreased risk of maternal breast cancer with longer durations of breastfeeding (Collaborative Group on Hormonal Factors in Breast Cancer, 2002; Chang-Claude, Eby, Kiechle, Bastert & Becher, 2000; Brinton et al., 1995). Research also suggests that mothers who breastfeed their older infants and young children experience an increased sensitivity and bonding with their child (Britton, Britton & Gronwaldt, 2006; Fergusson & Woodward, 1999).</td><td>
<table>
<tr><td></td><td>childhood leukemia infections in infants</td><td></td></tr>
<tr><td><6 months</td><td>Associated with decreased risk for developing acute ear infections in infants</td><td></td></tr>
<tr><td><6 months</td><td>Associated with decreased risk of becoming overweight later in life</td><td></td></tr>
<tr><td>Exclusive breastfeeding for 6 months and continued breastfeeding for ≤12 months</td><td></td><td>Associated with protection against breast cancer</td></tr>
</table>
</td></tr>
<tr><td>Complementary feeding begins with offering nutritious family foods.</td><td><u>Recommend that parents and caregivers increase the number of times per day that they offer complementary foods, and continue breastfeeding on cue.</u></td><td>

We recommend that this paragraph be rewritten to read: “Recommend that parents and caregivers offer complementary foods as regularly scheduled nutrient-rich meals and snacks, and continue to breastfeed.” (remove “on cue”)
Breastfeeding on cue beyond the first year of life is in contradiction with messaging to have a meal and snack routine/schedule established. We do not recommend any other milks to be fed on demand after the first year of life as this is a period where breastfeeding becomes part of the meal and snack routine.

</td></tr>
</table>

Principles and recommendations	Sub Statements and Rationale	Comment
		• There are two types of "on cue"; when and how much. See our suggestions under the general comment section.
	Rationale In the second six months, breastfeeding alone is no longer sufficient to meet all of an infant's nutrient needs (WHO, 2003). During the initial stages of complementary feeding, the foods offered should be energy dense and rich in protein and micronutrients such as iron (WHO, 2009). The Pan American Health Organization (PAHO) and the WHO have estimated energy requirements that for infants six to eight months of age. The energy contribution from complementary foods is approximately one fifth of the total requirement (WHO, 2009; PAHO, 2003). By nine to 11 months, complementary foods contribute just under half of the estimated total energy requirement. Breastfeeding continues to provide the main source of nutrition as other foods are introduced (WHO, 2009, Butte et al., 2004).	• When investigating references used for energy requirements, the originating source for the WHO, 2009 reference http://whqlibdoc.who.int/publications/2009/9789241597494_eng.pdf led to another WHO report from 2001 called "The optimal duration of exclusive breastfeeding: report of an expert consultation" http://whqlibdoc.who.int/hq/2001/WHO_NHD_01.09.pdf. There didn't appear to be any information related to energy requirements. A second reference from the 2009 document, let to a 2000 book called "Complementary Feeding: Family Foods for Breastfed Children. It's a book for "nutrition and health workers" to advise families on feeding http://whqlibdoc.who.int/hq/2000/WHO_NHD_00.1.pdf. This book is not referenced throughout, but has 4 references at the end, 2 of which could be the source for this information (but old and we question the relevance to Canada): o Department of Health. *Dietary reference values for energy and nutrients for the United Kingdom.* Report on Health and Social Subjects. London, HMSO, 1991. o WHO. *Complementary feeding of young children in developing countries: a review of current scientific knowledge* (WHO/NUTl98.1). Geneva, World Health Organization, 1998. • If complementary foods contribute "just under half" the estimated total energy requirement, breastmilk would provide just over half of the total energy requirement. It is misleading to say that it is the **"main"** source of nutrition • We recommend using the Dietitians of Canada evidence database Practice-based Evidence in Nutrition (PEN) chart that estimates energy and complimentary food intake based on DRIs for energy, WHO complementary feeding guidance and the WHO growth charts (access by subscription, but the Dietitians of Canada member on this NHTI project should be able to provide)

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	Frequency of complementary feeding For infants six to eight months of age it is suggested to offer complementary foods in two to three regular meals and one to two snacks each day, depending on the child's appetite (WHO, 2009). For infants nine to 11 months of age, the frequency increases to three to four regular meals a day with one to two snacks, depending, once again, on the child's appetite. The frequency of feeding and the amount of food increases with age to accommodate higher caloric requirements and developmental growth (WHO, 1998). As complementary foods are introduced, frequent breastfeeding continues on-cue. The WHO has noted that, "whether breastfeeds or complementary foods are given first at any meal has not shown to matter. A mother can decide according to her convenience and the child's [cues]" (WHO, 2009). The amount of food offered to infants should be based on the principles of responsive feeding. The nutrient density and frequency of the meals should be adequate to meet the child's needs. The amount consumed at a meal will differ for each child based on: • their breastmilk intake • their appetite and ability to eat • the energy density of the	Suggest for the 6-8 month age range, change the wording of "meals" and "snacks" to "feedings" to better reflect the on-demand or cue-based feeding that is practiced at this age • Suggest for the 9-12 month age range, the term "meals" and "snacks" can be used as the older baby is beginning to transition to a more established routine of meals and snacks by a year • For 6-8 months of age, there should be a range of number of complementary food feedings per day. We would recommend to start with 1-2 times per day with a gradual increase to up to 4 times per day by 8 months of age, depending on the infant's appetite • For 9-11 months of age, it is not practical to offer 4 meals a day as this is not the common meal pattern of Canadians. Would suggest rewording to 3 meals and 1-3 snacks per day depending on the infant's appetite • Suggest including the following statement: "At around 12 months of age, begin to establish a meal and snack routine. Offer a meal or snack every 2-3 hours." References: Satter, E. (2000). Child of Mine. Feeding with Love and Good Sense. Bulder, Colorado: Full Publishing Company; Ellyn Satter Institute: http://ellynsatterinstitute.org/htf/11to36months.php. • Note hyperlink from hunger cues goes to the section on responsive feeding. Suggest to hyperlink to "Division of roles and responsibilities" where the hunger cues are listed

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	complementary foods Parents and caregivers should be advised to start with small amounts of the family meal and offer more food depending on the child's appetite and hunger cues.	
	Family meals Complementary foods should be prepared and served in a way that is not too spicy or salty	• We recommend rewording the following statement: Prepare foods with limited or no added salt or sugar. • Recommend removing 'not too spicy'. Spice is subjective and differs between cultures. It is also appropriate to add herbs and spices to family foods. The focus should be on not adding salt and sugar to food.
Responsive feeding promotes the development of healthy eating skills.	Title: Responsive feeding promotes the development of healthy eating skills	• "Healthy eating skills" refers to the skill of eating (e.g., use a spoon). This section encompasses much more than the skill of eating – suggest replacing "healthy eating skills" with "healthy relationship with food"
	Encourage feeding that is responsive to the child's cues.	• When using the terminology of a child's "cues", there are two meanings, **how much to offer** and **when to offer** • After the first year of life, the term "cue" should be used in regards to the amount of food fed/offered to a child (not when to offer the food). • Structure and routine are part of Responsive feeding/Division of Responsibility during the second year of life. References: Satter, E. (2000). Child of Mine. Feeding with Love and Good Sense. Bulder, Colorado: Full Publishing Company; Ellyn Satter Institute: http://ellynsatterinstitute.org/index.php
	Promote finger foods and self-feeding from the start.	• How does a 6 month infant self-feed pureed and minced foods? Suggest to mention both self-feeding and assisted feeding during the initial weeks and beyond as needed • Suggest change wording to "Promote texture progression and encourage self-feeding"
	Responsive feeding • It uses different methods of	• Using" different methods of encouragement" is not responsive feeding as this term is likely to be interpreted by the parent and by the child as

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	encouragement, even if foods are initially refused.	pressuring a child to eat. The document needs to define and explain what is meant by "encouragement". If by encouragement you are talking about pressuring a child to eat, this is not recommended practice. Experiences and the social environment in which the child is fed are critical to the development of healthy eating habits later in life. Parents should trust their child/ren to decide to how much to eat or if to eat at all. In a non-controlling, non-coercive environment, healthy children have the ability to self-regulate the amount of food and energy consumed (Johnson SL. 2000. Improving preschoolers' self-regulation of energy intake. Pediatrics. 106(6); 1429-1435. Available from: http://pediatrics.aappublications.org/cgi/content/abstract/106/6/1429) • Suggest to include examples of encouragement that are not pressuring a child. Examples include: 1) Offer a selection of nutritious, age-appropriate foods at regular/predictable meals and sit-down snacks between meals and possibly at bedtime; (ie, a meal or snack every 2-3 hours; 2) Role modeling by eating together as a family whenever possible, with adults eating at least some of the same foods; 3) Have relaxed, pleasant, positive mealtimes without distractions from television or other activities; 4) Be patient when introducing unfamiliar foods and to support the acceptance of new foods. If a food is rejected the first few times, it should be offered again on a different day (may require up to 10 times); 5) Avoid pressuring children to eat particular foods (e.g., praise, rewards, bribery, punishment) as this is counterproductive in the long-term because it is likely to build resistance and food dislikes rather than acceptance; 6) Express pleasure and enthusiasm when eating foods such as, "Mmm! I love mangos"; 7) Draw a child's attention to a food on a child's plate without putting pressure on child to eat. • Suggest to make the above bullet an "In practice" question and also include what encouragement is not recommended. Suggest question to be "How do parents encourage their children to try new foods or foods they have refused in the past?"

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		• See Ellyn Satter factsheet http://www.ellynsatter.com/avoid-pressure-i-156.html
	Division of roles and responsibilities The development of healthy eating skills is a shared responsibility (Satter, 2012; Satter, 2000). Parents and caregivers provide a selection of nutritious foods, prepared and served in a safe manner. They decide when and where food is eaten by providing regular meals and snacks in a pleasant environment. The child decides how much they want to eat and, at times, even whether they eat. To support healthy eating skills, parents and caregivers should be encouraged to recognize and respond appropriately to their child's **hunger cues, such as restlessness or irritability and to satiety cues such as turning the head away, refusing to eat, falling asleep or playing (Satter, 2000).** They need to trust the child's ability to decide how much to eat and whether to eat (Satter, 2012). This kind of support promotes the development of autonomy (Satter, 1996).	• We are very pleased to see the section and reference to Ellyn Satter's Division of Responsibility method of feeding, however the document only refers to the young child age range and misses key elements for the younger age that are different. • Recommend that all three stages of Division of Responsibility are included based on the age range of the infant or young child. **The division of responsibility for infants:** • The parent is responsible for *what* • The child is responsible for *how much* (and everything else) **The division of responsibility for older babies making the transition to family food:** • The parent is still responsible for *what*, and is *becoming* responsible for *when* and *where* the child is fed. • The child is *still* and *always* responsible for *how much* and *whether to* eat the foods offered by the parent. **The division of responsibility For toddlers (young children):** • The parent is responsible for *what, when, where* • The child is responsible for *how much* and *whether* http://www.ellynsatter.com/ellyn-satters-division-of-responsibility-in-feeding-i-80.html • Please note: If all three stages of Division of Responsibility were included, it would satisfy the use of "on cue" throughout the document
	Finger foods add texture to the diet and encourage self-feeding. Safe finger foods……WHO guidelines suggest that foods offered as snacks to older and infants and young children should be	• At the end of the first paragraph, it suggests to only offer finger foods as snacks (according to the WHO guidelines). Recommend: Finger foods should be offered at both meals and snacks.

Principles and recommendations	Sub Statements and Rationale	Comment
	finger foods.	
	Open cup – section Offering infants an open cup decreases the exposure of the teeth to liquid containing sugar including milk, fruit juices, and fruit drinks. This exposure may increase the risk of dental decay (ADA, 2004)	• Pleased to see the inclusion of an 'open cup', particularly in terms of beverage choices for the young child. • We suggest differentiating between the types of cups with lids (i.e. sippy cups) – those with and those without valves • The discussion in this section indicates that a cup with a lid and valve (e.g. 'sippy' cups) should not be used. It is our opinion that drinking water from a cup that has a lid, but no valve, can also promote independent self-feeding. Cups with lids, but no valve are widely available and accessible and are a practical suggestion for parents. • We also suggest clearly indicating that there is a difference between offering water in a cup (open or otherwise) and carbohydrate containing beverages (e.g. milks, juices etc.). This should be more clearly explained in this section. Carbohydrate containing beverages should only be offered at meal and snack times, while water can be offered at anytime.
Iron-rich complementary foods help to prevent iron deficiency.	If parents and caregivers are introducing cow milk, advise them to delay until nine to 12 months of age. Limit cow milk to 500-750 mL (2-3 cups) per day.	• We agree with statement to introducing cow milk, advise them to delay until nine to 12 months of age. • However, should mention that cow's milk products such as yogurt, grated cheese and milk in cooking can be introduced in moderation before 9 months. • Provide examples for clarification
	Rationale	• Would suggest including statements regarding iron deficiency without anemia in addition to IDA as they both are associated with adverse, but preventable effects. We recommend inserting comments similar to the discussion in the American Academy of Pediatrics Clinical Report from 2010 (Baker et al., Clinical Report Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children. Pediatrics 2010; 126(5):1-11. • Suggest to include statements within document such as from the Baker article: "Iron deficiency (ID) and iron-deficiency anemia (IDA) continue to be of worldwide concern. Among children in the developing world, iron is the most common single-nutrient deficiency. In industrialized nations,

Principles and recommendations	Sub Statements and Rationale	Comment
		despite a demonstrable decline in prevalence, IDA remains a common cause of anemia in young children. However, even more important than anemia itself is the indication that the more common ID without anemia may also adversely affect long-term neurodevelopment and behavior and that some of these effects may be irreversible." • ID remains relatively common and occurs in 6.6% to 15.2% of toddlers, depending on ethnicity and socioeconomic status. • We suggest to be more specific with the factors of risk, eg specify which races and ethnicities; low socio-economic status?; what age is early introduction of cow milk; how long is prolonged exclusive breastfeeding or prolonged bottle feeding
	Iron-rich foods	• In the first paragraph under Iron–rich foods, there is direction as the frequency of times iron rich foods should be offered at different ages. There is no reference listed here. • Suggest to either list a reference or indicate that is expert opinion.
	Cow milk introduction Offering cow milk in an open cup can help avoid excess consumption	• Provide hyperlink to the discussion of type of milk (whole, 2%) in the in practice section in this section. • It needs to be clear that if milk is introduced between 9-12 months that it should be whole milk (3.25%)
	Iron deficiency	• In the section that lists brief questions to help identify infants – clarify what the parameters are for each question. What response would indicate risk of iron deficiency?
Foods offered to infants and young children must be prepared, served and stored safely.	…Counsel to avoid products containing raw or undercooked eggs, meat, poultry, or fish.	• Would suggest to also avoid raw (unpasteurized) milk • Possible reference for rationale for avoiding: Ontario Agency for Health Protection and Promotion (Public Health Ontario). PHO technical report: Update on raw milk consumption and public health: A scientific review for Ontario public health professionals. Toronto, ON: Queen's Printer for Ontario; 2013 • Consider linking to Health Canada document on raw milk: http://healthycanadians.gc.ca/eating-nutrition/safety-salubrite/raw-milk-lait-cru-eng.php

Principles and recommendations	Sub Statements and Rationale	Comment
Young children can begin to have regular meals and snacks based on Canada's Food Guide.		• See comments under the Responsive Feeding Principle regarding breastfeeding on cue (specifically between meals and snacks) after 12 months of age
	Variety To prevent nutrient deficiencies, parents and caregivers should offer a variety of foods daily from the four food groups in Canada's Food Guide. Most young children, if offered a varied diet from each of the food groups, will consume adequate amounts of nutrients and energy (Steyn, Nel, Nantel, Kennedy, & Labadarios, 2006). If they are not offered foods from all food groups on a regular basis, it is not possible for young children to self-select a nutritionally adequate diet. No single food, even if it is perceived as healthy and nutritious, should be consumed to excess (Bondi & Lieuw, 2009; Skinner, Ziegler, & Ponza, 2004). Based on the estimated average breastmilk intake in the second year (WHO, 1998), **nearly two thirds of a young child's energy requirements are provided by complementary foods (WHO, 2009; PAHO, 2003).** Frequent, nutrient-dense meals and snacks are important to meet a young child's nutrient and energy needs. Encourage parents and caregivers to offer young children two to four meals per day and	• Suggest renaming 'variety' section to "Using Canada's Food Guide to Ensure Variety." • Regarding the statement: "Encourage parents and caregivers to offer young children two to four meals per day and one to two small snacks" (WHO)." See our comments under the Complementary Feeding Begins with Offering Nutritious Family Foods principle • The Food Guide serving numbers need to be clear that these servings are **Canada's Food Guide servings**, ie, 4 **Food Guide servings** of vegetables and fruit; 3 **Food Guide servings** of Grain Products • Add notation regarding portion sizes for infants and young children are different from full Food Guide servings. Use language similar to the Food Guide such as: • One Food Guide Serving from a food group can be divided up into smaller amounts of food and served throughout the day (at meals and snacks) Reference: Canada's Food Guide, A Resource Guide for Educators and Communicators

Principles and recommendations	Sub Statements and Rationale	Comment
	one to two small snacks (WHO, 2007). Over the course of the second year, parents and caregivers should work up to offering the amounts and types of foods recommended at two years of age in Canada's Food Guide. This entails: 4 servings of vegetables and fruit 3 servings of grain products 2 servings of milk and alternatives 1 serving of meat and alternatives.	
	Limiting added sugar and salt (section) Added sugar and salt should be avoided when preparing food for infants and young children. Plain foods, prepared simply, allow young children to experience food's natural flavours	• "Added sugar and salt should be avoided". In other parts of draft, state "not too salty" and "little or no…". Choose one way of saying it • Recommend using the phrase: "little to no additional salt or sugar" • We recommend that the second sentence be changed to read: "foods prepared simply, allow young children to experience food's natural flavour". The use of the word 'plain' is ambiguous, therefore we suggest it be removed
	Fruit juices and sweetened beverages Fruits and vegetables should be emphasised instead of juice as recommended in Canada's Food Guide. Fruit juice lacks the fibre of whole fruit. Because of the fructose and sorbitol content of fruit juices, excessive intake may lead to diarrhea (AAP, 2001). In addition, fruit juice intake can displace intake of breastmilk and it may contribute to inadequate intakes of needed nutrients. Parents and caregivers should delay	• We recommend that the first two paragraphs be removed (or at least rewritten). Considering the methodological flaws in food recall and in particular, the ability of parents to accurately identifying the difference between fruit juice and fruit drink, the paragraph should be removed or rewritten to give a better context of the issue. • In third paragraph – fruit juice intake can displace intake of breastmilk – we strongly suggest adding that it may also displace other milks (e.g. cow milk in young children) and solid foods • In 4th paragraph: the document states to delay juice until able to drink from an open cup, but throughout the document, an open cup is recommended from 6 months of age. • Recommend including the statement: Advise parents that there is no nutritional reason that fruit juice has to be offered. Whole fruits and vegetables will provide the necessary vitamins and minerals. • Add the following statement: If juice is offered, suggest limiting daily

Principles and recommendations	Sub Statements and Rationale	Comment
	offering juice until an infant is able to drink from an open cup. Only 100% fruit or vegetable juice should be offered. If offered, intake should be limited to no more than one or two offerings per day. Based on infants energy needs, approximate daily amount could be 125-175 ml/d (AAP, 2001)	juice intake to 125-175 mL of 100% fruit juice. This should replace the wording "approximate daily amount could be…" this implies that juice should be included.
Recommendations on the use of breastmilk substitutes	Infant formula until nine to 12 months Follow up formulas are breastmilk substitutes designed for infants six to 12 months of age, when an infant is eating solid foods.	• Follow up formulas are designed and marketed to be from 6 months and up (e.g. 6-18 months), not 6-12 months of age as stated in the draft document (*reference: in-person visit to formula section of store and google image search of images of follow up formulas available in Canada*)
	Formula after one year of age For a child who is not breastfed, 500 mL (2 cups) of cow milk should be offered daily as part of meals and snacks	• Second paragraph at the end. Add to the statement "For a child who is not breastfed, 500 mL (2 cups) of cow milk should be offered daily as part of meals and snacks" - A child who is breastfed can be offered milk in smaller quantities
	• Vegetarian beverages	• This statement contradicts the statement on page 26 (in practice section) • Please see our comments regarding cow milk introduction, lower fat cow milk and soy beverages in the general comment section of our response
	Avoid prolonged bottle feeding The transition from bottle feeding to open cup feeding should occur no later than 18 months of age (IOM, 2011).	• There is a contradiction of messages on when to stop using the bottle in this document. In this section, it states 'transition from bottle feeding to open cup should occur no later than 18 moths of age", however in the responsive feeding principle, open cup section, the document states that " prolonged bottle feeding beyond 12-14 months of age is associated with the consumption of excess calories and an increased risk of obesity. Also under the recommendations for breast milk substitutes, the document suggestions weaning from the bottle should occur at the beginning of the second year.

Principles and recommendations	Sub Statements and Rationale	Comment
		• We recognize the limited evidence base for making a specific age recommendation, but do suggest being consistent with the wording for weaning from a bottle needs to be consistent throughout the document. • Gooze RA, Anderson SA, Prolonged Bottle Use and Obesity at 5.5 years J Pediatr 2011.
What supports are important for women to continue breastfeeding after returning to the workplace or school?		• This section is not practical information other than the last paragraph. The content in this section does not match the topic. It is not practical information for talking to families. • Would suggest more emphasis on the practical aspects of 'how' a mom can successfully continue to breastfeed after returning to work (e.g. breastfeeding in the before work, after work and before bed). Would suggest getting further input from lactation experts for wording on this.
Pages 26 At what age can children transition from whole milk to low fat milk (such as skim, 1% or 2% cow milk)?	It is suitable to offer full-fat, fortified soy-based beverage at one year of age, as long as the child is growing normally and consuming a variety of foods, including breastmilk or cow milk (Dunham & Kollar, 2006). However, non-fat varieties should be avoided along with flavoured soy-based beverages (such as chocolate and vanilla), which contain added sugar.	• See recommendations for this section and for the introduction of cow milk and soy beverages under the general comments section of our response • There needs to be a link to this section from the Iron Rich Complementary Foods Help Prevent Iron Deficiency principle
Page 26-27 What advice can be given to parents on introducing new foods if they have concerns about food allergies?	Every couple of days, an infant can be introduced to a new food.	• This statement should be clearer. The word 'couple' is not clear enough. • Suggest to say "Every two days, an infant can be introduced to a new food." There is no strong evidence base to support waiting a particular number of days, but there needs to be a level of consistency between recommendations made by health care professionals to parents. • Would recommend including the statement that the timing recommendation/guidance is based on expert opinion. See article for statement on timing: Fliescher DM et al. Primary Prevention of Allergic Disease Through Nutritional Interventions. J Allergy Clin Immunol: In Practice 2013;1:29-36). Although note that this article references the Pediatric Nutrition handbook for the statement on timing of introduction

Principles and recommendations	Sub Statements and Rationale	Comment
		to solids. • There is no information with the newer information around food allergies – what makes a child at higher risk, what are the recommendation for these children. Would consider including this information (reference NIH/NIAID position paper of the prevention and management of food allergies, 2011). • List common food allergens (Heath Canada priority 9) should be included • There is a hyperlink to "texture". This doesn't really belong in this section. Also the hyperlink goes to choking section
What guidance can be given for feeding a 'picky eater'?		• The hyperlink for this discussion of picky eaters goes to responsive feeding section. The division of roles and responsibility section on p. 9 is more relevant for picky eaters • Please also see suggestion for In Practice question regarding offering new foods, previously suggested in the Division of Roles and Responsibility section
What is the advice on vitamin D for children 1 year and older?	For young children, 12 months of age and older, encourage parents and caregivers to offer children vitamin D-rich foods, including cow milk, each day.	• Please see our recommendation for having a principle related to vitamin D in the general comment section of our response. • In the practice section, we would encourage a question around how long to continue the vitamin D supplement and clarity for practitioners to share messaging with parents (as discussed in the general comment section of our response)
Are there children who should continue with a vitamin D supplement after the first year?		• See comments regarding vitamin D in the general comment section at the beginning of our response

Principles and recommendations	**Sub Statements and Rationale**	**Comment**
At what age should parents and caregivers offer other liquids to a breastfed child?		• Mention that there is no nutritional need to offer juice as previously discussed under Canada's Food Guide section • The last paragraph on artificial sweeteners is good info but the may get lost under this section on other liquids if a reader wants to know about "foods" with artificial sweeteners • Use more examples to illustrate what is included in artificial sweeteners
What you can offer: Sample menus for families with older infants and young children	Important tips	• The tips either need to be inclusive of all age categories OR there needs to be important tips before each sample meal plan. In its current state – the important tips are appropriate for the 7 month old, but not for the 11 or 17 month old. • For example – following your infant's cures for decide WHEN to feed him or her is appropriate for the 7 month old, but as per the Division of Responsibility, as the infant grows older, the parent begins to take on the role of when to feed by beginning to provide some structure for older infants as they make the transition to family foods. At about one year, parents should be encouraged to offer meals and snacks every 2 to 3 hours. That way a child will be hungry and interested in eating, See division of responsibility for infants, older infants and toddlers below. (Note, the infant or child at any age is responsible for *how much* and *whether):* T**he division of responsibility for <u>infants:</u>** • The parent is responsible for *what* • The child is responsible for *how much* (and everything else) **The division of responsibility for <u>older babies</u> making the transition to family food:** • The parent is still responsible for *what*, and is *becoming* responsible for *when* and *where* the child is fed. • The child is *still* and *always* responsible for *how much* and *whether to* eat the foods offered by the parent. **The division of responsibility for <u>toddlers</u>:** • The parent is responsible for *what, when, where* • The child is responsible for *how much* and *whether*

Principles and recommendations	Sub Statements and Rationale	Comment
		• http://www.ellynsatter.com/ellyn-satters-division-of-responsibility-in-feeding-i-80.html • Question why is that that if it doesn't matter whether or one offers breastmilk before or after food does the 7 and 11 month sample menus (<12 months) always have breastmilk first on the list and the 17 month sample menu (>12 months) have breastmilk as the last item on the list of foods. This does not provide a consistent message, but implies that breastmilk should always be offered first.
	Sample menus	Add to the important tips for families: • Starting at about one year, offer 3-4 foods from the food groups at each meal and 2 or more foods from the food groups at each snack • The sample menus include iron-fortified infant cereal but infant cereal isn't mentioned anywhere in the document • For 17 month menu, specify 3.25% milk • For 17 month menu, don't need to include "from a cup" because this is a menu, and as such, only needs to list the food • For 17 month menu, should we have a footnote to say if child's source of milk is breastmilk, they may need a vitamin D supplement/drop • For 17 month menu – if the assumption is that wild blueberries are thawed – should specify that they are frozen. May be more simple and clear to read just to pick one type of berry