Response to Nutrition For Healthy Term Infants - Birth to Six Months
Draft 2, March 2012

Submitted by:
Ontario Society for Nutrition Professionals in Public Health (OSNPPH) – Family Health Nutrition Advisory Group

General comments:

- Many improvements from the last statement. We appreciate the separate section on formula feeding.
- Overall recommendations are clearer and streamlined.
- There is inconsistency regarding how the evidence used to support statement in the document is described; strength of the evidence should be provided and only certain types of research evidence should be recognized throughout.
- Like the "In Practice" section. Relevant information and good advice, although in places needs additional information and/or discussion to support health care professionals to adequately and appropriately support parents who are not breastfeeding.
- We are hopeful that Health Canada will communicate their dissemination plan for this document.

Location	Statement in NHTI Draft	Comment
Page 1 - Principles and recommendations for infant nutrition from birth to six months	Recommend exclusive breastfeeding for about the first six months of life with the introduction of complementary foods being led by the infant's signs of readiness.	• We agree with the inclusion of the signs of readiness as important information to use when deciding when to introduce complementary foods • We have concern with using the term 'about' regarding when to introduce complementary foods is too vague and can be interpreted differently by health care professionals. • There is not a 'one size fits all' answer to when to introduce complementary food. • We are concerned that complementary foods can be introduced too early and consequently interrupt exclusive breastfeeding, or that the introduction of complementary foods may be delayed past six months and consequently increase concern regarding iron stores and feeding issues.

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		• We recommend including a fulsome discussion of the evidence looking at the health outcomes of infants/children who were introduced to complementary foods at different ages (e.g. earlier than recommended, later than recommended, at the recommended age) . This would add to the understanding of the recommendations and the more consistent application of these population-based health recommendations. • If the term 'about' is to remain as part of the guideline – we recommend additional discussion regarding the parameters of 'about'. • Another option may to recommend **introducing complementary foods "at 6 months" with the explanation that in some situations baby may show signs of readiness it may be appropriate to start earlier.** • The currently proposed wording is inconsistent with the World Health Organization, Canadian Pediatric Society, Dietitians of Canada and the Breastfeeding Committee of Canada. As CPS, DC and BCC are member organizations of the NHTI are they going to change their statements?
Page 1 - Principles and recommendations for infant nutrition from birth to six months	Supplemental vitamin D is recommended for breastfed infants.	• Please refer to our comments on vitamin D in "In Practice: Talking to families about infant nutrition". • Potentially reword: All babies in Canada require adequate supplemental vitamin D.
Page 2 - Principles and recommendations for infant nutrition from birth to six months	Recommendations on the use of breastmilk substitutes Some infants may not be exclusively breastfed for personal, medical, or social reasons. Their families need support to optimize the infant's nutritional well-being. The International Code of Marketing of Breast-milk Substitutes (WHO, 1981) advises health professionals to inform parents about the importance of breastfeeding, the personal, social, and economic costs of formula feeding, and the	• This statement does not recognize non-traditional families (e.g. same sex partners) and/or babies conceived and carried using 'non-traditional' (e.g., surrogacy) methods. Would suggest including a comment that health care professionals who counsel non-traditional families where breastfeeding may not be a viable or realistic option be sensitive and supportive when discussing feeding methods.

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	difficulty of reversing the decision not to breastfeed. Individually counsel those families who have made a fully informed choice not to breastfeed on the use of breastmilk substitutes.	
Page 3 - Breastfeeding is the normal and unequalled method of feeding infants – Rationale	With exclusive breastfeeding, an infant is fed only breastmilk. The infant is given no other or liquid, not even water. Infants who are exclusively breastfed **may** still receive vitamin and mineral supplements or medicines, in the form of drops or syrups….	• The statement should read: • With exclusive breastfeeding, an infant is fed only breastmilk. The infant is given no other or liquid, not even water. Infants who are exclusively breastfed **should receive a vitamin D supplement and may receive** vitamin and mineral supplements or medicines, in the form of drops or syrups….
Page 3 - Breastfeeding is the normal and unequalled method of feeding infants	Recommend exclusive breastfeeding for about the first six months of life with the introduction of complementary foods being led by the infant's signs of readiness	• Need to clarify terminology "by about" regarding the timing of introduction of solid foods as per earlier discussion. • We are pleased to see the inclusion of 'signs of readiness' to the feeding recommendations
Page 3 - Breastfeeding is the normal and unequalled method of feeding infants - Rationale	3rd paragraph – "Observational research also points to the protective effect of breastfeeding against obesity later in life"	• The implication of this statement is that breastfeeding alone can prevent obesity or that formula fed infants will inevitably be overweight, which is simply not the case; the evidence is inconclusive and inconsistent. Observational research – the evidence is not clear or conclusive; we do not believe that accepting "observational" as reliable evidence in such a document (or without a fulsome discussion of the literature). o Further - Is it something in the breast milk? Does this relationship have to do with the breastfeeding environment/emotional factors? How much and how long does a mom have to breastfeed in order for this statement to be accurate? o There are too many complicated factors to make a strong statement such as this without providing the evidence. • It is recommended that this statement should be taken out, when there is stronger research to support this comment it can be added back in.

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Page 3: Breastfeeding is the normal and unequalled method of feeding infants - Rationale	3rd paragraph "For example, breastfeeding is associated with…."	• Recommend qualifier words be added to the sentence containing "breastfeeding is associated with…". o Mention health outcomes associated with strong associations from strong methodological studies. o Moderate associations should be listed separately. o Weak associations should not be mentioned at all. • Agree with how evidence from observational studies are listed separately already.
Page 3 - Breastfeeding is the normal and unequalled method of feeding infants	Exclusive breastfeeding to six months of age is associated with continued protection against gastrointestinal infections and illness (Kramer et al., 2003; Kramer & Kakuma, 2002) as well as from respiratory tract infections (Chantry, Howard, & Auinger, 2006). The breastfeeding mother also benefits from exclusively breastfeeding her infant to six months. Her weight loss is more rapid after birth and there may be a delayed return of menses (Kramer & Kakuma, 2002).	• In the first sentence, clarify that continued protection against gastrointestinal infections and illness is for the infant • Maternal health benefits of breastfeeding needs to be more fully explained. For example – what is the health benefit of a delay in menses? The discussion should reflect the health benefit and the evidence that supports the statement(e.g. iron stores). • Good description of the signs of physiological and developmental readiness of the infant.
Page 3 - Breastfeeding is the normal and unequalled method of feeding infants	By about six months of age, infants are developmentally ready for other foods (Naylor & Morrow, 2001). The signs of physiological and developmental readiness include:	See earlier comment regarding the use of the term 'about'.
Page 6 – Breastfeeding initiation and duration rates increase with active protection, support	General Comment under *Rationale*:	• Please add information about the common reasons why women do not achieve the recommended 6 month duration time frame.
Page 6 – Breastfeeding initiation and duration rates increase with active	"That is why mothers require greater support to breastfed exclusively for the first six months, and to continue breastfeeding	• The implication from this statement is that only greater support will lead to longer breastfeeding when it is obviously more than that • Recommend to clarify what exactly is meant by 'support' Regarding

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protection, support	for up to two years or long"	the wording: …. Mothers and their partners and families require greater education and support pre and postnatal to breastfeed exclusively for the first six months…
Page 6 – Breastfeeding initiation and duration rates increase with active protection, support and promotion	Rationale – last paragraph, last sentence "Implementation of the BFI is led by provincial and territorial governments in collaboration with the Breastfeeding Committee for Canada"	• Please include role of municipal or regional governments to the implementation of BFI.
Page 8 – Summary of the International Code of Marketing of Breastmilk Substitutes and relevant World Health Assembly resolutions	Last bullet under Summary of the Code: "Unsuitable products, such as sweetened condensed milk, should not be promoted for babies."	Recommend the inclusion of "evaporated milk" as well since this is a term/product more common in Canada.
Page 8: Under WHA Resolution 39.28 (1986)	Last sentence in this paragraph: "The practice being introduced in some countries of providing infants with specialty formulated milks (so-called follow-up milks) is not necessary"	• Recommend removing the sentence "The practice being introduced in some countries of providing infants with specialty formulated milks (so-called follow-up milks) is not necessary." • This sentence should be worded to reflect the Canadian context as this is a Canadian policy document. • Direction regarding *specialty formulas* should be in the infant formula section • Would be helpful to give a practice example of how the WHO Code is applied in community settings.
Page 9: Under WHA Resolution 54.2 (2001)	General Comment	• This is work that needs to be implemented at the federal level. Please either state what group/department is working on this or if action is being requested of health care professionals, this should be clear. o Is NHTI asking health professionals to lobby our members of parliament to create legislation to follow the CODE? o As written and in the context of the NHTI, as individual health care providers and/or health care agencies, we cannot comply with the resolution as written.
Page 10 – Supplemental	Supplemental Vitamin D is recommended for	• Refer to our comments on vitamin D in "In Practice: Talking to families

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Vitamin D is recommended for breastfed infants	breastfed infants – overall comments	about infant nutrition" regarding overall comments about the vitamin D recommendation. Overall, we feel that this section lacks the background information and rationale regarding vitamin D requirements for all babies living in Canada. • In addition, the following comments refer to the statement as it is currently written: • Strongly recommend adding "**from birth**" to the overall key message that currently states: Recommend a daily vitamin D supplement of 10 µg (400 IU) to breastfed infants o This policy statements needs to be very clear about the expectation that vitamin D supplementation is recommended ***to start at birth***. o Any attempt to be vague about this recommendation will not improve supplementation rates and may decrease if the key message does not provide clear direction. • Please add further information about what levels of vitamin D have been associated with the development of rickets (e.g. infants consuming 50 IU per day, 100 IU per day etc.). If there are research gaps in this information, please state. • Please comment about why we are not concerned about the vitamin D level/status maternally and subsequent possible stores in the infant at birth. Recent data from the Canadian Health Measures Survey reports only 3% of women ages 6-79 are vitamin D deficient. (see: http://www.statcan.gc.ca/pub/82-003-x/82-003-x2010001-eng.htm). • It has been argued in the past that vitamin D supplementation is not required because women at preconception and/or pregnancy may be sufficient in vitamin D and the infant, in turn may also have adequate levels of vitamin D. May be helpful to comment as to why Canada's approach is different from other developed countries (e.g. United Kingdom - http://www.unicef.org.uk/BabyFriendly/News-and-Research/News/UNICEF-UK-Baby-Friendly-Initiative-Statement-on-vitamin-D-supplementation-for-breastfed-babies/)

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		• Recommend removing the reference to 1 year in the vitamin D statement. The age at which vitamin D should be discontinued should be addressed in the 6-24 month statement.
Page 10 – Supplemental Vitamin D is recommended for breastfed infants	Paragraph One - Without supplementation, an infant's vitamin D stores will be depleted"	• Clarify when Vitamin D stores might be depleted in the healthy full term infant, exclusively breastfed. Provide supportive evidence. • Clearly define what is meant by "partially breastfed infants" • Remove the third paragraph on page 10, The level of adequate…..as it is unnecessary
Page 10 4th paragraph	Although sunlight, which stimulates the formation of vitamin D in the skin, is the primary sources of vitamin D for humans, current practice advises that infants under one year avoid direct sunlight due to the risk of skin cancer (Health Canada, 2006)	• Recommend mentioning that the use of sunscreen is not recommended for the first 6 months of life since sun exposure is highlighted.
Page 12 - First complementary foods should be iron-rich	Entire section and including page 1 where this topic is mentioned as well.	• Suggest consistent use of either 'iron-rich' or 'iron-containing' but not both. • Signs of readiness for solids should be included in this section in addition to (or in place of) its inclusion in the first principle (on page 3) • Suggest adding a statement that a more complete discussion for the first complementary foods will be found in the 6-24 month document. • Meat alternatives is unclear, list as eggs and legumes and this should be done throughout the document • Consider including some information on "baby led weaning" either in the "In practice" section or under this principle. • Include information re: concepts/practices, concerns with this practice and if it is recommended. This is an increasing trend and practice among parents. For more information: http://bmjopen.bmj.com/content/2/1/e000298.full.html#ref-list-1
Page 14 - Routine growth monitoring is important for assessing infant health	General Comments	• In this section (or in the practice section), recommend making reference and explaining the value of the Dietitians of Canada WHO Growth Chart Training Program. http://www.dietitians.ca/Knowledge-

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and nutrition		Center/Events-and-Learning/Online-Courses/WHO-Growth-Chart-Training.aspx • Recommend to include a statement regarding the importance of interpreting and communicating growth information to parents in the most appropriate way. A child's growth is often a sensitive issue for parents – must ensure discussion is conveyed in a way that is helpful, not harmful and doesn't lead parents to engage in behaviours to control their infant's weight using unhealthy means. For example – "the growth pattern shows that your infant's has low weight for their height, have you noticed any changes recently? There are ways to help her gain weight – we can talk about some options if that is alright with you."
Pages 15-17 Feeding changes are unnecessary for most common health conditions in infancy	General Comments	Everything addressed in this section is GI related. The title needs to be changed to "Feeding changes are unnecessary for GI health conditions in infancy"
Page 16 – Infantile Colic (from page 15)		• Recommend defining "severe colic" • Suggest removing "(rarely) cow milk allergy". It is an allergy and should not be under this section, it is not evidence based, very rare and by including it, you are supporting a myth • Removing lactose from the diet will lead to issues with underproduction of lactase later in life.
Page 16 - Constipation		• Entire section lacks advice on what to do if an infant is constipated There is a good explanation of what normal bowel movements are but no explanation of what constipation is (i.e., hard, small dry bowel movements, with or without the presence of blood) • Would suggest to include some suggestions on what to advise parents of their infant is constipated even if all that is included is that they should be referred to their physician
Page 16: Constipation	"Reassure the caregiver that bowel function is within normal variants if the infant is growing normally and there are no signs of obstruction or enterocolitis".	• This statement appears to be directed towards physicians. • Recommend adding a similar statement for other non-physician health care providers to refer families to physicians so they can be assessed for the above medical conditions.

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Page 16 – Acute Gastroenteritis		• Suggest addressing the use of juices or homemade oral rehydration therapies • Recommend defining "minimal to moderate dehydration" and "severe dehydration" • Include statement to continue to breastfeed during rehydration therapy • Consider providing guidelines/indications for the use of oral rehydration therapy and the amount and duration of this therapy.
Page 19 - Breastfeeding is rarely contraindicated	Galactosemia is one of only a few rare instances when an infant cannot tolerate breastmilk (WHO/UNICEF, 2009a).	• Would suggest if there are only a few rare instances, to list them all.
Page 19 - Breastfeeding is rarely contraindicated	2nd bullet "Advise that most medications are compatible with breastfeeding. Take a case-by-case approach when a mother is using medications or drugs."	• Suggest considering adding natural health products to the 2nd bullet to read: • "Advise that most medications are compatible with breastfeeding. Take a case-by-case approach when a mother is using medications, **natural health products** or drugs." • Suggest that NHPs have its own section, rather than embedded in the Medications and Illicit Drugs section. Or include information in the Medications section and create a separate section for Illicit Drugs
Page 20 - Medications and illicit drugs	Natural health products (NHP) and herbal remedies may contain pharmacologically active substances. They should be used with caution by breastfeeding mothers. Refer to Health Canada's NHP Monograph for guidance on specific substances.	• Would suggest to list any known NHPs or herbal remedies that are contraindicated during lactation. • Would suggest to include some information on the effectiveness of NHPs and herbal remedies on breastmilk production • Recommend to consider listing specific examples of over the counter medications that affect milk supply in first paragraph, even though Motherisk is referenced. • Should include alcohol and marijuana use during pregnancy and prenatally • Reference Motherrisk for more information on the transfer of alcohol and illicit drugs including marijuana

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		• Should add information about pumping (and dumping) to maintain milk supply while mothers are receiving unsafe medications or therapies
Page 22 – Recommendations on the use of breastmilk substitutes	First 4 paragraphs	• Expressed breastmilk from the mother is not a 'breastmilk substitute'. • Pasteurized human milk from appropriately screened donors is also breastmilk and is not a breastmilk substitute • There should either be a separate section or sub-section (with a new title) that specifically discussed expressed breastmilk. This section could include specifics about expressing breastmilk, food safety (e.g. sterilizing of feeding equipment and storing and warming expressed breastmilk) and a discussion on safety when feeding from a bottle (similar to the discussion on page 27 - Supervision of a feeding infant). • Overall, we are pleased to see the inclusion of expressed breastmilk discussed that is not specific to temporary separation of mother and child.
Page 22: Recommendations on the use of breastmilk substitutes	3rd paragraph – human donor milk	• Recommend the reference to human donor milk be removed. • While it is acknowledged that access to human milk banks is limited in Canada that sick or hospitalized infants have the highest priority to receive this milk, the mention of human milk banks for Healthy Term Infants in Canada is of little use for health care providers. • An unintended consequence of this paragraph may be the increased use of non-pasteurized, non-screened sources by mothers as currently popularized in the media and through social media sites. This is a potential risk. Alternatively, consider including a statement about unregulated breastmilk substitutes such as, "human milk available from unregulated sources is not recommended due to increased risk of…." . Provide clear rationale.
Page 22 – Recommendations on the use of breastmilk substitutes	Discourage the use of home-made, evaporated milk formula. Cow milk, goat milk, soy beverage, rice beverage or any other beverages should not be given to young infants.	• Suggest to remove the words 'to young infants' as this document is referring to infants 0-6 months.

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Page 22 – Background	2nd paragraph "Infant formulas may contain a number of nutritive substances, such as nucleotides…'	• Recommend providing examples of "nucleotides". • Is the document specifically referring to DHA enriched infant formulas?
Page 23 – Iron in formula	Currently, there are cow milk-based formulas on the market for term infants with lower iron levels, containing about 0.4 mg of iron per 100 mL. There are others with higher levels of about 1.2 mg per 100 mL. The lower iron formulas should provide sufficient iron for the healthy, term infant (ESPGHAN, 2005). The higher-iron formulas may need to be recommended for infants at risk of iron deficiency.	• Current 'standard' formula contain 1.2 mg iron per 100 ml prepared. These guidelines are recommending the 'lower-iron" formulas – what is the rationale from moving away from current practice in light of the following?: o Iron deficiencies in infancy may have serious and irreversible effects (as indicated on page 12) and the importance of iron-rich foods as first food are emphasized in this draft document, would suggest reconsidering this position on lower iron-containing formulas o The safety of iron fortified formulas (1.2 mg per 100 mL) has been established. (Baker, R.D., Greer, F.R. et al. *Clinical Report – Diagnosis and Prevention of Iron Deficiency and Iron Deficiency Anemia in Infants and Young Children (0-3 Years of Age)*. Pediatrics (American Academy of Pediatrics), October, 2010.) o a number of maternal conditions (anemia, maternal hypertension with intrauterine growth restriction, diabetes) , low socio-economic status may (or likely) result in low fetal iron stores in term infants • This draft states that "lower iron formulas <u>should</u> provide sufficient iron for the healthy, term infant". The word "should" does not provide clear guidance for a recommendation. For such a significant change in practice, it is also surprising that there is only one reference (ESPGHAN, 2005). What other references support this recommendation? • If this statement remains, please include a more complete evidence summary and comment on whether or not the use of 1.2 mg iron should be discouraged or contraindicated for infants not at risk of iron deficiency.
Page 23 – Formula based on partially hydrolyzed	3rd paragraph	• Recommend providing a hyperlink for a definition of infants at risk for atopy as was done for risk for iron deficiency in this section.

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cow milk protein		
Page 24 – Thickened infant formula	Entire section	• There is guidance when not to use thickened formulas but no guidance on when to use them – suggest including this information, or if no evidence to use these formulas for healthy infants, this should be stated. • Concern that parents utilize these 'specialty' formulas available at retail without clear medical need or guidance.
Page 24 - Essential fatty acids in formulas:	3rd paragraph "The addition of the fatty acids DHA and ARA to infant formula is not currently mandatory in Canada."	• Recommend removing the first sentence in this paragraph. • Second sentence should say: "Evidence is inconclusive on the benefit of including DHA and ARA in formula for any health related outcome for healthy term infants."
Page 24 - Live micoroorganisms (probiotics)	Last sentence in this paragraph	• Suggest replacing "equivocal" with "uncertain" for clarity.
Page 25 - Soy Based Formulas	First paragraph	• Recommend defining the term "non-IgE-mediated cow milk protein allergy"
Page 25 – Formulas for special medical purposes	Formulas for preterm infants on discharge from hospital may be available at the retail level. Advise parents that they are not appropriate for healthy term infants.	Add: Parents whose babies are discharged from hospital on specialized formulas such as preterm formulations should received adequate follow up to determine when/if baby can switch to alternative feeding method (e.g. exclusive breastfeeding where applicable, standard formulas)
Page 26 – Other milks	Cow milk and other animal milks, including goat milk, are not appropriate alternatives to breastmilk for young infants (WHO, 2009).	• Suggest removing the words 'for young infants'. Second paragraph: Not able to locate mention of occult blood loss in stool in the WHO 2009 reference. Please provide additional reference supporting this point.
Page 26 – Safe preparation and storage	Sterilization of all infant feeding equipment is recommended for the first four months, or as per the equipment manufacturer's instructions.	• This section requires more definitive direction on how long to sterilize equipment. Please state either an age or some sort of parameters • To provide a consistent and accurate message to the public, this information should come from Health Canada and not information supplied by industry. • Would suggest to add a statement that this is for all forms of infant formula (if this is not the case, please specify)

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		• Recommend adding that bottles, nipples etc used for pumped breastmilk for infants under 4 months also need to be sterilized. This information is buried in the infant formula section.
Page 26 Safe Preparation and Storage	Second bullet	• Use consistent language: recommend using the wording "bring water to a rolling boil" to keep consistent with wording in other Health Canada formula preparation guidelines. This would also be consistent with wording on page 27 under "Water".
Page 26 – Liquid formula	Ready-to-feed infant formula is the safest choice for higher-risk infants who are formula fed, including low birth weight and immuno-compromised infants.	• At-risk infants needs to be better defined - rather than stating 'including low-birth weight and immuno-compromised infants' (unless this is the complete list) • Please be more specific in the detail added for liquid concentrate. Add temperature information for the water. Add length of time equipment needs to be sterilized (eg. Until 4 months of age).
Page 26 – Liquid formula	• Although the liquid formula is sterile, parents and caregivers should follow the manufacturer's directions for preparation and avoid cross-contamination. • Liquid concentrate infant formula must be prepared by adding water according to manufacturer's directions.	• Please provide clear guidance on preparation steps rather than referring to manufacturer's instructions.
Page 27 – Powdered formula	General Comments	This section is quite confusing. Suggest that the document needs to be very clear what the recommendation is for healthy term infants vs. at risk infants. • How long is sterilization of equipment necessary? • Does the 70°C temperature apply to full term infants using PIF? • How long does it apply for at risk infants?
Page 27 – Powdered formula	If liquid formula is not available, powdered infant formula can be used if it is properly prepared.	• Is NHTI suggesting that liquid formula be used over powdered formula and that only if liquid formula not available, use powdered formula? If not, please clarify this statement • Add "and accessible" after 'available' in the statement. This is to

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		address the issue of increased cost between liquid and powdered formula.
Page 27 – Powdered formula	If the powdered formula will be fed immediately after preparation, it is safe to mix the powder with previously boiled water that has been cooled to room temperature (Health Canada, 2010c).	• Clarify that this guideline applies <u>regardless of the age of the infant</u>
Page 27 – Powdered formula	If they are preparing more than one bottle in advance, advise them to follow the guidelines for Preparation, Storage and Handling of Powdered Infant Formula (Health Canada, 2010c).	• Would suggest including the preparation steps in this document so that one doesn't need to refer to other documents. There is confusion on the Health Canada website as it refers to the WHO guidelines and they have a very different definition on infants at risk. Referring to an outside document on preparation steps is not helpful. • Would suggest to add comment regarding boiled water and how it can be left at room temperature for no longer than 30 minutes to ensure proper temperature when mixing with powdered formula.
Page 27 - Water	Entire section	• Recommend rewording first sentence. Municipal tap water is suitable for preparing powdered or concentrated infant formula. Commercially bottled water is an acceptable alternative (except carbonated or mineral water). o Rationale: while bottled water may be considered as 'safe' as municipal tap water by most public health officials, the added cost of bottled water to the consumer and the environment does not make it equivalent to municipal tap water. • Explain the issue with using distilled water. • Suggest including a statement on the use of commercial sterile, distilled, bottled 'baby water'. This is being sold in stores and is creating confusion to parents. Please address this product, its safety and use • There is a typo in the third paragraph in the water section, first section. Delete the word "for". • Include information on softened water use
Page 27 – Supervision of a	Breastfeeding allows close, skin-to-skin	• Change to "All infant feeding should allow close, skin-to-skin contact

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feeding infant	contact and constant attention to infants…"	and constant attention to infants…" • More information is needed on weaning from a bottle (if not here, in 6-24 month document)
Page 27 – Supervision of a feeding infant	The last statement "Also, the risk of feeding difficulties increases with prolonged use of a bottle as a pacifier"	• Vague as currently written and requires further discussion and definition of 'feeding difficulties' and 'prolonged use'. This also requires a reference.
Page 30 – In Practice Section	General Comments:	Additional Information to include: • Provide practice information for health care professionals who are asked by parents "which formula should I choose"? • Recommend including a statement on avoiding offering honey in the practice section, even though it may be mentioned in the 6-24 months statement.
Page 31 - What dietary advice can I offer a breastfeeding mother?	Day to day diet quality, however, does not affect milk production and has little effect on milk composition for most nutrients.	Additional information is required in this section. • The advice as stated in Canada's Food Guide should be included in this document. This would include the statement: o "women should continue to take a multivitamin containing folic acid while breastfeeding' • Would consider listing which nutrients are affected by maternal diet (e.g., omega-s fatty acids, vitamin D, trans fats) • Consider adding comment here that excess caffeine and methylmercury (e.g. from unsafe fish intake) can be passed on via breastmilk. • Include information regarding a mother's diet and impact on her infant's risk of developing allergies. Current research suggests that there isn't evidence to show that avoiding foods during lactation has an impact on an infant's risk of developing food allergies.
Page 30/31 – How can I reassure parents that an infant is nourished and growing well?	2nd paragraph - In the first two weeks, newborn experience normal weight decline and recovery."	• Concern that the wording of this is not clear. It suggests that continued weight loss of a newborn beyond day three is normal. Recommend re-wording to clarify. • Recommend adding information of how parents know a formula fed infant is growing well. This is the section of practical application – so

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		necessary to include this information to reflect the reality of many parents.
Page 31 - How can I use points of contact with expectant and new mothers to educate and support them to breastfeed?	"With prospective parents'	• Replace "Your" with "A health care professionals" • Consider adding statement that health care professionals need to be sensitive to the feeding challenges that non-traditional families may face and provide factual and practical advice in a sensitive manner. • Again, since this is the practice section - provide information on how to educate/discuss infant formula in a breastfeeding friendly way. • In real-life practice, health care providers are asked about infant formula on a daily basis. Parents will make their feeding choices and health care professionals must be able to address both in order to ensure that both feeding types to be conducted safely.
Page 32 - What advice should I offer on the texture of first foods	General comments	• Discuss pureed foods. • Add more detail on the types of infant cereal on the market. There is a need for practice advise on how to advise parents on this **iron- rich first food.** • Use the term infant cereal and include information about using homemade cereal (highlighting lack of iron if being used as a first food). • Consider using or adapting the phrase: "Both meat and iron fortified cereal were shown to have similar acceptability and tolerance"
Page 32 – Should parents be concerned about offering infants foods that are considered common allergens?		• Suggest adding more current references to support statement – specifically the NAID Allergy guidelines published in 2010.
Page 33 - Should parents be concerned about offering infants foods that are considered common allergens?	Exception: Health care providers should deal with cases where there is a family history of allergy on an individual basis.	Recent evidence suggests that even with a family history of allergies, avoidance of highly allergenic food is not indicated.
	Note: All nuts, as well as seeds, and fish with bones are chocking hazards and should	As currently written could be interpreted that these foods should not be offered. Although they aren't recommended as first foods because of

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	not be fed to infants.	texture, as infants get older there are age appropriate ways to introduce these foods. Reword to read: Note: all nuts, as well as seeds, fish with bones are choking hazards. Never feed whole nuts, seeds or fish with bones to a six month old infant. Instruct parents on age appropriate ways to introduce these foods to minimize risk.

Page 33 - Do infants under six months need iron supplements?	Since there is a potential for the development of iron deficiency in some healthy term infants born with lower iron stores….	• Again, this document is highlighting the importance of iron yet in the infant formula section, it is suggesting the 0.4 mg of iron per 100 mL infant formula is adequate.
		• We question the focus on iron supplementation in this section, when the draft NHTI previously mentions low iron infant formulas. What is the intent of the information in this section?
		• Recommend that the NHTI document offer practice recommendations on what health care providers should do with this at risk information. Are we recommending that all parents of breastfed infants in community settings be asked these screening questions for iron supplementation?
		  • Should all breastfed infants born less than 3000 should receive an iron supplement? What is the recommended dosage? Length of time?
		  • Regarding those infants born to iron deficient mothers – is this referring to only untreated iron deficient mothers? Does the infant's physician have this data? Is the recommendation that all breastfed infants born to iron deficient mothers receive an iron supplement? What is the recommended dosage? Length of time?
		  • Regarding the reference to mothers with diabetes – which form of diabetes? Type 1, type 2 and/or GDM? IS the recommendation that all breastfed infants born to mothers with any type of diabetes receive an iron supplement? What is the recommended dosage? Length of time?
		  • Same questions arise for alcohol intake.
		  • Is one risk factor sufficient to recommend iron supplementation or

Location	Statement in NHTI Draft	Comment
		is any 2, any 3 or do all 4 need to be present to recommend supplementation. • Consider including "early introduction of cow's milk and early introduction of solids prior to 4 months" as additional reasons infants might be at higher risk of iron deficiency.
Page 33 - What should parents look for when buying a vitamin D supplement?	Entire section	• Would suggesting that parents look for the correct dose of vitamin – include that parents should look for a supplement containing '400 IU of vitamin D' and caution on purchasing '1000 IU' versions (packaging may look similar). • Recommend including the chemical name of Vitamin D3 as well - Vitamin D3 = cholecalciferol and Vitamin D2 = ergocalciferol
Page 33 – Can breastfeeding mothers take a vitamin D supplement instead of giving it to the infant?		• Expand the rationale as to why maternal supplementation of vitamin D isn't currently recommended. This will provide health care professionals with more information to better discuss this issue with interested parents.
Page 34 - If infants are both breastfeeding and getting some formula, should they be given a vitamin D supplement?	Exclusively-formula fed infants do not require a vitamin D supplement because the formula contains vitamin D.	• All babies in Canada need vitamin D, bottle fed babies get it in the formula where breastfeed babies need to get Vitamin D externally • The recommendation, as written in the document could put infants who are exclusively formula at risk of inadequate vitamin D intake, based on the 2010 IOM vitamin D recommendations. • At the current levels of vitamin D added to standard formula, an infant would be required to consume 1000 mL of prepared formula per day to obtain 400 IU intake (the minimum recommended for breastfed babies). • The Adequate Intake (AI) for all babies from birth to one year is 400 IU vitamin D. (Institute of Medicine, 2010). This would suggest that the statement needs to be changed to all babies (this is not a breastfeeding baby issue only). • Many exclusively formula-fed babies never reach 1000 mL per day, or do not do so for long periods of time

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		• Most foods consumed by infants under 1 year of age (and in particular the 'first foods') most commonly recommended are not sources of vitamin D). • Suggest 3 possible approaches to vitamin D supplementation in infants (options 2 and 3 would be separate statements in addition to current breastfeeding and vitamin D statement). 1. All babies living in Canada should receive 400 IU of vitamin D daily (regardless if baby is being exclusively breastfed, partially breastfed or exclusively formula fed). 2. Formula fed babies should be given 400 IU vitamin D supplement daily until baby is consuming 1000 mL formula per day. 3. Formula fed babies should be given a vitamin D supplement on a sliding scale depending on how much formula is consumed (e.g. 400 IU every other day if drinking between 500-1000ml of formula per day).