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Guest Editorial

Baby-led weaning and current UK recommendations – are they compatible?

Young babies thrive and develop on a single source of nutrition in their early months – milk. Recent decades have seen a focus on breastfeeding in research, advocacy, policy and parental debate. However, the next step – introducing solid foods – has received relatively less attention. As understanding of the lifelong impact of early feeding practices increases, attention is moving to 'weaning'.

The aim of introducing solid foods is to begin a transition to a culturally appropriate nutritious, healthy diet. In the UK, in recent decades, the recommended age to introduce food had crept earlier and earlier until this was usually happening at an age and stage of development where food required careful modification for babies to physically cope with ingesting it. 'Weaning' came to entail numerous rules and special forms of preparation to produce purees of suitable consistency for semi-solid spoon feeding with a staged approach to the introduction of lumpier, more solid foods. This resulted in a cornucopia of manuals and recipe books with ways to tempt the infant palate. It also appears to have resulted in parental anxiety about following rules and concern about preparing special food for the youngest member of the family.

Ranges of commercial baby foods, both prepared purees and adapted versions of adult foods, are marketed with the promise of rescuing parents who may be slightly overwhelmed by navigating this stage of their baby's development. These confirm a popular perception of 'weaning' as a difficult stage to negotiate.

In the last 10 years, the recommended age and manner of introducing solids has changed. In 2003, the Department of Health (DH) adopted the World Health Organization recommendation for exclusive breastfeeding until 6 months – with this age for the introduction of foods recommended for all babies, whatever form of milk feeding (breastfeeding or infant formula feeding) they receive. This recommendation was partially informed by assessment of infant development that accounts for babies' muscular control, motor skills and development of the ability to move food to the back of the mouth and swallow.

A second development is the enthusiastic uptake by parents of observational research conducted by Rapley (2006). This investigated babies' responses to the offer of 'real' food, appropriately modified into graspable size, which they were encouraged to explore and feed themselves, while joining into family mealtimes. This gives the baby control over the process of conveying food into his mouth and when to stop, in contrast to the 'parent-led' use of a spoon. This approach acquired a label 'baby-led weaning' or BLW and has been disseminated via a book and DVDs for parents and in online forums. In the process, it also appears to acquired something of a mystique with parents seeking guidance on its 'rules', although this does not appear to have been the original intention. Indeed, Rapley & Murkett (2008) emphasize that 'it's not new. Parents the world over have discovered it for themselves' (p. 12).

The term 'baby led' is in use to describe breastfeeding, as an alternative to what used to be 'demand' feeding – feeding in response to hunger cues from the baby. It is meant to be a reminder that a baby is an active partner in feeding rather than a passive recipient of food.

There is a perceived opposition between 'usual' weaning advice and 'baby-led weaning' – which is somewhat curious since the DH has quietly transformed its own information for parents – acknowledging that the food appropriate to offer a 6-month-old baby is different from that given to a baby 2 months younger. The DH Weaning Leaflet (2007) suggested both purees or chunks of fruit or vegetables as suitable first foods. The latest edition of Birth to Five (Department of Health, 2009a) has 21 pages on introducing solid food (dropping the rather confusing term 'weaning') and mentions puree only once – suggesting pieces of fruit or vegetables or food mashed with a fork as first foods. The Start4Life campaign (Department of Health, 2009b) supports this trend to using ordinary

food, underpinning this with signs of babies' developmental readiness for eating.

Parents and professionals appear to continue to worry whether babies can cope with a slightly modified healthy family diet.

Into this situation, two studies provide a welcome injection of evidence. Wright *et al*. (2010) detail how, in a UK cohort, food diaries were completed, and an analysis was conducted of when babies reached out to eat solid foods. The data were collected before either the popularization of baby-led weaning or the recommendation for first introducing food at around 6 months. It represents what babies do when their parents are offering first foods on a spoon from before 6 months and adding finger foods in later. It thus allows a valuable historical control for contemporary observational studies.

The majority of these babies were reaching out and eating solid foods, which they held themselves by 8 months of age – although not all were offered these on a regular basis. The ability to do this developed at a wide range of ages (unsurprising, as this is the case with other infant milestones). Babies who were bottle fed exhibited the same self-feeding skills, indicating that this approach is suitable for a universal recommendation.

The authors comment on the 'discrepancy between capacity and opportunity' and the 'low parental expectation of self feeding' they discovered. Thus, if parents are taught that babies should have puree on a spoon, babies cannot show their ability to eat.

These babies seem to have received mainly toast and biscuits as first finger foods, rather than a fuller range including fruit and vegetables – as is emphasized in both DH literature and the BLW approach. Wright *et al*. endorse the ability of most babies to deal with food in solid, slightly modified form and conclude that offering babies the opportunity to feed these to themselves is probably feasible for most. Babies in this study who were relatively late in eating solids also exhibited later attainment of other developmental milestones, so that the authors conclude that there is room for attentive spoon feeding alongside offering finger foods.

Brown and Lee (2010) sampled mothers through an internet survey, demonstrating that many families have adopted a BLW approach in the last decade. BLW mothers offered solid foods later, breastfed longer and felt more confident. No causal relationship should be inferred from this, but this study indicates that an inequalities gap is opening between families who embrace BLW and those who have not taken on board the DH recommendations. Parents who already feel confident may be more likely to undertake the newer approach. However, there is relatively less difference between BLW and current DH recommendations than between these and the staged puree approach.

It is to be hoped that these contributions will help parents – and professionals – feel confident in following the suggestions in Birth to Five. Babies appear to have capacity to feed themselves and parents can feel confidence in the Start4Life recommendation that there need be 'no rush to mush'.

References

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