Paediatrics & Child Health, 2020, 77–78
doi: 10.1093/pch/pxz069
Practical Tips for Paediatricians
Advance Access publication 31 May 2019

Practical tips for paediatricians: Baby-led weaning

Laura N. Anderson PhD[1,2], Meta van den Heuvel MD PhD[2,3], Jessica A. Omand RD PhD[2], Peter D. Wong MBBS PhD[2,3]

[1]Department of Health Research Methods, Evidence, and Impact, McMaster University, Hamilton, Ontario; [2]Child Health Evaluative Sciences, SickKids Research Institute, Hospital for Sick Children, Toronto, Ontario; [3]Division of Paediatric Medicine, Department of Paediatrics, Faculty of Medicine, University of Toronto, Toronto, Ontario

Correspondence: Peter D. Wong, Department of Paediatrcs, University of Toronto, 722-115 Humber College Blvd., Toronto, Ontario M9V 0A9. Telephone 416-743-7520, fax 416-743-0101, e-mail peter.wong@sickkids.ca

Keywords: *Baby-led weaning; Child health; Complementary feeding; Nutrition.*

WHAT IS BABY-LED WEANING?

Baby-led weaning (BLW) is an approach to introducing solid foods in which infants at least 6 months of age (corrected for prematurity) feed themselves all of their food from the start of complementary feeding (1). This approach has gained popularity and is recommended in some parenting books, websites, and blogs, leaving parents wondering if this is a good choice for their family. BLW involves offering infants foods in their whole form rather than spoon-feeding foods in the blended or pureed form. In this context, the term 'weaning' refers to the transition from a diet of only milk feeds to introduction of solid foods; it does not refer to weaning the baby off the breast (or infant formula). BLW emphasizes that infants should be introduced to a wide variety of finger foods, allowed to choose what, when and how much they eat, and share in the family food and mealtimes.

Hypothesized benefits of BLW include optimal growth and reduced obesity (appetite control and self-regulation), improved coordination/motor development, improved speech (strong mouth and jaw muscles), and improved eating patterns (less picky eaters). However, *hypothesized* concerns about BLW include increased choking risk, poor growth (insufficient food intake), and low iron intake (limited meat and lack of iron fortified cereals).

PRACTICAL TIP 1: THERE IS LIMITED EVIDENCE TO SUPPORT OR REFUTE BLW AS A METHOD OF INTRODUCING SOLID FOODS

The Baby-Led Introduction to Solids Study (BLISS), a large randomized-controlled trial, compared BLW to traditional introduction of solids and identified no differences in choking (2), weight faltering or body mass index (3), but reduced food fussiness and lower satiety responsiveness were observed at 2 years of age for infants in the BLW intervention group (3). Importantly, in the BLISS trial, the BLW protocol was adapted to include specific advice about offering high-iron and high-energy foods and avoiding high-choking risk foods (2,3). Further, systematic reviews evaluating BLW identified few studies and concluded that more research is needed to answer key questions about whether BLW leads to sufficient nutrient intake (including iron) and aids in obesity prevention without increasing the risk of choking (4,5).

PRACTICAL TIP 2: THERE ARE NO CLINICAL GUIDELINES IN NORTH AMERICA FOR BLW

To the best of our knowledge, there are no North American clinical guidelines or recommendations on BLW. In the position paper about complementary feeding by the European Society for Paediatric Gastroenterology, Hepatology and Nutrition BLW was not recommended because of the lack of evidence (6). The World Health Organization (WHO) recommends the introduction of semisolid, pureed or mashed foods starting at 6 months of age with 'gradual increase of food consistency and variety' such that by eight months of age, infants can eat 'finger foods' and by 12 months, most can eat the foods prepared for their family (7). Responsive feeding, which is defined as the caregiver's prompt developmentally and emotionally appropriate

Received: December 3, 2018; Accepted: April 8, 2019

Table 1. Baby-led weaning: Information points for parents

1. Ensure that your baby is ≥ 6 months of age (correcting for prematurity) and developmentally ready to self-feed
2. Never leave your baby alone with food and always supervise them when they are eating
3. Make sure your baby is sitting upright when eating
4. Allow your baby to eat at his/her own pace
5. Introduce foods that your baby can mash on the roof of their mouth with their tongue (e.g., soft cooked vegetables)
6. Avoid high-choking risk foods (e.g., nuts, grapes, crackers, raw apple, raw vegetables, sausages or other foods cut in to rounds or 'coins')
7. Offer iron rich foods at each meal (e.g., meats [red meat, poultry, and fish] and alternatives [beans, lentils, and eggs])
8. Offer a wide variety of foods and at least one high-energy food at each meal (e.g., avocado, full fat cheese, plain yogurt, nut butters, meat, and alternatives)
9. Avoid processed foods and food with added salt and/or sugar
10. Pay attention to hunger and satiety cues

Adapted from the BLISS trial (2) and systematic review by D'Auria et al. (5).

reaction to their infant's hunger cues, is a core element of the WHO guide for the complementary feeding of infants (7). The Canadian Paediatric Society (CPS) encourages gradually increasing the texture of the complementary food after 6 months, with lumpy textures offered by nine months and a variety of textures offered by 1 year. The CPS also stresses the importance of responsive feeding in order to foster healthy eating skills (listening to hunger and satiety cues as well as offering finger foods to promote self-feeding) (8).

PRACTICAL TIP 3: PROVIDE PRACTICAL INFORMATION REGARDING THE INTRODUCTION OF SOLIDS TO PARENTS INTERESTED IN BLW

Parents should be informed about the lack of robust evidence and clinical guidelines to support BLW. If parents prefer this method of introducing solids, points of information regarding the introduction of solids can be provided (Table 1). Finally, practitioners should closely monitor the infant's growth (5).

Funding: There are no funders to report for this submission.

Potential Conflicts of Interest: The authors: No reported conflicts of interest. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

References

1. Rapley G. Baby-led weaning: Transitioning to solid foods at the baby's own pace. Community Pract 2011;84(6):20–3.
2. Fangupo LJ, Heath AM, Williams SM, et al. A baby-led approach to eating solids and risk of choking. Pediatrics 2016; 138(4):e20160772.
3. Taylor RW, Williams SM, Fangupo LJ, et al. Effect of a baby-led approach to complementary feeding on infant growth and overweight: A randomized clinical trial. JAMA Pediatr 2017;171(9):838–46.
4. Brown A, Jones SW, Rowan H. Baby-led weaning: The evidence to date. Curr Nutr Rep 2017;6(2):148–56.
5. D'Auria E, Bergamini M, Staiano A, et al.; Italian Society of Pediatrics. Baby-led weaning: What a systematic review of the literature adds on. Ital J Pediatr 2018;44(1):49.
6. Fewtrell M, Bronsky J, Campoy C, et al. Complementary feeding: A position paper by the European Society for Paediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN) committee on nutrition. J Pediatr Gastroenterol Nutr 2017;64(1):119–32.
7. World Health Organization. Complementary feeding : report of the global consultation, and summary of guiding principles for complementary feeding of the breastfed child. World Health Organization. 2003. Available from: http://www.who.int/iris/handle/10665/42739
8. Critch JN; Canadian Paediatric Society; Nutrition and Gastroenterology Committee. Nutrition for healthy term infants, six to 24 months: An overview. Paediatr Child Health 2014;19(10):547–52.