

Response to:

Grummer-Strawn LM, Lutter CK, Siegfried N, et al. Response to: World Health Organization (WHO) guideline on the complementary feeding of infants and young children aged 6-23 months 2023: A multisociety response. JPGN 2024

European Society for Paediatric Gastroenterology, Hepatology & Nutrition (ESPGHAN)

European Academy of Paediatrics (EAP)

European Society for Paediatric Research (ESPR), European Academy for Allergy and Clinical Immunology (EAACI)

Federation of International Societies for Paediatric Gastroenterology, Hepatology & Nutrition (FISPGHAN)

Latin American Society for Pediatric Gastroenterology, Hepatology & Nutrition (LASPGHAN)

Pan Arab Society for Pediatric Gastroenterology and Nutrition (PASPGHAN)

Asian Pan-Pacific Society for Pediatric Gastroenterology, Hepatology and Nutrition (AAPSGHAN)

North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN)

World Allergy Organization (WAO)

Asia Pacific Academy of Pediatric Allergy, Respiriology & Immunology (APAPARI)

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Abbreviations

WHO	World Health Organisation
ESPGHAN	European Society for Paediatric Gastroenterology, Hepatology & Nutrition
EAP	European Academy of Paediatrics
ESPR	European Society for Paediatric Research
EAACI	European Academy for Allergy and Clinical Immunology
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In a recent commentary on the new WHO Complementary Feeding (CF) Guideline (1), our Societies raised concerns about some recommendations (2) which we consider may have the potential to cause unintended harm in infants and young children. We highlighted the importance of adapting recommendations according to context, and suggested alternative or modified proposals as a basis for further discussion. We welcome the letter by Grummer-Strawn and the WHO CF Guideline Development Group (GDG) and appreciate that they have offered some clarification and explanation (3). However, they have not commented on our proposed modifications, and there is still no recognition or acknowledgement that a 'one-size-fits-all' approach to complementary feeding is not appropriate.

Of concern to us, the GDG justify their position by saying that the recommendations about which we raised concerns are '*fully aligned with long-standing WHO guidance and do not represent a change in WHO policies*'. This illustrates a fundamental problem as recommendations and policies *should and must* be changed as the evidence-base evolves.

We strongly maintain that *all* relevant stakeholders must be consulted in the development of global infant feeding guidance, not just those considered acceptable or unproblematic by the organization leading on the guidance. Issues of conflict of interest, whether commercial or non-commercial, can and should be dealt with as part of this process, as is already accepted practice for other bodies such as EFSA and for most national and international medical guidelines.

The GDG write that "*the.. guideline is applicable in low-, middle- and high-income settings alike. Issues recognized as particularly relevant in high-income countries, including overweight and allergies, were included as outcomes in all the systematic reviews, the assessment of modelling results, and deliberations of the GDG members*". We maintain our view that the group did not consider all relevant data on protein intake and adiposity, as explained in our commentary (1). We also note that these issues, which are also increasingly relevant in low- and middle-income settings due to the nutrition transition, are hardly mentioned or discussed in the guideline document (2).

The GDG say that they “*did not recommend against formula use at 6-11 months of age, only that is expensive and not necessary*”. However, because there is no discussion of context, this means that they do not recommend the nutritionally better and safer (in terms of protein intake) option in settings where it is available, safe to use and the most appropriate option considering the rest of the infant’s diet. They state that Optifood modelling showed that “*the percent of calories coming from protein among non-breastfed children 12-23 months of age was 10-16%*”. However, it is not clear whether the diets modelled included those commonly used in higher income settings, and they did not address our concern that no modelling was conducted for non-breastfed infants aged 6-11 months. The GDG highlight that there are other options for providing iron; in our commentary we acknowledged other strategies that can and should be used to improve infant iron status but noted that these are often not effective, so poor iron status remains a serious global concern.

Regarding the age at introduction of CF and risk of food allergy, the GDG state that their systematic review on this topic found no evidence of a benefit to introducing foods prior to 6 months (4). This review included only two of the (several) trials conducted on this topic although the reason for excluding other trials is unclear. Furthermore, the GDG seems to disregard the systematic review on allergy prevention by the European Academy for Allergy and Clinical Immunology (EAACI (5)), which included the per protocol analysis of the EAT study, indicating a significant impact on allergy prevention when peanut and egg were introduced between 4-6 months of age. Additionally, the GDG say that the PreventADALL study reporting on food allergy (6) published after publication of their systematic review “*was examined closely and was excluded because it does not in fact compare introduction at 6 months to earlier introduction*”. However, this makes no sense as the earlier publication from the same trial (reporting on atopic dermatitis) was already included in the systematic review (7). Infants in the PreventADALL trial were randomised to receive allergenic foods starting from 12 and 16 weeks versus no intervention and the trial reported a significantly lower risk of food allergy in the earlier introduction group, regardless of the amount or frequency of exposure to allergenic foods later in infancy (6). We are surprised that food allergy is hardly mentioned in the

WHO guideline document (2) even to acknowledge that this is a topic of debate or that context is important, when challenge proven prevalence of paediatric food allergy in some countries is reaching 10% and is also on the rise in low and middle-income countries (8-10).

The GDG conclude with a statement that “... *the guideline meets WHO’s vision of a world in which all peoples attain the highest possible level of health*”. We share this vision but are concerned that it is unlikely to be realised without the inclusion of all relevant stakeholders, appropriate consideration of all available evidence and the adaptation of guidance according to context.

We would welcome further discussion and the opportunity to work with WHO towards this goal.

References

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