ESPGHAN

INFANT FEEDING ALL SETTINGS FACT SHEET

Key Feeding Milestones

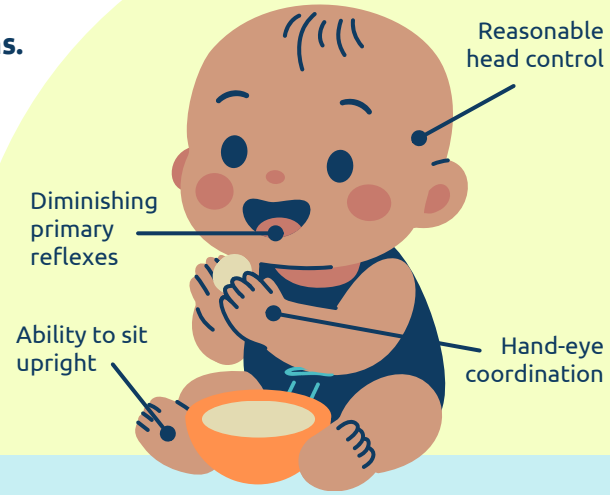
Food textures should progress without delay

Infants should be consuming **lumpy foods** by **8–10 months.**

Infants should be **mainly drinking from a cup** or training cup **by around 12 months**, following the infant's developmental readiness cues.

Finger foods and self-feeding should be encouraged when **developmental readiness is observed.**

Readiness Cues



Dietary Choices and Restricted Diets

Vegan or predominantly plant-based diets should ideally be used only under appropriate medical or dietetic supervision.

Key supplements and adequate protein to support healthy growth and energy needs:

VITAMIN B12 | VITAMIN D | IRON | ZINC | OMEGA-3 | CALCIUM

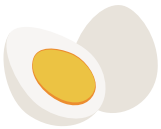
The **consequences of a poorly planned vegan diet** or failure to follow supplementation advice are **more serious in infants** than in older children or adults. They may include **irreversible cognitive impairment** and, in extreme cases, death.

Appropriately planned plant-based foods—including **pulses** (e.g., peas, beans and lentils), **tofu**, **soya-based alternatives**, and fortified products—can **contribute to protein and micronutrient intake**.

Practical resources for caregivers and health professionals **include national and international guidance** (e.g., national health service weaning resources, and guidance from professional bodies in high-, middle-, and low-income countries).

Introducing Allergenic Foods

Allergenic foods and gluten should be **treated like other complementary foods** and introduced in an age-appropriate, safe form when complementary feeding commences from **17 weeks**. Priority allergens should reflect **local patterns** of food allergy. Common allergens include:



Eggs

Nuts

Shellfish

Animal milk

Sugar and Drinks

Infants do not require added sugars as they obtain naturally occurring sugars from milk and whole fruits.

Concentrated fruit juices and **sugar-sweetened beverages** should be **avoided**, as liquid sugars are rapidly absorbed and contribute less to satiety. They may be more easily overconsumed than sugars consumed in **whole fruits with fibre**.

Free sugars may not always be clearly identified on food labels if only “added sugars” are listed.

MICRONUTRIENT PRIORITIES

Iron, **zinc**, **vitamin D**, and **iodine** are key nutrients during the complementary feeding period. Strategies to improve intake include:

Locally available **animal-source foods**, e.g., meat and eggs

Plant-based options and **fortified foods**

Supplements and multi-micronutrient powders

Healthcare professionals should guide families toward **locally appropriate**, **affordable**, and **culturally acceptable options** that align with national policies.

Weaning From Breastfeeding/Formula

As infants begin to eat more solid foods between 6 and 12 months, **breast milk or formula should gradually make up a smaller proportion of their diet**. Parents should be encouraged to **offer solids before milk feeds**, as offering milk first may reduce appetite for micronutrient-dense foods that provide adequate energy to support healthy growth. Milk remains an important source of nutrients and fluids throughout this period, but **it should not be the primary source of energy** once solids are established.

Responsive feeding principles still apply: follow the child’s hunger and fullness cues while supporting a gradual, comfortable shift from milk-led feeding to shared meals.

Responsive Feeding Practices

Parents should be supported to practise **responsive feeding**. This includes breastfeeding on demand, recognising hunger and satiety cues (e.g., understanding that crying does not always indicate hunger), avoiding pressure to finish meals, and not using food for comfort or as a reward.

Infants may require repeated exposure to accept new foods, **particularly those with bitter flavours**. As infants have an innate preference for sweet and salty tastes, parents should be encouraged to persist in offering a wide range of flavours and not to exclude foods based on initial rejection.

Structured meal routines and **modelling healthy eating behaviours** are recommended to support long-term dietary habits. Education and communication should acknowledge the influence of family members (e.g., grandparents), peers, community norms, and differing caregiver preferences; these should only be overridden when there is clear evidence that infant health may be compromised.

Higher vs Limited Resource Countries

HIGHER RESOURCE*

Beginning complementary feeding

Exclusive breastfeeding should continue for **at least 17 weeks**, and **complementary foods** should be **introduced after 17 weeks,** but **no later than 26 weeks.**

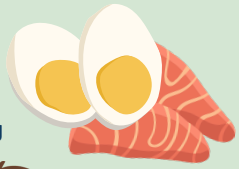
Milk and formula

Water and breastmilk are the recommended drinks. Animal milk should not be used as the main drink **before 12 months**. **After 12 months**, animal milk intake should be **limited to approximately 500 ml per day**. This helps reduce the risk of excessive protein intake, which can cause children to feel full before they have eaten a balanced and diverse diet.

Young Child Formulas are not required for children aged 1–3 years in high-income settings, however, they may be used as part of a broader strategy to support iron, vitamin D, and omega-3 intake while moderating protein exposure in settings where overweight and obesity are concerns.

High quality proteins

Protein intake should make up **no more than 15% of an infant's energy intake**. More than this may lead to excess weight gain and having overweight or obesity in later childhood.



*Typically no/fewer limitations on food availability (greater availability of high-fat, salt or, sugar (HFSS) foods) or affordability, greater concern about over-nutrition/ obesity, and lower morbidity due to infectious disease

**Typically limited food availability, affordability, and greater concern about under-nutrition, higher morbidity, and mortality due to infectious disease

LIMITED RESOURCE**

Beginning complementary feeding

Exclusive breastfeeding should be continued for **around 6 months**, where possible, with **complementary foods introduced by 26 weeks**.

Milk and formula

Whilst this is unlikely to be the case in well-resourced European countries, **where infant formula is not available**, **affordable**, or **safe**, full-fat animal milk may be used between 6 and 12 months. It is important to ensure the infant has **adequate iron in their diet**, as animal milks contain less iron than formula and can displace iron and other important micronutrients.

Safe water, **hygiene**, and **food-preparation practices are essential** for all complementary feeding. Where available, pasteurised dairy products should be used to reduce the risk of foodborne illness.

High quality proteins

Animal-source foods, including meat, fish and eggs, should be included in the diet when available and acceptable to provide high-quality protein, micronutrients, n-3 fatty acids, and other beneficial nutrients.

Community and family engagement

Family, friends, and community influences play a significant role in infant feeding practices in many contexts. Healthcare professionals should actively involve mothers, grandmothers, fathers, support networks, and community leaders in counselling to improve understanding, acceptance, and sustained adoption of complementary feeding guidance.

ESPGHAN Committee on Nutrition (2017). Complementary Feeding – A Position Paper. ESPGHAN Multisociety Response to WHO Complementary Feeding Guideline (2024/25 commentary). WHO (2023). Guideline for Complementary feeding of infants and young children 6–23 months. EFSA Panel on Nutrition, Novel Foods and Food Allergens (2019). Appropriate age range for introduction of complementary feeding. ESPGHAN Committee on Nutrition (2018). Young Child Formula Position Paper. EAACI Guideline (2021). Preventing the development of food allergy in infants and young children.