

Baby-led Weaning: A Preliminary Investigation

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ABSTRACT

Purpose: To date, baby-led weaning (BLW) has not been examined in a Canadian population. This research investigated common BLW practices and compared associated knowledge and perceptions of practicing mothers and health care professionals (HCPs).

Methods: Sixty-five mothers practicing BLW and 33 HCPs were surveyed using 2 online questionnaires. Mothers were recruited through the Newfoundland and Labrador BLW Facebook page and HCPs via email at 2 regional health authorities.

Results: Mothers described BLW in terms of food shape and consistency (whole, solid); however, in practice, some mothers offered puréed foods such as infant cereals. More HCPs than mothers indicated choking, inadequate energy, and iron intake as concerns. Mothers relied on the Facebook page over HCPs for BLW information and support. Although all practicing mothers would recommend BLW to others, less than half (48.5%) of HCPs would support it in their practice.

Conclusions: Mothers following BLW vary greatly in their experiences and adherence to BLW. They view the practice and its disadvantages very differently than HCPs. Although most HCPs were aware of BLW, few were familiar with specific practices. HCPs may benefit from a greater understanding of BLW to provide guidance to the growing number of mothers following this practice.

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RÉSUMÉ

Objectif. À ce jour, le sevrage induit par le bébé (SIB) n'a jamais fait l'objet d'un examen au sein d'une population canadienne. La présente recherche s'est penchée sur les pratiques communes de SIB et a comparé les connaissances et perceptions connexes des mères s'adonnant à cette pratique et des professionnels de la santé (PS).

Méthodes. On a demandé à 65 mères pratiquant le SIB et à 33 PS de répondre à deux questionnaires en ligne. Les mères ont été recrutées par l'entremise de la page Facebook relative au SIB de Terre-Neuve-et-Labrador, et les PS, par courriel dans deux autorités sanitaires régionales.

Résultats. Les mères devaient décrire le SIB en ce qui concerne la forme et la consistance des aliments (entiers, solides). Toutefois, en pratique, les mères offraient des aliments en purée, comme des céréales pour nourrissons. Plus de PS que de mères se sont dits préoccupés par l'étouffement, l'énergie insuffisante et l'apport en fer. Les mères se tournaient vers la page Facebook, plutôt que vers les PS, pour obtenir de l'information et de l'aide au sujet du SIB. Bien que toutes les mères qui pratiquaient le SIB le recommanderaient aux autres mères, moins de la moitié (48,5 %) des PS encourageraient cette pratique.

Conclusions. L'expérience et l'adhésion relatives au SIB varient grandement entre les mères qui le pratiquent. La perception des mères quant à la pratique et à ses inconvénients est très différente de celle des PS. Bien que la majorité des PS connaissaient le SIB, très peu étaient familiarisés avec les pratiques précises. Il pourrait être à l'avantage des PS de mieux comprendre le SIB pour donner des conseils au nombre grandissant de mères qui s'adonnent à cette pratique.

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INTRODUCTION

Current Canadian infant feeding guidelines recommend the introduction of complementary foods at about 6 months of age, while continuing to breastfeed for up to 2 years [1]. The World Health Organization recommends the introduction of small, semi-solid portions, increasing in quantity [2] and varying in consistency as the child develops [1, 2]. Prior to these guidelines, infant cereals and purées were spoon-fed by a caregiver between 4 and 6 months, transitioning later to minced and soft table foods as the child matures [3].

Recently, the term baby-led weaning (BLW) has been used to describe an alternative approach to traditional spoon-feeding. BLW promotes the introduction of appropriately prepared “finger foods” (i.e., cut into smaller pieces) at roughly 6 months of age, while continuing to breast or formula feed [4]. Strict BLW does not include any spoon-feeding by an adult and instead relies on the infant to completely self-feed

whole foods from the start of the complementary feeding period [5]. “Weaning” in this context is used to describe the addition of solid foods while continuing to breast or formula feed [4]. The term BLW was introduced by Gill Rapley, a co-author of *Baby-Led Weaning: The Essential Guide to Introducing Solid Foods*, originally published in the United Kingdom in 2008 and in North America in 2010 [4]. Research suggests that BLW has increased in popularity in the United Kingdom [6–8] and New Zealand [9, 10] and there is anecdotal evidence to suggest this practice is also being followed in Canada. For example, the Newfoundland and Labrador (NL) Canada BLW Facebook page [11] has grown to over 1200 members (September, 2015) in the past 2 years.

Health Canada's complementary feeding recommendations for health care professionals (HCPs) were updated in April 2014 and incorporate some of the fundamental aspects of BLW, primarily the introduction of finger foods as first

foods [1]. These guidelines cite an article for HCPs composed by Rapley [5], promoting BLW practices. Health Canada encourages self-feeding as a means to promote responsive feeding, relying on the infant's hunger and satiety cues for when, how much, and where the child eats [1]. BLW fosters similar principles but completely restricts spoon-feeding and purées which is the main difference between the 2 sets of recommendations [4].

HCPs are often used as a source of health-related information and support, playing an important role in parent decisions regarding infant feeding [10, 12]. There is evidence to suggest, however, that HCPs have different attitudes toward infant feeding than mothers [10]. The purpose of this study was to describe common BLW practices in NL. The study also compared the knowledge and perceptions of BLW between practicing mothers and HCPs. To date, BLW has not been examined in a Canadian population.

METHODS

Mothers and HCPs were recruited separately using convenience sampling methodology. Researchers drafted and distributed 2 online surveys, 1 for the mothers and the other for HCPs. The data collection period ranged from June to August 2014 inclusive. Surveys were managed through fluid surveys (Fluid-surveys.com). A questionnaire was designed specifically for each group. Both surveys addressed similar topics and contained a number of identical questions to allow for comparison. Most questions were adapted from a New Zealand study [10], and consisted of open-ended, close-ended, and "check all that apply" responses. The initial section of the mothers survey asked about the mother's location, her personal definition of BLW, infant information (current age and age of BLW onset), BLW experiences in reference to her youngest child (first foods, food consistencies, family meals, choking incidents), and overall opinions of BLW. In the second section, mothers were asked to identify potential advantages and disadvantages of BLW using this particular description: "BLW is 'a way of introducing solid foods that allows babies to feed themselves – there's no spoon feeding and no purées. The baby sits with the family at mealtimes and joins in when she is ready, feeding herself first with her fingers and later with cutlery' (Rapley, p. 2 [13]). Mothers are encouraged to start this method of weaning at 6 months of age while continuing to breast-feed".

The initial section of the questionnaire for HCPs asked about personal and professional characteristics, and knowledge of BLW. The second section provided Rapley's [13] description of BLW and again asked HCPs to identify potential advantages and disadvantages of the practice using this description. The survey also asked whether the HCPs would support BLW in their practice. Both surveys were reviewed by 5 mothers working in health care, to assess the face validity and readability.

To recruit mothers practicing BLW, the researchers approached the administrators of the NL BLW Facebook site

who subsequently posted a message inviting mothers to take part in the survey. The message included a web link to the online questionnaire. Recruiting participants through the Facebook page allowed researchers to access mothers claiming to follow BLW. To be eligible for the mothers' survey, mothers had to complete the majority of survey questions (a default setting of FluidSurveys.ca).

To recruit HCPs, the researchers asked 3 dietitians practicing in NL to send an email with a study invitation and web link to the survey to other NL HCPs in their professional networks. This approach was used because there were no publicly available lists (with email addresses) of HCPs working in each region. To be eligible for the HCP survey, respondents had to work for the Eastern or Western Regional Health Authority (RHA) at the time of data collection. Like the mothers survey, only questionnaires with the majority of questions completed were included.

Fluid surveys captured survey responses in 2 separate datasets. Both were imported into SPSS (IBM SPSS 22, Armonk, NY, 2013) and then merged. Open-ended questions were coded by 2 authors for recurring themes. Data were cleaned using frequencies to identify and remove implausible responses and coding errors (which were corrected by consulting original responses).

Frequencies were used to describe the mothers' locations, BLW experiences, and general opinions of BLW; and HCPs' characteristics and knowledge of BLW. Chi-square tests (and Fisher's exact tests, where applicable) were used to compare mothers' and HCPs' descriptions of BLW, sources of BLW knowledge, and perceived advantages and disadvantages of the practice. A *P* value of <0.05 was used to identify statistically significant differences between the 2 groups. This study was approved by the NL Research Ethics Board and the 2 regional health authorities in NL.

RESULTS

Ninety-nine mothers responded to the survey; 34 respondents (34.3%) with incomplete surveys were excluded, leaving 65 mothers (65.7%). Most participants lived in the St. John's area (78.5%).

Fifty-nine HCPs responded to the survey. Data from respondents with incomplete surveys (*n* = 13) and/or those who did not work at either the Eastern or Western Health Authority (*n* = 13) were excluded, leaving a total of 33 respondents (55.9%). The study sample included 18 registered dietitians, 8 nurses, 3 lactation consultants, 2 physicians, 1 occupational therapist, and 1 physiotherapist. All HCPs were female and 28 (84.8%) worked with children in a professional capacity.

Mothers' experiences with BLW

Mothers started their self-defined BLW when their infants were between the ages of 5 and 8 months (mean = 6.2 months). Most (61, 93.8%) were still practicing BLW at the

time of the survey, and they had been using BLW for a mean of 7.4 months (range 0–24 months) at that time.

Many mothers ($n = 42$, 64.6%) chose to follow BLW because it “made sense” and “felt natural”; however, they acknowledged the development of infant feeding skills, healthy habits, and healthy attitudes toward food ($n = 23$, 35.4%) as other contributing factors. Mothers’ sources of both information and support while practicing BLW are included in Table 1. In both cases, the NL BLW Facebook page was consulted more often than HCPs. All mothers reported that their infants ate with the rest of the family at mealtime. The first foods offered to infants at the start of the complementary feeding period, according to 96.9% of respondent mothers, were fruits and vegetables with the most commonly cited being avocados, bananas, sweet potatoes, broccoli, and carrots. Animal-based proteins were the second most commonly cited

complementary foods ($n = 37$, 56.9%). These included: red meat (moose, meatloaf, beef, steak, ground beef, pork, ham, bones), fish (cod, salmon, tilapia, trout), and poultry (chicken, turkey). Foods were most often described as being cut or formed into manageable pieces such as “strips” ($n = 42$, 64.6%), softened ($n = 35$, 53.8%), or whole/solid ($n = 26$, 40.0%). Some mothers also described first complementary foods as being puréed or mashed ($n = 14$, 21.5%). Most mothers ($n = 55$, 84.6%) indicated that their infant fed himself/herself more than 90% of the time at the start of BLW.

The most commonly cited ($n = 30$, 45.2%) concern about BLW was choking. Of these mothers, 13 (43.3%) were worried about choking prior to starting BLW but it became less of a concern once they began the practice. Only 3 mothers (4.6%) indicated that their child had a choking incident during BLW. In comments, mothers acknowledged the differences between gagging and choking but suggested that CPR/first aid training would be beneficial while practicing BLW.

HCPs’ and mothers’ knowledge of BLW

Most ($n = 27$, 81.8%) HCPs had heard of BLW prior to starting the survey. Practicing mothers and HCPs learned about BLW from different sources. Most mothers heard about BLW from a friend or online source (Facebook), whereas HCPs stated this knowledge came from another HCP, a client, or through professional development (Table 2). When describing BLW in their own words, mothers referred to 2 prominent themes: the form of food (solid, whole, appropriately sized, nonpuréed foods) and the infant’s control over feeding (how much they eat and when) (Table 2).

More mothers than HCPs believed BLW encouraged healthier eating and prevented fussy/picky eaters (Table 3). More than 80% of both mothers and HCPs believed that BLW promoted fine and oral motor skill development and shared

Table 1. Sources of infant feeding information and support stated by mothers practicing BLW ($n = 65$).

	Source of information, no. (%)	Source of support, no. (%)
NL BLW Facebook page	50 (76.9)	37 (56.9)
Friend/family	36 (55.3)	51 (78.5)
BLW book coauthored by Gill Rapley [4]	28 (43.1)	–
Other online sources	19 (29.2)	8 (12.3)
Health Canada	18 (27.7)	–
Health care professional	10 (15.4)	24 (36.9)

Note: Responses were “check all that apply”. (BLW, baby-led weaning; NL, Newfoundland and Labrador.)

Table 2. Mothers’ and health care professionals’ sources of BLW information and personal description of BLW.

	Mothers, $n = 65$ (%)	Health care professionals, $n = 33$ (%)	P value
Heard about BLW from			
Online forum or group	39 (60.0)	2 (6.1)	<0.001
Family/friend	22 (33.8)	4 (12.1)	0.029
Health care professional	0 (0.0)	12 (42.9)	<0.001
Client	0 (0.0)	4 (12.1)	0.011
Professional development	0 (0.0)	4 (12.1)	0.011
Other	4 (6.2)	1 (3.0)	0.660
Terms used to describe BLW			
Form of food (solid/whole/strips/nonpuréed)	53 (81.5)	16 (48.5)	0.001
Baby determines intake	46 (70.8)	9 (27.3)	<0.001
Start of solids directed by baby	16 (24.6)	9 (27.3)	0.775
Exploration and exposure to new foods/tastes	16 (24.6)	0 (0.0)	0.001
Family mealtime participation	13 (20.0)	2 (6.1)	0.082

BLW, baby-led weaning.

Table 3. Mothers' and health care professionals' perceived advantages and disadvantages of BLW.

	Mothers, n = 65 (%)	Health care professionals, n = 33 (%)	P value
Advantages of BLW			
Promotes fine motor skill development	63 (96.9)	30 (90.9)	0.201
Promotes shared family meals	62 (95.4)	30 (90.9)	0.232
Promotes oral motor development	61 (93.8)	27 (81.8)	0.063
Helps children respond to hunger/satiety cues	57 (87.7)	25 (75.8)	0.131
Encourages healthier eating	57 (87.7)	23 (69.7)	0.030
Convenience	51 (78.5)	21 (63.6)	0.116
Prevents picky/fussy eaters	47 (72.3)	14 (42.4)	0.004
Prevents transition difficulties (purées to solids)	45 (69.2)	22 (66.7)	0.796
Reduces parental anxiety/worry	22 (33.8)	10 (30.3)	0.821
Reduces mealtime mess	8 (12.3)	4 (12.1)	1.000
Other	5 (7.7)	1 (3.0)	0.660
Disadvantages of BLW			
Increases parental anxiety	26 (40.0)	19 (57.6)	0.133
Other	18 (27.7)	4 (12.1)	0.123
Increases risk of choking	17 (26.2)	23 (69.7)	<0.001
Inadequate energy intake	5 (7.7)	12 (36.4)	0.001
Increases competition between mothers	5 (7.7)	8 (24.2)	0.030
Inadequate iron intake	4 (6.2)	13 (39.4)	<0.001

Note: When identifying advantages and disadvantages, respondents were asked to consider the following definition: BLW is "a way of introducing solid foods that allows babies to feed themselves – there's no spoon feeding and no purées. The baby sits with the family at mealtimes and joins in when she is ready, feeding herself first with her fingers and later with cutlery". Mothers were encouraged to start this method of weaning at 6 months of age while continuing to breast-feed. Responses were "check all that apply". (BLW, baby-led weaning.)

family meals. Practicing mothers selected far fewer disadvantages than advantages for BLW; increased parental anxiety was their most commonly cited disadvantage. HCPs stated increased risk of infant choking, low energy and iron intake, and increased maternal competition as disadvantages more often than mothers.

All mothers reported that BLW worked for their families and that they would recommend the approach to other mothers. When asked to compare the advantages with the disadvantages, 16 (48.5%) HCPs reported that they supported BLW, 6 (18.2%) did not support BLW, and 11 (33.3%) were undecided.

DISCUSSION

BLW practices are gaining popularity among Canadian mothers. In our study, mothers who practiced BLW indicated many benefits of the approach. Overall, mothers were satisfied with BLW. They shared positive experiences and indicated that they would recommend BLW to others. Both mothers and HCPs identified shared family meals as an advantage of BLW. All mothers in the study reported that their infants ate with the rest of the family at mealtime. It should be noted, however, that there is no evidence to suggest that BLW infants eat with the rest of the family more often than non-BLW infants. The Canadian infant feeding guidelines support family meals as a means to model healthy eating habits [1]. Although

this relationship has not been examined in an infant population, there is evidence to suggest that family meals can improve dietary intakes [14] and increase healthy eating patterns and normal weight percentiles among children and adolescents [15].

Although most HCPs were aware of BLW, they were less likely to be supportive of the practice, citing such concerns as the potential of choking. At 6 months of age, most infants have reached the developmental milestones required for self-feeding, including sitting upright without support and grabbing for objects and accurately bringing them to the mouth [16]. One study also suggests that at 6 months, infants have developed a gag reflex to protect against swallowing foods that are too large [17]. Rapley and Murkett [4] suggested that gagging is common among BLW infants because an infant's gag reflex is triggered by stimuli closer to the front of the mouth and further away from the airway compared to adults. In the opinion of Rapley et al. [4], BLW infants learn to keep solid food away from their airway at an early age compared with spoon-fed infants consuming solely purées because of the location of an infant's gag reflex at 6 months. Although there is little research to support this claim by Rapley et al., few mothers in this study (n = 3) reported a choking incident, consistent with findings by Townsend and Pitchford [18].

The low prevalence of choking may stem from food choices. Unlike mothers in the United Kingdom who offered

their infants mainly bread and biscuits [17], mothers in the current study offered primarily fruits and vegetables, with avocados as the most reported source. Interestingly, avocados are neither a traditional nor local food for the province of NL. Since most foods offered to infants were soft and easy to chew, by nature or by their preparation method (avocado, banana, and sweet potato), it cannot be determined if a low incidence of choking is due to an infant's actual development at 6 months or because the foods offered were low-risk foods. In a similar study by Cameron et al. [10], 30% of mothers reported a choking incident mostly due to raw apple; these researchers discouraged mothers following BLW from offering hard foods, such as raw apple, to their infants.

Among the HCPs in our study, inadequate energy and iron intake were identified as other concerns with BLW. Rapley and Murkett [4] reminded mothers that infants often consume very little at the start of BLW and that at this stage, all necessary nourishment can be derived from breast milk or formula. Research suggests, however, that iron is a critical nutrient for infants at 6 months of age [1, 2]. In Canada, infant feeding guidelines promote the introduction of iron-rich complementary foods, 2 or more times daily to infants from 6 months to 1 year of age [1]. Infant iron stores deplete at 6 months [1, 19] and breast milk alone no longer provides enough nutrients to meet the needs of most growing infants [2, 3, 20]. Iron deficiency can lead to irreversible health outcomes including developmental delay and cognitive impairment [19].

Although most mothers in our study followed the Canadian recommendation to start complementary feeding at 6 months, few mothers expressed concern about iron or overall energy intake. While Rapley and Murkett [4] opined that most full-term infants have sufficient iron stores, more research is needed to assess whether BLW-fed infants actually receive sufficient nutrients and energy to support optimal growth. For example, in a study by Townsend and Pitchford [18], more BLW infants ($n = 3$) than spoon-fed infants ($n = 0$) were classified as significantly underweight.

Consistent with other studies [7, 9, 10], mothers had their own interpretation of BLW and specific practices that differed from Rapley's description [13]. For example, although most mothers defined BLW based on the form of foods offered to infants (solid, whole), some mothers reported using a mixed-method approach—a combination of self-feeding whole finger foods and spoon-feeding purées by an adult. Moreover, when asked to describe the consistency of foods offered, mothers reported a wide scope of consistencies ranging from puréed and mashed to solid and whole. In some instances, infant cereals were identified as first foods offered to infants. Although mothers did not indicate how each food was offered, it can be assumed that puréed foods and infant cereals would be offered via spoon-feeding by an adult, especially at the outset of BLW (at 6 months).

Cameron et al. [10] noted that mothers who identify themselves as following BLW may stray from the original BLW approach. For mothers, using the term BLW to describe their infant feeding practice could be more important than the

actual approach itself if they feel pressured to follow their peers. One HCP described a mother who felt pressure from her friends to continue BLW even though her infant was failing to thrive with minimal swallowing. HCPs should be aware of potential competition between mothers and associated anxiety when discussing BLW. Researchers have suggested that it may be more beneficial to discuss infant feeding practices along a continuum instead of labelling a practice strictly spoon-feeding or self-feeding [6, 18].

Our mothers relied on other mothers to learn about BLW rather than HCPs, likely because many HCPs were not supportive or sufficiently knowledgeable about the practice. When describing the practice, significantly fewer HCPs were able to identify elements of BLW compared with mothers. Although most HCPs may have a general awareness of BLW, our study highlights the need to increase HCP knowledge of BLW so that they can help mothers make informed infant feeding decisions and support mothers who choose to follow BLW. Many HCPs expressed concerns about BLW, especially regarding its possible associations with inadequate iron and/or energy intake of infants (Table 3).

Some limitations of this study are acknowledged. Owing to the nature of data collection, response rates could not be calculated. Online recruitment can lead to sample bias as individuals residing in urban areas, with higher incomes, and post-secondary educations are more apt to use the internet in Canada [21, 22]. This was a cross-sectional study based on self-reported data that may not be generalizable to all mothers in the province or outside NL. Although this was a small convenience sample with data collected during the summer, to the authors' knowledge, it is the first study to examine BLW in North America.

Long-term longitudinal studies of BLW are warranted to assess nutritional adequacy and overall intake, eating patterns, food preferences, safety, and growth trends.

RELEVANCE TO PRACTICE

Given the growing popularity of BLW in Canada, HCPs would benefit from a greater understanding of BLW, including its potential benefits and risks, to promote open communication with clients and guide infant feeding decision-making. HCPs are an important source of reliable information, particularly concerning iron-rich complementary foods at the outset of the weaning period. Further research is needed to assess the outcomes (both positive and negative) of BLW so HCPs can be confident in providing support or advice around BLW that includes evidence-based practice. The negative implications of iron deficiency and poor growth include irreversible health outcomes [18] and therefore need to be sufficiently addressed before recommendations can be made. HCPs should also be aware of the impact of social media as an accessible tool to promote and share information with clients. Online forums, like the Facebook group, provide an excellent opportunity to support and educate mothers. Dietitians might consider joining these groups as part of their public health practice.

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