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## **Iron-fortified formula use in young children and association with socioeconomic factors in the French nationwide ELFE cohort**

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**Short title:** Iron--fortified formula use and socioeconomic factors

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**Abstract (197 words)**

Sacri A—S, de Lauzon—Guillain B, Dufourg M—D, Bois C, Charles M A, Chalumeau M. Iron-fortified formula use in young children and association with socioeconomic factors in the French nationwide ELFE cohort.

**Aim:** To study the rate of iron--fortified infant formula (IFF) use in young children in France and its association with socioeconomic factors.

**Methods:** The ELFE national birth cohort included, in 2011, 18,329 living births in 349 hospitals randomly selected. The present analyses were restricted to children with follow--up at age 2 years. Milk consumption was evaluated by parental telephone interview, and its association with socioeconomic factors was studied.

**Results:** The 12,341 analyzed children had a mean age of 26 months; 50% were girls. Rate of IFF use before 2 years old and at 2 years old was 65% and 43%, respectively. At age 2 years, use of IFF was lower with young age of the mother (adjusted OR [aOR]=0.4, 95% CI: 0.3-0.5), low educational level (aOR=0.7, 95% CI 0.6-0.9), high parity (aOR=0.3, 95% CI 0.2-0.4), and mother smoking (aOR=0.8, 95% CI 0.7-0.9) as well as low household income (aOR=0.5, 95% CI 0.4-0.7), and parents' unemployment (aOR=0.7, 95% CI 0.5-0.9).

**Conclusion:** In this national population--based study, the rate of implementation of the ID prevention strategy was much lower at 2 years old than before 2 years old , and significantly lower in disadvantaged populations.

**Key notes**

- Iron deficiency in infants is a target of various preventive strategies worldwide and their implementation needs to be evaluated notably in high--risk populations
- Among the 12,341 children in the ELFE national population--based birth cohort, rate of iron--fortified formulas use was lower at 2 years old (43%) than between 1 and 2 years old (65%)
- Iron--fortified formula use was significantly lower in disadvantaged populations

**Keywords.** Iron deficiency; primary prevention; infant formula; socioeconomic factors, population-based cohort study

## 1 **Introduction**

2 Iron deficiency (ID) is considered the most frequent micronutrient deficiency worldwide, including in  
3 industrialized countries, and is strongly suspected to be associated with adverse short- and long-term  
4 neurocognitive effects when it occurs in neonates and infants (1). In this context, ID is a target of  
5 various primary preventive strategies supported by medical societies and public health authorities,  
6 based on advices to parents for the consumption of naturally iron-rich foods during complementary  
7 feeding, and/or iron-fortification (e.g., formula or cereals) (2-4). In France, the preventive strategy  
8 involves both parental education during complementary feeding and consumption of iron-fortified  
9 milk at breastfeeding cessation (5). Iron-fortified formulas (IFFs) include “follow-on formula” with a  
10 mean iron content of 0.85 mg/100 ml that has been recommended since the 1980s for all non-  
11 breastfed infants from 6 to 12 months old and young child formula (called “growing-up formula”)  
12 with a mean iron content of 1.13 mg/100 ml that has been recommended since the 1990s for all non-  
13 exclusively breastfed toddlers aged 10-12 to 36 months (5).

14 As for any universal health policy based on parental education, one of the main challenges for  
15 ID preventive strategies is to reach disadvantaged parents with low educational level or socioeconomic  
16 status, the main risk factors for ID in young children (2, 4, 6, 7). Thus, post-implementation surveys  
17 are crucial to evaluate the impact of preventive strategies, notably among these populations. The most  
18 recent evaluations of the implementation of the French fortification strategy consisted of national  
19 studies, in 2005 and 2013. The surveys showed that the mean iron intake among French young  
20 children was above the recommended 7 mg/day until 24 months old but slightly lower (about 6.5  
21 mg/day) after (8, 9). The rate of IFF use globally increased between 2005 and 2013 but gradually  
22 declined with age of children in both studies, from 80% and 89% at 6-7 months to 52% and 60% at  
23 12-17 months, 27% and 57% at 18-23 months, and 27% and 32% at 24-29 months (8, 10). However,  
24 in these studies, recruitment was based on a quota method using few maternal socioeconomic  
25 variables with a likely selection bias. Furthermore, these studies were not able to evaluate associations  
26 between rate of IFF use and precise socioeconomic factors.

27 Our objective was to study the rate of IFF use in young children from 1 to 2 years old and its  
28 potential associations with socioeconomic factors by using data from the longitudinal French study

1 since childhood (ELFE) cohort, the first national population--based longitudinal cohort in France,  
2 currently following children from birth to adulthood (11).

3

4

## 5 **Methods**

### 6 *General methodology*

7 The present study is based on data from the ELFE cohort whose purpose was to characterize the  
8 relation between the environment and the development, health and socialization of children. After  
9 receiving information from the investigator, written consent was obtained from the mothers of  
10 included children. Approvals for the survey were obtained from local ethics and administrative  
11 authorities (the Advisory Committee for the Treatment of Information on Health Research n°13.004,  
12 the National Agency Regulating Data Protection n°913071, and the National Statistics Council  
13 n°2013X719AU). We used the Strengthening the Reporting of Observational Studies in Epidemiology  
14 (STROBE) guidelines to report this study (**Table S1**).

15

### 16 *Participant selection*

17 The ELFE cohort was launched in 2011 and enrolled 18,329 children for a projected 20--year follow--  
18 up. The protocol, design and recruitment procedures of the ELFE survey were previously described in  
19 detail (11). Briefly, participation in the survey was proposed to women giving birth in 349 maternity  
20 hospitals randomly selected (see below). Recruitment took place in 4 “waves” of surveys of 4 to 8  
21 days totalizing 25 days covering the four seasons. Newborns and their mothers and fathers were  
22 eligible for data collection if they fulfilled the following criteria: infant born alive, term  $\geq$  33 weeks’  
23 gestation, single or twin pregnancy, mothers aged 18 years and older, understanding the main  
24 implications of the study in one of four proposed languages (French, Arabic, English, Turkish), and  
25 living and planning to stay in France for at least 3 years.

26 The national recruitment was based on a two-stage (maternity hospitals then mothers) random  
27 stratified sampling design. The participation rate was 92% and 51% for contacted maternities and  
28 mothers, respectively (**Figure 1**). For the present study, young children whose parents withdrew

1 consent within the first year or had missing data on the criteria of eligibility were excluded, and one  
2 twin in twin pregnancies was randomly selected to avoid family clusters. At the 2--year--old follow--  
3 up, children with no survey completed by a referent parent, with no data available on milk  
4 consumption or with maternal milk as their main source of milk, were excluded.

5

#### 6 *Data collection and management*

7 The ELFE baseline assessment took place during the maternity hospital stay, with information  
8 collected by midwives during a face--to--face interview with the mother and from the mother's  
9 medical record. During the follow--up, telephone surveys took place at 2 months, 1 year and 2 years  
10 after delivery (11). In the present study, we used the following sociodemographic data: parents' age,  
11 country of birth, region of residence, educational level, professional status, smoking habits, mother  
12 living in a couple relationship, parity, family health coverage fully funded publicly as well as monthly  
13 household income. The following declarative dietary data were collected at the 2--year--old follow--  
14 up: any type of milk consumption from 1 to 2 years old, main type of milk consumption at 2 years old,  
15 and frequency of consumption of naturally iron--rich foods (meat, fish, and eggs) at 2 years old. The  
16 predefined categories of milk were IFF, cow's milk, or other types (soy, almond, rice or goat milk;  
17 other milk or vegetable beverage).

18 For statistical analyses, parental age was used as a fractional polynomial because there was a  
19 deviance to linearity and was presented in categories by convenience. Parents' country of birth was  
20 classified in two categories: France and other European countries versus countries with emerging and  
21 developing economies (CEE) according to the definition of the International monetary fund. Parents'  
22 educational level was classified in five categories according to the maximum level obtained. Parents'  
23 professional status was redefined in two categories, employed or not (including unemployed,  
24 housewife, retired, students, apprentices, and interns). Family health coverage fully funded publicly  
25 was also used because it is an indicator strongly linked to poverty in France.

26

## 1 *Statistical analysis*

2 All descriptive data (rates) were weighted to take into account the inclusion procedure and biases  
3 related to non-consent in order to provide results representative of births in 2011 in France. Weighting  
4 also included calibration on margins from the state register's statistical data and the 2010 French  
5 National Perinatal study, which is an unbiased source of information about women delivering in  
6 France (12), on the following maternal variables: age, region, marital status, migration status, level of  
7 education and primiparity. This weighting was calculated for the sample follow-up at 2 months, as  
8 well as for the subsample that completed the questionnaire at 2 years.

9 We first described the children's milk consumption itinerary. Then, we described the rate of  
10 IFF use from 1 to 2 years old and studied uni- then multivariable associations with socioeconomic  
11 characteristics by using a logistic regression model including potential confounders selected according  
12 to a literature review and characteristics related to study design (maternal region of residence; size,  
13 level, and legal status of the maternity unit; and wave of recruitment). To avoid collinearity between  
14 maternal and paternal age and educational level, we used a summary variable to express the  
15 differences between maternal and paternal variables. The same approach was used to analyze the rate  
16 of IFF use at 2 years old.

17 Sensitivity analyses were performed, repeating descriptive analyses without the 2 year-old  
18 statistical weighting, and repeating all uni- and multivariable associations with the weighting. Missing  
19 data were not imputed. The analyses involved use of Stata/SE v13.1 (StataCorp, College Station, TX,  
20 USA).

21

## 22 **Results**

### 23 *Participants*

24 A total of 17,586 neonates were enrolled in the initial studied cohort (**Figure 1**). At the 2-year-old  
25 follow-up, 13,038 questionnaires (74% of the studied cohort) were completed by the referent parent  
26 (99% were mothers). For 554 (4%) questionnaires, no information was available on milk consumption,  
27 and for 143 (1%) young children, maternal milk was the main source of milk, which resulted in a  
28 population analyzed of 12,341 children (70% of the studied cohort).



1           At the time of the interview, the mean age of children was 26 months (standard error of the  
2 mean [SEM]: 0.01), 50% were girls, and 1% had cow's milk protein allergy according to parents. The  
3 mean age of mothers was 31 years (SEM: 0.07), 15% were born in a CEE, 11% had a middle--school  
4 educational level, 31% a high educational level, and 31% were unemployed (**Tables 1 and 2**). The  
5 mean age of fathers was 34 years (SEM: 0.09), 15% were born in a CEE, 12% had a middle--school  
6 educational level, 27% a high educational level, and 9% were unemployed (Tables 1 and 2).

7  
8 *IFF consumption itinerary and frequency of consumption of non--dairy naturally iron--rich foods*  
9 From 1 to 2 years old, 65% of children received IFF, exclusively for 40% or with cow's milk for 24%;  
10 29% received cow's milk only (**Table 3**). At 2 years old, 43% received IFF as a main dairy source,  
11 and 50% cow's milk. Among the children consuming IFF exclusively from 1 to 2 years old, 91%  
12 continued to consume it at 2 years old, whereas 7% consumed mainly cow's milk. Among the children  
13 consuming IFF with cow's milk from 1 to 2 years old, 24% consumed IFF mainly, whereas 74%  
14 continued to consume cow's milk mainly at 2 years old.

15           At 2 years old, 55% of children ate meat, fish, eggs once a day versus 2% less than several  
16 times a week (**Table S2**).

17

### 18 *Factors associated with IFF use*

19 On univariate analyses, the rate of regular use of IFF from 1 to 2 years old was significantly lower  
20 ( $p < 0.05$ ) with young maternal age (54%  $< 25$  years old versus 71%  $\geq 35$  years old), single motherhood  
21 (62% versus 66% with the mother living in a couple relationship), high parity (54% with  $\geq 3$  children  
22 versus 71% primiparous), mother smoking (55% versus 68% not smoking), low maternal educational  
23 level (58% middle school versus 73%  $> 2$  years of university), family health care coverage fully funded  
24 publicly (60% versus 66% not), low monthly household income (59%  $< 1800$  euros versus 78%  $\geq$   
25 5 000 euros), and parents' unemployment (58% versus 68% both parents unemployed) (Table 1). This  
26 rate was significantly higher if the mother was born in a CEE (73% versus 64% born in  
27 France/Europe). On multivariable logistic regression analysis, regular use of IFF from 1 to 2 years old

1 was lower with low maternal age and educational level, high parity, mother smoking, and low monthly  
2 household income and higher with both parents born in a CEE (Table 1).

3 On univariate analyses, rate of IFF use as the main source of milk at 2 years old was  
4 significantly associated with similar socioeconomic factors as for IFF use from 1 to 2 years old, except  
5 mother's country of birth (Table 2). On multivariable logistic regression analysis, IFF use as the main  
6 source of milk at 2 years old was associated with parents' unemployment and similar factors as for IFF  
7 use from 1 to 2 years old but not country of birth (Table 2).

8 The sensitivity analyses showed similar results as the main results for descriptive data without  
9 2 year--old statistical weighting and for uni- and multivariable associations with the weighting (**Tables**  
10 **S3 and S4**).

11

## 12 **Discussion**

13 In industrialized countries, policies for ID prevention in young children are based on variable  
14 combinations of consumption of naturally iron--rich foods and/or fortification of specific food. Data to  
15 evaluate the implementation of these national strategies at a population level are limited, and those on  
16 the rate of IFF use after 1 year old are scarce. In this first French prospective nation--wide study, the  
17 rate of implementation of the ID prevention strategy by IFF use was much lower at 2 years old (43%)  
18 than between 1 and 2 years old (65%). These results are in line with those of a sample, with a likely  
19 selection bias, performed at the same time in 2013, more than 2 decades after this policy's launch (8).

20 We confirm a global incre(2,3ase in the rate of IFF use in France, already noticed in previous non--  
21 random samples (8, 10). In the few other industrialized countries where the rate of IFF use was studied  
22 in the 2000s, the observed rates were below reported French ones: 30% to 53% at 1 year old (13-17) to  
23 3.5% to 35% at 2 years old (13, 15, 18, 19). In one small randomly selected sample in the Czech  
24 republic, the rate was close to those in the present study: 74% and 35% at 1 and 2 years old,  
25 respectively (18). The difference between France and other industrialized countries is probably related  
26 to the specificities of the French national recommendations that were periodically and strongly  
27 reaffirmed and that are shared both by the national health agency and the French society for pediatrics  
28 (2, 3, 5). The main arguments supporting the French national strategy are that using IFF can replace

1 the use of cow's milk, which is a known independent risk factor of ID, and that an IFF based strategy  
2 is theoretically easier to implement in day-to-day practice as compared with a balanced diet (20). The  
3 scientific arguments supporting the French specific position are the results of randomized controlled  
4 trials (21), and the findings from larger observational studies (22, 23). In five population-based or  
5 nearly population-based studies performed in United Kingdom, France and The Netherlands, the  
6 effectiveness of IFF consumption on iron status after 1 year old was shown, including after adjustment  
7 for non-dairy iron intake, in four studies (20, 22-25). Therefore, IFF might be considered an effective  
8 means for ID prevention after 1 year when a balanced diet is difficult to achieve. However, these  
9 results will need confirmation because IFF provides non-heme iron, which is less absorbed than heme  
10 iron from meat and fish. In other industrialized countries, the American Academy of Pediatrics, the  
11 European Food Safety Authority (EFSA) and the European Society for Paediatric Gastroenterology  
12 Hepatology and Nutrition (ESPGHAN) do not recommend IFF as the main source of iron after 1 year  
13 old because they consider that iron intake from naturally iron-rich foods can achieve iron requirements  
14 at this age (2-4). Besides, the EFSA has indicated that "follow--on formulas" are adapted to iron  
15 requirements after 1 year old and that there is no need to recommend a specific composition for  
16 "growing--up formulas", a position endorsed recently by the ESPGHAN (26, 27). The rate of use of  
17 other modes of ID prevention proposed in industrialized countries has rarely been studied. In the  
18 United States, the use of fortified cereals at 1 year old was estimated at only 46% in 2005-2007 (16).

19         Given the importance of preventing ID among young children, notably neurodevelopmental  
20 consequences, the current implementation level of the French national strategy should not be  
21 considered successful, and populations that are not reached by this preventive strategy should be  
22 identified. The ESPGHAN and EFSA have identified the ability of any ID prevention program to  
23 reach at--risk populations as crucial for its effectiveness (3, 4). In the present study, many factors  
24 associated with lack of implementation of the French strategy for ID prevention by IFF use, were  
25 linked to low economic level: low monthly household income, parents' unemployment, family health  
26 coverage fully funded publicly, or single motherhood. Low economic level is well known to be  
27 associated with ID (2, 4, 7) and the lack of IFF use in some preliminary reports (14, 22). These results  
28 are also consistent with those showing that the early use of cow's milk is associated with low

1 economic level in Europe and the United States (28). Thus, a direct financial barrier for IFF use seems  
2 possible given the higher mean prices as compared with cow's milk. Indeed, the additional cost for a  
3 daily intake of 500 ml of IFF, as recommended in France, compared to an equivalent amount of cow's  
4 milk is about 10.9 to 28.3 euros per month (5). Such expenses represent between 0.6% and 1.6% of the  
5 poverty line for a French couple with a child less than 14 years old (i.e., monthly income < 1800  
6 euros), a situation observed in 9% of the families in our study . In France, the national  
7 recommendation of a daily intake of 500 ml of IFF is not financially supported, in contrast to other  
8 universal programs aiming at preventing nutritional deficiencies such as vitamin D. Financial support  
9 may help to reach more disadvantaged families by removing financial barriers for the implementation  
10 of this national ID prevention strategy as proposed in programs involving food vouchers for low-  
11 income populations in the United Kingdom or United States, although a variable effectiveness of these  
12 programs has been reported (29, 30).

13         The other factors we found associated with lack of implementation of the French strategy for  
14 ID prevention by IFF use were directly or indirectly related to non--financial barriers such as parental  
15 knowledge, practices, and experience related to recommended healthy behaviors: mother's young age,  
16 low educational level, mother smoking, and high parity. In other studies, adherence to nutritional  
17 guidelines in the first year of life has been found associated with high mother's educational level and  
18 age, independently of low economic level (15). In our study, most infants consumed non--dairy iron--  
19 rich foods at a frequency recommended by the national guidelines for complementary feeding. The  
20 observed strong independent association between lack of IFF use and high parity could have practical  
21 explanations: "same food for all children at home for convenience". Indeed, a higher number of  
22 children in the household is associated with the early introduction of meals similar to that for adults,  
23 before 2 years old (31). The association between high parity and low IFF use could also be related to  
24 increased parents' personal experience in nutrition and self--confidence regarding the absence of  
25 visible immediate consequences of ID, which is associated with only long--term neurodevelopmental  
26 impairment, barely detectable by parents on a routine basis (8). Thus, a better understanding of  
27 knowledge and attitudes related to non-financial barriers to IFF use will help develop adapted

1 implementation strategies for ID prevention programs, as has been done in other fields of infant  
2 nutrition (32).

3 From 1 to 2 years old, the rate of IFF use was “paradoxically” associated with both parents  
4 born in a CEE, a result that could be attributed to an active recommendation of IFF to these families  
5 estimated at higher risk of ID from healthcare professionals or also to an active willingness to integrate  
6 from these families. Such paradoxical socio--behavioral profile was found for mothers’ food  
7 consumption during pregnancy in the ELFE cohort (33).

8

### 9 *Limitations*

10 The main limitation of this study was related to selection bias. Indeed, despite efforts made to recruit  
11 and follow a representative national sample, agreement to participate in the study and adherence to the  
12 follow--up process was lower in the most disadvantaged families. This resulted in a sample more  
13 likely to have a high socioeconomic level than the French National Perinatal Survey (12). This  
14 attrition was in the range of existing birth cohorts in industrialized countries and the relation between  
15 high socioeconomic level and adherence to birth cohort follow--up is well described . This selection  
16 bias was taken into consideration in the analyses by using weighting at 2--year--old follow--up, and  
17 this correction did not significantly modify the uni- and multivariable analyses.

18 Other limitations are related to the design of the ELFE study and the lack of collection of  
19 blood samples in early infancy. Thus, we do not know if the IFF use in this population was associated  
20 with lower ID prevalence. We did not have precise data on iron intake, which prevented us from  
21 studying the role of IFF use compared to non--dairy iron--rich foods to reach iron requirements. An  
22 ongoing national study will contribute to addressing these questions [ClinicalTrials.gov Identifier:  
23 NCT02484274].

24

### 25 *Implications*

26 This nationwide study of a birth cohort compared to previous French data found an ascending rate of  
27 implementation of the recommendation of universal IFF use at exclusive breastfeeding cessation for  
28 ID prevention. This ascending rate was found in a population with a high socioeconomic level after

1 statistical correction of the selection bias by weighting. The confirmation of a suboptimal  
2 implementation among disadvantaged families reinforces the need to develop new strategies to reach  
3 these families, who are at risk of ID, as shown in several studies including recent ones in France (2-4,  
4 7, 22). Knowledge, attitudes, and practice surveys may be useful to better understand existing  
5 implementation barriers and to prepare educational messages and tools for general and high-risk  
6 populations.

7

1 **Abbreviations**

2 CEE: country with Emerging economy

3 ID: iron deficiency

4 IFF: iron--fortified formula

5

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12

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14 The funders mentioned previously in "sources of funding" had no role in the study design, data  
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17

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1 **Table 1.** Socioeconomic characteristics of participants and association with use of iron--fortified  
 2 formula (IFF) from 1 to 2 year--old

Characteristics	Proportion, %	Use of iron--fortified formula (IFF) <sup>1</sup>			
		IFF +, %	IFF -, %	Crude OR (95% CI)	Adjusted OR <sup>2</sup> (95% CI)
	<b>n = 12 341</b>	<b>65 %</b>	<b>35 %</b>		
<b>Mother's age (years)</b>					
≥ 35	23	71	29	-	-
30-34	34	66	34	0.87 (0.79-0.96)	0.75 (0.66-0.85)
25-29	31	65	35	0.75 (0.67-0.83)	0.57 (0.49-0.66)
< 25	12	54	46	0.44 (0.38-0.52)	0.36 (0.29-0.45)
<b>Age difference between parents</b>					
Same age	53	67	33	-	-
Father younger	8	67	33	1.01 (0.84-1.23)	0.97 (0.82-0.14)
Mother younger	39	63	37	0.86 (0.77-0.95)	1.10 (0.99-1.22)
<b>Sex</b>					
Male	50	65	35	-	-
Female	50	66	34	1.03 (0.96-1.11)	1.06 (0.98-1.16)
<b>Single motherhood</b>					
No	93	66	34	-	-
Yes	7	62	38	0.79 (0.64-0.96)	0.95 (0.59-1.54)
<b>Parity</b>					
1	44	71	29	-	-
2	35	63	37	0.68 (0.62-0.74)	0.54 (0.48-0.59)
3	14	59	41	0.54 (0.48-0.61)	0.39 (0.34-0.45)
≥4	7	54	46	0.41 (0.35-0.49)	0.29 (0.23-0.36)
<b>Mother's country of birth</b>					
France/ Europe	85	64	36	-	-
CEE <sup>3</sup>	15	73	27	1.54 (1.28-1.85)	-
<b>Father's country of birth</b>					
France/ Europe	85	65	35	-	-
CEE	15	69	31	1.06 (0.93-1.22)	-
<b>Parents' country of birth</b>					
Both from France/ Europe	79	64	36	-	-
One from CEE	12	68	32	1.13 (0.98-1.30)	1.13 (0.96-1.34)
Both from CEE	9	72	28	1.30 (1.06-1.59)	1.55 (1.17-2.06)
<b>Mother smoking</b>					
No	78	68	32	-	-
Yes	22	55	45	0.61 (0.55-0.67)	0.77 (0.69-0.86)
<b>Mother's education level</b>					
> 2 years of university	31	73	27	-	-
2 years of university	20	69	31	0.79 (0.71-0.88)	0.94 (0.83-1.06)
General high school diploma	19	62	38	0.57 (0.51-0.64)	0.84 (0.73-0.96)
Professional high school diploma	19	56	44	0.44 (0.39-0.49)	0.76 (0.64-0.90)
Middle school	11	58	42	0.48 (0.41-0.57)	0.84 (0.66-1.09)
<b>Education level difference between parents</b>					
Same level	39	67	33	-	-
Father with lower level	38	66	34	0.85 (0.78-0.93)	0.94 (0.85-1.04)
Mother with lower level	23	62	38	0.75 (0.68-0.83)	1.01 (0.89-1.15)
<b>Health coverage fully funded publicly<sup>4</sup></b>					
No	88	66	34	-	-
Yes	12	60	40	0.69 (0.59-0.81)	-

Characteristics	Proportion, %	Use of iron--fortified formula (IFF) <sup>1</sup>			
		IFF +, %	IFF -, %	Crude OR (95% CI)	Adjusted OR <sup>2</sup> (95% CI)
	<b>n = 12 341</b>	<b>65 %</b>	<b>35 %</b>		
<b>Monthly household income (euros)</b>					
≥ 5 000	10	78	22	-	-
4 000-4 999	11	73	27	0.76 (0.65-0.90)	0.83 (0.70-0.98)
3 100-3 999	19	68	32	0.63 (0.55-0.73)	0.78 (0.66-0.91)
2 500-3 099	26	63	37	0.50 (0.43-0.57)	0.68 (0.57-0.80)
1 800-2 499	18	57	43	0.39 (0.34-0.46)	0.58 (0.48-0.71)
<1 800	16	59	41	0.38 (0.32-0.45)	0.62 (0.49-0.79)
<b>Mother's employment</b>					
Employed	69	68	32	-	-
Unemployed	31	58	42	0.63 (0.57-0.69)	
<b>Father's employment</b>					
Employed	91	66	34	-	-
Unemployed	9	62	38	0.78 (0.68-0.91)	
<b>Parents' employment</b>					
Both employed	67	68	32	-	0.87 (0.78-0.97)
One unemployed	29	59	41	0.67 (0.61-0.74)	0.83 (0.63-1.11)
Both unemployed	4	58	42	0.58 (0.46-0.74)	0.93 (0.64-1.33)

1 <sup>1</sup> percentages of IFF use are weighted and the measures of associations (odds--ratios) are non--weighted

2 <sup>2</sup> adjusted odds--ratios for the following variables: mother's age, age difference between parents, child's sex, single

3 motherhood, parents' country of birth, mother's smoking, mother's education level, education level difference between

4 parents, monthly household income, and parents' employment

5 <sup>3</sup> CEE: countries with emerging and developing economies

6 <sup>4</sup> health coverage fully funded publicly, an indicator strongly linked to poverty in France

7

8 Abbreviations: CI= confidence interval, n= number of participants, OR= odds ratio

9

**Table 2.** Socioeconomic characteristics of participants and association with use of iron--fortified formula (IFF) at 2 year--old

Characteristics	Proportion, %	Use of iron--fortified formula (IFF) <sup>1</sup>			
		IFF +, %	IFF -, %	Crude OR (95% CI)	Adjusted OR <sup>2</sup> (95% CI)
	<b>n = 12 341</b>	<b>43 %</b>	<b>57 %</b>		
<b>Mother's age (years)</b>					
≥ 35	23	50	50	-	-
30-34	34	46	54	0.90 (0.82-0.99)	0.75 (0.67-0.85)
25-29	31	40	60	0.68 (0.61-0.74)	0.54 (0.47-0.61)
< 25	12	27	73	0.36 (0.30-0.42)	0.37 (0.29-0.46)
<b>Age difference between parents</b>					
Same age	53	46	54	-	-
Father younger	8	40	60	0.90 (0.79-1.03)	0.90 (0.77-1.04)
Mother younger	39	39	61	0.79 (0.73-0.85)	1.04 (0.94-1.14)
<b>Sex</b>					
Male	50	42	58	-	-
Female	50	43	57	1.04 (0.97-1.12)	1.07 (0.99-1.16)
<b>Single motherhood</b>					
No	93	43	57	-	-
Yes	7	35	65	0.68 (0.56-0.83)	1.23 (0.77-1.97)
<b>Parity</b>					
1	44	49	51	-	-
2	35	40	60	0.66 (0.61-0.72)	0.51 (0.47-0.56)
3	14	37	63	0.57 (0.51-0.64)	0.40 (0.35-0.46)
≥4	7	34	66	0.40 (0.33-0.47)	0.29 (0.23-0.36)
<b>Mother's country of birth</b>					
France/ Europe	85	42	58	-	-
CEE <sup>3</sup>	15	47	53	1.10 (0.97-1.26)	-
<b>Father's country of birth</b>					
France/ Europe	85	43	57	-	-
CEE	15	41	59	0.83 (0.73-0.94)	-
<b>Parents' country of birth</b>					
Both from France/ Europe	79	43	57	-	-
One from CEE	12	43	57	0.99 (0.87-1.12)	1.04 (0.89-1.21)
Both from CEE	9	44	56	0.89 (0.74-1.07)	1.24 (0.95-1.61)
<b>Mother smoking</b>					
No	78	46	54	-	-
Yes	22	31	69	0.58 (0.53-0.64)	0.77 (0.69-0.86)
<b>Mother's education level</b>					
> 2 years of university	31	53	47	-	-
2 years of university	20	48	52	0.79 (0.72-0.87)	0.96 (0.86-1.07)
General high school diploma	19	38	62	0.51 (0.46-0.57)	0.77 (0.67-0.88)
Professional high school diploma	19	31	69	0.36 (0.32-0.40)	0.67 (0.57-0.80)
Middle school	11	32	68	0.37 (0.31-0.44)	0.73 (0.57-0.95)
<b>Education level difference between parents</b>					
Same level	39	45	55	-	-
Father with lower level	38	43	57	0.84 (0.78-0.91)	0.95 (0.86-1.04)
Mother with lower level	23	40	60	0.70 (0.64-0.78)	1.02 (0.90-1.15)
<b>Health coverage fully funded publicly<sup>4</sup></b>					
No	88	44	56	-	-
Yes	12	33	67	0.55 (0.47-0.64)	-

Characteristics	Proportion, %	Use of iron--fortified formula (IFF) <sup>1</sup>			
		IFF +, %	IFF -, %	Crude OR (95% CI)	Adjusted OR <sup>2</sup> (95% CI)
	<b>n = 12 341</b>	<b>43 %</b>	<b>57 %</b>		
<b>Monthly household income (euros)</b>					
≥ 5 000	10	61	39	-	-
4 000-4 999	11	54	46	0.78 (0.68-0.90)	0.85 (0.74-0.99)
3 100-3 999	19	48	52	0.64 (0.57-0.73)	0.78 (0.68-0.90)
2 500-3 099	26	40	60	0.46 (0.41-0.52)	0.65 (0.56-0.75)
1 800-2 499	18	34	66	0.35 (0.31-0.41)	0.54 (0.45-0.65)
<1 800	16	32	68	0.30 (0.25-0.35)	0.52 (0.41-0.65)
<b>Mother's employment</b>					
Employed	69	47	53	-	-
Unemployed	31	35	65	0.58 (0.53-0.63)	-
<b>Father's employment</b>					
Employed	91	45	55	-	-
Unemployed	9	32	68	0.64 (0.56-0.74)	-
<b>Parents' employment</b>					
Both employed	67	48	52	-	-
One unemployed	29	36	64	0.61 (0.56-0.67)	0.82 (0.73-0.91)
Both unemployed	4	30	70	0.45 (0.35-0.58)	0.73 (0.54-0.98)

1 <sup>1</sup> percentages of IFF use are weighted and the measures of associations (odds--ratios) are non--weighted

2 <sup>2</sup> adjusted odds--ratios for the following variables: mother's age, age difference between parents, child's sex, single

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8 Abbreviations: CI= confidence interval, n= number of participants, OR= odds ratio

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1 **Table 3.** Milk consumption from 1 to 2 year--old and at 2 years old

Milk consumption	At 2 year--old				Proportion Total
	Iron--fortified formula	Cow's milk	Other type of milk <sup>1</sup>	No milk	
<b>From 1 to 2 year--old</b>					
<b>Iron--fortified formula only</b>	91% <sup>2</sup>	7%	~0%	2%	<b>40%</b>
<b>Iron--fortified formula and cow's milk</b>	24%	74%	1%	1%	<b>24%</b>
<b>Iron--fortified formula and another type of milk<sup>1</sup></b>	60%	11%	26%	3%	<b>1%</b>
<b>Cow's milk only</b>	~0%	98%	~0%	2%	<b>29%</b>
<b>Cow's milk and another type of milk</b>	0	79%	19%	2%	<b>1%</b>
<b>Another type of milk only</b>	3%	5%	85%	7%	<b>2%</b>
<b>No milk</b>	7%	25%	3%	65%	<b>3%</b>
<b>Proportion total</b>	<b>43%</b>	<b>50%</b>	<b>3%</b>	<b>4%</b>	<b>100%</b>

2 <sup>1</sup> soy milk, almond milk, rice milk, goat's milk, other vegetable beverage, other animal

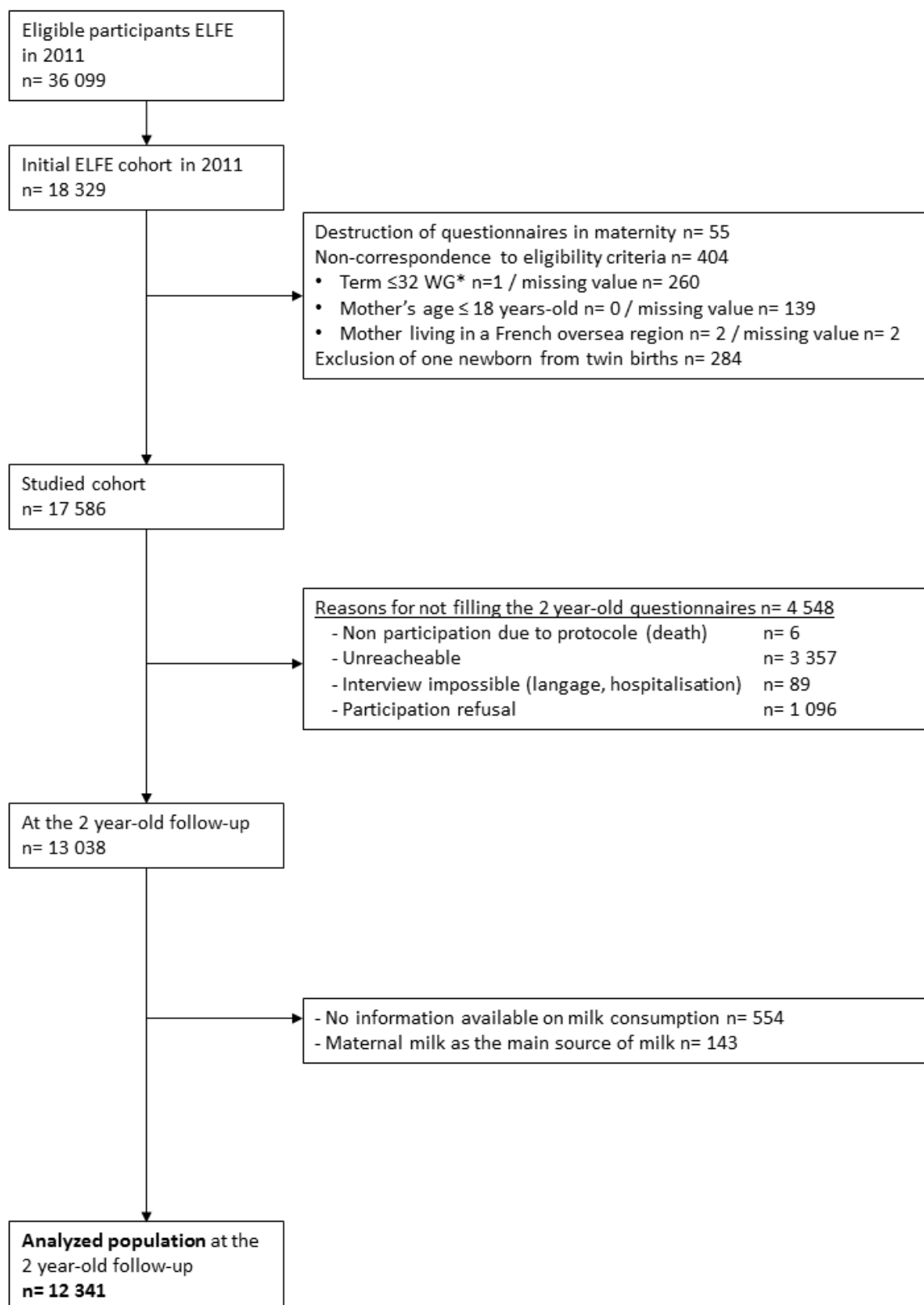
3 beverage

4 <sup>2</sup> row percentage

5

1 **Figure legend**

2 \*WG: weeks' gestation



3

1 **Figure 1.** Flow chart of the participants in the study