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Early Life Nutrition: Science, Safety, & Clinical Guidance



NEW INSIGHTS INTO SOY INFANT FORMULA AND LONG-TERM HEALTH

By Aline Andres, PhD, RD

What you need to know:

- **Soy infant formula results in similar growth and development as dairy-based infant formulas.** The Beginnings Study and Beginnings Follow-Up Study found no evidence of differences in growth, bone health, reproductive development, pubertal maturation, or overall cognitive function from infancy through adolescence.
- **Soy infant formula is a well-supported infant feeding option.** While breastfeeding remains the preferred feeding method, the Beginnings Studies provide reassuring evidence supporting the use of soy formula when chosen or medically appropriate.
- **The Beginnings Studies provide valuable evidence for patient counseling.** As one of the most comprehensive prospective studies of infant feeding, these studies offer long-term, real-world data to help health professionals confidently address common questions about soy infant formula.

The Beginnings Study and Beginnings Follow-Up Study represent some of the most comprehensive prospective research examining the long-term health effects of infant feeding practices.¹ The studies evaluated a broad range of outcomes including growth, body composition, bone health, cardiovascular health, reproductive development, neurodevelopment, and metabolic health. The studies involved adolescents who were healthy, full-term infants fed soy protein-based formula, cow's milk-based formula, or human milk.

For health professionals counseling families about infant feeding options, the findings are particularly valuable because they provide long-term data extending from infancy into adolescence. While breastfeeding remains the recommended infant feeding mode, the Beginnings findings offer important reassurance regarding the safety of soy infant formula and help address longstanding concerns about its effects on growth, development, and reproductive health.

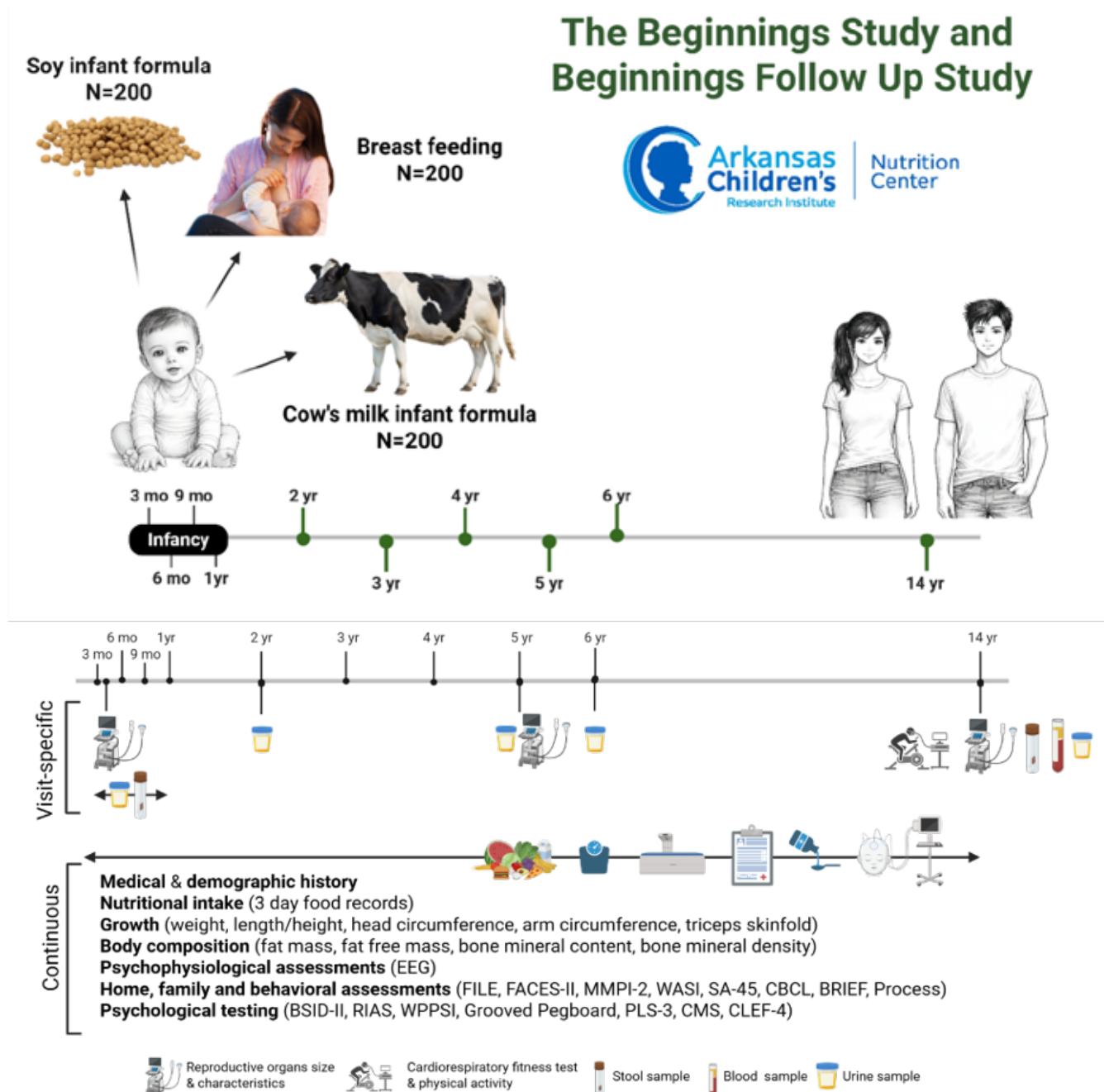
About the Study

The original Beginnings Study, initiated in 2002, enrolled 600 healthy term infants in Arkansas, with 200 infants in each of the following feeding groups: soy formula, cow's milk formula, and human milk. Participants were followed throughout infancy and childhood, with assessments conducted at regular intervals through age 6. A subset of participants later returned for the Beginnings Follow-Up Study at approximately 14 years of age, allowing researchers to evaluate adolescent outcomes (Figure 1).

A key consideration when interpreting the findings is that this research was an observational cohort study rather than a randomized controlled trial. Parents selected their infant's feeding method before enrollment, reflecting real-world feeding decisions. While this design limits the ability to establish causality, it provides clinically relevant information about outcomes associated with feeding choices as they occur in practice.

The study is notable for its breadth of assessment. Researchers evaluated dietary intake, growth, body composition, bone mineral density, reproductive organ development, pubertal maturation, neurodevelopment, autonomic nervous system function, microbiome composition, metabolomic biomarkers, and metabolic markers. No other infant feeding study has examined such a wide range of outcomes over such an extended period.

Figure 1: The Beginnings Study and Beginnings Follow-Up Study



Key Clinical Message: More Similarities Than Differences

Perhaps the most important overall finding is that there were substantially more similarities than differences between infants fed soy formula and cow's milk formula.

Across childhood and adolescence, soy formula was not associated with adverse differences in growth, skeletal development, reproductive health, pubertal maturation, or most measures of cognitive function. These findings are particularly important because concerns regarding soy formula have historically centered on its phytoestrogen content and the possibility that exposure to isoflavones during infancy could adversely affect endocrine, reproductive, or developmental outcomes later in life. Additionally, the studies reaffirmed findings consistently observed throughout the breastfeeding literature. Compared with formula feeding, breastfeeding was associated with lower adiposity and more favorable body composition measures later in life, as well as some early neurodevelopmental advantages.

Taken together, the findings support breastfeeding as the preferred feeding method while providing reassurance that soy formula remains a reasonable and safe alternative when breastfeeding is not possible, desired, or clinically appropriate.

Growth and Body Composition

One of the clearest patterns observed throughout the study involved differences between breastfed and formula-fed infants. During infancy, breastfed infants demonstrated slower weight gain and lower weight-for-length measurements than formula-fed infants. These findings are consistent with a substantial body of literature suggesting that breastfed infants follow a different growth trajectory than formula-fed infants. The differences persisted beyond infancy. Throughout childhood, children who had been breastfed generally exhibited lower BMI z-scores and lower fat mass indices compared with children who had received formula. By adolescence, those who had been breastfed continued to demonstrate lower fat mass indices and smaller waist circumferences. Importantly, the study did not identify meaningful differences between the soy formula and cow's milk formula groups. Adolescents who had received soy formula during infancy generally fell between the breastfed and cow's milk formula groups on body composition measures and were not significantly different from either group.

For clinicians, these findings reinforce two important messages. First, breastfeeding appears to confer long-term advantages related to adiposity and body composition. Second, soy formula does not appear to increase obesity risk or adversely affect body composition compared with standard cow's milk formula.

Bone Health and Skeletal Development

Bone health has historically been an area of concern regarding soy formula because soy contains phytates that may affect mineral bioavailability. Questions have also been raised about whether isoflavone exposure could influence skeletal development. The Beginnings Study provides some of the strongest prospective evidence available addressing these concerns.

Researchers observed some differences in bone mineral content during infancy. Breastfed infants demonstrated higher bone mineral content early in life, whereas formula-fed infants showed higher bone mineral content later in infancy. However, these early differences did not persist.

Through childhood and adolescence, researchers found no significant differences among feeding groups in bone mineral density or major skeletal outcomes. Assessments using dual-energy X-ray absorptiometry (DXA) and peripheral quantitative computer tomography (pQCT) demonstrated comparable bone health regardless of whether infants had received soy formula, cow's milk formula, or human milk.

Reproductive Development and Pubertal Outcomes

The reproductive findings are among the most clinically significant contributions of the Beginnings studies. Concerns have been raised that isoflavone exposure during infancy could affect reproductive organ development, alter pubertal timing, or influence future reproductive health. These concerns were addressed by using serial ultrasound evaluations and long-term follow-up into adolescence.

Researchers observed a small number of differences in reproductive organ size and characteristics during infancy. For example, some differences among groups in ovarian volume and ovarian cyst prevalence were identified among infant girls, while differences in testicular volume were observed among infant boys. However, these findings were transient and did not persist over time. By 5 years of age and again at adolescence, there were no significant differences among feeding groups in reproductive organ size or characteristics. Similarly, researchers found no differences in pubertal maturation. Measures including sexual maturity ratings and age at menarche were comparable across feeding groups.

These findings are particularly important because they represent data collected prospectively over more than a decade. Unlike retrospective studies, the Beginnings cohort tracked participants from infancy through adolescence

using standardized assessments and direct imaging methods. For clinicians discussing soy formula with families, the evidence from Beginnings provides strong reassurance that soy formula exposure during infancy is not associated with measurable adverse effects on reproductive development or pubertal timing through adolescence.

Neurodevelopment and Cognitive Outcomes

Understanding the neurodevelopmental findings is more complicated than other outcomes. On average, each group of infants in the study developed within normal ranges, regardless of feeding method. Across infancy, childhood, and adolescence, researchers did not identify evidence suggesting that soy formula negatively affected overall cognitive development.

Breastfed infants demonstrated some advantages in early cognitive and language-related measures as well as speech-processing patterns and cortical activity (EEG/ERP) during specific developmental windows. Researchers also observed differences in language-processing measures between breastfed and soy-fed infants. However, these findings were generally modest, varied across time points, and often disappeared as children aged. Most importantly, these early neurophysiological differences did not translate into clinically meaningful differences in overall cognitive performance. By 6 years of age, no significant differences were found among feeding groups in full-scale IQ, memory, language skills, or overall cognitive functioning.

Microbiome, Metabolomics, and Physiologic Findings

The research also generated valuable data regarding microbiome composition, metabolomics, and autonomic nervous system development. As expected, there were distinct microbial profiles among feeding groups. Breastfed infants demonstrated microbiome patterns commonly associated with human milk feeding, including greater abundance of *Bifidobacterium* and *Bacteroides* species. Soy-fed infants displayed unique microbial signatures, reflective of plant-based dietary intake, and greater microbial diversity than the other two groups. Similarly, urinary metabolomic analyses revealed distinct biochemical profiles among soy-fed infants, reflecting differences in nutrient composition and metabolism. While these findings are scientifically interesting, their clinical significance remains uncertain. Importantly, these differences did not translate into adverse health outcomes during childhood or adolescence. The primary value of these findings is that they confirm that soy formula represents a biologically distinct nutritional exposure.

Strengths and Limitations

The Beginnings Study and Beginnings Follow-Up Study possess several important strengths that enhance confidence in its findings. The studies were prospective, followed participants for many years, and included a relatively large sample size for a deep phenotype of the cohort. Researchers employed rigorous assessment methods including DXA imaging, reproductive ultrasonography, electroencephalogram, standardized neurodevelopmental testing, detailed dietary records (three-day food records), and statistical adjustment for multiple social and parental factors.

At the same time, important limitations should be recognized. Because the study was observational, unmeasured differences among feeding groups may have influenced outcomes. The breastfeeding group was also not fully breastfed for the entire first year, as ~57% of participants transitioned to cow's milk formula before age 12 months. Participant attrition represents another limitation. Only a subset of the original cohort completed adolescent follow-up assessments, raising the possibility of selection bias. However, a comparison of the completers vs. non-completers only identified a significant difference in feeding group, with more participants in the breastfeeding group completing the 14-year visit compared to the participants in the formula groups. Finally, the formulas studied reflected products available in the early 2000s. Although the findings remain highly relevant, clinicians should recognize that some product formulations have evolved since the study began.

Implications for Clinical Practice

The Beginnings studies provide some of the most comprehensive long-term evidence available regarding soy infant formula. The findings reinforce the recommendation that breastfeeding remains the preferred method of infant feeding and is associated with favorable body composition outcomes and some early neurodevelopmental advantages. Across more than a decade of follow-up, researchers found no evidence that soy formula adversely affected growth, bone health, reproductive development, pubertal maturation, or overall cognitive function.

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INFANT FORMULA THROUGH THE YEARS: SCIENCE, SAFETY, AND CLINICAL PRACTICE

By Michelle M. Bohan Brown, PhD, RDN

What you need to know:

- **Modern infant formulas are formulated by science.** Today's formulas are carefully designed using decades of research on human milk composition, infant physiology, and nutritional requirements to provide safe, appropriate nutrition when breastfeeding is not possible, insufficient, or not the family's chosen feeding method.
- **Safety is supported by rigorous oversight.** U.S. infant formulas must meet stringent FDA requirements for nutrient composition, manufacturing, growth and tolerance testing, and quality monitoring to ensure they are safe and nutritionally suitable for infants.
- **Infant formulas continue to evolve with emerging science.** Advances in understanding human milk, infant development, and ingredient technology continue to refine formula composition, while ongoing research and initiatives such as Operation Stork Speed seek to further strengthen product safety, transparency, and innovation.

Human milk from an infant's own mother is widely recognized as the gold standard for infant nutrition. However, when breastfeeding is not possible, insufficient, or not the family's chosen feeding method, health professionals play an important role in helping families select safe, nutritionally appropriate alternatives. Today, there are many options: mom's own milk supplemented with human milk fortifiers, mixed feeding of a combination of mom's own milk and formula or donor milk, sole donor human milk, or exclusive infant formula feeding.

From standard formulas for healthy, full-term infants to metabolic formulas for in-born errors of metabolism, infant formulas are developed using extensive scientific knowledge of human milk composition, infant growth and development, and infant physiology and metabolism. As technology and our understanding of infant nutrition advances, formulation of infant formulas can be designed with rigorous testing to ensure safety and nutritional suitability for intended use.

Origin Story — History of Infant Feeding

Before the development of modern infant formula, infants who did not receive human milk from their mother or wet nurse were often fed a variety of foods (gruel, pap, cereal, animal milk) that were not safe, reliable, or nutritionally complete.^{1,2} As a result, survival rates were poor. For example, in the early 1800s in London, around 10% of non-human milk fed infants survived to age 1.^{3,4} After the introduction of pasteurization, the benefit of pasteurized milk inspired physicians and scientists to develop milk-based infant formulas that could better support infant growth and survival.¹ The first commercial infant formula/food was developed by German chemist Justus von Liebig and consisted of wheat flour, cow's milk, malt flour, and potassium bicarbonate to correct pH.³ Following the success of von Liebig, others followed suit in the pursuit of producing formula for infants; however, all fell short of success as the nutritional composition was not suitable for infant growth and development. In 1915, synthetic milk adapted (SMA) was developed and was the first sole source formula based on human milk fat content.¹ However, there were still issues with micronutrient content that were present from the 1910s through the 1960s.^{1,5,6} As scientific understanding of infant nutritional requirements and human milk composition has advanced alongside technological innovation, today's infant formulas are vastly different from those available less than a century ago.

Designed to Meet Infant Needs: Human Milk as Inspiration

Human milk is the gold standard for infant feeding and is the inspiration for formula design. Formula designs and requirements evolve through advancements in knowledge of human milk and infant physiology and technology. Although all mammals produce milk, the composition of lipids, carbohydrates, and proteins varies considerably by species.⁷ The basis of early formula development focused on milk fat percentage.¹ Advances in our ability to characterize the full fatty acid profile of human milk has enabled manufacturers to use multiple fat sources to achieve fatty acid profiles that more closely replicate its composition.^{8,9}

In replicating human milk fatty acid composition, various sources of lipids are used in infant formulas today. No single ingredient source can replicate human milk; thus, all formulas are a mixture of different lipid sources to achieve a composition closer to human milk (Table 1). As evidenced by fatty acid composition in Table 1, the vegetable oil blend is closer in composition to human milk than the bovine milk fat with corn oil blend. Currently, infant formulas contain vegetable oils in varying amounts with or without bovine milk fat, typically added as whole milk. There are several reasons for the use of vegetable oils in infant formulas. Vegetable oils increase the mono- and polyunsaturated fatty acid content,¹⁰ allowing closer patterning to breast milk. In addition, the lower cost and greater availability of vegetable oils allow for more continuous supply and lower cost to consumers.¹¹ As our knowledge of human milk composition has advanced, other lipid sources have been added to infant formulas to pattern after breast milk and better meet the nutritional needs of infants.

One such prominent example of the application of recent scientific discovery is the addition of oils containing docosahexaenoic acid (DHA) in combination with arachidonic acid (ARA) to infant formula in the early 2000s. DHA is naturally present in breast milk and is important for cognitive and visual development in infants.¹²⁻¹⁴ Research-driven product innovation has also informed the protein and carbohydrates present in formula. Protein sources can be chosen to mimic the whey-to-casein ratio of human milk or more specialized ingredients found more prominently in human milk than cow's milk, such as alpha-lactalbumin and milk fat globule membrane.^{15,16} Formulas in the past 20 years have added carbohydrates beyond lactose and glucose polymers. These additional carbohydrates either mimic or are oligosaccharides found in human milk, which are important for gut microbiota, immunity, and stooling consistency and patterning.^{17,18,19} Many of the above advances in infant formula composition have occurred in the last quarter of a century.

Table 1: Fatty Acid Composition of Human Milk and Milk Fat and Vegetable Oil Formulas (Prior to Addition of DHA and ARA)*

Fatty Acids (g/100g FA)	Human Milk (Jensen 1996)	Mature Human Milk (Floris 2020)	Milk Fat Formula* _{a,b}	Vegetable Oil Formula* _{a,c}
Saturated FA				
C4:0	0.19	NR	3.21	0.04
C6:0	0.15	0.14	1.69	0.21
C8:0	0.46	0.25	0.99	2.13
C10:0	1.03	1.61	2.18	1.69
C12:0	4.4	6.14	3.04	13.07
C14:0	6.27	6.8	8.62	5.43
C15:0	0.43	NR	0.85	0.05
C16:0	22	22.2	24.76	26.5
C17:0	0.58	0.31	0.43	0.08
C18:0	8.06	6.46	8.62	3.86
C20:0	0.44	0.23	0.22	0.26
C22:0	0.12	0.1	0.11	NR
Monounsaturated FA				
C14:1	0.41	0.2	0.78	0.02
C16:1	3.29	2.3	1.13	0.16
C17:1	0.37	0.19	0.18	0.04
C18:1 trans isomers	2.67	2.03	2.41	0.39
C18:1 cis isomers	31.3	32.9	21.68	29.74
C20:1	0.67	0.45	0.1	0.15
Polyunsaturated FA				
C18:2 all trans isomer	1.15	0.12	2.41	0.39
C18:2 n-6 Linoleic	10.85	15	13.89	14.37
C18:3 n-3 Linolenic	1.03	0.97	0.71	1.33
C20:4 n-6 ARA	0.46	0.48	NR	NR
C20:5 n-3 EPA	0.12	0.09	NR	NR
C22:6 n-3 DHA	0.25	0.31	NR	NR

*Adapted from Berger 2000 (9). Note that these compositions are pre-addition of ARA and DHA to Infant Formulas in the United States.

^a Internal data, Nestle Research Centre, Lausanne, Switzerland.

^b Ingredients are bovine milk fat and corn oil

^c Ingredients are palmolein, soybean oil, coconut oil and residual amounts of bovine milk fat.

FA: Fatty Acid

Safety of Infant Formula and Operation Stork Speed

Worldwide regulations for infant formulas have different contaminant, nutritional, and labeling requirements, which can lead to confusion when comparing formulas from different countries and regions.^{20,21} Prior to the 1980s, the U.S. had no comprehensive federal regulations governing the nutritional quality or safety of infant formula. The Infant Formula Act, enacted in 1980 and strengthened through subsequent amendments, established requirements for formula manufacturing, safety, nutrient composition, quality control, labeling, and reporting.²⁰ Although additional amendments have been proposed, including legislation introduced on March 9, 2026 that remains under consideration,²² the Infant Formula Act continues to provide the regulatory framework for infant formula sold in the U.S. In addition, all infant formulas regardless of production location, must be registered with the FDA and meet federal safety and nutritional standards.²³

To introduce a new formula, a growth and tolerance trial is necessary to demonstrate its safety and nutritional suitability, in addition to providing other supporting data. The study follows strict criteria that includes enrollment of exclusively formula-fed infants younger than 2 weeks of age. Infants are followed for 15 weeks with three timepoints within the first month of the study, and once per month thereafter, to evaluate growth, feeding tolerance, and any adverse events.²³ Infant formulas introduced prior to 1980 did not necessarily undergo growth and tolerance trials that meet today's standards, or in some cases, any such studies at all. Evidence of safety for these formulas relies on other supporting scientific evidence and safe history of use from post market surveillance.

Operation Stork Speed was announced in March 2025 to "expand options for safe, reliable, and nutritious infant formula for American families"²⁴ through the thorough review of infant formula nutrients, increased transparency in communication and labeling, increased testing of contaminants and microbiological contaminants in formula, and increased research on infant and maternal nutrition and health outcomes.²⁴ In May 2026, Operation Stork Speed released the results of testing for contaminants in infant formula and human milk.²⁵ This analysis was in conjunction with FDA's Closer to Zero and FDA's routine food surveillance work for safe, reliable, and nutritionally suitable infant formula.

In brief, more than 300 infant formula samples available in the U.S. market were tested for lead, mercury, cadmium, arsenic, pesticides, and polyfluoroalkyl substances and phthalates. The vast majority of samples had undetectable or very low levels of contaminants, with all samples having levels of lead, mercury, arsenic, and cadmium lower than EPA requirements for drinking water.²⁶ More than 100 human milk samples from a state milk bank were also tested for lead, arsenic, mercury, and cadmium. The vast majority contained either undetectable or very low levels of these contaminants. For detailed information on methods and outcomes, see FDA's Infant Formula Product Testing Results.²⁵

Preventing bacterial contamination requires careful manufacturing and handling of both formula and human milk throughout the entire supply chain, from ingredient suppliers and manufacturers to distributors, transport, retailers, health professionals, and parents/guardians/caregivers. Safe infant feeding also depends on proper preparation and storage. Infant formula should always be prepared according to the manufacturer's instructions or healthcare provider's recommendations, and neither formula nor breast milk should be diluted.

Achieving contaminant levels that are as low as possible in formula will require coordinated efforts across academia, industry, government, and the public. Advances in testing methods and technology are also necessary to improve the detection of contaminants in both ingredients and finished formula products. Detecting specific contaminants in finished formulas is challenging because these products contain numerous ingredients, all bearing different compositions, matrices, and potential contaminants.²⁷ Additionally, all assays have limits of detection and limitations of sample composition/preparation, which can affect the ability to detect contaminants.

There are other factors beyond scientific evidence and safety regulations that must be met to ensure safe infant feeding and reduce contamination. Contaminants are present in our water, food/ingredients, and environment. Lowering contaminants in ingredients, formula, and human milk would require lower contaminants in the environment, food sources, and water. Infant formulas are evolving as science and technology advance. Together, we can improve the health and safety of nutrition for infants.

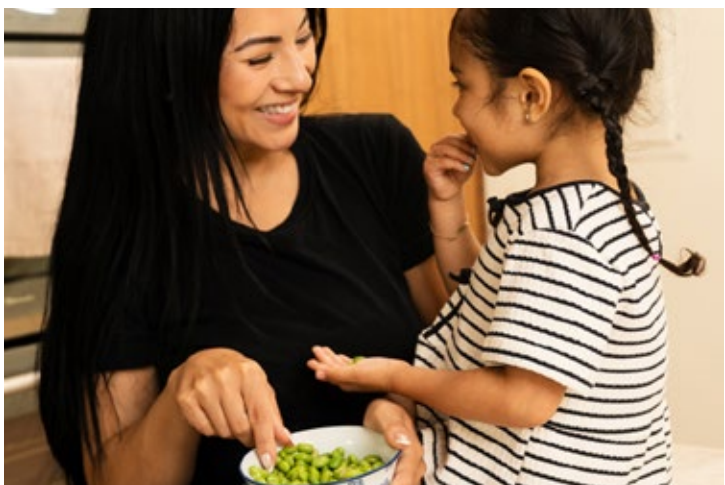
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SURVEY INSIGHTS: BRIDGING THE GAP IN SOY & CHILD NUTRITION COUNSELING

By Kaci Vohland, MS, RDN, LD

What you need to know:

- **Parents are seeking evidence-based guidance on nutrition.** Recent survey findings indicate parents place greater importance on nutritional value than many clinicians perceive and are receptive to discussions about soy infant formula and soy foods, creating opportunities for informed, individualized soy nutrition counseling.
- **Soy infant formula has a well-established safety profile for appropriate clinical use.** Decades of research support the nutritional adequacy of modern soy protein isolate-based formulas, with no evidence of adverse effects on growth, development, endocrine function, or reproductive health in healthy-term infants.
- **Health professionals can help close the gap between perception and evidence.** By addressing common concerns, particularly questions about hormonal effects and communicating the appropriate role of soy infant formula in pediatric practice, clinicians can help families make confident, evidence-based feeding decisions.

Soy protein-based infant formulas have been used for more than a century and were originally developed for infants who could not tolerate cow's milk-based formulas. Today, they are also used for infants with galactosemia, lactase deficiencies, and for families who prefer a plant-based dietary pattern (e.g., vegan). Decades of research continues to support the nutritional adequacy and safety of modern soy protein isolate-based infant formulas for healthy-term infants.¹ The American Academy of Pediatrics (AAP) has long recognized that soy formulas support normal growth and development while recommending their use for appropriate clinical indications rather than as a routine alternative to cow's milk-based formulas.² Although the AAP's 2008 clinical report was formally retired in 2025 as part of the Academy's routine document lifecycle, its evidence-based recommendations regarding appropriate use remain consistent with current pediatric practice.²

According to the International Food Information Council's (IFIC) 2025 Food and Health Survey, registered dietitians and health professionals are among the most trusted sources of nutrition information. Consumers rely on them for guidance about which foods to eat and which to avoid.³

What Do Parents and Health Professionals Think About Soy Infant Formula?

In 2025, a survey of 50 pediatric healthcare providers (HCPs) and 150 parents explored perceptions of soy and its role in child nutrition and development. Although the survey did not specifically assess attitudes toward soy infant formula, it did examine foods containing added soy protein. Key findings from the survey include:⁴

1. Both HCPs and parents agree that cost and child preference are prioritized when making nutritional decisions. Among HCPs surveyed, 70% believed cost and affordability were the primary drivers of parental nutrition choices, followed by taste and child preferences (56%). Parents, however, identified taste and child preferences as their top consideration (51%), with cost and affordability ranking second (40%).
2. Parents place greater importance on nutritional value than many HCPs realize. Forty-two percent of parents identified nutritional value as a top factor influencing their food choices, compared to just 22% of HCPs who believed parents prioritized nutrition. Although the survey focused on children ages 5–12 years rather than infants, the findings have important implications for infant feeding discussions. Parents choosing an infant formula often seek reassurance that it will support optimal growth and development. The assumption that

convenience or cost outweighs nutritional considerations may limit opportunities to discuss the evidence supporting appropriate formula options, including soy infant formula.

3. Both HCPs and parents view soy positively, but perceptions of soy consumption differ. Fifty-eight percent of HCPs and 52% of parents rated soy as a somewhat or very healthy nutritious choice for children/their child. Additionally, 72% of HCPs reported sometimes, often, or always recommending soy to patients, while 59% of parents said they regularly serve soy-containing foods to their children. Interestingly, 88% of HCPs said soymilk was the soy food parents most commonly provide, whereas the most frequently reported choice among parents (56%) was foods containing added soy protein.
4. Hormonal concerns remain the most common questions about soy (e.g., feminization in males and childhood puberty onset in females). The concerns HCPs most frequently hear from parents involve perceived hormonal effects in males (e.g., feminization; 74%) and females (e.g., early puberty; 68%). These questions often extend to soy infant formula because soy contains naturally occurring isoflavones (which are often classified as phytoestrogens or plant estrogens but are not the same as human estrogen). However, decades of clinical research consistently demonstrate that soy infant formula supports normal growth and development, with no evidence of adverse effects on sexual maturation, endocrine function, or reproductive health in healthy-term infants.^{1,2} After reviewing the available evidence, the AAP concluded that there is no conclusive evidence that dietary soy isoflavones adversely affect human development, reproduction, or endocrine function in infants.^{2,5}
5. Parents are receptive to evidence-based guidance on soy. One of the survey's most encouraging findings was that parents appear more open to discussing soy than many clinicians assume. More than 70% of parents reported feeling comfortable asking their HCP questions about soy, while 80% said they would be willing to introduce new soy-containing foods into their child's diet. In contrast, many HCPs believed parents would be hesitant because of taste preferences or preconceived negative perceptions. This disconnect presents an opportunity during infant formula counseling. Parents are not necessarily seeking to avoid soy-based formula discussion — they are looking for clear, evidence-based guidance on when soy infant formula is appropriate and when another formula may be a better choice. Both HCPs and parents expressed a desire for clearer recommendations from trusted organizations, including the AAP.

For health professionals, the challenge extends beyond understanding the science — it is ensuring that evidence-based guidance reaches the families who need it. The 2025 survey found that parents place greater importance on nutrition than many HCPs perceive and are receptive to professional recommendations.⁴ At the same time, HCPs expressed a desire for clearer guidance and educational resources to confidently address questions about soy.⁴ As misinformation about soy continues to circulate, clinicians have an important opportunity to close this gap. By understanding parents' priorities, drawing on the robust body of evidence, and clearly communicating the appropriate role of soy infant formula in pediatric practice, health professionals can help families make informed feeding decisions with confidence.

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