Feeding practices of infants and young children heavily influence their chances of short-term survival and their capacity to realise their long-term potential. They contribute to healthy growth, decrease rates of stunting and obesity and lead to higher intellectual development (Victora et al., 2016[9]). Starting at the beginning of a woman's pregnancy to the second birthday of her child, the first 1 000 days represent a key opportunity to ensure wellness and create the foundations of a productive and healthy life. Breastfeeding is often the best way to provide nutrition for infants. Breast milk provides infants with nutrients they need for healthy development, including the antibodies that help protect them from common childhood illnesses such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide (see Chapter 3. Child mortality). Breastfeeding is also linked with better health outcomes as children grow older (Rollins et al., 2016[10]). Adults who were breastfed as babies often have lower blood pressure and lower cholesterol, as well as lower rates of overweight, obesity and type 2 diabetes. Breastfeeding also improves IW, school attendance and is linked to higher income levels in adult life. More than 800 000 deaths among children under five could be saved every year globally, if all children 0-23 months were optimally breasted (Victora et al., 2016[9]). Breastfeeding also benefits mothers through its effect in fertility control, reducing the risk of breast and ovarian cancer later in life and lowering rates of obesity.

In LAC19, most of the countries reporting data have exclusive breastfeeding lower than the WHO goal with an average of 35% of children exclusively breastfed in the first 6 months of life (Figure 4.6). Over half of infants are exclusively breastfed in Peru, Bolivia and Guatemala, while the rate is lower than one in five in Barbados and less the one in ten in Dominican Republic.

After the first six months of life, an infant needs additional nutritionally adequate and safe complementary foods, while continuing breastfeeding. In 24 LAC countries with data, 83% of children receive any solid, semi-solid and soft foods in their diet, with Jamaica and Ecuador below 75%, and Argentina, Brazil, Cuba and El Salvador above 90%. Moreover, in average, 43% of children in LAC continued breastfeeding until having 2 years old, a rate below 30% in Saint Lucia and Brazil, and above 60% in Peru, El Salvador and Guatemala (Figure 4.7).

Exclusive breastfeeding is more common in lower and lower-middle income countries rather than higher income in LAC, as well as among poorer rural women with lower education than richer women with higher education living in cities (Figure 4.8). However, in countries such as Costa Rica, Dominican Republic, Jamaica and Paraguay, women living in urban areas breastfeed exclusively more than women in rural areas. Argentina is the only country with data where more educated and wealthier women show higher rates of exclusivity in LAC.

Key factors that can lead to inadequate breastfeeding rates are broad and encompass several dimensions of society. They include unsupportive hospital and health care practices and policies, lack of adequate skilled support for breastfeeding, specifically in health facilities and the community, aggressive marketing of breast milk substitutes and inadequate maternity and paternity leave legislation and unsupportive workplace policies. In conclusion, considering persisting high levels of children malnutrition, infant and young child feeding practices must be further improved to tackle current and forthcoming challenges (Rollins et al., 2016[10]).

Definition and comparability

Exclusive breastfeeding is defined as no other food or drink, not even water, other than breast milk (including milk expressed or from a wet nurse) for the first six months of life, with the exception of oral rehydration salts, drops and syrups (vitamins, minerals and medicines). Thereafter, to meet their evolving nutritional requirements, infants should receive adequate and safe complementary foods while continued breastfeeding up to two years of age or beyond.

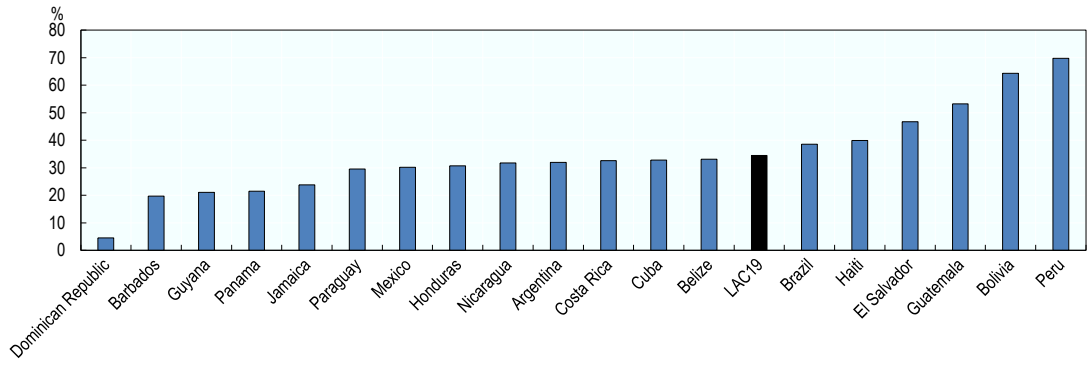
The usual sources of information on the infant and young child feeding practices are household surveys. They also measure other indicators of infant and young child feeding practices such as minimal meal frequency, minimal diet diversity and minimum acceptable diet. The most commonly used survey formats are the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS).

References

[10] Rollins, N. et al. (2016), "Why invest, and what it will take to improve breastfeeding practices?", *The Lancet*, Vol. 387/10017, pp. 491-504, *http://dx.doi.org/10.1016/s0140-6736(15)01044-2*.

[9] Victora, C. et al. (2016), "Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect", *The Lancet*, Vol. 387/10017, pp. 475-490, *http://dx.doi.org/10.1016/s0140-6736(15)01024-7*.

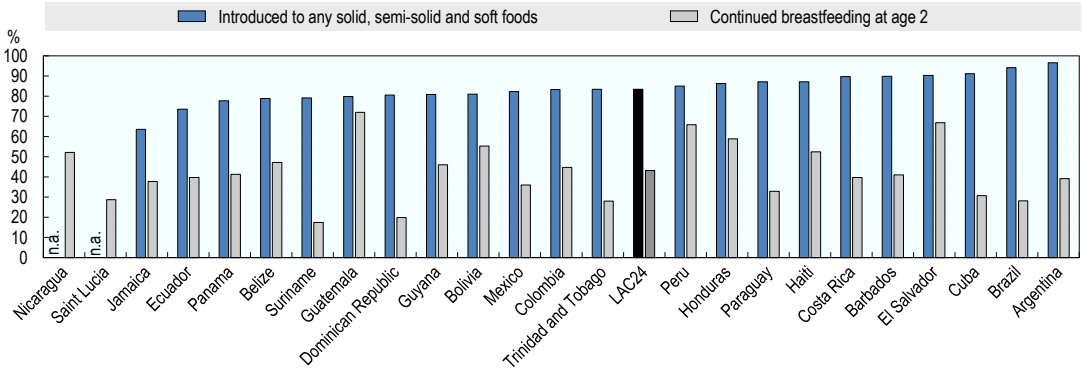
Figure 4.6. **Infants exclusively breastfed – first 6 months of life, 2016 or nearest year**



Source: UNICEF World Children Report 2017.

StatLink https://stat.link/cn87jk

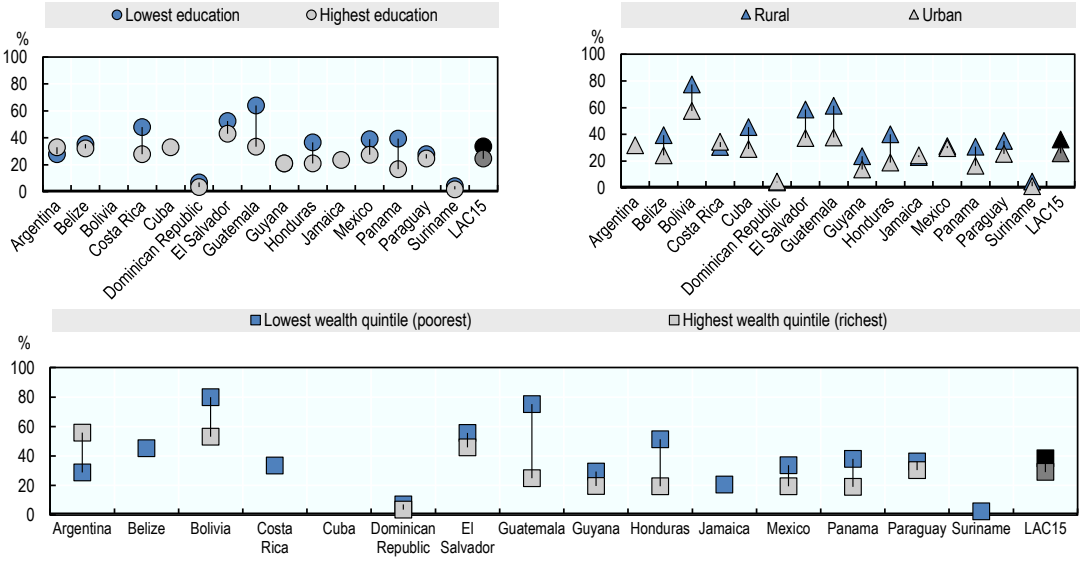
Figure 4.7. **Feeding practices after six months of age, selected countries (2006-17)**



Source: DHS and MICS surveys 2006-17; UNICEF Infant and young child feeding.

StatLink https://stat.link/h0ql1a

Figure 4.8. **Infants exclusively breastfed in the first six months of life, by select socio-economic and geographic factors**



Source: DHS and MICS surveys 2006-17; UNICEF Infant and young child feeding.

StatLink https://stat.link/0xvak7