# Breastfeeding in Argentina. A personal challenge

The importance of breastfeeding promotion and protection as a public health policy is widely recognized. But how to do it, not so much. This is because to do it, we have to know our reality. The first question is how many, which advances to why, and should be followed by what I can do.

Based on the National Survey on Breastfeeding, whose results are analyzed in this issue of *Archivos Argentinos de Pediatría*, Mangialavori et al.,[1] attempted to answer the initial questions: How many mothers seen in the public health system breastfeed their infants? And which of the many known factors affect this possibility? As the results of this study get published, some reflections arise.

First of all, it is worth noting that 20% of surveys were left out because participants were out of the age range or intake data were missing. Although such data loss is common in studies that use this methodology, we should wonder whether there is room for improvement. Actual data are critical for the implementation of effective policies. The concept of action responsibility and accuracy should be introduced at an early stage of education, both at home and at school, across all levels.

Another aspect is that 46.5% of infants younger than 6 months were receiving milk substitutes and, in 28.3% of cases, it corresponded to cow's milk, which is inadequate for infant growth and development needs given its high protein content, its lower antibacterial activity, its high renal solute load and higher risk for dehydration, and its association with amino acid, essential fatty acid, iron, zinc, and vitamin deficiency.[2]

The question why families opted for cow's milk as a substitute for their infants remains unanswered: Is it ignorance? A lack of financial resources to access infant formulas? Both of these scenarios depict the vulnerability and progressive worsening in lack of opportunities.

Delivery via C-section was associated with a lower prevalence of breastfeeding. In the public sector assessed in the study, 39% of births corresponded to C-sections. This figure almost doubles in the private sector, where the only few available data indicate it is 66.8%.[3] C-sections should not interfere with initial breastfeeding in the delivery room. The WHO recommends skin-to-skin contact between the mother and the baby immediately after birth, regardless of the type of delivery,[4] an intervention associated with breastfeeding promotion and a better breastfeeding duration.[5]

A low birth weight was also associated with a lower prevalence of breastfeeding. This information reflects the interferences occurring during the birth of these children in the delivery room due to the need of prioritizing their care. Not all newborns with a birth weight of less than 2500 g require immediate specialized care. Among stable newborns, it is possible to respect a timely cord clamping, an early skin-to-skin contact with the mother, initial breastfeeding in the delivery room, and even rooming in of mothers and their infants. Trained staff, an adequate infrastructure, and, above all, motivation, are required to this end.

Separation of the mother-child dyad reduces as knowledge about the importance of not doing it increases and as the health care team becomes more involved to maintain a continuous bond between the mother and the child, even in special situations. The mother-child dyad should never be separated when simple controls and care are required. Therefore, it is necessary to prioritize the importance of rooming in, medical and nursing staff training, and the development of health care protocols for these cases. Even when a newborn infant is admitted to the neonatal intensive care unit, parents should become part of the health care team, regardless of schedules, and receive support for breastfeeding initiation and continuation. All these actions call for a mind shift and imply an effort, but in the light of current knowledge, they are not optional.

The drop in breastfeeding rate after hospital discharge has a multifactorial origin, from a lack of critical guidance during the secretory activation in the first weeks of life to early return to work or a lack of breastfeeding support at child care centers.

The study by Mangialavori et al., provides data from public facilities. The private subsector of the Argentine health system is highly heterogeneous. In 2019, out of 622 038 live births, 257 328 (40.9%) took place in unofficial health centers, which accounts for a huge proportion of the mother and child population for whom no data are available, with a high rate of C-section deliveries and varying health care protocols.[6]

Many of the considerations made here are known. But they are meaningless if the person reading them does not rise to the challenges that may improve a situation of prime importance. From a wide vision, the list of possibilities is overwhelming: having reliable databases; implementing breastfeeding promotion and protection measures in the delivery room; improving rooming in care; making the family part of neonatal intensive care; creating breastfeeding support groups, especially for the first weeks after delivery; training staff at child care centers that accept infants to continue breastfeeding when the mother-child dyad is mandatorily separated.

We should at least commit to doing whatever is within our reach in our workplace and at this time of our professional career.

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http://dx.doi.org/10.5546/aap.2022.eng.148

**To cite:** Rossato NE. Breastfeeding in Argentina. A personal challenge. *Arch Argent Pediatr* 2022;120(3):148-149.

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