OUR APPROACH: **SHAPING NATIONAL POLICY**

Expanding breastfeeding by HIV-positive mothers in Nigeria: from consensus to action

In August 2011, Nigeria updated its National Policy and Guidelines on Infant and Young Child Feeding to include resolute language that instructs health workers to counsel HIV-positive mothers to breastfeed their infants and take anti-retroviral drugs during the breastfeeding period or longer. This policy abandons an approach in which these mothers were advised that breast milk and formula are equal options. Thanks to the consensus statement, adopted by the Nigerian Federal Ministry of Health (FMOH) and its partners more than one year before the policy became official, the country is able to take early action toward improving the survival of children affected by HIV through better feeding practices.

The Infant & Young Child Nutrition (IYCN) Project supported the FMOH and collaborated with a wide range of partners to achieve the recent policy changes. This document describes the experiences of IYCN and partners in influencing, shaping, and disseminating the new policy as part of national efforts to prevent malnutrition and improve HIV-free survival of children.

Settling confusion about feeding options

Nigeria's decision to promote a single feeding option in the context of HIV was a direct response to the World Health Organization's (WHO) 2009 rapid advice on HIV and infant feeding and its 2010 guidelines on HIV and infant feeding. When WHO supported six months of exclusive breastfeeding by HIV-positive mothers for the first time in 2006, it introduced the measure as an alternative to replacement feeding when artificial feeding was not acceptable, feasible, affordable, sustainable, and safe. Unfortunately, providing the high level of quality counseling required for conveying the risks of breastfeeding versus artificial feeding proved difficult in low resource settings, resulting in mothers getting biased advice rather than the information they needed to make an informed choice. The importance of exclusive feeding—either breastmilk or formula—for the first six months of life proved especially difficult to convey, as exclusive breastfeeding for six months is uncommon in many countries, and many HIV-infected mothers in countries where breastfeeding is the norm felt compelled to breastfeed in public to avoid revealing their HIV status. In the particular case of Nigeria, only 13 percent of mothers practice exclusive breastfeeding for the first six months of life, leading to high rates of malnutrition and contributing to a alarming infant mortality rate of 75 deaths per 1,000 live births.

The danger of mixed feeding—adding other foods or liquids before six months of age—is even more acute in the context of preventing the transmission of HIV from mothers to children. According to UNICEF, the risk of HIV transmission through breastfeeding is three to four times higher among infants who are mix-fed as opposed to those who are exclusively breastfed. It is believed that mixed feeding in the first six months poses a greater risk of transmission because the other liquids and foods given to a baby can damage their already delicate and permeable gut wall, creating opportunities for the virus to invade. Moreover, mixed feeding can have the same risks of contamination and diarrhea as artificial feeding (in non-ideal conditions).

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At the same time that experience was building to indicate that individual counseling for feeding choices was not working, exciting new findings emerged from research, demonstrating that antiretroviral (ARV) drug regimens for the HIV-infected mother and/or her baby can reduce the risk of HIV transmission through breastfeeding to very low levels. With these factors in mind, WHO's 2009/2010 recommendation urged national authorities in all countries to promote a single option for feeding infants that provides the best chance for HIV-free survival—whether breastmilk with ARV interventions or commercial formula—and abandon individual counseling approaches that attempt to explain the risks of different options and help mothers choose between them. The organization also expanded its earlier guidance to include earlier initiation of ARV medicines for HIV-positive women who are pregnant and continuing breastfeeding (with the introduction of complementary foods at six months of age) to twelve months instead of six.

While WHO stopped short of specifically recommending exclusive breastfeeding as the better option for preventing child mortality in the developing world, it is broadly recognized that the majority of poor countries lack the socio-economic conditions and adequate health services to make replacement feeding a practical option at the population level.

"I am proud that our nation came to a decision that protects and supports breastfeeding. With the high level of malnutrition among children under five and the low rate of exclusive breastfeeding, we need to promote consistent messages about infant feeding and ensure that optimal breastfeeding is the norm in Nigerian society."

—Prince Wasiu Afolabi, Former IYCN Country Coordinator

Adapting WHO breastfeeding recommendations in Nigeria

Nigeria was quick to respond to the WHO recommendations by beginning a review of its own policies in early 2010. The process would often prove to be somewhat tricky, though. In fact, during initial consultations organized by the national prevention of mother-to-child transmission (PMTCT) task team, some participants argued for validating replacement feeding as the method of choice for HIV-positive mothers.

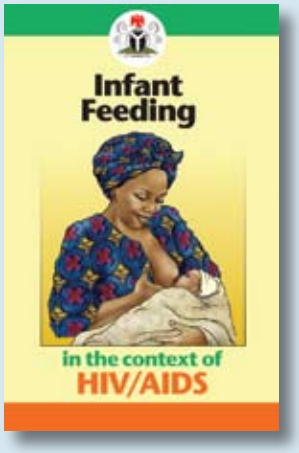
From the IYCN project's perspective, a hasty decision in favor of artificial milk not only ignored the risk it poses to child survival, but also the economic challenge of sustaining exclusive replacement feeding. As in many countries, there are well documented cases of Nigerian mothers using far-too-little formula when preparing milk as a way to make supplies last longer.

Stakeholders recognized that *any* recommendation needed government leadership and broad support from partners including nutrition, PMTCT, and orphans and vulnerable children (OVC) stakeholders. IYCN encouraged the original group to discontinue its deliberations and then supported the FMOH to organize meetings involving a broad array of partners, including funding logistical needs.

As a result, a series of national consultative meetings between nutrition and PMTCT stakeholders was kicked off in May 2010. The FMOH's HIV/AIDS and Sexually Transmitted Disease Control Program and Nutrition Division jointly led the discussions. Key players included the National PMTCT Task Team, UNICEF, WHO, and non-governmental organizations including the Network of People Living with HIV/AIDS in Nigeria, Pediatrics Association of Nigeria, Nutrition Society of Nigeria, and the Society for Obstetrics and Gynecology of Nigeria.

The group engaged in advanced discussions on what is practical from an economic and programmatic point of view. During one meeting, IYCN presented the benefits of promoting the breastfeeding option and explained the research behind

Turning consensus into action



Nigeria's new direction for infant feeding in the context of HIV was outlined in a brochure published in May 2011. The IYCN Project assisted in its development and printed 50,000 copies for immediate distribution to health workers in all 36 Nigerian states, plus the Federal Capital Territory, who were also provided a short session from the FMOH to review the brochure contents.

At the same time, IYCN began to support the FMOH to integrate the measures into a national curriculum for facility- and community-level workers. Adding to that, IYCN distributed copies of the brochure in several universities to make health and nutrition programs aware of the consensus statement. And, during World Breastfeeding Week in August 2011, the Minister of Health took part in a two-hour television program that discussed the need for exclusive breastfeeding in Nigeria—a message that was repeated on radio programs that aired for some time afterward.

All of this was going on months in advance of the August 2011 update to Nigeria's National Policy on Infant and Young Child Feeding that made the breastfeeding-only counseling approach official. Consensus statements like the one produced by the FMOH-led consultative group have been an effective way to enable quick action in many countries to on new and modified health strategies whose life-saving benefits should not be delayed by the often-lengthy process of fully enacting a policy update. Government decrees have been used to a similar effect in numerous places as well.

the WHO guidelines. The stakeholders eventually came to consensus that the best avenue for improving the HIV-free survival of children born to HIV-positive mothers in Nigeria was to only promote exclusive breastfeeding for the first six months of life and continued breastfeeding along with complementary feeding until twelve months.

This new *National Consensus on Infant Feeding in the Context of HIV* did not eliminate the potential of women opting for replacement feeding, but they will now only receive counseling on doing so if they specifically ask on their own. That being said, to further drive home the importance of exclusive breastfeeding in the context of HIV and in light of the way formula is so often under-used by families, the FMOH discourages HIV positive mothers from using formula and recommends against formula donations.

Is consensus reached at the program level shared on-the-ground?

Clearly, if counselors and families do not agree with consensus that is reached by program stakeholders, changes in feeding practices will not occur. Babajide Adebisi, Country Coordinator for the IYCN Project, remarked, "Although mixed feeding is so common in Nigeria, there has always been a strong sentiment amongst health workers and mothers that replacement feeding is not practical, mainly because of the cost." He further explained, "Nigeria's new policy on feeding in the context of HIV capitalizes on this sentiment by reinforcing the message to HIV-positive women that breastfeeding is the right choice and by providing them with improved counseling for optimal breastfeeding."

Adebisi estimates that seven of every ten health workers responded positively to the *National Consensus on Infant Feeding in the Context of HIV* when they first received their brochures and began implementing the new recommendations. "Many of the health workers who are still undecided work on PMTCT programs, and are waiting to see if upcoming guidelines for those programs will include the breastfeeding-only counseling approach," he said, noting that three of the key contributors to the consensus statement are now working on the new PMTCT guidelines. Adebisi also expects that the launch of full-fledged training will be a powerful means for further sensitizing health workers and addressing doubts.

IYCN concluded its Nigeria program in October 2011. Its role in influencing and supporting policy change that will lead to increases in exclusive breastfeeding by HIV-positive mothers is one of the project's most important and sustainable contributions to the country.

ABOUT THE INFANT & YOUNG CHILD NUTRITION PROJECT

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