B) HIV-infected woman who does not need ART for her own health

1st option: Centres with capacity for highly active antiretroviral therapy (HAART)

Mother: Start HAART prophylaxis from 14 weeks gestation or as soon as possible after presentation for ANC or HIV diagnosis, and continue until one week after cessation of breastfeeding.

Baby: Daily nevirapine for the first six weeks of life only.

2nd option: Centres without capacity for HAART

Mother: Start daily AZT from 14 weeks gestation or as soon as possible after presentation for ANC or HIV diagnosis; single-dose nevirapine at onset of labour; AZT + lamivudine during labour, delivery, and for seven days after delivery.

Baby: Daily nevirapine from birth until one week after cessation of breastfeeding. Breastfeed exclusively for the first six months, introducing complementary foods thereafter, and continue breastfeeding up to 12 months of age.

C) HIV-positive pregnant woman detected for the first time in labour

Mother: Evaluate for HAART eligibility and start on treatment accordingly.

Baby: Daily nevirapine until one week after cessation of breastfeeding.

D) HIV-positive mother who is Tuberculosis (TB) co-infected

Mother: Start anti-TB drug first. Evaluate and start ARV from 14 weeks gestation, or as soon as possible after commencement of anti-TB drug.

Baby: INH prophylaxis for the first six months of life. Daily nevirapine for the first six weeks of life.

NOTE: In all scenarios, even when the mother chooses not to breastfeed, her baby should receive daily nevirapine for the first six weeks of life.

10. Where can I get more information?

For more information, please contact the Nutrition Division, Federal Ministry of Health, Federal Secretariat, Phase 3, 10th Floor, Central Area, Abuja OR HIV/ AIDS Division (NASCP), 2nd Floor, Edo House, Ralph Shodeinde Street, Central Area, Abuja.

The **Federal Ministry of Health** is committed to these recommendations as an important step to improving the health and survival of mothers and children in **Nigeria**.

Published by the Federal Ministry of Health in collaboration with its partners. 2011.

World Health Organization unicef USAID FROM THE AMERICAN PEOPLE IYCN

Infant Feeding

in the context of HIV/AIDS

1. Who is the audience for this document?

This flyer is intended for policymakers, health workers, support groups,NGOs, donors, UN agencies, and other stakeholders.

2. Why is infant feeding important?

Babies have specific nutritional needs and are born with an undeveloped immune system. Therefore, infants and young children need food that meets these demands. Breast milk remains the best food for infants, as it provides both nutrients and immune support, which contribute to optimal survival, growth, and development.

The Federal Ministry of Health (FMOH) emphasizes the value of breastfeeding for mothers as well as for infants and young children. It recommends exclusive breastfeeding for the first six months of life, with the introduction of appropriate complementary foods while continuing breastfeeding for up to two years and beyond. However, within the context of HIV, specific infant and young child feeding recommendations exist.

3. Why do we talk about infant feeding within the context of HIV?

A few babies born to HIV-infected women may become infected through breastfeeding. At the same time, many babies who are not breastfed because of fear of HIV transmission die from diarrhoea, pneumonia, or other diseases (not related to HIV), because they are not protected by the immune substances found in breast milk. Thus, HIV-infected mothers need to be well guided on how best to feed their infants to ensure that more babies survive without becoming infected with HIV.

4. What are the new updated national recommendations on HIV and infant feeding?

Following extensive review of evidence-based research, global recommendations were issued and consensus was reached at a national consultative meeting on the following points:

- The goal of all prevention of mother-to-child transmission (PMTCT) interventions in Nigeria is **HIV-free survival,** which focuses on both prevention of HIV transmission and child survival.

- All mothers, including HIV-infected mothers, should exclusively breastfeed their infants for the first six months of life and introduce complementary foods at six months of age. However, HIV-infected mothers should continue breastfeeding until 12 months, while mothers who are HIV-negative should continue breastfeeding for up to two years and beyond.

- Improved complementary feeding of all infants, especially those born to HIV-infected mothers, should be promoted, and where possible, supported.

- The FMOH will continue to provide antiretroviral (ARV) drug interventions to reduce the risk of HIV transmission through breastfeeding, and strongly recommends that all mothers, including those known to be HIV infected, breastfeed their infants.

- HIV-infected mothers should be assessed to determine if they need lifelong antiretroviral therapy (ART), according to national recommendations, and if so, should start as early as possible after presentation for antenatal care (ANC) or HIV diagnosis.

- If HIV-infected mothers do not require ART for their own health, ARVs should be started to reduce the risk of HIV transmission, and provided until one week after the end of all breastfeeding.

5. What is the basis for these recommendations?

- ARVs can safely prevent 99 percent of HIV transmission through breastfeeding.

- Exclusive breastfeeding results in significant survival and economic benefits.

- Formula feeding is associated with increased infant mortality from malnutrition, diarrhoea, and pneumonia.

- In Nigeria, a large number of women practice mixed feeding (giving both infant formula and breast milk), which has been proven to significantly increase the risk of HIV transmission to the baby.

6. Is counselling on infant feeding options still necessary?

No, health workers should no longer counsel HIV-infected mothers on infant feeding options.

Before this recommendation, health workers used to provide information on all the feeding options available, and allowed HIV-infected mothers to make decisions based on individual circumstances. This is no longer necessary because the FMOH strongly recommends that HIV-infected mothers exclusively breastfeed their infants for the first six months of life and thereafter introduce complementary foods with continued breastfeeding up to 12 months. ARVs will be provided during the period of breastfeeding, according to the national guidelines.

7. What if an HIV-infected mother decides not to follow the new recommendations?

If an HIV-infected mother decides not to breastfeed her baby, health workers should provide support, such as advising the mother on how to make nutritionally adequate and safe food for her baby. Otherwise, they should refer the mother to where she can receive such support.

8. What is the role of ARVs in HIV and infant feeding?

There is evidence that ARVs given to either the HIV-infected mother or HIV-exposed infant can significantly reduce the risk of post natal transmission through breastfeeding. Accordingly, the FMOH has modified existing guidelines on the use of ARVs for PMTCT.

9. What are the Nigerian guidelines on the use of ARVs in the context of HIV and infant feeding?

The Nigerian guidelines are a set of specific ways of using ARVs in different clinical settings for PMTCT. The details are summarised below:

A) HIV-infected woman in need of ART for her own health

Mother: Start ART irrespective of the gestational age, and continue throughout pregnancy, labour, delivery, and thereafter.

Baby: Daily nevirapine for six weeks only. Exclusive breastfeeding for the first six months of life. Introduce complementary foods thereafter and continue breastfeeding until12 months of age.