MINISTRY OF HEALTH AND SANITATION

Sierra Leone National Food and Nutrition Policy

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LIST OF ACRONYMS

BFHI	Baby Friendly Hospital Initiative
CBIMCI	Community Based Integrated Management of Childhood Illnesses
CBO	Community Based Organisations
CMAM	Community Management of Acute malnutrition
CEDAW	Convention on Elimination of Discrimination Against Women
DHMT	District Health Management Team
GDP	Gross Domestic Product
GMP	Growth Monitoring and Promotion
GoSL	Government of Sierra Leone
IMR	Infant Mortality Rate
LBW	Low Birth Weight
MAFFS	Ministry of Agriculture, Forestry and Food Security
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MI	Micronutrient Initiative
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality rate

MOFDEP	Ministry of Finance, Development and Economic Planning
MOEYS	Ministry of Education, Youth and Sports
MOHS	Ministry of Health and Sports
MOTI	Ministry of Trade and Industries
MTASP	Medium Term Agricultural Strategic Plan
NaCFaN	National Commission for Food and Nutrition
NGO	Non-Governmental Organisation
NL	Nutrition Lens
PHC	Primary Health Care
PHU	Peripheral Health unit
PRSP	Poverty Reduction Strategy Paper
Pop/FLE	Population Family Life Education
RCH	Reproductive and Child Health
SL-DHS	Sierra Leone Demographic and Health Survey
SO	Specific Objective
TB	Tuberculosis
UNICEF	United Nations Children’s Fund
VAS	Vitamin A Supplementation

WHO	World Health Organisation

FOREWORD

CHAPTER 1: Nature, extent and causes of food security and nutrition problems in Sierra Leone

1.1 Background

Since gaining independence in April 1961, Sierra Leone has withstood many challenges including instability and poverty. At the time of independence in 1961, Sierra Leone's economic prospects were promising. The economy grew significantly during the 1960s by about 4.5 percent per annum, due mainly to mining, agricultural productivity and exports. The economy, however, slowed down during the 1970s and 1980s as the effect of the decline in corporate mining spread through the monetized economy. Financial and associated economic decline was also caused by adverse international market conditions for domestic exports and inappropriate domestic policies. By the end of the 1980s, the economy had almost collapsed and was characterized by declining GDP per capita, rapid inflation, and a severe external payments imbalance. Despite the tremendous efforts by Government and development partners to raise living standards for the Sierra Leonean population, the country's poverty profile is still unsatisfactory and has contributed to low health and nutritional status of the population.

Several International conferences have been held to find solutions to global food insecurity, famine and under-nutrition. The United Nations Conference on Food and Agriculture held in 1943 had an overall objective of achieving "an adequate diet for all". The World Summit for Children (1990) focused on the improvement of the nutrition of children. The International Conference on Nutrition (1992) and World Food Summits (1996 & 2002) addressed equity of food distribution and the resultant macro- and micro-nutrient malnutrition among children and women, to mention but a few. Sierra Leone recognizes International conventions and treaties on the right to adequate food as fundamental human right (as enlisted in Article 25 (1) of the Universal Declaration of Human Rights and Article 11(1) and 11(2) of the International Covenant on Economic, Social and Cultural Rights).

In the last decade, the Government has formulated a number of strategy documents aimed at improving the living standards of the population. The most recent one is the First Generation Poverty Reduction Strategy Paper (SL-PRSP, 2007), and the newly launched Poverty Reduction Strategy under the President's Agenda for change. The strategy highlights food security and nutrition as growing challenges for Sierra Leone. The objectives are set with reference to the Millennium Development Goals (MDGs), which aim at reducing poverty and its various symptoms by 2015, and for the international community to strive side by side, with national governments, to achieve these goals within a partnership and cooperative framework. Sierra Leone started the implementation of the full PRSP in 2005, only ten years to the target date of 2015. The recently concluded First MDG Report for Sierra Leone indicates that the country would meet only two out of eight of the MDGs if current trends continue (GoSL: 2005a). To address the challenges involved in reducing poverty, agriculture, fisheries, and malnutrition have identified as key food security and nutrition elements of the agenda for change in addressing food security and nutrition, and therefore form components of the backbone in constructing the country's poverty reduction strategy.

Therefore the Food and Nutrition Policy is intended to serve as a framework to address the challenges in addressing the food security and nutrition situation as outlined in the PRSP.

1.2 SITUATION ANALYSIS

1.2.1 Basic statistics

The population of Sierra Leone is estimated at about 5,866,000 (2007) and about 66 % of the population lives in rural areas (SLPRSP, 2005-7). It is estimated that about 75 % of the population live in poverty and that more than two-thirds of the poor could be described as living in conditions of extreme poverty (SLPRSP, 2005-7). At the national level, about 26 % (1.5 million) of Sierra Leoneans cannot afford adequate daily food intake to sustain a healthy life. (SLPRSP, 2005-7).

The major consequences of malnutrition are morbidity and mortality and the groups most affected are women and children. World Health Organisation (WHO) has estimated that malnutrition is associated with over half of all child deaths that occur in developing countries and underlies 55% of all child mortalities.
Infant mortality rate (IMR) in Sierra Leone has reduced from 140 per 1000 live births in 2003 to 89 per 1000 live births (DHS 2008). Similarly, under-five mortality rate has reduced from 190 per 1000 live birth 10-14 years before the 2008 DHS survey to 140 per 1000 live births for the 5-year period before the survey (DHS 2008). Maternal mortality ratio (MMR) is estimated to be 857/100,000 (DHS 2008) and even though this is primarily due to unsafe obstetric care can also be caused by poor nutrition such as anaemia. Life expectancy at birth is 34.3 years (35.6 years for female and 33.1years for male (SLPRSP 2005-2007).
Even though these statistics show a downward trend especially in infant and under five mortality rates, the current situation is still unacceptably high and indicates the need to further strengthen strategies to overcome the main causes of the situation.

1.3 FOOD AND NUTRITION SITUATION

1.3.1 Food security

Agriculture is the primary occupation in Sierra Leone, employing two-thirds of the labor force and accounting for 50% of GDP. Most Sierra Leoneans live on small, scattered farms, following a scheme of bush-fallow rotation, slash-and-burn field preparation, and the use of fertilizer by farmers is limited. Agricultural exports in 2001 amounted to nearly $7.5 million and consisted of coffee, cocoa, palm kernels, cassava, kola nuts, and ginger.

Food production which was high during the period 1960 to 1979 declined drastically in the period 1981 to the present. Rice, which is grown by 80% of farmers, is the most important subsistence crop and, despite a current 70% self-sufficiency in rice production nationally it is now imported in large quantities to supplement the low local production. Other food items such as maize, cassava,

sweet potato are currently produced in excess of national requirements. The nation is self-sufficient in the production of palm oil.

The livestock sub-sector grows at a slower rate than crop production. Livestock holdings are small in size, dispersed and, except for chickens and small ruminants, there are cultural constraints with regards to their improvement.

The relatively high cost of meat products has increased the demand for fish. Over 100,000mt of fish is produced annually, making the sector a major contributor to the enhancement of livelihoods of the poor in most fishing communities. However, about 75% of the catch by foreign trawlers is exported, and the artisanal fisher folk who supply the bulk of the fish for the local population, do not have the capacity to satisfy the market.

Post harvest losses contribute to food insecurity and could be as high as 25-30% in one season.

1.4 Nutrition situation

1.4.1 Undernutrition

The prevalence of low birth weight (LBW) is estimated at 24% (MICS3), a level that is well above the regional average of 15 percent[1].
The Sierra Leone Demographic and Health Survey (SLDHS 2008) revealed that 36% of Sierra Leonean children are stunted, with 21% being severely stunted and stunting peaks at 48 % among children aged 24-35 months. This is an indication of the prevalence of chronic household food insecurity. The survey also found the proportion of children suffering from wasting to be 10%, with 4% being severely wasted. Almost one-fifth of Sierra Leonean children are underweight, with 7% classified as severely underweight.

[1] One of the major challenges in measuring the incidence of low birth weight is the fact that more than half of infants in the developing world are not weighed at birth. In the past, most estimates of low birth weight for developing countries were based on data compiled from health facilities. However, these estimates are biased because the majority of newborns are not delivered in facilities; those who are born in facilities represent a select sample of all births that is not representative of the overall population.

1.4.2 Micronutrient malnutrition

Anaemia is a major problem especially among young children and pregnant women. Overall, 76% of children aged 6-59 months have some level of anaemia: 28 percent of children are mildly anaemic, 44% are moderately anaemic, and 4 percent of children have severe anaemia[2]. The prevalence of any anaemia among women age 15-49 in Sierra Leone is 46 %: 34% are mildly anaemic, 11% are moderately anaemic, and less than 1% severely anaemic. (SLDHS 2008)

Of children aged 8-14 years, approximately 34% was found to have low urinary levels of iodine (less than100 µg/l) National Survey 2003). The percentage of households that consume adequately iodized salt in Sierra Leone has doubled in the past five years and 45% of households now consume salt that is adequately iodized[3] (SLDHS 2008). The lack of in-country facilities to iodize salt continues to hamper efforts to achieve universal salt iodization in Sierra Leone.

Vitamin A deficiency affects about 47% of the under five population (UNICEF/MI 2004), largely due to diets lacking in vitamin A-rich foods[4]. 49% of children aged 6-59 months received a high dose vitamin A supplement during the six months prior to the MICS3 survey. Vitamin A Supplementation (VAS) coverage among postpartum women is estimated at 55%.

1.4.3 Diet related non-communicable diseases

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[2] The classification is based on criteria developed by WHO (De Maeyer et al., 1989) as follows:
Mild: haemoglobin concentration 10.0-10.9 gldl; Moderate: haemoglobin concentration 7.0-9.9 g/dl; Severe: haemoglobin concentration less than 7.0 g/dl

[3] GoSL policy states that all salts imported into the country should be iodized. However, local production of non-iodised salt in costal communities continues and this salt is sold in the market.

[4] Based on UNICEF/WHO guidelines, the Sierra Leone Ministry of Health and Sanitation (MoHS) recommends that children aged 6-11 months be given one high dose Vitamin A capsules (100,000 IU) and children aged 12-59 months be given a vitamin A capsule (200,000 IU) every 6 months.

Hospital reports indicate that Sierra Leone is experiencing a marked upsurge of chronic non-communicable diseases such as hypertension with its complications, diabetes and gout with a dietary implication. As such there is an increase in the admission of such cases in hospitals.
The SLDHS 2008 revealed that 8% young children are overweight. The highest proportion of overweight children is in age group below 9 months; 12% of children in that age group are overweight.

1.4.4 HEALTH SITUATION

Malnourished children have impaired immune systems that predispose them to sickness and death. Acute Respiratory Illness (ARI), malaria, and dehydration caused by severe diarrhoea are major causes of childhood mortality in Sierra Leone. Water and sanitation facilities are critical for providing a healthy and disease-free environment for the general population. In particular, vulnerable groups such as pregnant women and children under five are more susceptible to infections and illnesses as a result of poor water and sanitation conditions. Currently, and estimated 45% of household are using improved water facilities and 30% are using improved sanitation facilities (MICS 2005).
Communicable diseases such as tuberculosis and nutrition are intimately interrelated and nutrition plays an important role in the etiology, complications and therapy of the disease.
Women who are malnourished are more likely to face reproductive problems that can lead to maternal and infant deaths. Improved nutrition reduces the severity of some diseases and minimizes the incidence of others.
According to the DHS 2008, less than 2% (1.5%) of the respondents tested were found to be HIV positive. Women (1.7%) are slightly more likely to be HIV positive than men (1.2%). HIV prevalence is more than two times higher in urban areas than in rural areas (2.5 % and 1% , respectively). There is a small but steady increase in HIV ·prevalence with increasing education for both women and men.

1.5 UNDERLYING CAUSES OF FOOD AND NUTRITION SITUATION

Three clusters of underlying factors lead to the achievement of adequate dietary intake and low incidence of disease. These are: (1) adequate supply of safe and nutritious food in a household to meet the physiological needs of all household

members all year round. (2) Adequate sanitation in and around homes, hygienic handling of food, coupled with access to adequate health services. Infections speed nutrient loss and suppress appetite so sick children do not eat as much as they should and the cycle continues. (3) Adequate care for women and children encompassing all measures and behaviours that translates the availability of food and health resources into good child growth and development

1.5.1 Factors contributing to inadequate food supply

Several factors contribute to inadequate supply of food at the household level. Low agricultural productivity due to dependence on rain-fed agriculture, droughts, floods, pests, and civil strife disrupt food systems and have exerted additional pressures on the chronically poor. In most locations, farmers rely heavily on human labour for land preparation, weeding, and harvesting. Low asset endowments of small farmers combine with endemic livestock diseases to limit animal production, productivity, and traction.

Insufficient access to food at the household level by large parts of the population could be attributed to two factors: (1) lack of financial resources to purchase food on continuous basis. The incidence of poverty in the country is highest in the agricultural sector, with about 79% of those engaged in the sector being poor. The intensity of poverty in the agricultural sector is more than twice as high as in the construction sector (2) lack of physical access to the food due to inadequate infrastructure such as markets and roads to transport the food, lack of storage facilities and high post-harvest losses resulting in high food prices.

1.5.2 Factors contributing to ineffective food utilization

Even when nutritious food is available in adequate quantities, proper food utilization requires that an individual be able to consume diversified, properly prepared safe foods and effectively absorb the energy and nutrients in the foods consumed. Diseases such as diarrhea, respiratory conditions, measles, malaria, TB and HIV/AIDS interfere with proper food utilization.

Other factors including access to reliable health services, living in sanitary environments with access to potable water, are all necessary for proper food utilization. The general population utilization rate of health care facilities in Sierra

Leone is estimated at 0.5 contacts per capita per annum, implying that only one-half of the population attends a health care facility once a year. In addition, only 24% of households have both an improved source of drinking water and improved sanitation facilities. (MICS3).

1.5.3 Factors contributing to inadequate Feeding practices

The reasons behind the rising rates of malnutrition and micronutrient deficiencies remain ingrained in traditional and cultural beliefs, as well as knowledge, attitudes and practices regarding infant and young child feeding.

Even though breastfeeding is very common in Sierra Leone and the duration of breastfeeding is long, only 11% of children less than 6 months of age are exclusively breastfed[5] and 33% of newborns are given breastmilk within one hour of birth (MICS 2005).

According to the MICS survey 2005, 52% of 6 to 9 month-old infants receive timely complementary foods and therefore many children lack nutrients essential for survival, growth and development. Sub-optimal feeding practices in early childhood contribute immensely to the progressive increase of malnutrition levels in Sierra Leonean children in the first two years of life. By age 6-9 months, more than nine in ten Sierra Leonean children are still being breastfed, and most breastfeeding children are receiving complementary foods in addition to breast milk.

The rising incidence of diet related diseases reflects the changing dietary practices of the population. The food a person chooses translates into the type of diet related disease and also affects how well the body heals itself.

1.5.4 Other factors

Human resource

The public health service delivery system is three tiers and based on the Primary Health Care (PHC) strategy. Presently services are provided by 5 Government tertiary referral hospitals, 45 government and private secondary hospitals, and

[5] Following international guidelines, the Ministry of Health and Sanitation in Sierra Leone recommends that infants be exclusively breast-fed from birth to about 6 months of age.

1,092 peripheral Health Units. There are 300 Maternal and Child Health(MCH) aides in paid government employment pay roll as well as several trained Maternal and Child Health (MCH) aides that are not receiving government salaries but are working in government Peripheral Health Units (PHU). The public sector has 1477 beds, 211 doctors and dentists, 8 Pharmacists, 261 Registered nurses, 250 Enrolled nurses, 144 community nurses, 122 public health officials and 8 laboratory technologists. The number of physicians per 100,000 persons is estimated at nine (PRSP).
There are 8 nutritionists within the health sector. Two of them are located at the National level, with two in hospitals and four with the District Health Management Teams (DHMTs).

There are wide variations in the number of health care workers available per district with an over concentration of health personnel per capita in the Western area.

Education

Level of education especially of women contributes positively to reduction of malnutrition. 66% of women have never been to school, compared with 50% of men. Likewise, 18% men are twice likely to attend senior secondary school as compared to 6%women (DHS 2008).
The SLDHS 2008 also indicates that children of mothers with some secondary or higher education are much less likely to be stunted than children whose mothers achieved only the primary level or never attended school.

Chapter 2: Goals and Objectives of the National Food and Nutrition Policy

The problem of malnutrition is of a multifactorial nature and so the Government of Sierra Leone calls for a multi sectoral effort in drawing and implementing a National Food and Nutrition Policy.

2.1 Vision

A healthy and well nourished population with communities and families well informed and empowered to take appropriate action on food and nutrition situation.

2.1.1 Goal

The overall goal of the National Food Nutrition Policy is to contribute to the improved health, social and economic well-being for all the people in Sierra Leone, especially women, children and other nutritionally vulnerable groups.

2.1.2 General Objective

To improve the current nutritional status of the population especially infants and young children, pregnant and lactating women and other vulnerable groups in Sierra Leone

2.1.3 Specific Objectives (SO)

I. To undertake advocacy for policy makers, policy advisors and programme designers at national and district levels on Nutrition issues and its relationship to development.
II. To actively promote and facilitate adequate household food security (quantity, quality and safety) to satisfy daily dietary needs of the population.
III. To promote adoption of appropriate feeding practices of households.
IV. To strengthen preventive measures against nutrition related diseases

V. To provide curative services to individuals who are either malnourished or present a condition requiring diet therapy.
VI. To institute nutritional surveillance system for monitoring the food and nutrition situation in the country.
VII. To promote operational research and periodic surveys into food and nutrition issues
VIII. To coordinate activities of relevant agencies involved in food and nutrition issues

2.2 Policy directives

The following policy directives will underpin each of the specific objectives:

SO1. To undertake advocacy for policy makers, policy advisors and programme designers at national and district levels at national and district levels on Nutrition issues and its relationship to development.

Policy: All relevant organizations should integrate nutrition considerations in programmes and activities

SO2. To actively promote and facilitate adequate household food security (quantity, quality and safety) to satisfy daily dietary needs of the population.

Policy: **Small scale farmers should be provided effective support to improve their access to domestic food production and supplies.**

SO3. To promote adoption of appropriate feeding practices of households.

Policy: a. Protect, promote and support early and exclusive breastfeeding for infants from birth until six months, followed by introduction of nutritious and appropriate complementary foods with continued breastfeeding for up to two years and beyond.

b. Promote appropriate feeding practices for the family especially pregnant and lactating women at facility and community levels.

SO4. To strengthen preventive measures against nutrition related diseases

Policy: Antenatal, Post natal and the Family Package services should be promoted and introduced at the community level especially through outreach clinics

SO5. To provide curative services to individuals who are either malnourished or present a condition requiring diet therapy.

Policy: a. Patients in hospitals should be provided with optimum dietary services to complement their clinical management.

b. Community-based Management of Acute Malnutrition (CMAM) approach should be integrated into child survival and development initiatives

c. Supplementary feeding programme should be integrated to ensure continuum of care for malnourished children.

SO6. To institute nutritional surveillance system for monitoring the food and nutrition situation in the country.

Policy: A regular and coordinated food and nutrition system that assists in long term health and development planning, programme management, timely warning and design of intervention programmes should be instituted

SO7. To promote operational research and periodic surveys into food and nutrition issues

Policy: Effective operational research and periodic surveys aimed at improving food security and nutrition should be integrated into programmes of relevant research institutions

SO8. To coordinate activities of relevant agencies involved in food and nutrition issues

Policy: Nutrition Division of the Ministry of Health and Sanitation should ensure that activities to address nutrition issues are reflected in plans of other programmes of the Ministry and implemented in a coordinated manner

2.3 Guiding Principles

The policy is based on the following guiding principles:

- that adequate food and nutrition is a fundamental human right
- that the government with support from development partners, takes necessary measures to ensure national food security through emergency preparedness for times of crises such as floods and droughts
- that the policy is owned by the government and supported by development partners
- that the policy is linked with other policies and national documents such as PRSP, MDG, UN Joint Vision and other WB and EU visions
- that the policy on food and nutrition is part and parcel of the overall national health and development policy
- that gender considerations and the needs of all vulnerable groups are integral to all components of the policy
- that the Sierra Leone Government is accountable and obligated as set out in national laws and international conventions, treaties and resolutions on the right to food
- that there is better collaboration between the stakeholders
- that in the planning, budgeting and implementation of the policy, a Rights-Based Approach will be adopted to promote and protect the right to adequate food and nutrition, ensuring the participation of the rights' holders.

- that the Government of Sierra Leone would adopt, promulgate and implement the Food and nutrition policy and plan of action for the improvement of the quality of life of Sierra Leoneans

CHAPTER 3: Strategies for achieving the Food and Nutrition Policy Objectives

To achieve the objective of the food and nutrition policy, the following strategies have been defined for each of the specific objectives outlined.

3.1 Advocacy on Nutrition issues

Policy: All relevant organizations should integrate nutrition considerations in programmes and activities

Key strategies

- Communicate nutrition policy at national and district levels
- Develop mechanism to involve other sectors in formulation of food and nutrition activities at national and district levels
- Develop a continuous programme for dissemination of information to key decision makers at national and district levels
- Explore avenues within programmes of relevant sectors to integrate nutrition using the "Nutrition Lens" (NL) approach[6]

3.2 Promoting and facilitating adequate national and household food security[7]

[6] Nutrition Lens is a tool for analysis, planning and programme delivery. The aim of NL is to facilitate, coordinate and leverage opportunity. Applying "nutrition lens" across sectors is evidence of national political commitment to end hunger and malnutrition. It provides policy and planning tool to: ensure MDGs are seriously considered in the investment planning process; integrate nutrition "best practices"; encourage awareness of the impacts of poor policy decisions; ensure development investments "do no harm"; encourage coordinated management, information exchange and monitoring.

[7] The main strategic approaches to improve the situation of the rural poor include measures to increase agricultural production and productivity and prevent post harvest losses. These measures are already addressed in the "Medium Term Agricultural Strategic Plan" (MTASP) and therefore not repeated here and reference is made to the MTASP.

Policy: **Small scale farmers should be provided with effective support to improve their access to domestic food production and supplies.**

Key strategies

3.2.1 Increasing production and supply of food

- Ensure availability of adequate and appropriate technologies together with improved agricultural inputs at the appropriate time during agricultural season, especially for the poorer groups
- Expand Operation Feed the Nation programme[8] to cover all vulnerable districts
- Integrate nutrition activities into Farmer Field Schools programme which is designed for decentralized community-based market organizations [9]
- Collaborate with private sector to improve food storage, processing with value addition, marketing and distribution systems for local markets[10]
- Strengthen and implement National Food Standards, and laws including code and guidelines on food hygiene for locally produced and imported foods
- Establish partnership with consumer protection organisations
- Strengthen and implement community based agriculture extension services

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[8] In 2002, with FAO support, the Government of Sierra Leone launched the Operation Feed the Nation under the Ministry of Agriculture, Forestry and Food Security and within the framework of the National Recovery Strategy and now the National Poverty Reduction Strategy.

[9] Decentralized community-based market organizations are being created through Farmer Field Schools, Agricultural Business Units and District Networks. In addition, food security activities such as Food Security through commercialization, school gardens, value added activities, income generation, post harvest losses, awareness raising on HIV/AIDS, malaria control programmes, adult literacy programmes, mechanisation, social safety nets, infrastructures, and community banking/village saving schemes have been incorporated into Operation Feed the Nation.

[10] Fourteen District Networks for marketing, commercialization and credit have been established by over 40 000 farmers involved in Operation Feed the Nation. Literacy and health issues are being incorporated into the on-going up-scaling stage by the Government of Sierra Leone

3.2.2 Improving access to food

- Document, promote and improve indigenous food processing techniques and their use at the household level
- Train communities on different food processing, preservation and packaging techniques
- Promote food diversification in communities and at all levels
- Identify and implement income generating ventures which are sustainable for rural women
- Encourage and provide support for dry season gardening for vulnerable households to ensure access to food supplies all year round.
- Strengthen and implement national guidelines on food safety and hygiene

3.3 Adoption of appropriate feeding practices for households

Policy: 1. Protect, promote and support early and exclusive breastfeeding for infants from birth until six months, followed by introduction of nutritious and appropriate complementary foods with continued breastfeeding for up to two years and beyond.

2. Promote appropriate feeding practices for the family especially pregnant and lactating women and other vulnerable groups at facility and community levels.

Key strategies

- Develop, adopt and implement Code on Marketing of Breast Milk Substitutes
- Promote and strengthen the implementation of Baby Friendly Hospital Initiative (BFHI) and Baby Friendly Community Initiative (BFCI)
- Promote appropriate complementary feeding for children from six months to two years, and optimum feeding practices for children 2-5 years
- Develop nutrition messages aimed at decision makers in households (fathers, mothers in-law, grandmothers)

- Integrate feeding counseling for pregnant and lactating women into antenatal, post natal and outreach services.

3.4 Strengthening of preventive measures against nutrition and other related infectious diseases[11]

Policy*:* Antenatal, Post natal and the Family Packages services should be promoted and introduced at the community level especially through outreach clinics[12].

Key strategies

- Ensure mass distribution of vitamin A capsule to children 6-59 months of age, and postpartum women
- Intensify the delivery of the integrated ante-natal, post natal and family packages using available structures at community level.
- Promote the production and consumption of locally available micronutrient-rich foods.
- Fortify widely consumed foods such as wheat flour and locally produced complementary foods with iron, B vitamins vitamin A and ***other appropriate minerals***
- Collaborate with relevant programme managers to strengthen and implement packages (ante-natal, post natal and family)
- Ensure that all salt for human and animal consumption, is fortified with adequate levels of iodine
- Strengthen other public health measures to protect the vulnerable groups such as increased access to potable water and sanitation facilities

[11] The provision of safe drinking water and sanitation has been a major intervention under the National Recovery Strategy and is part of many rural development programmes and projects implemented in the country. The PRSPP envisages the promotion of human development with a comprehensive set of measures which will bring about improved food utilization: Education, health, water supply and sanitation.

[12] The Family Package includes interventions such as insecticide treated bednets, exclusive breastfeeding, immunizations, complementary feeding, nutritional supplements use of iodised salt. Antenatal package includes interventions such as deworming, insecticide-treated bednets, and iron-folate supplementation use of iodised salt. Post natal package includes breastfeeding, GMP, Vitamin A and iron folate supplementation, health and nutrition education

- Ensure that all health and other relevant personnel are trained on the appropriate application of guidelines for the nutritional management of people living with HIV/AIDS (PLHIV)
- Use Essential nutrition Actions (ENA) to consolidate the technical content of the various nutrition messages to serve as base for education and information sharing
- Promote and implement Community based Growth Monitoring and Promotion (GMP)
- Use all available channels of communication[13] for public education on food and nutrition

3.5 Provision of curative services to malnourished individuals

Policy: Patients in hospitals should be provided with optimum dietary services to complement their clinical management.

Community-based Management of Acute Malnutrition (CMAM) approach should be integrated into child survival and development initiatives

Supplementary feeding programme should be integrated to ensure continuum of care for malnourished children

Key strategies

- Ensure effective therapeutic and supplementary feeding for sick and malnourished children based on local foods
- Establish functional nutrition units comprising nutrition and catering staff and headed by a nutritionist/dietician in all hospitals
- Revise national protocol on CMAM
- Conduct training and capacity building activities for health workers and health volunteers to better equip them to implement the CMAM approach and protocols as well as supplementary feeding.

[13] Different media (short movies, TV, radio, posters leaflets) should be used for public campaigns depending on media access by the intended clients (urban, rural, remote rural, illiterate, women, mothers, fathers etc)

- Use all available channels of communication for sensitizing communities on availability of services for malnourished children
- Scale up the Community-Based Integrated Management of Child Illness (CBIMCI) initiative in all districts of the country
- Create awareness and mobilize communities to utilize available nutrition services within the Peripheral Health Units (PHUs)

3.6 Nutritional surveillance system

Policy: A regular and coordinated food and nutrition system that assists in long term health and development planning, programme management, timely warning and design of intervention programmes should be instituted

Key strategies

- Develop early warning system incorporating food security and nutrition status indicators
- Adapt child growth chart using the new 2006 WHO standards
- Promote and implement Community based Growth Monitoring and Promotion (CBGMP)

3.7 Research into food and nutrition issues

Policy: Effective operational research and periodic surveys aimed at improving food security and nutrition should be integrated into programmes of relevant research institutions

Key strategies

- Collaborate closely with researchers to identify and carry out action oriented research on food and nutrition issues.
- Ensure that appropriate nutrition issues are incorporated into national surveys

- Collaborate closely with researchers in conducting of nutrition surveys

3.8 Coordination of nutrition activities

Policy: Nutrition Division of the Ministry of Health and Sanitation should ensure that activities to address nutrition issues are reflected in plans of other programmes of the Ministry and implemented in a coordinated manner

Key strategies

- Develop and implement appropriate structures to implement and coordinate nutrition activities

CHAPTER 4: INSTITUTIONAL ARRANGEMENTS

4.0 Implementation Mechanism for the Sierra Leone's Food And Nutrition Policy

Food and Nutrition security issues are multi-dimensional in nature and therefore, implementation of activities to address the issues shall be undertaken in a multi-sectoral way. For this reason, there is a need for a coordinating body at the national level. A Nutrition Technical Task Force was established in 2008 and met monthly mainly to discuss therapeutic diets for severely malnourished children in health facilities. Membership of this task force comprised representatives from Ministry of Health and Sanitation, United Nations agencies and NGOs with expertise in nutrition. The Nutrition Technical Task Force should be transformed into a Nutrition Technical Committee, its membership expanded and should submit report of its activities through the Reproductive and Child Health (RCH) Directorate to the Health Coordinating Committee chaired by the Chief Medical Officer. A similar structure should be established at the district level.

4.1 Functions of Nutrition Technical Committee

- Serve as an advisory body on all technical issues relating to nutrition in the country.
- Identify nutritional problems and provide strategies to solve or alleviate such problems in a coordinated manner.
- Serve as a supervisory and coordinating body for all nutrition activities carried out in the country.
- Provide a forum for networking and collaboration among stakeholders on nutrition matters
- Mobilize resources for food and nutrition interventions in the country

- Monitor the implementation of the Food and Nutrition Policy

4.2 *Functions of Nutrition Technical Committee at district level*

- Advise the District Health Management Team on food and nutrition issues
- Collate, analyse and disseminate data on the status of food and nutrition in their respective areas;
- Advocate and ensure that food and nutrition issues are incorporated in the district development plans; and
- Co-ordinate activities of all government institutions, Non Governmental Organisations (NGOs) and Community Based Organisations (CBOs) involved in food and nutrition programmes in their areas of jurisdiction

4.3 *Functions of Line Ministries – MOHS, MAFFS, MOEYS, MOFDEP, MOTI MMRF*

- Ensure adequate provision for human, financial and material resources for all nutrition related activities in their ministries.
- Ensure that nutrition considerations are integrated in the various plans and programmes of the ministry
- Participate in the implementation of nutrition programme activities under their ministries.

4.4 *UN Agencies*

- Provide technical support and mobilize funding to support nutrition programmes in the country.
- Assist in the implementation, monitoring and evaluation of nutrition programmes

4.5 International NGOs

- Provide technical support and funding for nutrition activities
- Assist in the implementation, monitoring and evaluation of nutrition programmes.
- Engage in sensitization activities at community level

4.6 Local NGOs and CBOs

- Collaborate with district nutrition technical committees for effective implementation and monitoring of nutrition programmes in the field.

4.7 Private Sector

- Collaborate with the different sectors in programme implementation.
- Undertake fund raising to support programme activities

4.8 Funding

The funds for implementing the activities of the policy shall consist of:

- Money from the Government consolidated funds; and
- Grants and/or donations from the Government and other sources.

4.9 Related documents

The following key documents shall be reviewed when using the Food and Nutrition policy:

- Agenda for Change/PRSP11
- MDGs
- Vision 2025
- National Strategic Health Plan
- RCH Plan
- National HIV strategic Plan

- Education sector Plan-nutrition education in schools
- Joint UN vision
- Agriculture Master Plan
- Policy on gender mainstreaming
- Youth Policy
- Convention on the Rights of Children
- African Chapter on Child's Convention
- Convention on Elimination of Discrimination Against Women (CEDAW)