SIERRA LEONE NATIONAL STRATEGY FOR INFANT AND YOUNG CHILD FEEDING
FORWARD

Appropriate feeding practices are essential for the nutrition, growth, development and survival of infants and young children. Infants should be exclusively breastfed for the first six months of life, and thereafter should receive nutritionally adequate and safe complementary foods while breastfeeding continues up to two years and beyond.

Sierra Leone is making progress in reducing malnutrition; however, the numbers of infants and young children affected with malnutrition is still a matter of concern. I am pleased that the “National Strategy for Infant and Young Child Feeding” has been developed to lay the road-map for reducing malnutrition through improvements in breastfeeding and complementary feeding. I have full confidence that if the comprehensive actions identified within the National Strategy are fully implemented, our children will be better protected from the scourge of malnutrition.

Special attention and practical support is needed for feeding in exceptionally difficult circumstances, including low birth weight infants, malnourished children, infants and children in emergencies, infants born to HIV-positive parents, and other vulnerable children living under challenging circumstances.

The National Strategy for Infant and Young Child Feeding builds on past and continuing achievements in infant and young child feeding in Sierra Leone, and has been developed in the context of national policies, strategies and programmes. It is consistent with the Global Strategy for Infant and Young Child Feeding and is based on accumulated evidence on interventions with proven positive impact. It identifies comprehensive actions that will be taken to improve legislation, policies and standards to protect optimum infant and young child feeding practices, and to strengthen the capacity of health services and communities to protect, promote and support the nutritional needs of infants and young children. The roles of the critical partners - government, international organizations, non-government organizations and other concerned parties - are also identified to ensure that collective action contributes to the full attainment of the National Strategy’s goal and objectives.

The National Strategy will bring substantial benefits for individuals, families and the entire nation. Improvement in infant and young child feeding will move Sierra Leone closer towards the achievement of the World Health Assembly Global Target for 2025, including a reduction in extreme poverty, hunger and child mortality. Investment in this crucial area is needed to ensure that every Sierra Leonean child develops to his or her full potential, free from malnutrition and preventable illnesses. It is now time for everyone concerned to move swiftly to implement the National Strategy.

I congratulate the Directorate of Food and Nutrition for taking the initiative to develop the National Strategy, and for organizing and coordinating all the workshops that led to its development. I acknowledge the valuable contributions by experts from the UN agencies, NGOs, research institutes and development partners, whose relentless efforts made this National Strategy possible. The challenge before us now is the implementation of the National Strategy in its entirety, and I call upon all stakeholders and partners for their continued support in this respect.

Dr. Brima Kargbo (GOOR)
Chief Medical Officer
Ministry of Health and Sanitation
ACKNOWLEDGEMENTS

The Ministry of Health and Sanitation, Directorate of Food and Nutrition gratefully acknowledges the generous technical support from all health and nutrition partners in the process of development, reviewing, finalization and validation of the National Infant and Young Child Feeding Strategy document.

Our special thanks go to UNICEF for funding this undertaking. We would also like to deeply thank WHO and UNICEF for their technical support through finalization.

The Ministry of Health and Sanitation, Directorate of Food and Nutrition would like to express its utmost appreciation to the Nutrition Technical committee, and especially to the Technical Working Group members for their unflinching effort over a period of several months including all those institutions, groups and individuals, not mentioned by name who in one way or another directly or indirectly contributed and supported the successful finalization of the whole development process of this valuable document.

We hope that these and many other partners will continue supporting the implementation phase of the operational strategy in order to attain the desired results.

[Signature]

Aminata Shamit Koroma
Director Food and Nutrition
Ministry of Health and Sanitation
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AFASS</td>
<td>Acceptable, Feasible, Affordable, Sustainable and Safe</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immuno-Deficiency Syndrome</td>
</tr>
<tr>
<td>BCC</td>
<td>Behaviour Communication and Change</td>
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<tr>
<td>BFCI</td>
<td>Baby friendly Community Initiative</td>
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<tr>
<td>BFHI</td>
<td>Baby friendly Hospital Initiative</td>
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<tr>
<td>BMS</td>
<td>Breast Milk Substitutes</td>
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<tr>
<td>BPEHS</td>
<td>Basic Package of Essential Health Services</td>
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<tr>
<td>CBO</td>
<td>Community Based organization</td>
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<tr>
<td>CCM</td>
<td>Community Case Management</td>
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<td>CF</td>
<td>Complementary Feeding</td>
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<tr>
<td>CHC</td>
<td>Community Health Centre</td>
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<tr>
<td>CHP</td>
<td>Community Health Post</td>
</tr>
<tr>
<td>DHMT</td>
<td>district Health Management Team</td>
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<tr>
<td>EBF</td>
<td>Exclusive Breastfeeding</td>
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<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<tr>
<td>EVD</td>
<td>Ebola Virus Disease</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IEC</td>
<td>Information Education Communication</td>
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<tr>
<td>ILO</td>
<td>International Labour Law</td>
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<tr>
<td>IMAM</td>
<td>Integrated Management of Acute Malnutrition</td>
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<td>IMNCI</td>
<td>Integrated Management Neonatal Child Illness</td>
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<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
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<tr>
<td>JPWF</td>
<td>Joint Programme of Work and Funding</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MNP</td>
<td>Micro-Nutrient Powder</td>
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<tr>
<td>MSWGCA</td>
<td>Ministry of Social Welfare Gender and Children’s Affaire</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NHSSP</td>
<td>National Health Sector Strategic Plan</td>
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<tr>
<td>PBF</td>
<td>Performance Based Financing</td>
</tr>
<tr>
<td>PHUs</td>
<td>Peripheral Health Units</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-To-Child Transmission</td>
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<tr>
<td>RAF</td>
<td>Result and Accountability Framework</td>
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<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>SLDHS</td>
<td>Sierra Leone Demographic Health Survey</td>
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<tr>
<td>SLNNS</td>
<td>Sierra Leone National Nutrition Survey</td>
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<tr>
<td>SOP</td>
<td>Standard Operation Procedure</td>
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<tr>
<td>SUN</td>
<td>Scaling Up Nutrition</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER 1: NATIONAL INFANT AND YOUNG CHILD FEEDING

Introduction

A strong and prosperous nation requires a healthy population. One of the most critical components to achieving a healthy, productive nation includes improving the nutrition status in the first 1000 days, which begins from pregnancy onto the first two years of life. The nutritional needs are essential for adequate growth and development of a child. Known as the “window of opportunity” for prevention of growth faltering, these critical years present a window period whereby if a child is not adequately nourished can be detrimental and irreversible impacts on a child’s growth and development. The immediate consequences of poor nutrition during these formative years include significant morbidity and mortality and delayed mental and motor development. In the long-term, early nutritional deficits are linked to impairments in intellectual performance, work capacity, reproductive outcomes and overall health during adolescence and adulthood. Of all proven preventive health and nutrition interventions, IYCF has the single greatest potential impact on child survival. Therefore, reduction of child mortality can be reached only when nutrition in early childhood and IYCF specifically are highly prioritized in national policies and strategies.

Provision of mother’s breast milk to infants within one hour of birth is referred to as “early initiation of breastfeeding” and ensures that the infant receives the colostrum, or “first milk”, which is rich in protective factors. Current evidence indicates that skin-to-skin contact between mother and infant shortly after birth helps to initiate early breastfeeding and increases the likelihood of exclusive breastfeeding for one to six months of life as well as the overall duration of breastfeeding. Infants paced in early skin-to-skin contact with their mother also appear to interact more with their mothers and cry less.

WHO recommends that mothers initiate breastfeeding within one hour of birth. Babies should be placed in skin-to-skin contact with their mothers immediately following birth for at least an hour and mothers should be encouraged to recognize when their babies are ready to breastfeed, offering help if needed.

The 2003 landmark Lancet Child Survival Series [3] ranked the top 15 preventative child survival interventions for their effectiveness in preventing under-five mortality. Exclusive breastfeeding up to six months of age and breastfeeding up to 12 months was ranked number one, with complementary feeding starting at six months number three. These two interventions alone were estimated to prevent almost one-fifth of under-five mortality in developing countries. The 2008 Lancet Nutrition Series [4] also reinforced the significance of optimal IYCF on child survival. Optimal IYCF, especially exclusive breastfeeding, was estimated to prevent potentially 1.4 million deaths every year among children under five (out of the approximately 10 million annual deaths). According to the Nutrition Series, over one third of under-five mortality is caused by under-nutrition, in which poor breastfeeding practices and inadequate complementary feeding play a major role.
Exclusive breastfeeding is recommended up to six months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond. This is globally recognized as the ideal form of nutrition for an infant from birth up to 2 years and beyond. An exclusively breastfed infant is guaranteed the utmost food security during the first six months of life since breast milk contains all the nutrients and water needed, in the right quantities, temperature, and composition for optimal digestion. Additionally, breast milk contains maternal antibodies to build a strong immune system and protect the infant against common childhood illnesses. Exclusive breastfeeding also has many benefits to the mother and family, such as reduced household expenses from spending money on breast milk substitutes and reduced medical expenses from potentially unsafe or unhygienic breast milk substitutes. In addition to nutrition for the child, maternal nutrition during pregnancy and lactation is a key issue to address to ensure that mothers are not only caring for and feeding their children properly, but are also themselves maintaining optimal nutrition and wellbeing.

When breast milk is no longer enough to meet the nutritional needs of the infant, complementary foods should be added to the diet of the child. The transition from exclusive breastfeeding to family foods, referred to as complementary feeding, typically covers the period from 6 to 24 months of age, and is a very vulnerable period. It is the time when malnutrition starts in many infants, contributing significantly to the high prevalence of malnutrition in children under five years of age world-wide.

Complementary feeding should be timely, meaning that all infants should start receiving foods in addition to breast milk from 6 months onwards. It should be adequate, meaning that the complementary foods should be given in amounts, frequency, consistency and using a variety of foods to cover the nutritional needs of the growing child while maintaining breastfeeding.

Foods should be prepared and given in a safe manner, meaning that measures are taken to minimize the risk of contamination with pathogens. They should be given in a way that is appropriate, meaning that foods are of appropriate texture for the age of the child and applying responsive feeding following the principles of psycho-social care.

The adequacy of complementary feeding does not only depends on the availability of a variety of foods in the household, but also on the feeding practices of caregivers. Feeding young infants requires active care
and stimulation. Caregiver should be responsive to the child’s clues for hunger and also encourages the child to eat appropriately.

WHO recommends that infants start receiving complementary foods at 6 months of age in addition to breast milk, initially 2-3 times a day between 6-8 months, increasing to 3-4 times daily between 9-11 months and 12-24 months with additional nutritious snacks such as fruits offered 1-2 times per day, as desired.

A pregnant or lactating mother has many demands on her body, both nutritionally and emotionally; therefore the importance of maternal nutrition must not be forgotten when discussing infant and young child feeding. In light of these factors, the National Infant and Young Child Feeding (IYCF) Strategy strives to recognize and adopt the key elements of the Global Strategy on Infant and Young Child Feeding, the World Health Assembly’s Innocenti Declaration for the Protection, Promotion and Support of Breastfeeding, and the International Code of the Marketing of Breast Milk Substitutes (BMS) with the aim of improving the lives of all infants and young children in Sierra Leone. Therefore infant and young child nutrition should be a priority for the nation to address for the prosperity and growth of its citizens.

1.1 Situation Analysis

1.1.1 Mortality and Malnutrition in Children

The nutrition situation in Sierra Leone is vast and presents many challenges for the entire population. In particular, the high rate of malnutrition in children, compounded by inappropriate infant and young child feeding practices have led to Sierra Leone having high rates of infant and under-five mortality. According to the Sierra Leone Demographic Health Survey (SLDHS 2013) infant and children under five mortality rates are 92/1,000 live births and 156/1,000 live birth, respectively. At these mortality levels, 1 in every 11 Sierra Leonean children dies before reaching age 1 and 1 in every 7 does not survive to his or her fifth birthday.

The Sierra Leone National Nutrition Survey (SLNNS, 2014) showed that 28.8% of children under five are stunted, while 4.7% are wasted and 12.9% are underweight. Furthermore, approximately 1% of these children are severely malnourished. Micronutrient deficiencies in children continue to plague the nation with a staggering 76% of children under 5 suffering from anaemia, 80% of households consumed iodized salt, and 83% of children 6-59 months given vitamin A supplementation.

1.1.2 Current Situation on Infant and Young Child Feeding Practices

According to the SLNNS 2014 report, 58.8% of infants were exclusively breastfed for the first six months of life and 54.9% of infants initiated breastfeeding within the first hour after birth. There has been an increase in exclusive breast feeding rates from 2008 at 11% to 58.8% in 2014. Furthermore, the DHS 2013 reported an estimated 62% of infants 6-9 months were breastfed and received complementary foods. However, only 7% of breastfed children in Sierra Leone are receiving minimum acceptable diet and just 6% of non-breastfed children are being fed in accordance with IYCF recommendations.

These figures indicate the need to address infant feeding practices through various methods, including exploring cultural traditions and practices around feeding. It is critical to understand why mothers should receive adequate support and counsel on early and exclusive breastfeeding, and why so many families believe that infants need to begin complementary foods far earlier than recommended. In all of these instances, one can never assume knowledge translates into improved practices, behaviours or attitudes related to nutrition. Communities themselves must be engaged in identification of the barriers to optimal feeding practices and strategies for removing them.
1.2 Infant and young child feeding: Contribution to the Millennium Development Goals

<table>
<thead>
<tr>
<th>MDGs</th>
<th>Contribution of Infant and Young Child feeding</th>
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<tr>
<td><strong>Goal 1</strong>: Eradicate extreme poverty and hunger</td>
<td>Breastfeeding significantly reduces early childhood feeding costs (Bhattacharjee et al., 1996). Breastmilk is a low-cost and high quality food and provides sustainable food security for the child. Exclusive breastfeeding and continued breastfeeding for two years is associated with a reduction in underweight (Dewey, 1998) and is an excellent source of high quality calories for energy.</td>
</tr>
<tr>
<td><strong>Goal 2</strong>: Achieve universal primary education</td>
<td>Breastfeeding and adequate complementary feeding are prerequisites for readiness to learn (Anderson, 1990). The long chain fatty acids and micronutrients in breastmilk and appropriate complementary foods support appropriate neurological development and enhance later school performance.</td>
</tr>
<tr>
<td><strong>Goal 3</strong>: Promote gender equality and empower women</td>
<td>Breastfeeding is the great equalizer, giving every child a fair start to life. Most differences in growth between sexes begin as complementary foods are added to the diet, and gender preference begins to act on feeding decisions. Breastfeeding also empowers women: breastfeeding helps to space births and prevents maternal depletion; only women can provide it, enhancing women’s capacity to feed children; and it increases the focus on the need for adequate women’s nutrition.</td>
</tr>
<tr>
<td><strong>Goal 4</strong>: Reduce child mortality</td>
<td>By reducing infectious disease incidence and severity, breastfeeding can reduce child mortality by about 13%, and improved complementary feeding can reduce child mortality by about 6% (Jones et al., 2003). In addition, about 50-60% of under-5 mortality is caused by malnutrition due to poor breastfeeding practices and inadequate complementary foods and, also, to low birth weight (Pelletier &amp; Frongillo, 2003). The impact is increased in unhygienic settings.</td>
</tr>
<tr>
<td><strong>Goal 5</strong>: Improve maternal Health</td>
<td>The activities called for in the National Strategy include increased attention to support for the mother’s nutritional and social needs. In addition, breastfeeding is associated with decreased maternal postpartum blood loss, breast cancer, ovarian cancer, and endometrial cancer, as well as the probability of decreased bone loss post-menopause. Breastfeeding also increases the duration of birth intervals, reducing maternal risks of closely spaced pregnancies, including lessening risk of maternal nutritional depletion. Breastfeeding promotes return of the mother’s body to pre-pregnancy status, including more rapid involution of the uterus and postpartum weight loss (obesity prevention).</td>
</tr>
<tr>
<td><strong>Goal 6</strong>: Combat HIV/AIDS, malaria, and other diseases</td>
<td>Children born to HIV positive mothers need to be exclusive breastfed in the first six months of life. Optimal breastfeeding during illness and appropriate complementary feeding is essential as a child survival and development.</td>
</tr>
<tr>
<td><strong>Goal 7</strong>: Ensure environmental sustainability</td>
<td>Breastfeeding is associated with decreased milk industry waste, pharmaceutical waste, plastics and aluminium tin waste, and decreased use of firewood/fossil fuels for alternative feeding preparation. Less carbon dioxide emission as a result of fossil fuels, and less emissions from transport vehicles as breastmilk needs no transportation.</td>
</tr>
<tr>
<td><strong>Goal 8</strong>: Develop a global partnership for development</td>
<td>The National Strategy fosters multi-sectoral collaboration, and can build upon the existing partnerships for support of development through breastfeeding and complementary feeding.</td>
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The consequences of inappropriate feeding practices in early childhood are major obstacles to the government’s efforts towards sustainable socioeconomic development and poverty reduction. In addition, the Millennium Development Goals (MDGs) will not be achieved without action to reduce the rate of malnutrition in infants and young children. Appropriate feeding contributes directly to achievement of MDG 1 (eradicate extreme poverty and hunger), MDG 4 (reduce child mortality), and to the six other MDGs (see 1.3). Recent research has shown that under-five mortality can be reduced by 13% with optimal breastfeeding and a further 6% with optimal complementary feeding (Jones et al, 2003). The correction of inappropriate feeding practices can also prevent malnutrition and its consequences, including developmental delays, impaired educational ability, a lifetime of poor health, increased risk of chronic disease and early death.
Chapter 2: National Strategy

2.1 Goal

To provide the framework for ensuring the survival of, and enhancing the nutrition, health, growth and development of infants and young children, as well as strengthening the care and support services required to achieve optimal IYCF.

2.2 Objectives

- Promote, protect, and support exclusive breastfeeding for the first months of life, with continued breastfeeding up to 2 years and beyond.
- Ensure nutritionally adequate and safe complementary feeding from 6 months of life while breastfeeding continues.
- Support PMTCT services while promoting optimal IYCF in HIV-exposed children.
- Strengthen the care, support, and follow-up services for pregnant women, mothers and caretakers in order to practice optimal IYCF.
- Enhance optimal IYCF in other exceptionally difficult circumstances.
- Advocate for appropriate interventions that promote and support the practice of optimal IYCF for all women, including employed mothers.
- Contribute to the prevention and reduction of childhood and maternal malnutrition, illness and death.
- Foster coordination and identify institutional arrangements among government, local and international organisations and other stakeholders in promotion of optimal infant and young child feeding practices.

2.3 Statement on optimal infant and young child feeding practices

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important health implications for mothers. Breastfeeding should be initiated within an hour of delivery, and no prelacteal foods should be given. Infants should be exclusively breastfed for the first six months (180 days) of life to achieve optimal growth, development and health. Furthermore to meet their evolving nutritional requirements, infants should be fed nutritionally adequate and safe complementary foods and breastfed up to two years of age or beyond.

Exclusive breastfeeding from birth is possible except for a few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production, even in women with suboptimal diets. Even though it is a natural act, breastfeeding is also a complicated behaviour that must be learned. Virtually all mothers can breastfeed provided they have accurate information, and support from their husbands, families and communities and from the health care system. They should also have access to skilled practical help from, for example, trained health workers, lay and peer counsellors who can help to build mothers’ confidence, improve feeding technique, and prevent or resolve breastfeeding problems.

One of the common barriers to exclusive breastfeeding in Sierra Leone is that mothers often believe they are unable to produce enough milk to meet the infant’s needs (IYCF study UNICEF, 2007); mothers need reassurance that they are able to exclusively breastfeed their infants for six months, even if they have suboptimal diets. At the same time, every effort is needed to improve the dietary intake of these mothers. The dangers of bottle feeding and of breast milk substitutes should be clearly communicated to mothers, their husbands and families at every opportunity.

Women in paid employment can be helped to continue breastfeeding by being provided with minimum
enabling conditions, for example paid maternity leave of sufficient duration, part-time work arrangements, support from co-workers, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding breaks. Women with high household workload also need similar support from their husbands and other family members to breastfeed and give complementary foods to their young children.

Good complementary feeding practices are essential to protect infants and children from both undernutrition and overnutrition. Infants are particularly vulnerable during the transition period when complementary feeding begins. Ensuring that their nutritional needs are met requires that complementary foods be:

- timely - meaning that they are introduced when the child has completed 6 months (180 days) of life, when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding
- adequate - meaning that they provide sufficient energy, protein and micronutrients to meet a growing child’s nutritional needs
- safe - meaning that they are hygienically prepared and stored, and fed with clean hands using clean utensils and not bottles and teats
- responsively fed - meaning that they are given consistent with a child’s signals of appetite and satiety, and that meal frequency and feeding method (actively encouraging the child, even during illness, to consume sufficient food using fingers, spoon or self-feeding) are suitable for the age of the child.

Appropriate complementary feeding depends on accurate information and skilled support from the family, community and health care system. Providing appropriate nutrition counselling to mothers of young children and recommending the widest possible use of locally available foodstuffs will help ensure that local foods are prepared and fed safely in the home. Since the mother does not always have the ability to take decisions that affect what and how her child is fed, other family members also need to be targeted with information and counselling, particularly husbands and mothers-in-law. Inadequate knowledge about appropriate foods and feeding practices is often a greater determinant of malnutrition than the lack of food.

However knowledge will not help in improving complementary feeding practice unless access to quality food is ensured. Diversified approaches are required to ensure access to foods that will adequately meet energy and nutrient needs of growing children, for example use of home- and community- based technologies to enhance nutrient density, bioavailability and the micronutrient content of local foods; promotion of homestead food production; and interventions to increase household purchasing power. The agriculture sector has important roles to play to ensure the availability and affordability of suitable foods for complementary feeding.

Low-cost complementary foods made of local ingredients using household or community production technologies can help to meet the nutritional needs of older infants and young children. Processed food products for infants and young children must always meet the quality standards issued.

Food fortification and universal or targeted nutrient supplementation will be necessary methods to ensure that older infants and young children receive adequate amounts of micronutrients for proper growth and development. These include vitamins and mineral supplements or home fortificants, iodized salt, vitamin A-fortified oil and other fortified products.

2.4 Feeding in exceptionally difficult circumstances

Families in difficult situations require special attention and practical support to be able to feed their children adequately. These situations include orphaned children, those born to adolescent mothers, HIV-positive mothers, or those whose mothers cannot breastfeed for medical reasons, in emergency and out-
breaks and acute malnutrition situations. In such cases, the likelihood of not breastfeeding increases, as do the dangers of artificial feeding and inappropriate complementary feeding. In exceptionally difficult circumstances, mothers and babies may remain together and be given ample support to provide the most appropriate feeding options.

Every effort should be made to provide children who cannot be breastfed by their biological mother with a healthy wet-nurse as the first option. Whenever breast-milk substitutes are required for social or medical reasons, the quantity, distribution and use of these substitutes should be strictly controlled to prevent any “spillover effect” of artificial feeding into the general population. A nutritionally adequate breast-milk substitute should be fed by cup only to those infants who have to be fed on breast-milk substitutes. Those responsible for feeding a breast-milk substitute should be adequately informed and equipped to ensure its safe preparation and use. Feeding a breast-milk substitute to minority of children should not interfere with protecting, promoting and supporting breastfeeding for the majority. The use of infant feeding bottles and artificial teats should be actively discouraged at all times.

In all exceptionally difficult circumstances it is important to create conditions that will support the mother, for example, by provision of appropriate maternity care, extra food rations and drinking-water for pregnant and lactating women, and staff who have breastfeeding counseling skills

2.4.1 Human immunodeficiency virus (HIV)

The prevalence of HIV in Sierra Leone is still low, and the opportunity exists to prevent the infection from expanding beyond the current low level. The National Strategy has a clear role to play in this issue. The overall objective of HIV and infant feeding actions is to improve child survival by promoting appropriate feeding practices, while working to minimize the risk of HIV transmission through breastfeeding. It is recommended that only when replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), avoidance of all breastfeeding by HIV infected mothers is recommended.

Mothers who are known to be HIV uninfected or whose HIV status is unknown should be counselled to exclusively breastfeed their infants for the first six months of life and then introduce complementary foods while continuing breastfeeding for 24 months or beyond. Mothers whose status is unknown should be offered HIV testing. (Guidelines on HIV and infant feeding (WHO, 2010)

Recommending breast milk substitutes should never be done without careful consideration. For this reason the acceptable, feasible, affordable, sustainable and safe conditions are expressed forthrightly. Taking the choice to use replacement feeding could be a dangerous decision in an environment where poverty, stigma, food insecurity, mother and child malnutrition, and high disease rates prevail, as each can easily threaten the health of the non-breastfed infant. A lack of breastfeeding exposes children to increase risk of malnutrition and life-threatening diseases, especially in the first year of life. In fact, not breastfeeding during the first two months of life is associated with a six-fold increase in mortality due to infectious diseases in developing countries (WHO, 2000).

Women at higher risk of HIV and their husbands need access to Voluntary Counseling and Testing (VCT) services. For women who test negative for HIV, or who are untested, exclusive breastfeeding is the only recommended feeding option. Women who test HIV positive and their husbands should receive counseling on several issues including their own nutritional requirements, the risk of HIV infection compared with the risks of not breastfeeding and how to determine which of available feeding options is acceptable, feasible, affordable, sustainable and safe (AFASS). This guidance will allow the mothers, fathers and other caregivers to make an informed choice on the safest feeding option for their situation. Through this approach, it should be possible to achieve the ultimate goal of increasing overall child survival, while reducing HIV infection in infants and young children. Couples with HIV should also have follow-up care and support, including family planning and nutritional support, and where possible should be linked with support groups for people living with HIV.
The evidence base for HIV and infant feeding is still growing and many questions will not be answered for months or years. As new information is released on HIV and infant feeding, the benefits and risks associated with the different feeding options will need to be re-assessed and clearly communicated to maintain policy consensus.

2.4.2 Emergencies and outbreaks

Infants and children are among the most vulnerable victims of natural or manmade disasters, and this vulnerability often lasts long after the immediate crisis has ended. The challenging conditions typically faced by women and families during emergencies and outbreaks can undermine breastfeeding practices and interfere with crucial support for breastfeeding women. The shortage and often unsuitability of food resources during emergencies and outbreaks make essential aspects of feeding and care still more difficult. Interrupted breastfeeding and inappropriate complementary feeding heighten the risk of malnutrition, illness and mortality.

The protection, promotion and support of infant and young child feeding practices should be in the first actions taken to address an emergency situation. Optimal practices for feeding infants and young children during emergencies and outbreaks are essentially the same as those that apply in other more stable conditions. For the vast majority of infants, the emphasis should be on protecting, promoting and supporting breastfeeding and ensuring timely, safe and appropriate complementary feeding. Every effort should be made to keep breastfeeding mothers and children together, to re-establish breastfeeding among mothers who have stopped, and to identify alternative ways to support infants whose biological mothers are unavailable, including the provision of a healthy wet-nurse.

The quantity, distribution of breast-milk substitutes in emergencies and outbreaks should be strictly controlled to prevent unnecessary use. Clear action-orientated messages on appropriate practices should be given at points of contact with affected families in emergencies. Mothers need secure uninterrupted access to appropriate ingredients with which to prepare nutrient-dense foods for themselves and their young children. Alternatively, pregnant women, breastfeeding women and children aged 6-59 months should be provided with extra rations of fortified supplementary foods. Micronutrient supplements are also required to prevent vitamin and mineral deficiencies (vitamin A supplements for children 6-59 months and postpartum women, iron-folate or multiple micronutrient supplements for pregnant and breastfeeding women, and children aged 6-59 months). Nutritional status should be continually monitored to identify malnourished children and mothers so that their condition can be assessed and treated, and prevented from deteriorating further.

2.4.3 Malnutrition and low birth weight

Infants and young children who are malnourished are most often found in environments where improving the quality and quantity of food intake is particularly problematic. To prevent a recurrence and to overcome the effects of chronic malnutrition, these children need extra attention both during the early rehabilitation phase and over the longer term. Continued frequent breastfeeding and, when necessary, re-lactation are important to ensure the best possible nutrition for the child. Nutritionally adequate and safe complementary foods may be particularly difficult to obtain and nutritional supplements may be required for these children, as well as treatment of underlying diseases.

Severely wasted children require therapeutic feeding with appropriate supplements. Severely wasted children with complications should be referred to an inpatient facility with trained staff for nutritional rehabilitation and treatment. Severely wasted children with no complications who are alert, have good appetite and are clinically well can be managed at home in the community.

Low birth weight infants also need special attention. Most of these infants are born at or near term and can and should be breastfed within an hour of birth. Breast milk is particularly important for preterm
infants and the small proportion of term infants with very low birth weight who are at increased risk of infection, long term ill-health and death. These children are also born with a higher risk of micronutrient deficiencies compared to normal birth weight children.

2.5 Improving feeding practices

Mothers, fathers and other caregivers should have access to objective, consistent and complete information about appropriate feeding practices, free from commercial influence. In particular, they need to know about the recommended period for early, exclusive and continued breastfeeding; the timing of the introduction of complementary foods; what types of food to give, how much and how often; and how to feed these foods safely. The messages on optimal infant and young child feeding practices need to be delivered at the appropriate time in the life cycle.

Mothers should have access to skilled support to help them initiate and sustain appropriate feeding practices, to prevent difficulties and manage them when they occur. Trained health workers are well placed to provide this support, which should be a routine part not only of regular antenatal, delivery and postnatal care but also of services provided for the well and sick child. Community based networks offering mother-to-mother support, and trained breastfeeding counsellors working within, or closely with, the health care system, also have an important role to play in this regard. Where fathers are concerned, research show that breastfeeding is enhanced by the support and companionship they provide as family providers and caregivers. In Sierra Leone, the role of mothers-in-law is also important, and they too need to be targeted with correct information on appropriate infant and young child feeding practices.

Mothers should also be able to continue breastfeeding and caring for their children after they return to paid employment. This can be accomplished by implementing maternity protection legislation and related measures, and providing day-care facilities and paid breastfeeding breaks for all women employed outside the home.
### 2.5.1 Time appropriate topics for discussion with mothers, husbands and families on IYCF

<table>
<thead>
<tr>
<th>Time in Life Cycle</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pregnancy</strong></td>
<td>• Put the child to the breast with skin to skin contact within an hour of delivery&lt;br&gt;• Correct position and good attachment&lt;br&gt;• No pre-lacteal feeds&lt;br&gt;• Feed colostrum&lt;br&gt;• Exclusive breastfeeding for 6 months&lt;br&gt;• No breast milk substitutes or bottles&lt;br&gt;• Iron-folate supplements for pregnant woman&lt;br&gt;• Adequate dietary intake (quality and quantity) for pregnant woman</td>
</tr>
<tr>
<td><strong>Delivery/postpartum</strong></td>
<td>• Put the child to the breast with skin to skin contact within an hour of delivery&lt;br&gt;• Good breastfeeding practices (i.e., positioning, attachment, emptying of the breast, frequency for day and night feeds)&lt;br&gt;• No pre-lacteal feeds&lt;br&gt;• Feed of colostrum&lt;br&gt;• Exclusive breastfeeding for 6 months&lt;br&gt;• No breast milk substitutes or bottles&lt;br&gt;• Post-partum vitamin A supplement and iron-folate supplements for the mother&lt;br&gt;• Adequate dietary intake (quality and quantity) for the breastfeeding mother</td>
</tr>
<tr>
<td><strong>Infant up to 6 months of age (First 180 days)</strong></td>
<td>• Exclusive breastfeeding for 6 months&lt;br&gt;• No breast milk substitutes or bottles&lt;br&gt;• Good breastfeeding practices (i.e., positioning, good attachment, emptying of the breast, frequency for day and night feeds)&lt;br&gt;• Coping with lactation problems (engorgement, not enough milk, mastitis, cracked nipples etc.)&lt;br&gt;• Adequate dietary intake (quality and quantity) for the breastfeeding mother&lt;br&gt;• How to manage breastfeeding and work both inside and outside of the home&lt;br&gt;• Family planning methods during breastfeeding&lt;br&gt;• Growth monitoring and promotion for the child every month</td>
</tr>
<tr>
<td><strong>Child on completion of 6 months and up to 12 months</strong></td>
<td>• Continued breastfeeding&lt;br&gt;• No breastmilk substitutes or bottles&lt;br&gt;• Good breastfeeding practices (i.e., positioning, attachment, emptying of the breast, frequency for day and night feeds)&lt;br&gt;• Coping with lactation problems (engorgement, not enough milk, mastitis, cracked nipples etc.)&lt;br&gt;• Introduction of family based complementary foods on completion of 6 months (180 days)&lt;br&gt;• Quantity, quality, frequency, consistency, variety, safety of family-based complementary foods for various age groups&lt;br&gt;• Child on completion of 6 months and up to 12 months&lt;br&gt;• How to feed a child with individual bowl or plate.&lt;br&gt;• Adequate dietary intake (quality and quantity) for the breastfeeding mother&lt;br&gt;• Vitamin A supplementation for child at 6 months of age&lt;br&gt;• Growth monitoring and promotion for child every month</td>
</tr>
</tbody>
</table>
| Child on completion of 12 months and up to 24 months | • Continued breastfeeding  
• No use of breast milk substitutes or bottles  
• Good breastfeeding practices and coping with lactation problems  
• Quantity, quality, frequency, consistency, variety, safety of family-based complementary foods for various age groups  
• Adequate dietary intake (quality, quantity and safety) for the breastfeeding mother  
• Vitamin A supplements for child every six months  
• Growth monitoring and promotion for child every month |
Chapter 3. Strategic Priorities

The priority strategies for infant and young child feeding in Sierra Leone fall into four categories:

1. Legislation
2. Skilled support by the health system
3. Community-based support, communication and
4. Support in exceptionally difficult circumstances

Legislation:
Legislation, policies and standards are needed to protect infant and young child feeding practices. They include measures to prevent unethical marketing of breast-milk substitutes, to protect the breastfeeding rights of employed women, and to ensure adequate labelling and quality of products intended for consumption by infants and young children.

Skilled support by the health system:
The practices and routines of all health facilities should actively promote the initiation and promotion of breastfeeding. Every opportunity should be taken during contacts between mothers and health service providers to counsel on infant and young child feeding through integration of infant and young child feeding activities with health and nutrition programmes. Health service providers themselves need updated knowledge and skills to effectively support infant and young child feeding.

Community-based support, communication:
Mothers need support for infant and young child feeding in the communities where they live. Community-based support and family support of infant and young child feeding should therefore be an essential element of efforts to improve practices. Community-based support may take the form of mother support groups, peer counsellors or women’s groups.

Support in exceptionally difficult circumstances:
Special emphasis on the protection, promotion and support of infant and young child feeding is needed when exceptionally difficult circumstances arise, for example, acute malnutrition, emergencies, outbreaks and HIV/AIDS. Without special attention, these circumstances often hinder the ability of a mother to feed her child at the very time when her child needs it most.

2.5.1 Time appropriate topics for discussion with mothers, husbands and families on IYCF

| **Enabling Environment – Legislation, Policy and Standards** |
| Strategy 1 : | Code on marketing of breast-milk substitutes |
| Strategy 2 : | Maternity Protection in the workplace |
| Strategy 3 : | Codex standards on Infant Formulas and food safety |
| Strategy 4 : | National policies and plans |

| **Skilled Support by the Health System** |
| Strategy 5 : | Institutionalization of Baby-Friendly Hospital Initiative |
| Strategy 6 : | Mainstreaming and integration into health service curriculum |
| Strategy 7 : | Capacity Development for health service providers |

| **Community-based support** |
| Strategy 8 : | Integrated community based IYCF counselling services (Creation of mother support groups for peer-to-peer support) |

| **Communication** |
3.1.1 Strategy 1: Code of marketing of breast-milk substitutes

Breast milk is the best food for an infant’s first six months of life. It contains all the nutrients an infant needs and it stimulates the immune system and protects from infectious diseases. Breast milk substitutes are an expensive, inferior and often dangerous substitute for breast milk, but formula manufacturers have nonetheless advertised and marketed them. Recognizing the need to regulate these practices, the World Health Assembly (WHA) adopted the International Code of Marketing of Breast-milk Substitutes in 1981, and subsequently the Government of Sierra Leone took action to adapt the Code on Marketing of Breast-milk Substitutes. The aim of the National Code is to contribute to the provision of safe and adequate nutrition for infants by ensuring appropriate marketing and distribution of breast-milk substitutes and to prohibit their promotion.

Strategy 1: Code of marketing of breast-milk substitutes:

Strengthen the implementation, monitoring and enforcement of the Breast Milk Substitutes (Regulation of Marketing) Ordinance and amendments.

The National Strategy calls for adoption, implementation and monitoring of the National Code to ensure that all provisions of the International Code and subsequent world Health Assembly (WHA) resolutions are incorporated. The scope of the Code should be broadened to ensure that all products intended for consumption by infants and young children are appropriately marketed and distributed. There is need to strengthen the monitoring and enforcement procedures of the National Code so that code violations are more effectively detected and swift legal action is taken. The awareness of policy-makers, infant-food manufacturers, wholesalers/marketers, health service providers and the general public about the Code needs to be raised.

Key Activities:
1. Advocacy to create mass awareness on the BMS Code to keep its implementation high on the political and legislative agenda
2. Conduct in-depth training of policy makers and lawyers for developing national legislation
3. Draft Code legislation to incorporated all provisions and any subsequent WHA resolution as a minimum standard and include the necessary implementation and enforcement provisions by identifying an independent body responsible for monitoring
4. Conduct regular independent monitoring using standard developed protocols to ensure the enforcement of the National Code for effective detection of code violations and to accelerate the legal process.
5. Conduct a review of the strengths, weaknesses, opportunities and threats to the monitoring mechanism and enforcement procedures, and determine what improvements can be made
6. Revise the monitoring system and enforcement procedures according to the recommendations of the review, and amend the National Code if necessary.
7. Ensure that the response to HIV and outbreaks does not include the introduction of non-Code compliant donations of breast milk substitutes or the promotion of breast milk substitutes.
8. Raise awareness on the National Code and the need for effective implementation at the national level among key policy-makers, infant food manufacturers and the public.
9. Develop and disseminate user-friendly guidelines for government officials on the contents of the National Code and guidance notes on staff interactions with infant formula manufacturers.
10. Educate health service providers and others on their responsibilities under the National Code.

3.1.2 Strategy 2: Maternity protection in the workplace

Increasing numbers of women are joining the workforce in both rural and urban areas of Sierra Leone, and their contribution to the economy is considerable. At the same time, their ability to exclusively and continually breastfeed their infants and young children is essential to ensure a healthy, well nourished, and economically productive future workforce. The two roles of women as workers (economically productive) and mothers (reproductive) should be respected and accommodated by both the government and society.

The International Labour Organization (ILO) Maternity Protection Convention C-183 was passed in 2000 to protect the maternity and breastfeeding rights of employed women. Sierra Leone has not ratified the ILO Maternity Protection Convention 183 (2000) and Domestic Workers Convention 189 (2012) although there is a labour law with provision of full-paid maternity leave. However, in Sierra Leone the present labor law is inadequate and does not offer maternity protections and provision for breastfeeding breaks or facilities at work places, with only 12 weeks of maternity paid leave provided. It is silent on provisions for the private sector (Regulations of Wages and Industrial Relations Act (no 18 of 1971). The private sector working arrangements prevent working mothers from optimally feeding their infants and young children, and force them to choose between income today and protecting the child’s future health and development. In addition, there are inequities as current law does not take into consideration the women in the informal/unorganised sector. There is work currently on reviewing of all Labor Laws.

**Strategy 2: Maternity protection in the workplace**

*Enact adequate legislation protecting the breastfeeding rights of working women in a full range of employment and establish the means for its enforcement*

Amendments to the current legislation to include all provisions of the ILO Maternity Protection Convention C-183 for all employed women including at least fourteen (14) and more weeks paid maternity leave for postpartum women in public and private sectors with flexibility of breaks for breastfeeding after maternity leave. The legislation needs to be widely publicized among all stakeholders, especially employers and the public, and a mechanism for its monitoring and enforcement should be established. Employers and co-workers should also be motivated to create an enabling environment for women to breastfeed at the workplace including the creation of crèches, breastfeeding breaks, and comfortable private spaces to breastfeed. Mothers who take maternity leave should be informed that one of the most important reasons for maternity leave is to enable the mother to exclusively breastfeed her child; they should be counselled on the importance of exclusive breastfeeding for six months and given necessary support.

**Key Activities:**

1. Conduct communication activities targeting working mothers to support the continuation of breastfeeding
2. Conduct culturally appropriate advocacy about how maternity protection benefits employers and the society
3. Increase public awareness on the benefits of combining work and breastfeeding, and publicize legislation among all stakeholders, especially among employers and the public.
4. Advocate with employers to create better opportunities for women to breastfeed at the workplace including the creation of crèches, breastfeeding breaks, and comfortable private spaces to breastfeed at the workplace (“Mother-Friendly Workplaces”).
5. Encourage unions and workers’ groups to advocate for maternity entitlements which support women workers’ who breastfeed.
6. Advocate for the adoption of the Maternity Leave Law 2001 to include all provisions of the ILO Maternity Protection Convention No. 183 for all employed women, and periodically update as required.
7. Establish mechanism to monitor and enforce the legislation

3.1.3 Strategy 3: Codex standards

The Codex Alimentarius is the international body that aims to protect the health of consumers. Codex standards cover infant formula, tinned baby food, processed cereal-based foods for infants and children, and follow-up food. There are also Codex guidelines for formulated supplementary food for older infants and young children with advisory lists of mineral salts and vitamin compounds that may be used in these foods as well as a code of hygienic practices. The Codex standards for infant formula and processed cereal-based foods for infants and children define the products and their scope and cover composition, quality factors, food additives, contaminants, hygiene, packaging, labelling and methods of analysis and sampling.

**Strategy 3: Codex Alimentarius**

Ensure that processed infant and complementary foods are safe and nutritionally adequate, in accordance with the relevant Codex Alimentarius standards.

Where locally available foods can be difficult to access, such as urban areas, support and encourage expansion of locally and centrally produced appropriate complementary foods to fully meet the nutrition requirements of young children. The strategy will advocate for compulsory certification of all Private and public sectors manufacturer and importers of infant and complementary foods intended for consumption by infants and young children. The certification should comply with Codex Standards for appropriate packaging, labelling, and distribution of complementary foods.

**Key activities:**

1. Conduct a review on the use of the Codex Alimentarius in Sierra Leone and compliance with its standards on available products for infants and young children.
2. Develop standards for nutrient content, safety, and appropriate labelling of processed complementary foods intended for infants and young children.
3. Enforce compulsory certification of all processed complementary foods by adding them to the list of items that must be obligatorily tested by the Sierra Leone Standards Bureau before sales in Sierra Leone.

3.1.4 Strategy 4: National policies and plans

Optimum breastfeeding and complementary feeding practices not only improves short- and long- term health outcomes but also contribute to a stronger economy by reducing health expenditure, improving educational achievement and productivity among adults. The focus of national development policies and plans on infant and young child feeding should be commensurate with these impacts.

Examples of existing policies and plans that would benefit from a stronger focus on infant and young child feeding include the Poverty Reduction Strategy Paper (2013-2018), National health Sector Strategic Plan (NHSSP 2011-2015), National Food and Nutrition Security Implementation Plan (2013-2017), Basic Package for Essential Health Services (BPEHS), Joint Programme of Work and Funding (JPWF 2012-2014), Results and Accountability Framework (RAF) and Performance Based Financing (PBF).

**Strategy 4: National policies and plans**

Incorporate infant and young child feeding interventions into national development policies and plans, major health initiatives and other projects to advocate for its importance and mobilize resources.
The National Strategy calls for infant and young child feeding to be strongly anchored within the broad development agendas of the government and in all relevant programmes. All opportunities should be taken to incorporate infant and young child feeding interventions into national policies and plans, major health initiatives, such as Malaria, HIV/AIDS, EPI, FP, RCH, WASH programmes to advocate for effective collaboration, integration and action.

**Key Activity:**
Incorporate infant and young child feeding interventions into national development policies and plans, major health initiatives and other projects to advocate for its importance and mobilize resources.

### 3.1.5 Strategy 5: Institutionalization of Baby-Friendly Hospital Initiative (BFHI)

Hospitals set a powerful example for mothers, and they all have an important role as centres of breastfeeding support to improve hospital routines and procedures so that they are supportive of the successful initiation and continuation of optimal breastfeeding practices. A hospital is designated as “baby friendly” when it has agreed not to accept free or low-cost breast milk substitutes, feeding bottles or teats, and to implement 10 specific steps to support breastfeeding (“Ten steps to successful breastfeeding”). BFHI certification will be conducted by the Directorate of Food and Nutrition for hospitals that are accredited.

#### Strategy 5: Baby-Friendly Hospital Initiative

Ensure that every health facility successfully and sustainably practices all the “Ten steps to successful breastfeeding” and other requirements of the BFHI.

The National Strategy calls for adaptation and implementation of BFHI to achieve full coverage of all maternity hospitals in the country, including private and nongovernment facilities; to monitor the quality of implementation to ensure adequate standards of care; to strengthen the reassessment (recertification) of baby-friendly status; and to mainstream BHFI into the health system as an essential component of quality assurance and improvement of care. Ways should also be found to strengthen the link with the community-based support groups as an important avenue to increase coverage of skilled support (the tenth step of the “Ten steps to successful breastfeeding” of BFHI).

#### Key Activities:

1. Adopt the Ten Steps to Successful Breastfeeding and expand the BFHI to all health facilities providing mother and child services in the country, including private and non-government facilities.
2. Determine and implement ways to sustain the “baby-friendly” status of health facilities, such as Breastfeeding Management Centres.
3. Link baby-friendly health facilities with “baby-friendly” communities with the help of community support groups available at the community level.
4. Create a national monitoring system for BFHI certification, accreditation and recertification, with guidelines on how often a health facility should be assessed for BFHI status.
5. Incorporate BHFI into the standard operating procedures of health facilities, including the facility’s quality control, monitoring and evaluation system.
6. Incorporate BFHI into the accreditation procedures of new health facilities.

### 3.1.6 Strategy 6: Mainstreaming and integration into health service

Optimal infant and young child feeding requires substantial behaviour change on the part of a mother. This cannot be achieved through a single contact with a health service provider - mothers need multiple contacts to acquire knowledge, reinforce positive behaviors and solve problems throughout the latter stages of pregnancy and during the first two years of life of a child. It is therefore essential that IYCF activities are incorporated, to the extent possible, as a priority action in all existing programmes and projects with
which the mother has contact during this crucial period.

**Strategy 6: Mainstreaming and prioritization of IYCF activities**

Integrate skilled behavior change counseling and support for infant and young child feeding into all points of contact between mothers and health service providers during pregnancy and the first two years of life of a child.

The National Strategy calls for the integration of skilled behaviour change counseling and support for infant and young child feeding at all points of contact between mothers and health service providers during pregnancy and the first two years of life of a child, including antenatal care, delivery care, postnatal care, immunization visits, growth monitoring and promotion, and child health services.

**Key Activities:**

1. Identify all contact opportunities between pregnant women, infants, young children and health, nutrition and development programmes/projects, and opportunities to mainstream (integrate) IYCF activities.
2. Determine the limiting factors in integrating IYCF and how to overcome them.
3. Advocate for mainstreaming and prioritization of IYCF activities.
4. Promote consistency of approaches across all programmes/projects, including the use of uniform guidelines, training materials, and job aids.
5. Integrate with other health programmes: maternal and neo-natal health, antenatal and postnatal care, child health (EPI), IMNCI or other facility-based child illness treatment programmes, growth monitoring, child health days, community case management (CCM), integrated management of acute malnutrition (IMAM) and prevention of mother to child transmission (PMTCT)
6. Integration with early childhood development (ECD) programs

**3.1.7 Strategy 7: Capacity Development for health service providers**

Health service providers, nutritionists and allied professionals who care for mothers need up-to-date knowledge on infant and young child feeding legislation, policies and guidelines, and skills training for interpersonal communication, counselling and community mobilization.

The most sustainable way to address the current knowledge and skill gaps is to include essential knowledge and competences in the pre-service curricula. While such efforts progress, there is also need to increase the skills of those who are already in service through action-oriented, skills focused training.

**Strategy 7: Knowledge and skills of health service providers**

Improve the knowledge and skills of health service providers at all levels to give adequate support to mothers on infant and young child feeding, including skills training on interpersonal communication, behaviour change counselling and community mobilization.

The National Strategy calls for a revision and periodic update of pre-service and in-service curricula and training materials. Conditions to ensure sustainable implementation and training include guidelines on infant and young child feeding; teams of experienced trainers for both in-service and pre-service education; strict criteria for selection of trainers and trainees; and monitoring of the quality of training and follow-up. A detailed plan of action is needed for roll-out of in-service training at all appropriate levels.

**Key Activities:**
1. Adapt, integrate and implement 40 hours WHO/UNICEF IYCF (2007) course and model chapter for medical students and health professionals (WHO 2009) into pre-service and in-service education curriculum at all levels

2. Improve follow-up and supportive supervision of health workers to sustain their knowledge and skills and the quality of counseling.

3. Assess levels of skills and knowledge, needs for improvement, and training needs of health service providers.

4. Develop guidelines and standard training materials on infant and young child feeding for health service providers at appropriate levels, including:
   - Breastfeeding counseling
   - Complementary feeding counseling
   - HIV and infant feeding counseling
   - Management of severe malnutrition
   - Management of low birth weight
   - Infant and young child feeding in emergencies and outbreaks
   - Responsibilities for monitoring of the National Code of marketing of breast milk substitutes
   - Develop quality job aids on infant and young child feeding for health service providers
   - Develop a team of core trainers on maternal, infant and young child feeding for training of health service providers.

3.1.8 Strategy 8: Integrated community based IYCF counselling services

Every mother faces unique challenges in meeting her infant and young child’s needs for food during the first two years of life. Mothers need access, within their communities, to a reliable and accessible source of information, guidance and counselling to overcome the day-to-day challenges they face in practicing exclusive breastfeeding, continued breastfeeding and appropriate complementary feeding. This requires that support for breastfeeding and complementary feeding be extended from health facilities to the communities where mothers live and work. The need for community-based support is particularly high in communities that are remote, where health care is less accessible, poverty and food security are greater problems and misinformation on appropriate infant and young child feeding practices is more widespread.

Strategy 8: Community-based support

Develop community-based networks to help support appropriate infant and young child feeding at the community level, e.g. mother-to-mother support groups and peer or lay counsellors.

The National Strategy calls for much greater attention to community-based support of infant and young child feeding in Sierra Leone. Community-based support mechanisms have the potential to vastly improve infant and young child practices by increasing access to information, guidance and counselling. Behaviour change counselling is a key intervention and can be delivered by a peer, family member, Mother to mother support groups, community health worker or volunteer. Home visits, group meetings, growth monitoring sessions, and cooking sessions are all good opportunities for sharing information and counselling. The counsellor needs to have accurate knowledge and skills about infant and young child feeding, be equipped to negotiate feasible actions, and be able to inspire the mother with confidence in her abilities.

Community-based interventions should, where possible, build on existing structures, integrate with the health system, and involve partnerships with various sectors and groups. Interventions should extend the care that is provided within the health system to families in the home and mechanisms should be in place to refer mothers and babies with problems, preferably to a baby-friendly facility. The same community should also take steps to ensure that the National Code for marketing of breast-milk substitutes is respected, and that there is maternity protection in the workplace. Appropriate efforts should also be made to involve the private sector, including private practitioners, doctors, midwives, nurses and traditional birth
attendants. There must also be sustained involvement of the health sector in support and supervising activities at the community level. The challenge is to identify which individuals or groups are most appropriate for promoting infant and young child feeding in the community. This depends on their frequency of contact with mothers during pregnancy and breastfeeding, geographical coverage and number, existing work load, ability to provide accurate information, advice and behaviour change counselling skills, motivation and sex. More than one type of individual or group will be necessary to cover the all target groups and all areas of the country effectively.

**Key Activities:**

1. Extend the concepts of BFHI to create Baby-Friendly Community Initiatives (BFCI) where entire communities have adopted a baby-friendly approach
2. Support the formation, expansion and sustainability of peer counsellors and community-support group using mother-to-mother support groups in all communities to provide counselling and guidance to mothers in their communities.
3. Integrated Traditional birth attendants into peer counselling groups to facilitate safe delivery and ensure early initiation of breastfeeding immediately after birth
4. Develop core team of trainers for peer counsellors and community-based support groups.
5. Identify primary and secondary target groups to tailor BCC messages
6. Develop a training package to improve knowledge and skills of peer counsellors and community-support groups on maternal, infant and young child feeding, interpersonal communication, problem solving, counselling and group facilitation.
7. Produce and disseminate information, education and communication (IEC) materials, including appropriate media materials, on appropriate maternal, Infant and young child nutrition
8. Establish community-based support groups and peer counsellors, with supportive supervision from health system or NGO.
9. Train peer counsellors, community-based support groups and their supervisors in IYCF promotion and support, and skills in interpersonal communication, counselling and group mobilization.
10. Monitor and supervise activities by community-based support groups and peer counsellors.
11. District health management teams to support and promote community based initiatives addressing IYCF
12. Ensure all stakeholders should adhere and work towards a strong linkage between health facilities and community-based initiatives

**3.1.9 Strategy 9: Communication for behaviour and social change**

Infant and young child feeding require both advocacy and behaviour change. Advocacy is needed to keep infant and young child feeding high in the public health agenda and to obtain proactive support at all levels including local elites, religious leaders, government officials and political leaders. Behaviour change will focus on the actions that need to be taken by the mother, her family, her employers, community and many others in support of breast feeding and complementary feeding practices that will best serve the nutritional needs of infant and young children.

**Strategy 9: Communication for behaviour and social change**

*Develop communication for behaviour and social change on infant and young child feeding through multiple channels*

Communication strategies must address not only behaviour change of the mother but also the beliefs of those who influence her at all levels; particularly husbands, mothers-in-law, elders, family and community members.

**Key Activities:**
1. Conduct formative research on knowledge, attitudes and behaviours related to infant and young child feeding at all levels (including policy and programme managers, health service providers, employers, infant food manufacturers, traditional birth attendants, community members, parents and mothers) to help identify effective messages on IYCF.
2. Develop an advocacy and communication strategy, based on the formative research, to support all interventions to improve infant and young child feeding practices.
3. Develop advocacy and communication materials for all audiences/stakeholders to support the strategy.
4. Monitor the effectiveness of the advocacy and communication interventions, and adjust strategy if required.

3.1.10 Strategy 10: Improved quality of complementary foods

Appropriate complementary feeding practices are essential to protect infants and children from both under nutrition and over nutrition. Infants are particularly vulnerable during the transition period when complementary feeding begins. Ensuring that their nutritional needs are met, it is critical that complementary foods should be age appropriate, amount, frequency, texture, variety; active/responsive feeding and hygiene practices are taken into consideration.

**Strategy 10: Improved quality of complementary foods**

*Improve the availability and use of local foods through increasing agricultural production of high quality local foods (e.g. homestead production, animal husbandry, linking with agricultural extension)*

**Key Activities:**
1. Ensure improved quality of complementary foods through promotion of available and utilization of locally available ingredients
2. Conduct formative research to introduce and scale-up multiple micronutrient powders (MNP) as home fortification to improve nutrient quality of complementary food
3. Establish linkages with social protection schemes for nutrition component of complementary feeding such as access of vulnerable households to complementary foods, vouchers and/or cash transfers
4. Development of recipes of complementary foods from locally available foods for education and promotion to communities
5. Collaboration with agriculture sector to improve the availability and use of local nutritious foods through increasing agricultural production (e.g. homestead production, animal husbandry, linking with agricultural extension)
6. Integration with early childhood development (ECD) programs
7. Integration with agriculture, food security and livestock programmes to increase food availability and access to animal food sources

3.1.11 Strategy 11: Strengthen IYCF services in exceptionally difficult circumstances (HIV/AIDS, malnutrition, emergencies and outbreaks)

Families in exceptionally difficult circumstances require special attention and practical support to be able to feed their children adequately. These circumstances include HIV infection of the child’s mother or father, emergencies and malnutrition. All these circumstances require an enabling environment, where appropriate infant and young child feeding practices in the general population are protected, promoted and supported, and where special attention and support is available to address the difficult circumstances.

**Strategy 11a: HIV and IYCF**

The National Strategy calls for special attention to support infant and young child feeding in circumstances...
where the child’s mother or father has HIV. There is need to develop and update guidelines on HIV and infant feeding; expand access to and demand for HIV testing and counselling; and to build capacity of health service providers and peer support groups of people living with HIV/AIDS to counsel HIV-positive parents on HIV and infant feeding so that they can make informed infant feeding choices (considering AFASSA) and are supported in carrying out their choice.

**Strategy 11a: HIV and IYCF**

*Develop capacity among the health system, community and family to provide adequate support to HIV-positive women to enable them to select the best feeding option for themselves and their infants, and to successfully carry out their infant feeding decisions.*

**HIV/AIDS and IYCF**

**Key Activities:**

1. Coordinate with stakeholders in the field of HIV/AIDS and sexually transmitted infections prevention to increase access and demand for HIV testing and counselling, before and during pregnancy and lactation to enable women and their husbands to know their HIV status, and be counselled on infant feeding.

2. Establish guidelines on HIV and infant feeding, following UN guidelines.

3. Periodically update the guidelines on HIV and infant feeding, as required, in light of new research findings and/or international recommendations.

4. Disseminate all guidelines, and any revisions, to public, private and NGO health facilities and service providers.

5. Develop the capacity of health service providers and peer support groups of people living with HIV/AIDS to effectively counsel HIV-positive parents and other household members so that they can make informed infant feeding choices and are supported in carrying out their choice.

6. Review relevant policies and strategies related to HIV/AIDS, nutrition, integrated management of childhood illness, safe motherhood, prevention of parent-to-child transmission of HIV/AIDS and feeding in emergencies and outbreaks to ensure consistency with the overall infant and young child feeding strategy as it relates to HIV/AIDS.

7. Adapt the BFHI to make provision for expansion of activities to prevent HIV transmission to infants and young children.

**Strategy 11b: Emergencies/Outbreaks and IYCF**

The National Strategy calls for inclusion of key interventions to protect promote and support optimal feeding for infants and young children in the emergency response to any emergency that affects women and children. Because of the urgency with which these interventions are required when an emergency arises, these interventions need to be in place so that they can be effective during an emergency. Updated guidelines are needed for infant and young child feeding in emergencies, including a framework for action, and infant and young child feeding actions should be incorporated into emergency response plans. Increased awareness and knowledge about the benefits of breastfeeding in the emergency situation is needed among all stakeholders.

A pool of expert trainers should be formed to train government and humanitarian agency staff on good practices in infant and young child feeding in emergencies and to assist these agencies in developing interventions to improve practices. In the event of an emergency, infant and young child feeding activities should be coordinated and monitored through the inter-agency coordination group responsible for nutrition in emergencies.
Strategy 11b: Emergencies/Outbreaks and IYCF

Develop capacity among the health system, community and family to ensure appropriate feeding and care for infants and young children in emergencies

Key Activities:
1. Establish guidelines on infant and young child feeding in emergencies and a framework for action, in particular, the support for exclusive breastfeeding and complementary feeding, and regulation of breast-milk substitutes.
2. Establish guidelines on infant and young child feeding in outbreaks of contagious diseases such as Ebola Viral Disease (EVD) especially for infants 0-5 months and 6-24 months.
3. Periodically update the guidelines, as required, in light of new research findings and/or international recommendations.
4. Disseminate all guidelines, and any revisions, to public, private and NGO health facilities and service providers.
5. Collaborate with the government, NGOs and all other stakeholders working in disaster preparedness and response to ensure that IYCF is adequately reflected in emergency response plans and Standard Operating Procedures (SOP).
6. Develop a communication package on IYCF in emergencies that can be rapidly produced, replicated and disseminated in the event of an emergency.
7. Form a team of expert trainers to train government and humanitarian staff responsible for emergency preparedness and response on infant and young child feeding in emergencies; train infant feeding counsellors on how to support mothers during complex emergencies.
8. Ensure that infant and young child feeding activities are coordinated in the event of an emergency through the interagency coordination group responsible for nutrition in emergencies.

Strategy 11c: Malnutrition and IYCF

Develop the capacity among the health system (both facility and community based), community and family to manage malnutrition, including severe wasting

Key Activities:
1. Strengthen implementation and adherence to integrated the management of severe acute malnutrition (MAM) protocol for infants less than 6 months at facility and community levels, and on the management of low birth weight infants.
2. Periodically update the guidelines, as required, in light of new research findings and/or international recommendations.
recommendations
3. Disseminate all guidelines, and any revisions, to public, private and NGO health facilities and service providers.
4. Develop and implement a training plan for health service providers on integrated management of severe acute malnutrition and management of low birth weight infants.
5. Support local development of an age appropriate fortified supplementary food for children and for pregnant and breastfeeding women.
Chapter 4: Cross-Cutting Strategies

4.1 Gender Concerns in Nutrition

Poor nutrition early in life reduces learning potential, increases reproductive and maternal health risks and lowers productivity. Similar to other developing countries, the main problem that women face in Sierra Leone is poor access to land, information, technology, low participation in decision making forums and high poverty levels. This is precipitated by a number of reasons that include; social, religious and cultural barriers, poor organization of women, disproportionate labour or inadequate working conditions (including in the informal sector) and low literacy levels. These lead to women disempowerment and they get caught in a vicious circle of poverty and under nutrition.

To address these problems, a number of strategies will be applied. They include the roll out of the three gender acts by MSWGCA in order to highlight and minimize the socio-cultural and economic threats to the wellbeing of women, mass sensitization and mobilization of women to ensure that they are better organized to receive support (livelihoods, inputs, training etc.). Advocacy at the community level targeting the Paramount Chiefs, other local authorities, Local councils and secret societies will be conducted to address cultural barriers and promote the girl child school enrolment. Finally, deliberate efforts will be made to actively target men and increase their participation in food and nutrition security interventions for them to better provide support to the women.

4.2 Communication

In Sierra Leone, many high level policy makers and national programme designers do not have adequate knowledge on the relevance of Nutrition to national development. This is despite the fact that nutrition related interventions are articulated in national policy documents as well as other sectoral policy documents. Due to limited knowledge of the relevance of nutrition, they neither demand for nutrition-related data for decision making nor consider nutrition outcomes in national programme design. A national food and nutrition security forum was conducted in Sierra Leone in 2011 but more needs to be done to increase the knowledge level. At the beneficiary level, the messages are not well integrated and targeted and are not reaching the targeted groups in ways that could impact positively on their lives. The lack of a harmonized policy that explicitly guides each sector on their roles and responsibilities with a clear accountability framework has been one of the shortfalls.

To address these gaps, stakeholders will develop a joint communication/advocacy strategy targeting policy makers and programme designers and disseminate the policy implementation plan to all relevant sectors at the national and district level. An investment case for nutrition advocacy will be developed and used to advocate for increased investment in nutrition to support nationwide scale-up of nutrition interventions.

Similarly, at the intervention level, nutrition education is a crosscutting issue with many players across all sectors. There will be a need to harmonize messages and leverage on each agencies’ comparative advantage to successfully accomplish the nutrition education component. This requires a common nutrition communication strategy to build consensus on joint messages and delivery mechanisms and joint development of nutrition messages. The materials developed will then be used by all the stakeholders. In addition, advocacy efforts will be undertaken for integration of nutrition communication into the curricula of pre-service training of public health and extension workers. Measures to strengthen community participation in planning, implementation, monitoring and evaluation of communication activities will also be put in place.
4.3 Capacity Development

The human capacity in most sectors in government is currently inadequate. Most of the government ministries are trying to request for additional staff to implement food and nutrition security interventions. For example, the MoHS and MAFFS are in the process of building up their staff capacity especially nutritionists. In 2011, the number of staff in key ministries is as stated in Table 1 below. To scale up food and nutrition security interventions contained in this plan, additional capacity will be needed especially at the district level. However, the actual numbers and skills sets cannot be determined until a capacity assessment is conducted to determine existing gaps including gaps in pre and in-service training needs in the main sectors concerned in food and nutrition security interventions. Some of the measures to develop capacity will be the recruitment of additional nutritionists, Maternal & Child Health Aides at the health centers, agricultural extension workers and Social development workers at the chiefdom level. Staff on the post will also receive on-the-job training and ministries would also need to work in collaboration with training institutions to revise and update their curricula to reflect current design and implementation realities. The areas that will require curricula review have already been identified under each intervention.

4.3.1 Capacity at community

<table>
<thead>
<tr>
<th>Sector</th>
<th>Facilities/Channels</th>
<th>First Line Human resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>CHC 201</td>
<td>Community Health Centers: 229</td>
</tr>
<tr>
<td></td>
<td>CHP 233</td>
<td>Community Health Nurse: 196</td>
</tr>
<tr>
<td></td>
<td>MCHP 620</td>
<td>MCH Aide: 1876</td>
</tr>
<tr>
<td></td>
<td>Hospitals 147</td>
<td>Midwife: 81</td>
</tr>
<tr>
<td></td>
<td>Tertiary 8</td>
<td>Nutritionists: 13</td>
</tr>
<tr>
<td>Agriculture</td>
<td>Agricultural Business Centres: 192</td>
<td>District Agricultural Officers: 13</td>
</tr>
<tr>
<td></td>
<td>Extension training centres: 2 (Kenema and Tonkolili)</td>
<td>Subject Matter Specialists: 78</td>
</tr>
<tr>
<td></td>
<td></td>
<td>District Extension Coordinators: 26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Block Extension Supervisors: 65</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Field/block Extension workers: 520</td>
</tr>
</tbody>
</table>

4.4 Operational Research

Operational research is currently taking place on a low scale in Sierra Leone with limited collaboration among relevant sectors and inadequate dissemination of research findings. As a result, advocacy, policy and programme decision making are not well informed and backed by empirical evidence. This in turn has led to constraints in the identification of relevant research areas and the utilisation of research recommendations to strengthen the impact of programmes. There is need to conduct timely and appropriate operational research taking into consideration the gaps identified in food and nutrition security interventions. To improve the situation, efforts will be made to integrate operational research into the food and nutrition intervention programmes and advocate for more resources for relevant research. More collaboration between programmes and universities (internships, scholarships and consultancy) will be enhanced and partnerships with international research institutions will also be useful in developing capacities where needed.
4.5 Coordination

The MoHS will take the lead in coordinating and engaging multi-sectoral stakeholders in initiatives to promote and support optimal infant and young child feeding practices. At national, district, and community levels, the appropriate stakeholders should be identified and encouraged to participate in such activities. Clearly defined roles and responsibilities of the various stakeholders in IYCF activities is an essential component of successful implementation of this strategy and all initiatives. A multi-sectoral approach should include government, including pertinent line Ministries, development partners, non-government organizations, and health and medical professional associations/boards.

The National IYCF Working Group comprised of technical representatives from all relevant departments of the government, UN agencies, development partners and NGOs will provide technical support to strategize and plan, coordinate implementation, and monitor and evaluate IYCF interventions at the national level. The following broad tasks will be performed by this working group:

1. Recommend new/changes to policies and strategies for IYCF and submit to the technical committee for approval
2. Develop technical guidelines on infant and young child feeding
3. Develop a 5 year and annual plan of action for infant and young child feeding
4. Monitor the implementation of the plan of action and progress towards the objectives and targets of the National Strategy.
5. Provide any other technical assistance required for effective implementation. To perform these functions, the National Technical Committee should be an integral part of the governmental system, with funding provided and mandate approved by the government.
6. A full-time national IYCF Officer will responsible to provide leadership for IYCF activities.
7. Infant and young child feeding activities will be coordinated and monitored at district level through the District Health Coordination Meetings, the District Nutrition Technical Committee will also utilized.

The responsibilities of partners at various levels are as follows:

- **National Level**
  - Establish a National Baby Friendly Initiative Committee/Authority comprised of key stakeholders from line Ministries, UN Agencies, and other relevant non-government organizations
  - Spearhead advocacy strategies for adoption of optimal feeding practices, involving media
  - Appoint a national breastfeeding/IYCF coordinator
  - Ensure that every facility providing maternity services fully adopts the BFHI Ten Steps to Successful Breastfeeding

- **District Level**
  - Provide district-wide support of infant and young child feeding activities through the district health management teams (DHMT), including the district nutritionists and nutrition focal persons
  - Implement BFHI in all district health facilities

- **Community Level**
  - Carry out campaigns on sensitisation to achieve optimal feeding practices at all levels
<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| **Government of Sierra Leone** | • Formulate, implement, monitor and evaluate policies and strategies for infant and young child feeding  
• Identify and allocate human, financial and organizational resources for implementation of the National IYCF Strategy |
| **Health professional bodies and** | • Education and training in IYCF for all health service providers  
• Promote achievement and maintenance of “baby-friendly” health facilities.  
• Integration of IYCF into antenatal, postnatal, reproductive health, child health and nutrition services.  
• Observe in their entirety their responsibilities under the National Code of marketing of breast-milk substitutes  
• Encourage the establishment and recognition of community support groups and refer mothers to them |
| **Non-governmental organizations, including community support groups** | • Provide members with accurate, up-to-date information about infant and young child feeding.  
• Integrate skilled support for infant and young child feeding in community-based interventions and ensuring effective linkages with the health care system.  
• Contribute to the creation of mother- and child-friendly communities and workplaces that routinely support appropriate infant and young child feeding.  
• Work for full implementation of the principles and aim of the National Code of marketing of breast-milk substitutes. |
| **Manufacturing Companies** | • Companies producing food products for infants and children.  
• Companies producing and distributing products within the scope of the International Code of Breast Milk Substitutes.  
• Ensure that processed food products for infants and children, when sold, meet applicable Codex Alimentarius (International Food Safety) standards  
• All manufacturers and distributors of products within the scope of the National Code for marketing of breast-milk substitutes are responsible for implementing the Code and monitoring their marketing practices. |
### Social partners
- Employers

- Ensure that the maternity entitlements of all women in paid employment are met, including breastfeeding breaks and other workplace arrangements.

### Other groups
- Mass media
- Child-care facilities

- Provide accurate information through schools and other education channels to children and adolescents to promote greater awareness and positive perceptions.
- Provide information on parenting, child care and products within the scope of the National Code of marketing of breast-milk substitutes.
- Permit working mothers to care for their infants and young children.

### UN agencies, international NGOs.
- UN agencies,
- International NGOs.

- Advocate for increased human, financial and institutional resources for implementation of the National IYCF Strategy.
- Support development of norms and standards.
- Support policy development and promotion.
- Support national capacity-building.

### Donors

- Provide funding support.
- Advocate for increased human, financial and institutional resources for implementation of the National IYCF Strategy.

### 4.6 DISASTER PREPAREDNESS

Food and nutrition disaster preparedness platform is currently at its early stages of development. The country has no contingency plan and early detection of emergencies is also a constraint and thus the need to strengthen the food and nutrition early warning and surveillance system. To strengthen disaster preparedness, the following should be put in place:

**Coordination mechanism:** An emergency nutrition platform will be established to plan and respond to disasters. The cluster will work closely with other emergency preparedness mechanisms.

**Development of a nutrition contingency plan:** The priority of the contingency plan will be to prevent death from starvation and diseases, reduce malnutrition by supporting and protecting breastfeeding, especially exclusive breastfeeding including in Ebola context, Infant and Young Child Feeding (IYCF), therapeutic feeding and supplementary feeding, providing essential micro-nutrients and feeding orphans. It will also focus on the need to improve the nutritional status of women. The contingency plan will provide a common framework to guide the actions of all partners.
CHAPTER 5: Monitoring and Evaluation

Monitoring and evaluation is a key component in identifying the achievements, as well as gaps, made in progress towards improving infant and young child feeding practices at all levels of implementation. The following list of indicators for programmatic assessment and IYCF practice assessment can be used as a guide for monitoring and evaluating progress. These indicators should be, as appropriate, taken into account during periodic and regular surveys, as well as when linking data collection into a larger national and district-level health information system.

5.1 IYCF Programmatic or Systems Indicators:

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby Friendly Hospital Initiative</td>
<td>proportion of hospitals, PHU’s and communities with established and monitored Baby Friendly Initiative</td>
</tr>
<tr>
<td>Code of Marketing of BMS</td>
<td>national adoption of the Code with established monitoring system</td>
</tr>
<tr>
<td>Workplace support</td>
<td>proportion of workplace settings and employers providing a baby-friendly environment</td>
</tr>
<tr>
<td>Health worker training</td>
<td>proportion of health workers trained to use the child health card</td>
</tr>
<tr>
<td>Breastfeeding committees</td>
<td>proportion of districts with an established and functional breastfeeding committee</td>
</tr>
<tr>
<td>Breastfeeding coordinator</td>
<td>one breastfeeding coordinator appointed at national level</td>
</tr>
<tr>
<td>Integration of IYCF</td>
<td>number of IYCF indicators integrated into health information system</td>
</tr>
</tbody>
</table>
### 5.2 IYCF Core Indicators:

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description of Indicators</th>
<th>Sampling Universe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early initiation of breastfeeding</td>
<td>Proportion of children who were put to the breast within one hour of birth</td>
<td>All children born in the last two years</td>
</tr>
<tr>
<td>Exclusive breastfeeding up to 6 months</td>
<td>Proportion of infants 0-5 months of age who are fed exclusively with breast milk</td>
<td></td>
</tr>
<tr>
<td>Continued breastfeeding at 1 year</td>
<td>Proportion of children 12 - 15 months of age who are fed with breast milk</td>
<td></td>
</tr>
<tr>
<td>Introduction of solid, semi-solid or</td>
<td>Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods</td>
<td></td>
</tr>
<tr>
<td>soft foods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum dietary diversity</td>
<td>Proportion of children 6-23 months of age who receive foods from 4 or more food groups</td>
<td></td>
</tr>
<tr>
<td>Minimum meal frequency</td>
<td>Proportion of breastfed and non-breastfed children 6-23 months of age who receive solid,</td>
<td>Living children 0-23 months</td>
</tr>
<tr>
<td></td>
<td>semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more</td>
<td></td>
</tr>
<tr>
<td>Minimum acceptable diet</td>
<td>Proportion of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk).</td>
<td></td>
</tr>
<tr>
<td>Consumption of iron-rich or iron-</td>
<td>Proportion of children 6-23 months of age who receive an iron-rich food or iron-fortified food that is specifically designed for infants and young children, or that is fortified at home.</td>
<td></td>
</tr>
</tbody>
</table>
### 5.3 IYCF Optional Indicators

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Description of Indicators</th>
<th>Sampling Universe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued BF at 2 year</td>
<td>proportion of children 20-23 months of age who are fed breast milk</td>
<td>Living children 0-23</td>
</tr>
<tr>
<td>Children ever breastfed</td>
<td>Proportion of children born in the last 24 months who were ever breastfed</td>
<td>All children born in the last two years</td>
</tr>
<tr>
<td>Age-appropriate breastfeeding</td>
<td>Proportion of children 0–23 months of age who are appropriately breastfed</td>
<td>Living children 0-23</td>
</tr>
<tr>
<td>Food safety, hygiene and sanitation</td>
<td>proportion of mothers who are able to demonstrate knowledge of adequate food safety, hygiene and sanitation practices in the household and related to food preparation for young children</td>
<td>Living children 0-23</td>
</tr>
<tr>
<td>Appropriate care during feeding</td>
<td>proportion of mothers who provide appropriate care during feeding for young children</td>
<td>Living children 0-23</td>
</tr>
</tbody>
</table>
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