

Nutrition Policy in Sierra Leone



What does this brief tell you?

This brief summarizes nutrition-relevant policies in Sierra Leone.

We examine i) nutrition context, policy objectives, indicators, budget, and activities, ii) key beneficiaries, actors and coordination, iii) monitoring, evaluation, and accountability, and iv) whether current policies are aligned with the World Health Assembly (WHA) global targets.

Key messages

Why was this brief developed?

- To strengthen understanding of the current direction of nutrition-relevant policy in Sierra Leone and its implications. It was developed in response to partners' request and priorities.

What are the key findings?

- Nutrition is featured most prominently in nutrition, health, agriculture/food security, and social protection policies.
- Young children and women are the most frequently mentioned groups and targeted beneficiaries.
- Of the six WHA targets and their indicators, policies' content focuses most on U5 stunting, U5 wasting and exclusive breastfeeding. The Multisector Strategic Plan to Reduce Malnutrition in Sierra Leone adopts all six WHA target values as its own.
- Almost all of the policies point to the importance of multisectoral coordination.

What are the policy recommendations?

- Address gaps and incoherence in nutrition-relevant policies, clearly aligning nutrition targets, objectives, activities and indicators.
- Prioritize nutrition across policy areas, including education/research, water, sanitation and hygiene, environment, climate and resource management, and other cross-cutting policies (e.g. gender/family, governance).
- Build and sustain strong vertical and horizontal coordination mechanisms to tackle mutually reinforcing issues which call for multi-stakeholder engagement.
- Mainstream nutrition in policies and strategies that are now being drafted to overcome shortcomings identified in current policy documents.

The state of nutrition in Sierra Leone

Sierra Leone is on-track to achieve the World Health Assembly (WHA) 2025 target on exclusive breastfeeding (EBF) during the first 6 months of life (31.2% in 2010 to 54.1% in 2019ⁱ) and overweight in children under five years of age (U5) (4.5% in 2019ⁱⁱ). The country has made some progress toward achieving the WHA target on U5 stunting (32.7% in 2010 and 29.5% in 2019ⁱⁱⁱ), although the prevalence of U5 stunting remained one of the highest in the African region. Some progress has also been made toward achieving the WHA target on U5 wasting (with a prevalence of 7.5% in 2010 and 5.4% in 2019^{iv}). Anemia in women of reproductive age (WRA) has shown no progress since 2012 (47.9% in 2012 and 48.4% in 2019^v), while Low Birth Weight (LBW) did not change significantly between 2012 and 2015 (14.9% in 2012 and 14.4% in 2015^{vi}).

Current nutrition policy landscape in Sierra Leone

Six nutrition-relevant policies currently in use or in the advanced drafting stage are included in this brief (see **Table I**). They are in the areas of nutrition ($n=1$), health ($n=3$), agriculture/food security ($n=1$) and economic/social ($n=1$). No nutrition-relevant policies identified in the areas of education/research, water/sanitation/hygiene, environment/climate/resource management, or other cross-cutting policies (e.g. gender/family, governance, etc.), were found to be sufficiently nutrition-oriented following their assessment based on the policy review's inclusion criteria and were therefore excluded from this brief.

Table 1: List of nutrition-relevant national policies

| NR | Area | Policy Name | Acronym | Start | End |
|----|---------------------------|---|---------|-------|------|
| 1 | Nutrition | Multisector Strategic Plan to Reduce Malnutrition in Sierra Leone | MSSPRM | 2019 | 2025 |
| 2 | Health | Reproductive, Newborn and Child Health Strategy | RMNCAH | 2017 | 2021 |
| 3 | | National Health Sector Strategic Plan | NHSSP | 2017 | 2021 |
| 4 | | National Community Health Worker Policy | NCHWP | 2016 | 2020 |
| 5 | Agriculture/Food Security | National Sustainable Agriculture Development Plan | NSADP | 2010 | 2030 |
| 6 | Economic/Social | National Social Protection Policy | NSPP | 2017 | 2022 |

Methods

All nutrition-relevant national policies, strategies, and action plans currently in use or in the advanced drafting stage as of September 2020 were included in this brief. Inclusion criteria were the presence of a nutrition objective, a budget for nutrition, and/or a nutrition indicator. Policies were not included in our analysis when i) we did not have access to the policy documents; ii) they were released or updated after expert consultation (September 2020).

We obtained potentially relevant documents from a systematic search that included pre-identified websites (e.g., relevant national government ministries, United Nations agencies and nongovernmental organizations), a Google search, a reference search, and country expert consultation. Targeted consultations with regional and in-country experts were used to access documents not available online and for validation. We screened identified documents (see Annex 1) against our eligibility criteria. Six documents met our inclusion criteria. Coding, data extraction, and content analysis for these documents was carried out with NVivo qualitative analysis software and Excel.



PROBLEM

What is the focus of policies' presentations of the nutrition context and what problems are highlighted?

All except one health policy, namely the NCHWP, provide some nutrition context. This context is most comprehensive for nutrition and health policies. Across policy areas, the nutrition context focuses predominantly on the country level. However, one nutrition policy (MSSPRM) also links to the regional and global level, while an agriculture/food security policy (NSADP) refers to the ECOWAS sub-regional and African continental context. Only these two policies also explicitly recognize geographical and/or rural/urban disparities in Sierra Leone's nutrition-related situation analysis, while only the MSSPRM presents any disaggregated information on gender disparities.

Across policy areas, the analysis of the nutrition context does not present a holistic view of malnutrition issues, focusing primarily on undernutrition. Only the MSSPRM, a nutrition policy, and the NHSSP, a health policy, present more holistic contextual information on underweight, stunting, wasting and U5 anemia, with less attention for other micronutrient deficiencies, with the exception of vitamin A deficiency which is mentioned in one nutrition policy (MSSPRM) and one health policy (RMNCAH). Two policies, namely the MSSPRM and NHSSP, respectively from the nutrition and health policy areas, make reference to overweight, obesity and non-communicable diseases (NCDs), including nutrition-related NCDs such as diabetes and arterial hypertension, and their risk factors. Three out of the six included policies spell out the determinants of malnutrition in Sierra Leone, and in Africa more generally. These include immediate causes such as

inadequate dietary intake and disease, underlying causes, such as insufficient access to food, inadequate maternal care and childcare practices, poor water and sanitation and inadequate health services, as well as basic causes such as deep poverty and lack of access to nutrition and health services. Other key drivers mentioned in the situational analysis include the need to ensure that political commitments, good governance and prioritized interventions are followed through at district and local levels, with a particular focus on equitable access to livelihoods, social protection and safety nets, as well as adequate disaster risk management in emergency situations. The coexistence of co-morbidities is also mentioned, with particular reference to infections such as malaria, acute respiratory tract infections and diarrhea being a more prevalent cause of anemia than iron deficiency in Sierra Leone. Genetics are another factor in the aetiology of anemia in Sierra Leone, including sickle cell anemia and β -thalassemia. The ebola epidemic is mentioned as an exacerbating factor. Food preparation and food chain-related processes (including food harvesting, storage, processing and preparation practices) are mentioned as contributors to some micronutrient deficiencies. The consequence of malnutrition issues most cited across policies is mortality, whether with relation to the whole population or specific age groups, e.g. U5 children, with human capital productivity being mentioned in one social protection policy (NSPP). Only two of the six policies do not make any specific mention of consequences of malnutrition, one in the health (NCHWP) and one in the agriculture/food security (NSADP) policy areas.

Table 2 highlights policies that include contextual information on WHA nutrition indicators. Three policies, in nutrition ($n=1$, namely the MSSPRM) and health ($n=2$, namely RMNCAH and NHSSP), include U5 stunting, U5 wasting and exclusive breastfeeding, with

each policy containing one additional WHA indicator (respectively low birth weight, WRA anemia and U5 overweight). Three of the policies, in the health, agriculture/food security and social protection policy areas, do not include any of the WHA target indicators in their situational analysis.

Is the nutrition context evidence-based?

The nutrition context is most evidence-based (i.e., cites references) in nutrition and health policies. No evidence is cited in agriculture/food security policies. In those policies where the evidence is cited, citations are predominantly for statistics rather than textual information. Cited data sources for evidence on the nutrition context in the policies include the Sierra Leone National Nutrition Survey 2017, MOHS-UNICEF Sierra Leone 2017 report, Demographic and Health Survey 2013, Sierra Leone Micronutrient Survey 2013, SMART survey 2013, WFP PLHIV/TB and OVCs nutritional surveillance status analysis 2012 (Western Areas statistics), National NTDP survey 2016, National Anemia prevention and Control Strategy, Comprehensive Food Security and Vulnerability Analysis (joint publication of Government of Sierra Leone, WFP, FAO, AfDB, EU & World Bank). Additional sources cited in health policies are Irish Aid, the National Nutrition Survey 2014 Review report, the Reproductive, Newborn and Child Health Strategic Plan 2011-2015.



What is included in the relevant policies to address the highlighted problems?

As shown in **Table 2**, four of the included policies, in the nutrition (n=1), health (n=2) and economic/social (n=1) policy areas, include nutrition in their general and/or specific **objectives**. These objectives contain nutrition-specific (e.g., improving the nutritional status of the population) and nutrition-sensitive content (e.g., reinforcing nutrition-sensitive health or social protection interventions). Only three policies, in the areas of nutrition (n=1) and health (n=2), include **nutrition indicators**. Almost all included nutrition indicators are outcome or output indicators, although one policy in the area of health also includes coverage indicators. In terms of nutrition problems, indicators focus predominantly on undernutrition, in particular on stunting and wasting and, to a lesser extent, micronutrient deficiencies, with few indicators on overweight/obesity, which are addressed in detail only in the MSSPRM, a nutrition-specific policy. Notably, overweight/obesity and diet-related NCDs are not addressed in nutrition-sensitive policies, with import for the potential missed opportunities in creating an enabling environment for tackling their risk factors. The MSSPRM is also the only policy that contains disaggregated nutrition indicators. The WHA target indicators most prevalent in the policies are U5 stunting and U5 wasting (MSSPRM, RMNCAH and NHSSP), followed by low birth weight and exclusive breastfeeding (MSSPRM and RMNCAH), then WRA anemia and U5 overweight (MSSPRM). **Planned nutrition activities** are detailed in all of the six policies. The MSSPRM (a nutrition policy) presents the most comprehensive range

of nutrition activities, although health policies also include a range of nutrition-specific and-sensitive activities which cover different age groups. The same three policies that feature nutrition indicators also have a **budget for nutrition**. Content on **scaling up** focuses on mechanisms for implementing the policy (e.g., guiding principles; use of new or existing committees to manage implementation and facilitate coordinated action; plans and strategies for implementation and extension of coverage; sharing best practices; capacity building, institutional development, gap assessment, research, communication strategies, institutional and financial support). The MSSPRM, in particular, presents itself as a tool designed specifically for scaling up nutrition.

How do policies' targets align with the WHA 2025 Global Targets?

























Table 2 shows three policies with nutrition indicators that coincide with WHA indicators. Two of these policies, from the nutrition and health areas, include targets for at least one of these indicators. Both set different years as their target date (MSSPRM: 2023, NHSSP: 2021). If targets were met, they would generally put Sierra Leone on track to achieve or even surpass four of these targets, namely U5 wasting, U5 overweight, exclusive breastfeeding, and WRA anemia. There is, however, one policy (MSSPRM) with a target for low birth weight that, even if met, would not necessarily put Sierra Leone on track to achieve the WHA target by 2025.

Is there coherence within policies?

Policies with nutrition objectives would be expected to include both planned nutrition activities and nutrition indicators, while policies without nutrition objectives would be expected to include neither. Yet there are several instances (see Table 2) where this is not the case. Generally, this is not necessarily due to a lack of

coherence within policies but because a) policies' objectives are broad and do not explicitly link to nutrition (while their indicators or planned activities are specific enough to make this link explicit), or b) indicators and/or planned activities are to be addressed in a separate programmatic document (which is sometimes noted in the main policy document). There are, however, some cases where there is incoherence within different parts of the same policy. The policy which presents the strongest overall internal coherence is the MSSPRM, in the nutrition area, with direct links between the challenges identified in the nutrition context, its objectives, activities, and both nutrition and coverage indicators. A similar degree of coherence is found in the RMNCAH, in the health policy area, with challenges and drivers addressed by objectives and activities, but without the inclusion of coverage indicators linked with these activities, although the policy does feature nutrition indicators. The internal coherence of the NHSSP, in the health area, is comparatively poor. The stated objectives do not align with challenges identified in the nutrition context, weakening internal coherence. However, planned activities are somewhat aligned with challenges in the nutrition context and the policy presents coverage indicators that are linked with these activities. The NSPP shows clear links between objectives and context, although the latter is not very detailed. There are important gaps in the alignment of objectives and interventions, and a lack of nutrition and coverage indicators. Finally, two of the policies, the NCHWP and NSADP, one in the health and one in the agriculture/food security areas, do not indicate internal coherence in any of the process steps analyzed, namely alignment between the nutrition challenges and drivers identified in the context and the policies' objectives, planned activities and indicators.

Table 2: Inclusion of nutrition and WHA indicators in policies' context, objectives, indicators, activities, and budget; key scaling-up mechanisms

| NR | Area | Acronym | Nutrition context on WHA indicators ¹ | Nutrition objective | Nutrition indicators | Nutrition indicators on WHA indicators ² | Planned nutrition activities | Budget for nutrition ³ | Key scaling-up mechanisms |
|----|----------------------------|---------|---|---------------------|----------------------|---|------------------------------|-----------------------------------|---|
| 1 | Nutrition | MSSPRM |     | ✓ | ✓ |       | ✓ | ✓ | Scaling up of nutrition-specific and nutrition-sensitive interventions; the policy itself is a scaling up tool (through logical framework, plans, review, mapping) |
| 2 | Health | RMNCAH |     | ✓ | ✓ |     | ✓ | ✓ | Scaling up of the model, including multisectoral adolescent health and education program (package of interventions covering school feeding programs, cash transfers to ensure retention of girls in school, comprehensive sexual education, prevention and management of gender-based violence). |
| 3 | | NHSSP |     | ✗ | ✓ |   | ✓ | ✓ | Strengthening of governance, leadership, and management; supporting resource mobilization and advocacy efforts; establishment and promotion of partnerships; training. |
| 4 | | NCHWP | ✗ | ✓ | ✗ | ✗ | ✓ | ✗ | Planned extension of coverage to national scale for ensuring the provision of a basic but comprehensive package of services to hard-to-reach communities. |
| 5 | Agriculture /Food Security | NSADP | ✗ | ✗ | ✗ | ✗ | ✓ | ✗ | Training; capacity building; strengthening of sectoral policy formulation, planning, monitoring and evaluation, and resource management; advocacy. |
| 6 | Economic/Social | NSPP | ✗ | ✓ | ✗ | ✗ | ✓ | ✗ | Temporary relief interventions to be scaled up or expanded in the long run to engender universal coverage within the context of state priority interventions; capacity building; training; research; guiding principles include universal basic needs and human rights, redistribution, citizenship, social participation, inclusiveness; institutional development; institutional support; gap assessment; knowledge-based decision-making, qualitative and quantitative data for evidence-based decision-making, effective policy design, implementation and reforms; media communication and influencing strategy; effective and sustained social protection delivery through annual budget and appropriate allocation financed with public and private resources. |

 U5 STUNTING  WRA ANEMIA  LOW BIRTH WEIGHT  U5 OVERWEIGHT  EXCLUSIVE BREASTFEEDING  U5 WASTING

¹ U5 stunting is indicated for policies with nutrition context on chronic malnutrition. U5 wasting is indicated for policies with nutrition context on acute malnutrition.

² U5 stunting is indicated for policies with nutrition indicators on chronic malnutrition. U5 wasting is indicated for policies with nutrition indicators on acute malnutrition.

³ Not applicable (NA) indicates policies that do not have sufficiently detailed budget information to assess whether nutrition is included, while ± is used for policies that provide sufficient budget information but with no mention of nutrition.



Who are the key people and organizations targeted by and responsible for these policies?

Which target groups are the focus of nutrition context?

The groups that feature most often in the context analysis of the nutrition-oriented policies identified are children under five years of age (n=4) and women (n=3), as well as the general population (n=4). Adolescents feature in the MSSPRM, as well as nutritionally or otherwise vulnerable populations, including orphans, people living with chronic diseases and people with special needs. Two of the policies, namely the NCHWP and NSADP, do not provide detailed information on the nutritional situation of population groups. None of the policies refer to the nutrition status of the adult or elderly population, although these are covered implicitly as part of vulnerable groups or the general population, especially in rural settings, at least in the MSSPRM.

Who are the beneficiaries?

As shown in **Table 3**, overall, the target groups that feature most often as primary and/or secondary beneficiaries are children (including infants and U5) and women (including mothers, PLW and WRA). All of the policies, across policy areas, also include adolescents/youth, as well as adults, who are targeted as part of either vulnerable groups or the general population. The elderly are specifically targeted in the

NHSSP, a social protection policy, and more implicitly in other policies which target at population level. With relation to gender, the focus is predominantly on women as primary beneficiaries.

Who are the actors?

All six policies explicitly mention at least one actor involved in policy development, with the national government being the most often mentioned, followed by local government, NGOs/civil society/technical & financial partners and communities, while only one policy, the NSADP, mentions the involvement of the private sector in this capacity. As shown in Table 3, nutrition and social protection policies tend to have many types of actors involved in many capacities, but the national government has the most extensive role beyond policy development, including management/coordination, financing, implementation, and monitoring and evaluation. Across policies, a wide array of governmental actors are listed, including both national (n=6) and local (n=4) government. The Ministry of Health and Sanitation is the lead state actor for health and nutrition policies. Other actors involved include the Health Sector Coordinating Committee (HSCC), Directorate of Primary Health Care, the Reproductive and Child Health Directorate, the National Community Health Worker (CHW) Hub, the CHW Steering Committee, the District Health Management Teams and Local and District Councils, involved primarily in management, implementation and M&E roles, with the HSCC, the National CHW Hub and the CHW Steering Committee also involved in financing. Other ministries involved in the delivery of nutrition components across policy areas are the Ministry of Agriculture, Forestry and Food Security, and

the Ministries in charge of Financial, Economic and Social Policies. Additional actors mentioned in social policy include the Government Social Protection Inter-Agency Forum, the National Technical Steering committee, Ministry of Labor and Social Security, National Social Protection Council, Sierra Leone Social Protection Trust Fund, Anti-Corruption Commission, Parliamentary Public Accounts Committee (PPAC), National Civil Registration Authority (NCRA) and Statistics Sierra Leone (SSL), National Commission for Social Action (NaCSA), National Social Protection Board (NSPB), National Social Protection Secretariat, National Social Protection Technical Committee (NSPTC), District SP, Parliament Technical Committee, National Social Protection Board Ministries, Departments and Agencies, as well as universities, research institutions and think-tanks. Other actors involved in the delivery and M&E of nutrition-sensitive policy and food security components include the Monitoring and Statistics Division (PEMSD) of the Ministry of Agriculture, the Coordination Unit (CU) - MAFFS, the Agriculture Advisory Group (AAG) and the Ministry of Finance and Economic Development (MOFED). A prominent role in terms of responsibilities is also given to NGOs, technical and financial partners and civil society organizations, which are mentioned in most policies (n=5). The private sector (n=5), as well as communities and community-based organizations (n=5) are also mentioned in most of the policies as active stakeholders.

Is there multisectoral coordination mentioned in the policy?

Multisectoral coordination mechanisms are detailed in almost all of the policies, with the exception of the

NSPP, although their importance is recognized and warranted across all policies. Coordination mechanisms include a harmonized and coordinated system, integrated across different sectors, links between Scaling Up Nutrition and nutrition steering and technical committees for mobilizing multiple sectors (e.g. water supply and sanitation, agriculture, food security/livelihoods, education, health, social protection) and multiple stakeholders (civil society, development partners, government, private sector), measures for improving district-level coordination, including tools for district and central level mapping, planning, targeting, resource tracking, gap identification, monitoring and reporting; multisectoral partnerships, prioritized action plans, national level coordination forum for the planning and implementation of prioritized multisectoral interventions at district and chiefdom level, and representative and coordinating bodies for harmonization of actions between key stakeholders.

Table 3: Summary of beneficiaries, actors, and multisectoral coordination mechanisms

| NR | Area | Acronym | Primary beneficiaries | Other key beneficiaries | Actors' roles | | | | | Primary actors | Multisectoral coordination mechanisms |
|----|-----------|---------|---|--|---------------------|------------------|-------------|----------------|---|---|---------------------------------------|
| | | | | | National government | Local government | Communities | Private sector | Civil society NGOs technical and financial partners | | |
| 1 | Nutrition | MSSPRM | Newborns and U5; adolescents (particularly, but not exclusively, girls); WRA; persons with special needs (including people living with HIV or TB, people with mental or physical disabilities, orphans and vulnerable children); internally displaced persons (IDPs) and returnees; urban poor; female heads of households (particularly, but not exclusively, in rural areas); victims of natural and man-made disasters | X | 1,2,3,4 | X | 1,3 | I | 1,2,3,4 | National government | ✓ |
| 2 | Health | RMNCAH | Women, children, adolescents | U5, women aged 15-19 years, newborns; populations at different stages of the lifecycle (infancy and childhood, adolescents, pre-pregnancy); disadvantaged, marginalized and most vulnerable population | 1,2,3,4 | 1,3 | X | I | 3,4 | National government (Ministry of Health and Sanitation) | ✓ |
| 3 | | NHSSP | U5, women | PLW, mothers and their children; adolescents; women and children in deprived communities; infants; adult women aged 15-49; adults aged 15-49 living with HIV; general population | 1,2,3 | X | I | I | X | National government | ✓ |

| NR | Area | Acronym | Primary beneficiaries | Other key beneficiaries | Actors' roles | | | | | Primary actors | Multisectoral coordination mechanisms |
|----|----------------------------|---------|-----------------------|--|---------------------|------------------|-------------|----------------|---|---|---------------------------------------|
| | | | | | National government | Local government | Communities | Private sector | Civil society NGOs technical and financial partners | | |
| 4 | | NCHWP | U5, women | General population, especially people living in hard-to-reach areas; PLW and newborns, U5 and WRA, families and households, adolescents (especially girls), women with previous obstetric complications, HIV-infected women | 1,2,3,4 | 1,4 | 1 | X | 1,4 | National government (Ministry of Health and Sanitation); National Community Health Worker Hub | ✓ |
| 5 | Agriculture /Food Security | NSADP | Farmers | Women in agriculture, youth in agriculture | 1,2,3,4 | X | 2 | 1 | 1,2,4 | National government (Ministry of Agriculture, Forestry and Food Security) | ✓ |
| 6 | Economic/Social | NSPP | Poor, most vulnerable | Children from poor households, PLW, U5, minors, elderly above 65 years; extremely poor households; vulnerable groups (orphans, people with physical and mental disabilities, people living with HIV/AIDS, victims of abuse including children, women and others, vulnerable women, children and adolescents) | 1,2,3,4 | X | 1,3,4 | 1,3,4 | 1,2,3,4 | National government | X |

* Roles: 1 = Implementation; 2 = Monitoring and evaluation; 3 = Management/coordination; 4 = Financing



What are the monitoring, evaluation, and accountability mechanisms?

All policies mention **monitoring and evaluation (M&E)**, with most containing a dedicated M&E section or framework. M&E activities include standardized M&E implementation plans at the national, regional, district, and sectoral levels, data collection on set indicators and targets, the establishment or maintenance of databases, alignment and harmonization of data monitoring tools, indicators and information systems. Additional activities include monitoring of key flagship initiatives as well as results-based delivery approaches, routine data monitoring and regular reporting and reviews (quarterly/mid-year/annual), and formative and final evaluations to ensure timely implementation of government priorities, collaboration on sharing of data for decision making and operational research.

Accountability mechanisms are also mentioned in all six policies. They include establishment or strengthening of existing structures to ensure effective governance, coordination, clear lines of vertical and horizontal accountability, inclusiveness, transparency and accountability, logical framework for results-based management, platforms for coordination and mutual accountability, accessibility of key documents, meeting minutes, etc., commitment to strong communication, transparency, accountability, and iterative learning, introduction of compulsory budget transparency, annual resource mapping, quarterly, semi-annual and annual reports at district and national level, encouragement of employment of social accountability strategies, extended enforcement of existing grievance mechanisms for the participation of civil society, publicizing of grievance handling mechanisms and

standards, calls for mandatory audits under the auspices of the Auditor General's Department, downward accountability.

Gaps and recommendations

This policy note is intended to inform national decisions makers, policymakers and a wider audience including implementing partners across all relevant nutrition sectors. Its analysis can help to better understand gaps and incoherence within existing policies. Furthermore, the recommendations emanating from this analysis can inform revisions of existing or the development of new nutrition-relevant policies to improve impact on nutrition in their country.

Recommendation 1: Address gaps and incoherence in nutrition-relevant policy.

The analysis above highlights a number of gaps and incoherencies in current nutrition-relevant policy in Sierra Leone. Future policies or revisions could:

- Ensure that nutrition context, objectives, indicators, and /or planned activities align, in terms of nutrition problems and targeting of populations (e.g., nutrition objectives target several different groups but nutrition indicators only measure progress for some of these groups). This would allow to achieve better coherence within policies, introduce well-aligned impact pathways, from broad objectives to specific indicator measures, and enable identification of gaps and challenges, leading to more effective targeting.
- Better define nutrition concepts and indicators to allow for common understanding across actors and

policy areas, as well as coherence in measurement of indicators. Only few policies highlight nutrition disparities across regions, gender, urban/rural and socioeconomic status; even if some policies targeting vulnerable populations focus on specific beneficiary groups, disaggregated nutrition indicators and targets are not clearly defined. Ideally, indicators are also disaggregated by gender, geographic area and between urban and rural settings, to capture the disparities identified in a policy's context analysis, and to ensure effective progress tracking.

- Invest more in inclusion of marginalized and/or underrepresented population groups. The policies we assessed provided limited nutrition context information on adolescents, men and the elderly. The policies can benefit from more inclusive consideration of these groups, as they play an important role in contributing to a child's growth, development and life chances, calling for their involvement in activities addressing children's nutrition
- Invest in fighting malnutrition in all its forms in Sierra Leone by capitalizing on shared drivers, entry points and delivery platforms. In order to curb current trends in malnutrition, namely the coexistence of multiple forms, a holistic lifecycle approach is essential to address causes and consequences of malnutrition and disease burden in the country. A rising burden of overweight/obesity and diet-related NCDs across the region calls for targeting not only key groups through interventions that will impact on a child's life course, but also on the lifecycle in terms of different age groups currently being affected by different and often coexisting burdens of malnutrition, including within the same households and communities

- Ensure clear budget allocation plans for nutrition across nutrition-relevant policies and sectors. Most of the policies we assessed lacked clearly defined nutrition budgets, although budgetary information may be provided in some form in additional documents. Overcoming this limitation is crucial for meeting the WHA targets, or at least for narrowing the gap between these and the current situation.

Recommendation 2: Continue to invest in strong multisectoral coordination.

Strengthening multisectoral coordination and actions across sectors, ministries, and departments will be essential for achieving the WHA targets in Sierra Leone. Multisectoral and multi-actor coordination is the basic guiding principle of governance for most of the nutrition policies included in this note. Despite the presence and the importance of multisectoral coordination highlighted in most of these policies, significant challenges for its functionality were mentioned. Leadership can be strengthened by clearly defining the roles of all actors at a higher hierarchical level with an authority over all of the contributing sectors. The application of strong vertical and horizontal coordination mechanisms would buttress the country's potential to achieve the WHA targets.

Recommendation 3: Mainstream nutrition into future documents across diverse policy areas.

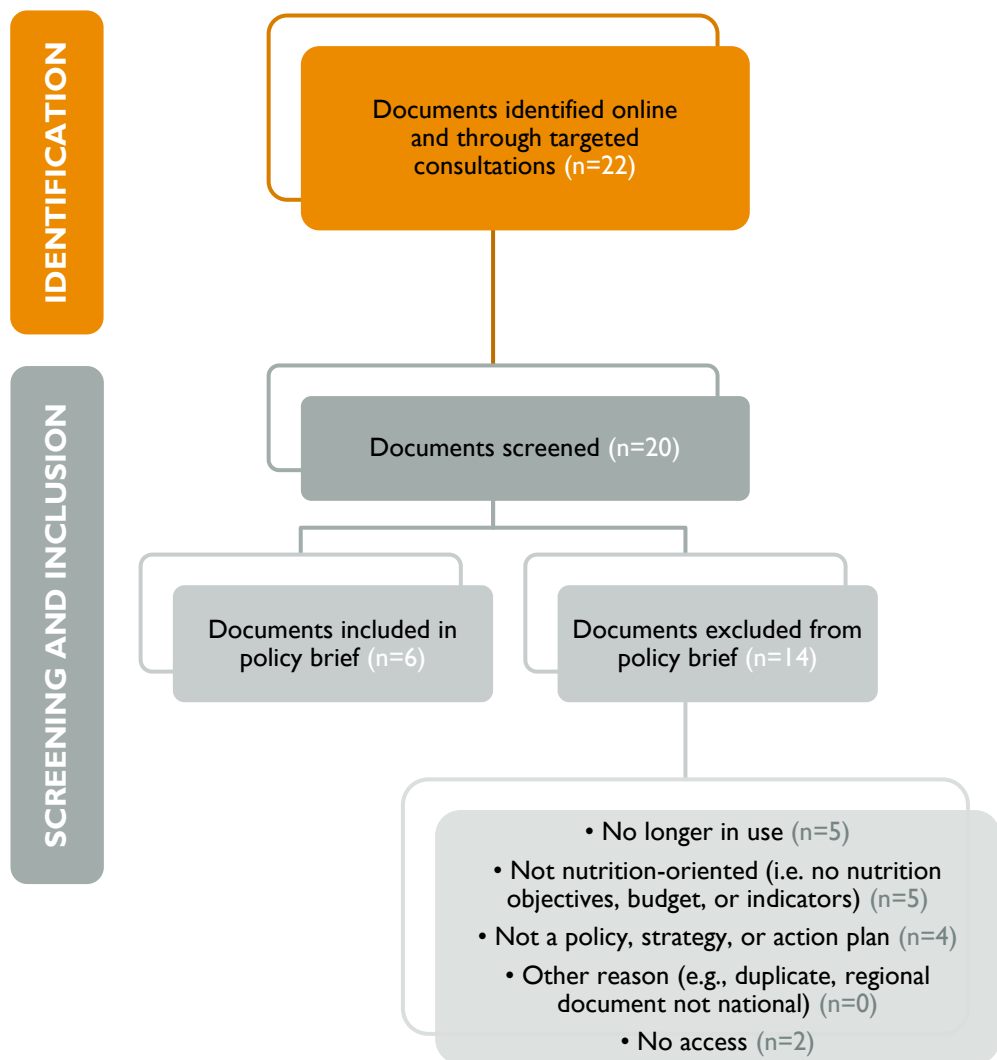
Only some policies adequately cover nutrition by including nutrition-oriented objectives and actions. The remaining policies could improve the integration of

nutrition into their nutrition context, objectives, planned activities, indicators, and budgets. To begin mainstreaming nutrition into future policies and operational documents into diverse policy areas, policymakers could refer to the gaps identified throughout this policy review. This includes missed opportunities in sectors excluded from this synthesis because the policies identified were not sufficiently nutrition-oriented (namely education/research, water, sanitation and hygiene, environment/climate/resource management, or other cross-cutting policies (e.g. gender/family, governance, etc.)). Strong multi-stakeholder engagement across the policy landscape is essential for ensuring that nutrition is integrated across sectors to create and sustain an enabling environment for tackling malnutrition.

Recommendation 4: Recognize nutrition as a cross-cutting area in ongoing policy drafts/revisions.

The revision of existing policies and the drafting of new ones provides an opportunity for better integration of nutrition through the alignment of activities and indicators with the nutrition issues, objectives and target groups indicated in the policies. By incorporating the above recommendations, any new or revised policy could contribute to advancing nutrition at national level.

Annex I: Flow diagram of documents included in the policy brief



Endnotes

ⁱ United Nations Children's Fund, Division of Data, Analysis, Planning and Monitoring (2020). Global UNICEF Global Databases: Infant and Young Child Feeding: Exclusive breastfeeding, Predominant breastfeeding, New York, July 2020.

ⁱⁱ DHS 2019

ⁱⁱⁱ UNICEF/WHO/World Bank Joint Child Malnutrition Estimates Database, April 2021,

^{iv} Ibid.

^v World Health Organization, Global Health Observatory Data Repository/World Health Statistics (apps.who.int/gho/data/node.main.1?lang=en).

^{vi} UNICEF/WHO Low birthweight estimates: Levels and trends 2000–2015. Geneva: World Health Organization; 2019. data.unicef.org.

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