transform nutrition WEST AFRICA

Evidence Notes

APRIL 2019

Nutrition Policy in Burkina Faso

What does this brief tell you?

This brief summarizes nutrition-relevant policies in Burkina Faso. 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.

Transform Nutrition West Africa is funded by the Bill & Melinda Gates Foundation and led by IFPRI.

IFPRI INTERNATIONAL FOOD POLICY RESEARCH INSTITUTE

The state of nutrition in Burkina Faso

Burkina Faso is on track to achieve the World Health Assembly (WHA) 2025 targets on under five (U5) overweight (1.1% in 2018[i]) and exclusive breastfeeding in the first six months (increased from 24% in 2010 to 50% in 2014[ii]). It is not on track for the U5 wasting target (prevalence of 7.6% in 2016[iii]). Despite improvements in U5 stunting (from 34% in 2011 to 27% in 2016[iv]) and anemia in women of reproductive age (WRA) (from 51% in 2010 to 49% in 2016[v]), Burkina Faso is not on track to meet either of these targets. Low birth weight was estimated at 14% in 2010[vi], with no recent data to assess progress toward the WHA target. Beyond the WHA targets, U5 anemia (86% in 2016[vii]) and vitamin A deficiency (52% in 2013[viii]) remain high. There is a double burden of underweight and overweight/obesity in the adult population: while 16% (2010) of WRA are thin[ix], overweight/obesity is rising, with 29% (2016) of women overweight/obese[x].

Key messages

Why was this brief developed?

To strengthen and widen understanding of the current direction of nutrition-relevant policy in Burkina Faso 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, and agriculture/food security policies.
- Children and women are the most frequently mentioned beneficiary groups.
- Of the six WHA targets and their indicators, policies' content focuses most on U5 stunting and wasting and least on U5 overweight.
- All policies point to the importance of multisectoral coordination.

What are the policy recommendations?

- Address gaps and incoherence in nutrition-relevant policies.
- Prioritize and invest in strong multisectoral coordination mechanisms.
- Mainstream nutrition into future documents across diverse policy areas.
- Recognize nutrition as a cross-cutting theme in the next version of the PNDES.

Current nutrition policy landscape in Burkina Faso

Sixteen nutrition-relevant national policies currently in use are assessed in this brief (See **Table 1** on p. 3). These are in the areas of nutrition (n=3), health (n=5), agriculture/food security (n=4), economic/social (n=2), environment (n=1), and research/innovation (n=1).

The Plan National de Développement Économique et Social (PNDES), which is one of the policies included in this brief, sets the overarching policy structure in Burkina Faso. It defines 14 planning sectors, each of which is entitled to one sectoral policy. Cross-cutting themes are not covered by their own policy, but are covered in the PNDES, the 14 sectoral policies, and/or by strategies. Nutrition is not considered to be a planning sector or a cross-cutting theme, but rather is a sub-domain embedded into the health planning sector. While three sectoral policies are nutrition-relevant (containing nutrition-specific and/or nutrition-sensitive elements) and therefore included in this brief (PSS, PS-PASP, PSRI), at least five more of Burkina Faso's 14 planning sectors could potentially contribute to and/or benefit from better nutrition. These sectoral policies[a] were developed in 2017 and 2018 but contain no nutrition objectives, indicators or budget, and as they did not meet our inclusion criteria for nutrition relevance were therefore not included in this analysis.

[a] Politique sectorielle transformations industrielles et artisanales (2017-2026); Politique sectorielle commerce et services marchands (2018-2027); Plan sectoriel de l'éducation et de la formation (2017-2030); Politique sectorielle travail, emploi et protection sociale (2018-2027); and Politique sectorielle environnement, eau et assainissement (2018-2027)

Table 1: List of nutrition-relevant national policies

NR	Area	Policy Name	Acronym	Start	End
1	Nutrition	Politique Nationale de Nutrition[1]	PNN	2016	Not Applicable
2		Plan Stratégique Multisectoriel de Nutrition[2]	PSMN	2017	2020
3		Stratégie Nationale de plaidoyer, mobilisation sociale, et communication pour le changement social et de comportement en faveur de la Nutrition au Burkina Faso	SNNBF	2017	2021
4	Health	Plan National de Développement Sanitaire	PNDS	2011	2020
5		Plan Stratégique de Santé des Personnes Agées	PSSPA	2016	2020
6		Plan Stratégique integré de Lutte contre les Maladies Non Transmissibles	PSLMNT	2016	2020
7		Plan stratégique intégré de la Santé Reproductive, Maternelle, Néonatale, Infantile, des Adolescents, des Jeunes et de la Personne Âgée	SRMNIA-PA	2017	2020
8		Politique Sectorielle Santé	PSS	2017	2026
9	Agriculture/ food security	Politique Nationale de Sécurité Alimentaire et Nutritionnelle	PNSAN	2013	2025
10		Priorités Résiliences Pays	PRP-AGIR	2016	2020
11		Stratégie de Développement Rural	SDR-2025	2016	2025
12		Politique Sectorielle Production Agro-Sylvo-Pastorale	PS-PASP	2017	2026
13	Environment	Plan National d'Adaptation aux changements climatiques	PNA	2015	Not Applicable
14	Research/ innovation	Politique Sectorielle de la Recherche et de l'innovation	PSRI	2017	2026
15	Economic/ social	Plan National de Développement Économique et Social	PNDES	2016	2020
16		Stratégie Nationale de Développement Intégré de la Petite Enfance	SNDIPE	2007	Not Applicable

[1] The version of PNN included in this brief is currently under revision and may not remain a policy, as nutrition is not one of the 14 planning sectors detailed in the PNDES (so should not have its own policy).

[2] The version of PSMN included in this brief is currently under revision.

Methods

All nutrition-relevant national policies, strategies, and action plans currently in use or in the advanced drafting stage as of December 2018 were included in this brief. Inclusion criteria were the presence of a nutrition objective, a budget for nutrition, and/or a nutrition indicator.

We obtained potentially relevant documents from a systematic search including pre-identified websites (e.g., relevant national government ministries and United Nations agencies), a Google search, and through country experts. Targeted consultations with regional and in-country experts were used to access documents not available online. We screened identified documents (see Annex) against our eligibility criteria. Sixteen documents met our inclusion criteria. We used qualitative software to code and analyse these documents.

PROBLEM

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

All policies but one (PSRI) 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, over half of the policies (across all areas except for environment and research/innovation) do present the regional or global context, including Burkina Faso's adhesion to the SUN Movement and REACH support. Policies in the nutrition (n=3), health (n=4), and agriculture/food security (n=3) areas recognize wide rural/urban and/or regional disparities in Burkina Faso's nutrition context. Only one policy (PSLMNT) presents any sex-disaggregated nutrition data.

Across policy areas, the focus is on undernutrition. Nine policies present the context on micronutrient deficiencies, namely vitamin A, iodine, and iron deficiencies. Eight present information on noncommunicable diseases (NCDs), including nutrition-related NCDs such as diabetes and high blood pressure, and their risk factors. Overweight/obesity are featured as NCDs in most of these eight policies, although PSLMNT frames overweight/obesity solely as a driver of NCDs. The role of nutrition in contributing to certain NCDs is also not heavily emphasized in the policies. Nutrition, health, and agriculture/food security policies present a more holistic picture of nutrition problems than the other policy areas, although SNDIPE (economic/social areas) also has a relatively holistic nutrition context related to young children.

Over half of policies, across most areas and especially in nutrition and health areas, outline causes and/or consequences of nutrition problems. Causes include environmental factors, poverty, low levels of education, poor diet, and inadequate health/nutrition services. Consequences include mortality, morbidity, negative cognitive impacts, reduced productivity and economic growth, and negative reproductive impacts in the country.

Table 2 highlights policies that include nutrition context on WHA indicators. U5 stunting, and U5 wasting, and WRA anemia are most frequently included. U5 overweight is not mentioned in any policy. Apart from U5 stunting and U5 wasting, WHA indicators mentioned are almost exclusively confined to nutrition and health policies. The two most recent health policies include more WHA indicators than earlier health policies.

Is the nutrition context evidence-based?

The nutrition context is most evidence-based (i.e., cites references) in health policies, followed by nutrition and agriculture/food security policies. Across all policy areas, citations are predominantly for statistics rather than textual information. Cited data sources for evidence in policies' nutrition context include the Standardized Monitoring and Assessment of Relief and Transition (SMART) Survey, Enquête Nationale Iode et Anémie du Burkina (ENIAB), the WHO STEPwise approach to Surveillance (STEPS), and the Analyse Globale de la Vulnérabilité, de la Sécurité Alimentaire et de la Nutrition (AGVSAN). Evidence that is cited mainly relates to prevalence levels of nutrition problems. Seven of the ten policies that present information on geographical nutrition disparities in Burkina Faso cite references related to this. The sex-disaggregated data in PSLMNT is also cited. Few policies outside of the health area cite references on causes or consequences of nutrition problems.

POLICY

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

As shown in **Table 2**, most policies, across almost all 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, to a lesser degree, nutrition-sensitive content (e.g., reinforcing nutrition-sensitive food security interventions). Almost all included **nutrition indicators** are outcome indicators (e.g., U5 stunting), although policies in the areas of health (n=3), nutrition (n=1), and economic/social (n=1) also include output indicators (e.g., proportion of health districts implementing the infant and young child feeding package). In terms of nutrition problems, indicators focus on undernutrition and, to a lesser extent, micronutrient deficiencies, with few indicators on diet-related NCDs, including overweight/obesity. Only one policy (SDR-2025) includes a disaggregated nutrition indicator (sex-disaggregated U5 underweight). WHA indicators most addressed in policies are U5 stunting, U5 wasting, and exclusive breastfeeding. **Planned nutrition activities** are detailed in 12 of the policies, across most policy areas. PNN (a nutrition policy) presents the most comprehensive range of nutrition activities, although PSS (a health policy) also includes a wide range of nutrition-specific and -sensitive activities. Most health and nutrition policies and one agriculture/food security policy have a **budget for nutrition.** Content on **scaling up** focuses on mechanisms for piloting and implementing the policy (e.g., guiding principles; use of new or existing committees to manage implementation and facilitate dialogue; plans and strategies; sharing best practices); nutrition doesn't feature specifically. A few policies mention risks or challenges to scaling up, namely physical insecurity, political disorder, poor governance, insufficient resources and capacities, and insufficient adhesion by key actors.

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

Table 2 shows nine policies with nutrition indicators that are the same as WHA indicators. Seven of these policies, across health (n=3), agriculture/food security (n=2), nutrition (n=1), and economic/social (n=1), include targets for at least one of these indicators. All set 2020 as their target date. While Burkina Faso's 2020 targets sometimes vary across policies, if they were met, they would generally put Burkina Faso on track to achieve or even surpass the WHA targets by 2025. There are, however, two policies with targets that, even if met, would not necessarily put Burkina Faso on track to achieve the WHA targets by 2025: PRP-AGIR (U5 stunting and WRA anemia targets) and PNDS (U5 stunting target).

Is there coherence within policies?

Policies with nutrition objectives would be expected to include both nutrition indicators and planned nutrition activities, while policies without nutrition objectives include neither of these. There are several cases (see **Table 2**) where this is not the case. Generally, though, this is not due to a lack of coherence within policies but because a) policies detail that indicators and/or planned activities will be addressed in a separate document or b) 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).

There are, however, some cases of incoherence within different parts of policies. First, populations targeted in nutrition objectives are not always the same as those targeted in nutrition indicators and/or planned nutrition activities. For example, the objectives of PSMN cover all Burkinabés, but the nutrition indicators and activities focus on U5 and WRA. Second, problems featured in policies' nutrition context are not always included in policies' nutrition indicators. For example, two policies highlight that low birth weight is a nutrition problem, but don't include an indicator for it (despite including indicators for other nutrition problems identified in the policy and including nutrition objectives that could encompass low birth weight). Third, despite the fact that context in ten policies highlights nutrition disparities, especially between regions and rural/urban areas, none of these specify that nutrition indicators should be disaggregated to capture the disparities identified. Finally, several policies fail to clearly define concepts (e.g., chronic and/or acute malnutrition), definitions, or age ranges for prevalence 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	PNN	1, 2[4], 3, 5, 6	✓	✓	2	✓	NA	Governance; Legislation
2		PSMN	1, 2[4], 3, 5, 6	✓	✓	1, 2, 4, 5, 6	✓	✓	Use of existing organs/structures for implementation; CNCN's mission to drive scale-up
3		SNNBF	1, 2[4], 5, 6	✓	✗	✗	✓	✓	Dissemination of good practices; Multisectoral implementation
4	Health	PNDS	3	✓	✗	1	✗	✓	Dissemination of good practices
5		PSSPA	✗	✗	✓	✗	✓	✓	Legislation; Regulation; Data production and use
6		PSLMNT	✗	✗	✓	✗	✓	✓	Governance; Improved monitoring and coordination; Strong adhesion of actors
7		SRMNIA-PA	2[4], 3, 6	✓	✓	1, 5	✗	±	Guiding principles for implementation at scale; Governance; Multisectoral collaboration and integrated approach; Data production and use
8		PSS	1, 2[4], 6	✓	✓	1, 5, 6	✓	NA	Integrated approach; Legislation; Regulation
9	Agriculture/ food security	PNSAN	1, 6	✓	✗	✗	✗	NA	Focus on risks to scale up (governance, lack of adherence)
10		PRP-AGIR	1, 2[4]	✓	✓	1, 2, 5, 6	✓	✓	Guiding principles for implementation at scale; Use of existing organs/structures/frameworks for implementation
11		SDR-2025	1, 6	✓	✓	✗	✓	NA	Guiding principles for implementation at scale; Implementation of national programs; Use of five-year phases;
12		PS-PASP	1	✓	✓	1	✓	NA	Guiding principles for implementation at scale; Instruments (e.g., operational action plans); Sectoral dialogue bodies; Governance
13	Environment	PNA	✗	✓	✓	✗	✓	NA	Capacity building; Communications; Dissemination of good practices
14	Research/ innovation	PSRI	✗	✗	✓	✗	✗	NA	Guiding principles for implementation at scale; Organs for implementation; Instruments (e.g., matrices, action plans)
15	Economic/ social	PNDES	1, 6	✓	✓	1, 6	✓	NA	Mass communication; Leadership; Risks to scale up
16		SNDIPE	1, 2, 6	✓	✓	1, 3, 6	✓	NA	Guiding principles for implementation at scale; Program-specific action plans; Integration of policy into existing programs; Mobilization and resource management mechanisms

[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.

[4] WRA anaemia (pregnant women)

1 U5 STUNTING 2 WRA ANAEMIA 3 LOW BIRTH WEIGHT 4 U5 OVERWEIGHT 5 EXCLUSIVE BREASTFEEDING 6 U5 WASTING

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

Which target groups are the focus of nutrition context?

Children, then women, feature most in policies' nutrition context. Most policies, across policy areas, also address adults. Elderly are mentioned in several health policies, with PSSPA focusing on elderly. Only one policy each specifically mentions men (PSLMNT) or adolescents (SNDIPE).

Who are the beneficiaries?

As shown in **Table 3**, primary beneficiaries of policies vary by area. Overall, the most frequent primary beneficiaries are children and women (especially WRA). Other primary beneficiaries include the general population, decision makers and influencers, and rural households. While not generally among primary beneficiaries, eight policies – across almost all policy areas (including all three agriculture/food security policies) – include adolescents as beneficiaries. Elderly and men/fathers are each mentioned as beneficiaries in three policies. Besides the focus of the agricultural policies on rural areas, no policies detail geographic areas of focus (e.g., regions) for targeting.

Who are the actors?

For policies that explicitly mention at least one actor involved in their development (n=14), national government was most often mentioned (n=13), followed by civil society/NGOs/technical and financial partners (n=12), local government (n=5), communities (n=6), and private sector (n=6). As shown in **Table 3**, the agriculture/food security policies tend to have many types of actors involved in many roles, while health policies detail extensive roles primarily for national government. The Ministry of Health is the lead state actor for health and nutrition policies; however, many other ministries are cited as involved. For example, PSMN recognizes the nutrition role of ministries across various sectors and identifies nutrition objectives, indicators, and activities that these actors could lead/contribute to. Communities are most featured as actors in agriculture/food security and economic/social policies, although approximately half of the health and nutrition policies also see communities as actors through financing (e.g., paying for health services).

Is there multisectoral coordination?

The importance of multisectoral coordination is highlighted across all policies and policy areas. Coordination mechanisms include multi-actor and -sector committees and groups; documents and tools; workshops and events; the use of sectoral policies; and government leadership to ensure coherent action. For example, nutrition policies point to the Conseil National de Concertation en Nutrition (CNCN) and Conseils Régionaux de Nutrition (CRN) as key groups to ensure coordination between actors. Almost all policies highlight challenges associated with multisectoral coordination, which center around a high number of actors, lack of synergy, multiple policy frameworks and priorities, and weak involvement of certain actors. For example, PSMN suggests that the CNCN should be reviewed and strengthened in order to overcome operational difficulties and ensure better coordination. Nevertheless, roughly half of policies, mostly in the agriculture/food security and health areas, do highlight some successes in using coordination mechanisms to address these challenges and improve multisectoral coordination.

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	PNN	Women (including WRA); Children (including U5)	Health structures/agents; Academic actors (students, teachers); Nutrition actors; General population	1,2,3,4	1,2,4	4	1,4	1,2,4	State	✓
2		PSMN	Women (including WRA); Children (including U5)	Health structures/agents; Academic actors (students, teachers); Association members	1,2	1		1	1,2	State (Ministry of Health (MoH))	✓
3		SNNBF	Decisionmakers and influencers at all levels	Health agents; General population (including men, youth, WRA, elderly); Technical and financial partners; Social mobilisation actors	1	1,4	1,4	4	1,4	State (MoH)	✗
4	Health	PNDS	General population	U5; Mothers	1,2,3,4	1,2,3,4	4	1,4	1,2,3,4	State (MoH)	✓
5		PSSPA	Elderly	Health structures/agents; Regional actors	1,2,3,4				1	State (MoH)	✓
6		PSLMNT	Health agents	Pregnant women; Media; Association members; Government; Schools	1,2,4	4	4	1	1,2,4	State (MoH)	✓
7		SRMNIA-PA	WRA, neonatal, infants, children, adolescents, youth, elderly	Local elected officials; Communes	1,2,3				1	State (MoH)	✓
8		PSS	Women (including WRA); Children (including infants)	General population (including at-risk groups for malnutrition and vulnerable, youth, girls); Health agents; Communities	1,2,4	1,2,4	4	1,2,4	1,2,4	State (MoH)	✓

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

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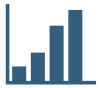
NR	Area	Acronym	Primary beneficiaries	Other key beneficiaries	Actors' Roles					Primary actors	Multisectoral coordination mechanisms
					National Government	Local Government	Communities	Private Sector	Civil society NGOs Technical and financial partners		
9	Agriculture/ food security	PNSAN	General population	Vulnerable households; U5; Women, including pregnant and breast-feeding women; youth	1,2,3,4	1,2,4	1,2,4	1,2,4	2,3,4	State as lead, with important roles for civil society, technical and financial partners, private sector, and collectivités territoriales	✓
10		PRP-AGIR	Vulnerable households/ populations	U5; Women, including pregnant and WRA; Schools; Youth; Agricultural producers; Local committees/groups/services	1,2,3,4	1,2,3,4	1,2,4	1,2,3,4	1,2,3,4	State (although lots of roles for all other actors)	✓
11		SDR-2025	General population (especially rural)	Children; Populations vulnerable to climate change; Rural actors (e.g., producers); State structures (including at commune and territorial level)	1,2,3,4	1,2,4	1,2,3,4	1,2,4	1,2,4	State; Collectivités territoriales; Non-state actors (including rural populations); Technical and financial partners	✓
12		PS-PASP	Farmers and rural households/ populations	Youth; Herders; Vulnerable populations; Communes; State; Civil society	1,2,3,4	1,2,4		1,2,4	1,2,4	State; Collectivités territoriales; Consular institutions; Non-state organizations and partners; Private sector	✓
13	Environment	PNA	Women (including pregnant and breastfeeding women); Children (including U5)	Men; Vulnerable households; Decision makers from various bodies/population groups	1,2,3,4			1,4	1,4	State	✓
14	Research/ innovation	PSRI	Research community	Agriculture producers; Populations; Technical and administrative staff; Scientific journalists; Technicians	1,4	1,4		1,4	1,4	State (Ministry of Higher Education, Scientific Research, and Innovation)	✓
15	Economic/ social	PNDES	For nutrition-related components: Women; Children (many other groups from population in other sections)	Security actors and subsector; Populations (including marginalized populations); Youth; Technical/training schools; Research sector	1,2,3,4	1,2	1,2	1,2,4	1,2,4	State	✓
16		SNDIPE	Children 0-8 years; Mothers (with focus on most vulnerable children and mothers)	Fathers; Schools/childcare centers and their personnel; Members of organizations; Health structures and their personnel; Populations; Households	1,2,3,4	2,3,4	1,2,4	1,4	1,2,3,4	State (Ministère de l'Action Sociale et de la Solidarité Nationale as lead, with many other ministries involved); Families and communities (especially mothers); Institutions	✓

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



DATA GAPS

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. Some policies, such as PSLMNT and PNA, contain very detailed M&E information. Many partners tend to be involved in M&E, although policies generally designate a lead actor. M&E activities include data collection and monitoring of the policy's indicators; regular reporting; and formative and final evaluations.
Accountability mechanisms are also mentioned in most policies. They include use of M&E to identify progress and needed improvements; technical committees and dialogue frameworks to propose course corrections and monitor progress toward action plans; regular progress reviews; and ensuring effective accountability mechanisms at all levels.

Gaps and recommendations

Recommendation 1: Address gaps and incoherence in nutrition-relevant policy.
The analysis above highlights a number of gaps and incoherence in current nutrition-relevant policy in Burkina Faso. To address these, policies could:

- Better recognize and describe how nutrition is a cause and/or a consequence of sectoral issues (for policies other than nutrition or health policies), to raise ownership about responsibility for addressing malnutrition outside of the nutrition and health sectors.
- Better consider gender by including sex-disaggregated nutrition context and indicators and by specifically targeting men/fathers where relevant.
- Clearly and consistently define concepts and indicators to allow for common understanding across actors and policy areas, as well as coherence in measurement of indicators.
- Ensure that their nutrition context, objectives, indicators, and activities align, both in terms of nutrition problems and targeting of populations.
- Invest in malnutrition in all its forms in Burkina Faso, including overweight/obesity.

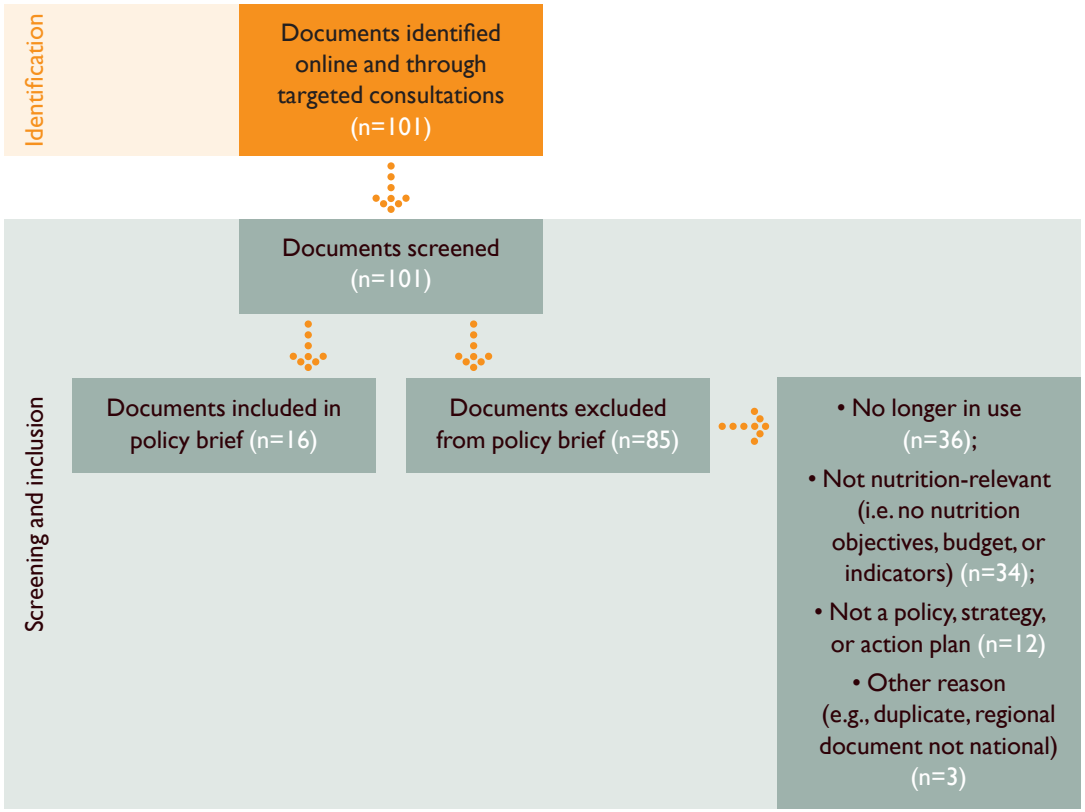
These gaps and incoherence could be addressed in future policies, as well as operational documents for existing policies (e.g., implementation or monitoring and evaluation plans).

Recommendation 2: Prioritize and invest in strong multisectoral coordination.
In response to the coordination challenges highlighted by reviewed policies, strong multisectoral coordination could improve policy implementation, the mainstreaming of nutrition into future policies and operational documents, and coherence and synergies between policies. For example, it could ensure that gaps and incoherence identified above are addressed in ways that improve synergies between policies and ensure that policies sufficiently address important nutrition problems and beneficiaries. While current policies have varying targets related to the WHA targets, strong multisectoral coordination could bring together indicators and targets to have policy areas working toward common targets. Most policies outline mechanisms that, with sufficient investment and prioritization, could improve multisectoral coordination. These include multi-actor and multi-sector bodies, tools, and events. Moving leadership for nutrition coordination to a higher hierarchical level that has authority over all contributing sectors and policy areas could also improve multisectoral coordination. For example, the CNCN could be anchored at the supra-ministerial level.

Recommendation 3: Mainstream nutrition into future documents across diverse policy areas.
Only four of the 16 policies in this brief come from outside of the areas of nutrition, health, and agriculture/food security. Environment and research/innovation policies could improve the integration of nutrition into their objectives, indicators, activities, and budgets. To begin mainstreaming nutrition into future policies and operational documents from diverse policy areas, policymakers could refer to nutrition objectives, indicators, and relevant activities listed in the PSMN, which details roles for actors across numerous sectors.

Recommendation 4: Recognize nutrition as a cross-cutting sector in the next version of the PNDES.
PNDES, the policy that defines and guides sectoral planning, is due to be revised in 2020. Its revision is an opportunity to mainstream nutrition in this overarching policy document. If nutrition were recognized as a cross-cutting theme, it would be integrated into all relevant sections of the PNDES (not just within health) and its integration into each relevant planning sector would be monitored. Seizing this opportunity for change will require a strong commitment to nutrition at the highest political level.

Annex: Flow diagram of documents included in the policy brief



Endnotes

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[ii] United Nations Children's Fund, Division of Data Research and Policy (2018). Global UNICEF Global Databases: Infant and Young Child Feeding: Exclusive breastfeeding, Predominant breastfeeding, New York, May 2018.

[iii] UNICEF/WHO/World Bank Joint Child Malnutrition Estimates, May 2018, New York.

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[vi] National Institute of Statistics and Demography, ICF International, 2012. Demographics and Health and Multiple Cluster Survey of Burkina Faso, 2010. Calverton, Maryland, USA

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[viii] Stevens, G. A. et al. (2015). Trends and mortality effects of vitamin A deficiency in children in 138 low- and middle-income countries: pooled analysis of population-based surveys. Lancet. Volume 3, No. 9, e528–e536, September 2015.

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[x] Non-Communicable Disease Risk Factor Collaboration (NCD-RisC). Data Downloads. Retrieved on February 27th 2019 from http://www.ncdrisc.org/data-downloads.html

To cite this publication:
Vanderkooy A., Verstraeten R., Becquey E., Dogui Diatta A., Buttarelli E., Diop L., et Touré M. (April 2019). Nutrition Policy in Burkina Faso (Transform Nutrition West Africa, Evidence Note #1)

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It is funded by the Bill & Melinda Gates Foundation from 2017–2021 and is led by the International Food Policy Research Institute.
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