Burkina Faso

EARLY CHILDHOOD DEVELOPMENT

SABER Country Report
2014

Policy Goals	Status
1. Establishing an Enabling Environment National laws and regulations promote some health care for pregnant women but leave out some important aspects of health care for young children. Burkina has an explicitly stated multisectoral policy called the Stratégie Nationale de Développement Intégré de la Petite Enfance (2007) but coordination at the level of service delivery needs more attention. In terms of financing Early Childhood Development (ECD), no transparent criteria for resource allocation are used in the education sector, while some criteria are used in the health and nutrition sectors. Overall, the level of ECD finance is inadequate in the education sector. The health sector is more adequately financed than the education sector.	Emerging
2. Implementing Widely More attention to equity in access to ECD services is required in Burkina Faso. Despite the government's efforts to ensure access to essential ECD services for all children, coverage levels remain low, particularly for children from disadvantaged families and those living in rural or marginalized areas. ECD service delivery should be expanded in all sectors to ensure that children have the opportunity to reach their full potential in life.	Emerging
3. Monitoring and Assuring Quality Quality standards for infrastructure and service delivery for early childhood education facilities are established; however, compliance with those standards is not systematically monitored by the government. More than 90 percent of early childhood education centers are run by community-based and private-for-profit operators. The Ministry of Social Action and the Ministry of Education are attempting to increase the number of these centers that are registered with the government in order to better monitor compliance of these centers with official standards.	Emerging

Systems Approach for Better Education Results-Early Childhood Development (SABER-ECD)

SABER-ECD collects, analyzes and disseminates comprehensive information on ECD policies around the world. In each participating country, extensive multi-literature is collated and interviews are conducted with a range of ECD stakeholders including government officials, service providers, civil society, development partners and scholars. The SABER-ECD framework presents a holistic and integrated assessment of how the overall policy environment in a country affects young children's development. This assessment can be used to identify how countries address the same policy challenges related to ECD, with the ultimate goal of designing effective policies for young children and their families.

Box 1 presents an abbreviated list of interventions and policies that the SABER-ECD approach looks for in countries when assessing the level of ECD policy development. This list is not exhaustive, but is meant to provide an initial checklist for countries to consider the key policies and interventions needed across sectors.

Three Key Policy Goals for Early Childhood Development

SABER-ECD identifies three core policy goals that countries should address to ensure optimal ECD outcomes: (i) Establishing an Enabling Environment (ii) Implementing Widely and (iii) Monitoring and Assuring Quality. Improving ECD requires an integrated approach to address all three goals. As described in Figure 1, for each policy goal, a series of policy levers are identified, through which decision-makers can strengthen ECD. Strengthening ECD policies can be viewed as a continuum; as described in Table 1 on the following page, countries can range from a latent to advanced level of development within the different policy levers and goals.

Box 1: A checklist to consider how well ECD is promoted at the country level

What should be in place at the country level to promote coordinated and integrated ECD interventions for young children and their families?
Health care
• Standard health screenings for pregnant women • Skilled attendants at delivery • Childhood immunizations • Well-child visits
Nutrition
• Breastfeeding promotion • Salt iodization • Iron fortification
Early Learning
• Parenting programs (during pregnancy, after delivery and throughout early childhood) • High quality childcare for working parents • Free preprimary school (preferably at least two years with developmentally appropriate curriculum and classrooms, and quality assurance mechanisms)
Social Protection
• Services for orphans and vulnerable children • Policies to protect rights of children with special needs and promote their participation/ access to ECD services • Financial transfer mechanisms or income supports to reach the most vulnerable families (could include cash transfers, social welfare, etc.)
Child Protection
• Mandated birth registration • Job protection and breastfeeding breaks for new mothers • Specific provisions in judicial system for young children • Guaranteed paid parental leave of least six months • Domestic violence laws and enforcement • Tracking of child abuse (especially for young children) • Training for law enforcement officers in regards to the particular needs of young children

Figure 1: Three core ECD policy goals

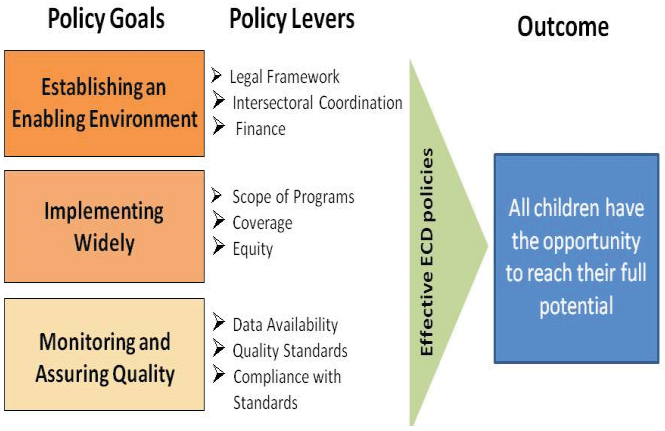


Table 1: ECD policy goals and levels of development

ECD Policy Goal	Level of Development →			
	Latent ●○○○	Emerging ●●○○	Established ●●●○	Advanced ●●●●
Establishing an Enabling Environment	Non-existent legal framework; ad hoc financing; low inter-sectoral coordination.	Minimal legal framework; some programs with sustained financing; some inter-sectoral coordination.	Regulations in some sectors; functioning inter-sectoral coordination; sustained financing.	Developed legal framework; robust inter-institutional coordination; sustained financing.
Implementing Widely	Low coverage; pilot programs in some sectors; high inequality in access and outcomes.	Coverage expanding but gaps remain; programs established in a few sectors; inequality in access and outcomes.	Near universal coverage in some sectors; established programs in most sectors; low inequality in access.	Universal coverage; comprehensive strategies across sectors; integrated services for all, some tailored and targeted.
Monitoring and Assuring Quality	Minimal survey data available; limited standards for provision of ECD services; no enforcement.	Information on outcomes at national level; standards for services exist in some sectors; no system to monitor compliance.	Information on outcomes at national, regional and local levels; standards for services exist for most sectors; system in place to regularly monitor compliance.	Information on outcomes from national to individual levels; standards exist for all sectors; system in place to regularly monitor and enforce compliance.

Policy Goal 1: Establishing an Enabling Environment

➢ Policy Levers: Legal Framework •Intersectoral Coordination • Finance

An Enabling Environment is the foundation for the design and implementation of effective ECD policies[1]*. An enabling environment consists of the following: the existence of an adequate legal and regulatory framework to support ECD; coordination within sectors and across institutions to deliver services effectively; and, sufficient fiscal resources with transparent and efficient allocation mechanisms.*

Policy Lever 1.1: Legal Framework

Emerging ●●○○

The legal framework comprises all of the laws and regulations which can affect the development of young children in a country. The laws and regulations which impact ECD are diverse due to the array of sectors which influence ECD and because of the different constituencies that ECD policy can and should target, including pregnant women, young children, parents, and caregivers.

National laws and regulations promote some health care for pregnant women. Under the National Health Policy (*La politique nationale de sante) (2010),* the Government of Burkina Faso (GoBF) provides free prenatal visits for women and subsidizes 80 percent of the cost of delivery. According to this policy, standard health screenings for HIV and STDs are provided for pregnant women in addition to referrals to other services as required.

National laws and regulations leave out some important aspects of health care for young children including delivery of a full course of childhood immunizations and providing well-child visits for children past the age of 5. According to the Ministry of Health's *Direction de la Prevention par les vaccination,* children are required to receive a complete course of childhood immunizations[2] except for meningitis and mumps which they do only when there is an epidemic.

According to the National Health Policy - *Politique Nationale de la Sante - document national de reference*- young children below the age of 5 are provided with regular well-child visits. After 5 years of age, children are only entitled to free medical visits in cases of malaria.

[1] Brinkerhoff, 2009; Britto, Yoshikawa & Boller, 2011; Vargas-Baron, 2005

[2] EPI complete course of immunizations targets nine vaccine preventable diseases: tuberculosis; diphtheria; pertussis; tetanus; poliomyelitis; measles; hepatitis B; Haemophilus influenza type b; and yellow fever.

The frequency of visits before five years of age is as follows: two times before 1 month of age, one time per month between 2 to 12 months and every three months between the ages of 1 to 5 years. However, there is no policy in place for regular child visits after 5 years of age. The government is in the process of developing a regulation for services for children beyond 5 years of age.

National laws and regulations promote appropriate dietary consumption by pregnant women and children. The nutrition policy (*Politique de Nutrition, 2007*) encourages breastfeeding. In addition, the policy mandates food fortification including fortification of oil with vitamin A, salt with iodide, and wheat with iron. However, corn and rice are not required to be fortified according to this policy.

Some policies protect pregnant women and new mothers and promote opportunities for parents to provide care to newborns and infants in their first year of life; however, more could be done. According to the Labor Code (*Code du Travail, 2008)*, Burkina Faso provides 14 weeks of maternity leave with 100 percent pay while paternity leave is three days. Further, some of the guidelines suggested by the ILO Maternity Protection Convention are followed in Burkina Faso. Burkina Faso's Code du Travail (2008) penalizes and prevents the dismissal of pregnant women. However, it is not illegal for an employer to ask about family status during a job interview, employers are not required to give employees an equivalent position when they return from maternity leave, and while public service employers are required to provide breaktime for nursing mothers (1.5 hours), nursing rooms are not guaranteed. Table 2 shows that leave policies in Burkina Faso are comparable to those offered by other countries in the region.

Table 2: Comparison of maternity and paternity leave policies in Sub-Saharan Africa

Burkina Faso	Cote d'Ivoire	Mali	Niger	Senegal
98 days of paid maternity leave at 100% salary, 3 days of paternity leave at 100% salary	98 days of paid maternity leave at 100% salary, 2 days of paternity leave at 100% salary	98 days of paid maternity leave at 100% salary, 3 days of paternity leave at 100% salary	98 days of paid maternity leave at 100% salary, 1 day of paternity leave at 100% salary	98 days of paid maternity leave at 100% salary, no data on paternity leave

Source: ILO, 2012

Free pre-primary education is not mandated in the country. The gross enrolment rate in Burkina Faso is just 3.5 percent with more than 85 percent of the enrolment in the non-state and private sector (UIS, 2011-2012).

Child and social protection policies and services are well developed. According to the *Ministère de l'Action Sociale et de la Solidarité Nationale* (MASSN), there is a policy mandating the registration of children at birth. The government promotes the reduction of family violence through the following initiatives: violence prevention through home visits, training provision for Early Childhood Care and Education (ECCE), teachers' identification of child abuse and neglect, and child abuse tracking and reporting activities. According to MASSN, the national judiciary provides training for judges, lawyers, law enforcement officers, specialized courts, and supports the creation of specialized child advocates.

Key Laws and Regulations Governing ECD in Burkina Faso

- La strategie national de developpement integre de la petite enfance (SNDIPE)
- Programme national d'education prescolaire (PNEP)
- Programme national d'education parentale
- La politique nationale de sante revisee 2010
- La politique de nutrition revisee 2007

Policy Lever 1.2: Intersectoral Coordination

Emerging

Development in early childhood is a multidimensional process.[3] In order to meet children's diverse needs during the early years, government coordination is essential, both horizontally across different sectors as well as vertically from the local to national levels. In many countries, non-state actors (either domestic or international) participate in ECD service delivery; for this reason, mechanisms to coordinate with non-state actors are also essential.

Burkina Faso has an explicitly stated multisectoral ECD policy. In 2007, *La Stratégie Nationale de Développement Intégré de la Petite Enfance* was adopted by the Council of Ministers. The 10-year strategy covers the Education, Health, Nutrition, Social Protection, Child Protection and Water, Sanitation and Hygiene sectors and is applicable at the federal, provincial, and local

[3] Naudeau et al., 2011; UNESCO-OREALC, 2004; Neuman, 2007

levels. However, there are no implementation or resource mobilization plans for the strategy. It should be noted that a plan for the integrated development of ECD was elaborated in 2008, to cover 2009-2012 but no funds have been mobilized to implement the plan.

While there is no designated institutional anchor to coordinate ECD across all sectors, including health, education, social protection and nutrition, there are specific units charged with ECD program and policy development within MASSN and the *Ministère de l'Education Nationale et de l'Alphabétisation* (MENA). Within MASSN, the Directorate of Early Childhood (*Direction de la Promotion de l'encadrement de la Prime Enfance*) ensures the implementation of development programs for children 0-3 years of age while the *Direction de l'Education Prescolaire* is responsible for pre-primary education for 3-5 year-olds within MENA. The different actors involved in the implementation of the national strategy for integrated early childhood development do not meet regularly. However, integrated service delivery manuals and guidelines are available. For example, there are manuals for parent education and teaching programs, and guidelines for field workers.

According to MASSN, annual coordination meetings are organized between state and non-state stakeholders. These are the National Council sessions for childhood.

Box 2: The Chilean Experience: Benefits of Multisectoral Policy Design and Implementation

Summary: A multisectoral ECD policy is a comprehensive document that articulates the services provided to children and key stakeholders involved, including responsibilities of service providers and policy makers. The policy should also present the legal and regulatory framework in a country and address any possible gaps. Typically, a policy can include a set of goals or objectives and an implementation plan that outlines how they will be achieved. The benefits of doing so are manifold. The preparation process requires all stakeholders to contribute, which in turn promotes a more holistic, synergetic approach to ECD and identifies possible duplication of objectives by individual stakeholders. Another benefit is that the policy framework clarifies the boundaries within which all stakeholders are to operate and can create accountability mechanisms.

One such example is *Chile Crece Contigo* ("Chile Grows With You", CCC), an inter-sectoral policy introduced in 2005. The multi-disciplinary approach is designed to achieve high quality ECD by protecting children from conception with relevant and timely services that provide opportunities for early stimulation and development. A core element of the system is that it provides differentiated support and guarantees children from the poorest 40 percent of households with key services, including free access to pre-primary school. Furthermore, the CCC mandates provision of services for orphans and vulnerable children and children with special needs. The creation and implementation of the CCC has been accomplished through a multisectoral, highly synergistic approach at all levels of government. At the central level, the Presidential Council is responsible for the development, planning, and budgeting of the program. At each of the national, regional, provincial, and local levels there are institutional bodies tasked with supervision and support, operative action, as well as development, planning and budgeting for each respective level. The *Chile Crece Contigo* Law (No. 20.379) was created in 2009.

Key considerations for Burkina Faso:

- ✓ Multisectoral policy that articulates responsibilities for each government entity
- ✓ Highly synergetic approach to service delivery
- ✓ Guaranteed support for poorest households

Policy Lever 1.3: Finance

While legal frameworks and intersectoral coordination are crucial to establishing an enabling environment for ECD, adequate financial investment is key to ensuring that resources are available to implement policies and achieve service provision goals. Investments in ECD can yield high public returns, but are often undersupplied without government support. Investments during the early years can yield greater returns than equivalent investments made later in a child's life cycle and can lead to long-lasting intergenerational benefits[4]. Not only do investments in ECD generate high and persistent returns, they can also enhance the effectiveness of other social investments and help governments address multiple priorities with single investments.

The budget process is somewhat transparent in Burkina Faso in the health sector, but not transparent in the education sector. No criteria are used in the education sector to determine budget allocations, while some criteria are used in the health and nutrition sectors. The budget for ECD is coordinated across MASSN and MENA. The two ministries hold joint meetings for planning and allocation of the budget. The government can accurately report public expenditure for ECD in health, education, social protection, and nutrition.

The level of ECD finance is inadequate. Table 3 displays the distribution of pre-primary spending across other countries in the region. Public expenditure data from 2007 show just 0.6 percent of the public education budget was spent on pre-primary education. According to MICS, in 2011, 32 percent of routine EPI vaccines were financed by the government.

Table 3: Public expenditures on pre-primary in selected Sub-Saharan African countries

	Burkina Faso	Cote d'Ivoire	Mali	Niger	Senegal
Distribution of public education expenditure on pre-primary	0.6%	NA	0.3%	2.0%	0.3%
Pre-primary expenditure as percentage of GDP	0.1%	NA	NA	0.1%	NA

Source: UNESCO Institute of Statistics, 2010-2012 (most recent data available)

The level of public finance is somewhat equitably distributed across various segments of society. For publicly run early childhood education centers, the costs vary depending on the location (urban, semi-urban, or rural). The government ensures only the initial investments (building and equipment) and salaries of teaching staff (early childhood educator and monitor). Other types of fees that are charged and that may vary greatly from one center to another include: registration, tuition, educational supplies, uniforms, and parent association fees. In the health sector, 20 percent of the labor fee is charged to mothers, while treatment for immunizations, diarrhea, TB, and antenatal care is free. According to the World Health Organization (WHO), out-of-pocket expenditure was 36 percent of total health expenditure in 2012 for Burkina Faso. Table 4 compares health expenditure indicators in Burkina Faso with other countries in the region. It is interesting to note that the government of Burkina Faso spends more on health per capita compared to Mali and Niger, its peer countries.

Table 4: Regional comparison of select health expenditure indicators

	Burkina Faso	Cote d'Ivoire	Mali	Niger	Senegal
Total health expenditure as a percentage of GDP	6%	7%	6%	7%	5%
Out of pocket expenditure[5] as percentage of private health expenditure	80%	77%	100%	88%	77%
General government expenditure on health per capita (adjusted for purchasing power parity)	90	144	74	44	96
Routine EPI vaccines financed by government	32%	30%	NA	14%	32%

Source: WHO Global Health Expenditure Database, 2013; UNICEF, 2013

The level of remuneration for ECCE service personnel is low relative to other human development professionals in the country. In early childhood centers, the minimum salary for a trained preprimary educator is more than 40 percent less than that of a primary school teacher (USD 210 per year versus USD 371 per year). These salaries reflect government requirements for trained teachers,

[4] Valerio & Garcia, 2012; WHO, 2005; Hanushek & Kimko, 2000; Hanushek & Luque, 2003

but in reality, the majorities of teachers are untrained and work in the non-state sector where their compensation is likely less than USD 210 per year earned by public preschool educators. Community-based childcare center professionals are not paid for by the government. *Bisongos* are the prevalent form of community-based childcare center in Burkina Faso and these teachers are paid by the community. Further, extension health service professionals are not paid by the government.

Policy Options to Strengthen the Enabling Environment for ECD in Burkina Faso

- **Legal framework.** Burkina Faso has developed policies and regulations in all relevant sectors to support ECD. Although the government has introduced a number of policies in recent years to support preprimary education, preprimary enrolment rates remain significantly low in Burkina Faso. Burkina Faso could consider introducing a policy of mandatory preprimary education and a phased approach to expanding universal coverage. In terms of health policy, the GoBF should consider expanding national laws and regulations to require a full course of childhood immunizations including meningitis and mumps. It should consider strengthening policies that protect pregnant women and new mothers and promote opportunities for parents to provide care for newborns including making it illegal for an employer to ask about family status, and guaranteed employment upon return from parental leave.

- **Intersectoral coordination.** Develop a costed implementation plan to support the multisectoral policy. The government could consider forming a multisectoral working group whose first project could be to identify resources available within the GoBF and in public/ private sector for implementation of multi-sectoral policy. It is important that the gap between internally available resources and the cost of implementation of policy be identified. Training and capacity building of government staff to enable them to engage and advocate effectively for financial support from international donors would greatly support efforts to mobilize resources toward ECD.

- **Finance.** It is important that the government commit to a sustained financial support for the implementation of ECD policies. Currently, the government provides limited ECD financing and there are no mechanisms for ministries to coordinate spending on ECD. The GoBF could improve data collection by relevant ministries on spending by age group in order to better track resources available for ECD. It should also develop mechanisms for joint planning between ministries on ECD spending and sharing data on ECD-related budget allocations and spending.

Policy Goal 2: Implementing Widely

Policy Levers: Scope of Programs • Coverage •Equity

Implementing Widely refers to the scope of ECD programs available, the extent of coverage (as a share of the eligible population) and the degree of equity within ECD service provision. By definition, a focus on ECD involves (at a minimum) interventions in health, nutrition, education, social and child protection, and should target pregnant women, young children and their parents, educators, and caregivers. A robust ECD policy should include programs in all essential sectors; provide comparable coverage and equitable access across regions and socioeconomic status, especially reaching the most disadvantaged young children and their families.

Policy Lever 2.1: Scope of Programs

Effective ECD systems have programs established in all essential sectors and ensure that every child and expecting mother has guaranteed access to the essential services and interventions they need to live healthfully. The scope of programs assesses the extent to which ECD programs across key sectors reach all beneficiaries. Figure 2 presents a summary of the key interventions needed to support young children and their families via different sectors at different stages in a child's life.

Figure 2: Essential interventions during different periods of young children's development

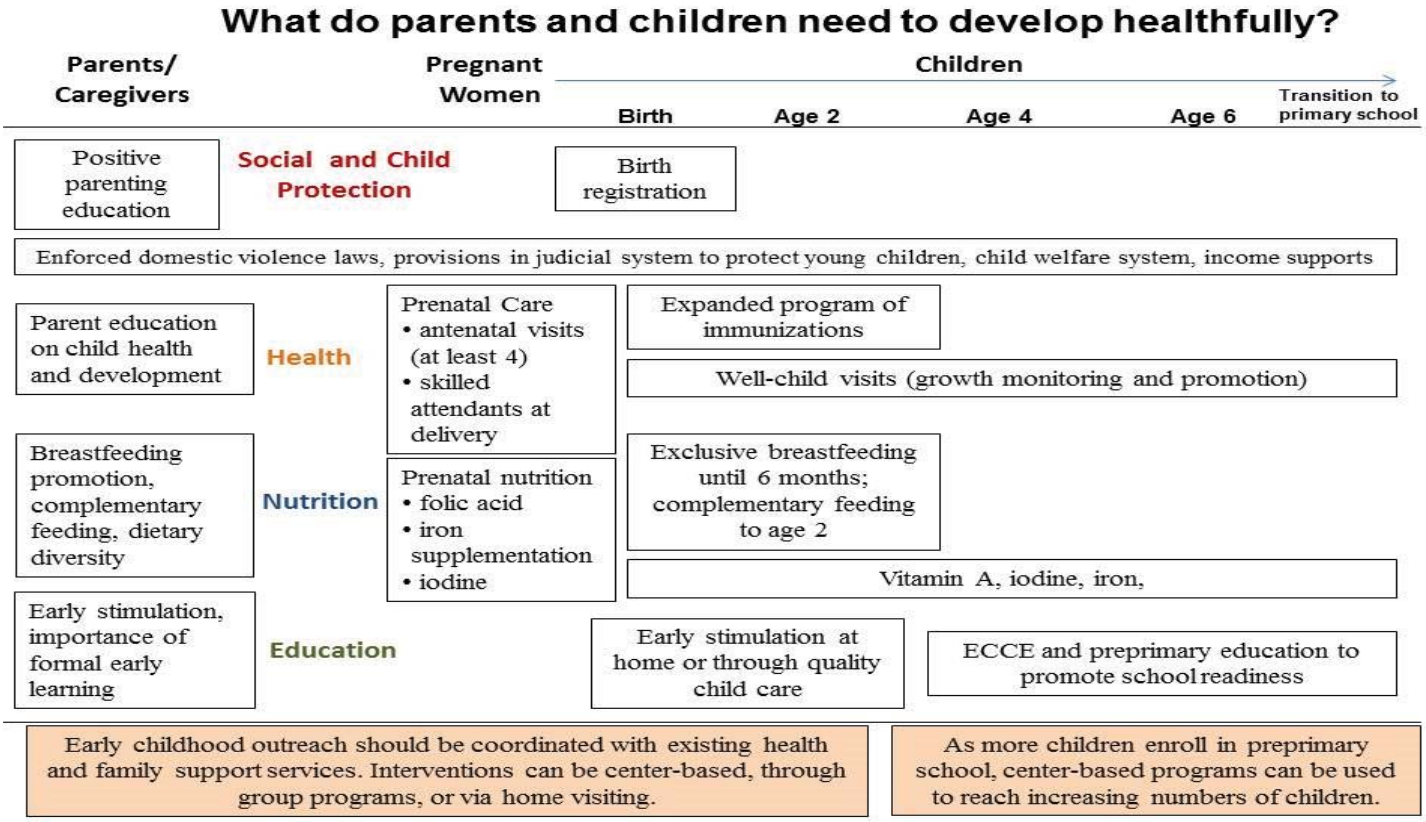


Table 1 summarizes the range of ECD interventions available in Burkina Faso at present.

Table 1: ECD Programs and Coverage in Burkina Faso

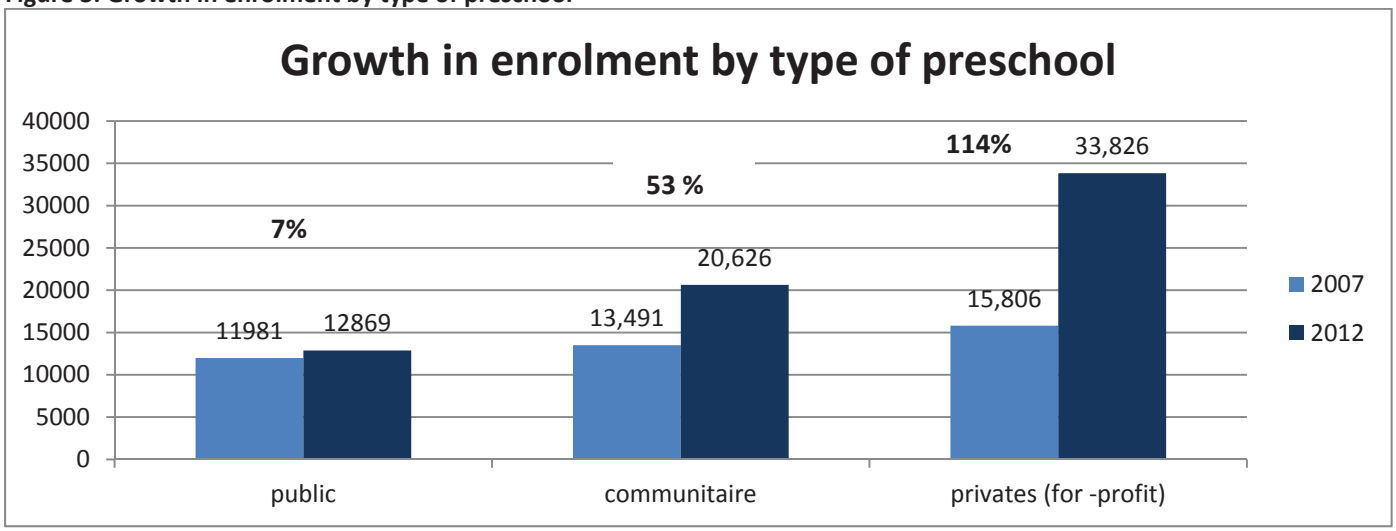
ECD Programs and Coverage in Burkina Faso				
ECD Intervention	Scale			
	Pilot program	Low coverage, all regions	High coverage, some regions	Scaling nationally
Health				
Prenatal healthcare		X		
Comprehensive immunizations for infants				X[6]
Childhood wellness and growth monitoring	X			
Education				
Publicly-provided early childhood care and education		X		
Privately-provided early childhood education		X		
Community-based early childhood care and education		X		
Nutrition				
Micronutrient support for pregnant women		X		
Food supplements for pregnant women	X			
Micronutrient support for young children	X			
Food supplements for young children	X			

[6] Refers to 1-year-old children immunized against DPT (corresponding vaccines DPT3ß) only.

Food fortification				**X**
Feeding programs in preprimary schools	**X**			
Parenting				
Parenting integrated into health/community programs		**X**		
Home visiting programs to provide parenting messages		**X**		
Anti-poverty				
Cash transfers conditional on ECD services or enrollment	**NA**			
Special Needs				
Programs for OVCs	**X**			

Preschool education models operating in Burkina Faso at present include those delivered by the public sector, the private sector, and those that are managed by the community. There were 309 community based centers and 522 private-for-profit centers registered in 2012-2013. The Government also operates about 90 public preschools that are concentrated in the main cities. Community-based centers called Bisongo and the Center for Educational Enlightenment (3E) are funded by partners such as UNICEF, Bornefonden, Hunger Project and Solidar Suisse. The implementation of this model is financed by the community while technical assistance for the set up of the centers and facilitators training is provided by the government and its partners.

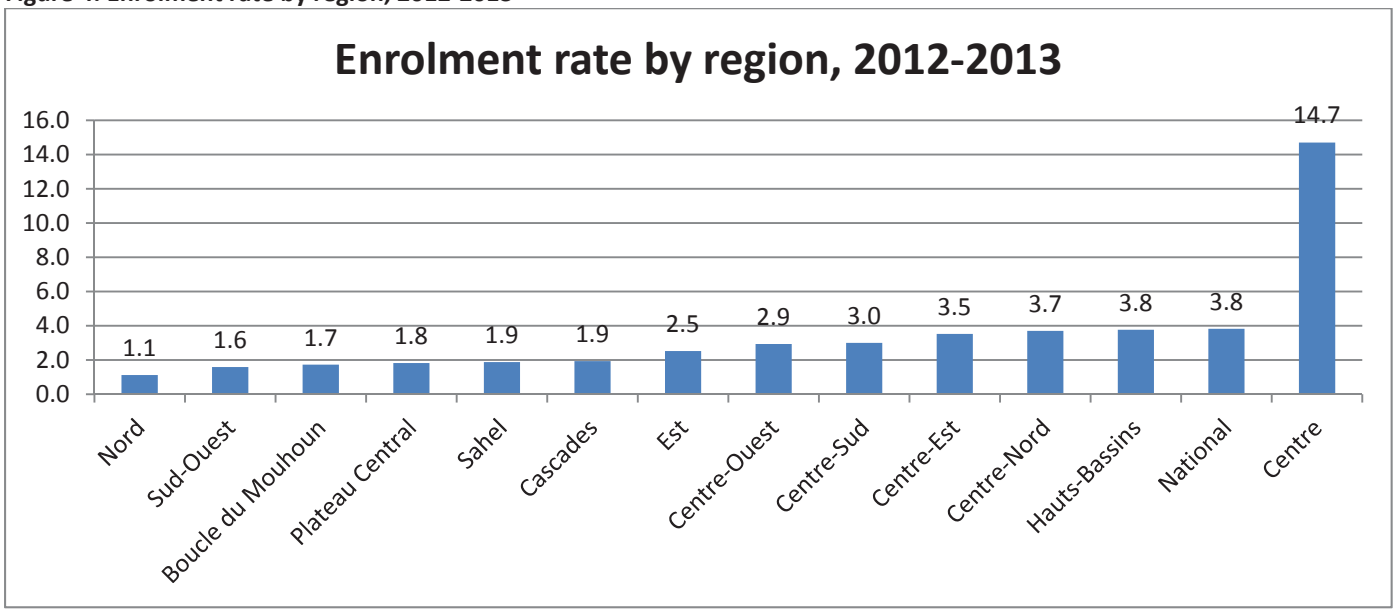
Figure 3: Growth in enrolment by type of preschool



Source: Annuaire Statistique, 2012

Figure 3 shows a significant growth in preschool enrolment in Burkina Faso over the 5-year period between 2007-2012. The majority of the growth comes from the private sector where enrolment levels have grown by 114 percent (over 15,000 new children enrolled).

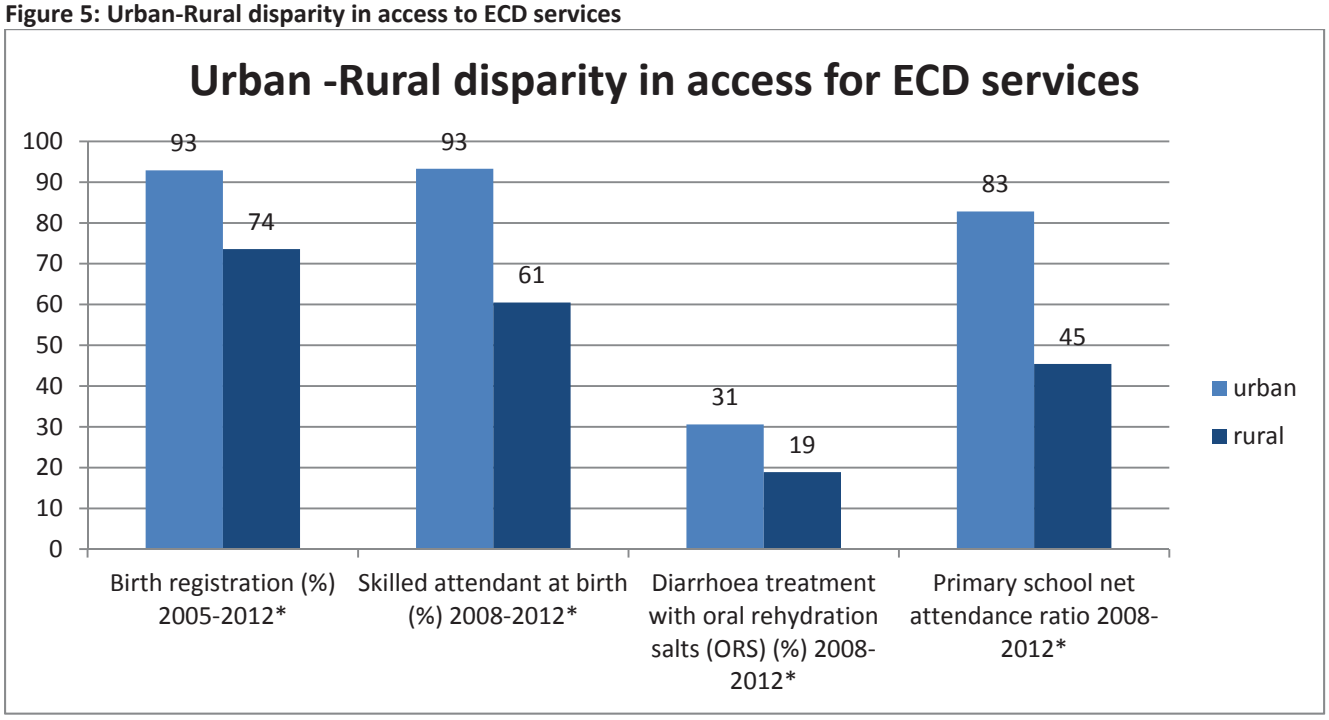
Figure 4: Enrolment rate by region, 2012-2013



Source: Annuaire Statistique, 2012

Figure 4 shows the range in enrolment levels among the various regions in Burkina Faso. As seen above, the regions with lowest access are Nord, Sud-Ouest, and Boucle du Mouhoun. Enrolment levels are highest in Centre region, where the major urban center of Ouagadougou is located.

Figure 5: Urban-Rural disparity in access to ECD services



Source: Annuaire Statistique, 2012

Figure 5 shows a significant level of disparity in access to ECD services in Burkina Faso for those living in rural areas compared to those in urban areas. This coverage rates on four important ECD service indicators that are highlighted above.

Social protection programs addressing the needs of parents of children aged 0-8 are varied in Burkina Faso. The government has a national parenting program focused on ECD which is implemented in the entire country by MASSN and other partner ministries such as MENA and the Ministry of Health. The Christian Children's Fund for Children of Canada, an international NGO, has also developed a positive parenting program. As of August 2013, about 1,300 adults across 14 communities in caregiving roles, including parents, teachers, preschool and community workers, were trained in the importance of early childhood development and education using the Learning Through Play (LTP) early childhood development methodology developed by Hincks-Dellcrest for parental education. There are also government-run domestic abuse prevention programs and some availability of temporary housing in the main cities of Ouagadougou and Bobo-Dioulasso for Orphans and Vulnerable Children (OVCs). The following two programs related to AIDS are offered free of charge: PTME (Prévention de la Transmission Mère-Enfant du VIH/SIDA) and traitement antirétroviral du VIH/SIDA.

Health and nutrition programs addressing ECD issues are delivered both by government and by international partners. Health services available through the government health facilities include free prenatal visits, availability of government subsidized infant delivery services (80 percent price reduction), vaccine coverage, birth control coverage , insecticide-treated bed net (for pregnant women and children), HIV transmission prevention services, free retroviral drugs, and tuberculosis vaccines.

On the nutrition side, the government partners with international organizations to deliver services. For example, the Micronutrient Initiative is an international NGO working with the government to eliminate vitamin and mineral deficiencies in Burkina especially among young children. The World Food Programme (WFP) is another partner supporting more than 12,000 people affected by HIV in Burkina Faso. In addition to providing nutritional support, WFP helps them start their own businesses so they can sustain themselves and their families.

Policy Lever 2.2: Coverage

Emerging

A robust ECD policy should establish programs in all essential sectors, ensure high degrees of coverage and reach the entire population–especially the most disadvantaged young children– equitably, so that every child and expecting mother has guaranteed access to essential ECD services.

Access to essential ECD health and nutrition interventions for pregnant women is in need of expansion. Thirty-four percent of pregnant women benefited from at least four antenatal visits in 2011. Further, 66 percent of HIV+ pregnant women received ARVs for PMTCT in 2012.

Table 5: Regional comparison of level of access to essential health and nutrition interventions for pregnant women

	Burkina Faso	Cote d'Ivoire	Mali	Niger	Senegal
Skilled attendant at birth	About 70% (average urban and rural)	59.4%	56.1	29.3	65.1
Pregnant women receiving antenatal care (at least once)	34%	90.6%	74.6	82.9	93.3
Prevalence of anemia in women	>40%	>40%	>40%	>40%	>40%
Prevalence of anemia in pregnant women (2006)	68.3%	55.1%	73.4 %	65.5%	57.6%

Source: UNICEF MICS4, 2012;UNICEF Country Statistics, 2008- 2012; UNAIDS, 2012; WHO Global Database on Anemia, 2006

Burkina Faso is close to providing a high level of access to essential health interventions for young children. The country already has a high coverage rate (93 percent) for antibiotics for children with suspected pneumonia. It also has a high coverage rate for 1-year-old children immunized against DPT. However, the government has more work to do in treating children with diarrhea and ensuring that they sleep under an insecticide-treated bed net (ITN).

Table 6: Regional comparison of level of access to essential health interventions for ECD-aged children

	Burkina Faso	Cote d'Ivoire	Mali	Niger	Senegal
1-year-old children immunized against DPT (corresponding vaccines DPT3ß)	90%	94%	74%	74%	92%
Children below 5 with suspected pneumonia receive antibiotics	93%	19.2	43.9	NA	NA
Children below 5 with suspected pneumonia taken to health provider	56%	38.2	41.8	57.7	49.9
Children below 5 with diarrhea receiving oral rehydration salts	32.6%	36.3%	32.3%	44.3	22.4

Source: UNICEF MICS4, 2011; UNICEF Country Statistics, 2007-2011; WHO Global Database on Anemia, 2006

Access to essential nutrition interventions is emerging. The vitamin A supplementation coverage rate for children 6-59 months of age is 97 percent. Only 25 percent of children below the age of 6 months are exclusively breastfed. The percentage of the population that consumes iodized salt is 34 percent while over 40 percent of women have anemia, according to WHO.

Table 7: Regional comparison of level of access to essential nutrition interventions for ECD-aged children

	Burkina Faso	Cote d'Ivoire	Mali	Niger	Senegal
Children below 5 with moderate/severe stunting	32.9	29.8	27.8	43.9	26.5
Infants exclusively breastfed until 6 months	38.2	12.1	20.4	23.3	39
Infants with low birth weight	14.1	17	18	27	18.6
Prevalence of anemia in preschool aged children	91.5%	69%	82.8%	81.3%	70.1%

Source: UNICEF MICS4, 2011; UNICEF Country Statistics, 2007- 2011; WHO Global Database on Anemia, 2006

According to UNICEF, total birth registration is 76.9 percent (2005-2012) in Burkina Faso.

Table 8: Regional comparison of birth registration rate

	Burkina Faso	Cote d'Ivoire	Mali	Niger	Senegal
Birth registration 2000-2010	76.9% (2005-2012)	65	80.8	31.8	74.6

Source: UNICEF MICS4, 2011; UNICEF Country Statistics, 2007-2011

Box 3: Relevant lessons from Colombia: *Ruta Integral*

Summary: The Government of Colombia has recently developed the *De Cero a Siempre,* or "From Zero to Forever" strategy to promote a comprehensive ECD system across relevant sectors. A major component of the new strategy is the *Ruta Integral de Atenciones,* or the "Scheme for Comprehensive Services," which is an established list of specific ECD services that should be delivered to all young children. This *Ruta Integral* provides an operational framework which spans the prenatal period to 6 years of age and includes interventions related to the health, nutrition, socio-emotional development, cultural understanding, and protection of the child. Colombia's new ECD strategy emphasizes implementation at the local level; each municipality is expected to establish a municipal ECD committee. These municipal committees are responsible for coordinating interventions at the level of service delivery to ensure that children receive all essential services outlined in the *Ruta Integral.*

Key considerations for Burkina Faso:

- ✓ Because policy decisions and interventions in ECD span multiple ministries in Burkina Faso (such as Ministry of Education, Ministry of Health, Nutrition Dept., Ministry of Social Solidarity, it is important to have a common plan of action, not only at the policy level, but at the service delivery and local level.

Box 4: Brazil's campaign to promote breastfeeding, and lessons for Burkina Faso

Summary: Brazil's campaign to promote breastfeeding is an example of a successful effort to change public perception and health care practices, resulting in a significant increase in breastfeeding. The campaign was initiated in 1980 by the National Food and Nutrition Institute. UNICEF and the Pan-American Health Organization helped to develop public awareness materials that addressed the lack of informational materials on breastfeeding in Portuguese. Instructional brochures were widely distributed to mothers. A media campaign featured radio, television, and print media spots, and endorsements by well-known personalities. The WHO and UNICEF held training courses on breastfeeding for health care workers and managers, and the Baby Friendly Hospital Initiative was widely implemented to initiate early feeding. A coalition of numerous actors helped make the campaign a success. The Catholic Church, mothers groups, associations of medical professionals, community leaders, politicians, and the media were all engaged in the effort. The exclusive breastfeeding rate rose from 3.6 percent in 1986 to 40 percent in 2006.

Key recommendations for Burkina Faso, drawing on Brazil's experience:

- ✓ Develop and disseminate local language materials on the benefits of breastfeeding for a variety of audiences. These could include training materials for health care workers, awareness pamphlets for community leaders and NGOs, and instructional brochures for mothers, including mothers who are illiterate
- ✓ Encourage breastfeeding from an Islamic perspective, and engage religious organizations and leaders to spread awareness
- ✓ Train health care workers to educate mothers on the benefits of breastfeeding, and to support them in initiating and maintaining the practice
- ✓ Engage the support of NGOs, women's associations, health workers, community leaders, etc.

Source: Implementation of Breastfeeding Practices in Brazil: http://www1.paho.org/English/DD/PUB/NutritionActiveLife-ENG.pdf

Policy Lever 2.3: Equity

Based on the robust evidence of the positive effects ECD interventions can have for children from disadvantaged backgrounds, every government should pay special attention to equitable provision of ECD services[7]. One of the fundamental goals of any ECD policy should be to provide equitable opportunities to all young children and their families.

The level of equity in access to services among regions is low. There is a wide gap in preschool enrolment levels between regions. For example, the Centre region had a preprimary enrolment rate of 14.7 percent while Nord province had the lowest enrolment rate of all regions at 1.1 percent in 2012-2013.[8]

There is equitable access to preprimary school by gender with 3 percent of girls enrolled and 3 percent of boys enrolled between 2008 and 2012[9]. This level of gender equity in enrolment is noted across each region of the country.

ECCE services do not yet accommodate children with special needs. However a policy is being elaborated with UNICEF to better serve children with special needs (planned completion in 2014). Instruction in the mother tongue is encouraged in preschools but it is not mandatory. Curriculum and language materials are not translated into major local languages.

Equity in access by socioeconomic status is low and in need of improvement. For example, the richest 20 percent of women are assisted by a skilled birth attendant 92 percent of the time, while the poorest 20 percent of women are assisted by skilled birth attendants only 46 percent of the time. Similarly 95 percent of children of the wealthiest households are registered at birth, while only 62 percent of the poorest households are registered.

Equity in access to ECD services in rural and urban areas ranges from high to low depending on the service. In urban areas, the birth registration rate is 93 percent and in rural areas it is 74 percent. Further, in urban areas, 50 percent of people have access to improved sanitation services while only 6.5 percent of people in rural areas have improved sanitation services. Skilled attendants are present in urban areas for 93 percent of births, while in

[7] Engle et al, 2011; Naudeau et al., 2011

[8] Source: Table 2, Annuaire Statistic 2012-2013

[9] UNICEF. Burkina Faso Country profile. Date accessed June 8 2014. Data available: http://www.unicef.org/infobycountry/burkinafaso_statistics.html

rural areas, they are present for 61 percent of births (between 2007 and 2012) showing that the disparity in location is significant.

Policy Options for Implementing Widely in Burkina Faso

- **Scope of Programs.** As shown in Table 1, the GoBF should consider increasing the range of programming in the areas of nutrition, anti-poverty, and interventions for OVCs.
- **Coverage.** Enrolment rates in preschool are growing quickly but coverage is still low at 3.5 percent nationally. The government should investigate service delivery models that are low-cost and accessible to children in both urban and rural areas. One such example is Interactive Audio Instruction (IAI) which has been successfully implemented in Zanzibar in order to dramatically increase enrolment rates.

  In terms of health programming, less than 50 percent of pregnant women have access to antenatal visits. There is an opportunity for the government to investigate partnerships and options for expanded coverage in this area. Nutrition programming should also be improved: a low proportion of the population consumes iodized salt; the proportion of women who breastfeed needs to improve and; a large proportion of women are anemic.
- **Equity.** The poorest and more rural populations have less access to ECD interventions. The government should consider targeting mechanisms to reach the most marginalized families with young children; this could include expanding its conditional cash transfer program or introducing block grants to the most vulnerable villages in order to support ECD services. Block grants can be used to support developing health and nutrition programs for children and/or providing ECCE access based on the needs of particular regions.

Box 5: Relevant lessons Senegal: Improving access to nutrition interventions in hard-to-reach populations

Example from Senegal: Coordinating service delivery across sectors

In 2002, the Nutrition Enhancement Program (NEP) was launched by the Government of Senegal to provide multisectoral support for nutrition and enhance nutritional conditions for children below the age of five and pregnant and lactating women. It includes community-based growth monitoring and promotion, and community IMCI (Integrated Management of Childhood Illness) with maternal counseling, home visits, and cooking demonstrations. The project integrated nutrition interventions (i.e. growth monitoring and promotion) with existing health sector interventions (i.e. IMCI). The Ministry of Health and local development agencies already provided a relatively good scope of coverage of health interventions in local communities. Thus, the nutrition sector leveraged existing resources to deliver the NEP interventions. Due to the synergetic effect of bringing together the nutrition and health sectors, NEP became a mechanism for delivering other essential health and nutrition services provided by existing programs (including insecticide-treated bed nets and vitamin A supplements). By 2012, the Government of Senegal expanded the community nutrition program to reach more than 60 percent of the target population.

Key Lessons for Burkina Faso:

✓ The government can consider taking a community-based approach to enhancing nutritional supports. Linking government staff and health sector workers with those in nutrition could be a way to leverage resources. The government already provides relatively good access to health services, including birth attendants and prenatal care so these health sector programs could be expanded to include nutritional components.

✓ Promoting feeding practices combined with the delivery of essential health services could be an effective strategy to promote the holistic development of children.

Policy Goal 3: Monitoring and Assuring Quality

➢ Policy Levers: Data Availability • Quality Standards • Compliance with Standards

Monitoring and Assuring Quality refers to the existence of information systems to monitor access to ECD services and outcomes across children and standards for ECD services and systems to monitor and enforce compliance

with those standards. Ensuring the quality of ECD interventions is vital because evidence has shown that unless programs are of high quality, the impact on children can be negligible or even detrimental.

Policy Lever 3.1: Data Availability

Accurate, comprehensive and timely data collection can promote more effective policymaking. Well developed information systems can improve decision making. In particular, data can inform policy choices regarding the volume and allocation of public financing, staff recruitment and training, program quality, adherence to standards and efforts to target children most in need.

Some administrative and survey data are collected on ECD access and outcomes. Table 9 displays the availability of selected ECD indicators in Burkina Faso.

Table 9: Availability of data to monitor ECD in Burkina Faso

Administrative Data:	
Indicator	**Tracked**
ECE enrolment rates by region	✓
Special needs children enrolled in ECE (# of)	X
Children attending well-child visits (# of)	X
Children benefitting from public nutrition interventions (# of)	✓
Women receiving prenatal nutrition (# of)	✓
Average student-to-teacher ratio in public ECE	✓
Is ECE spending in education sector differentiated within education budget?	✓
Is ECD spending in health sector differentiated within health budget?	X
Individual children's development outcomes	X
Survey Data	
Indicator	**Tracked**
Population consuming iodized salt (%)	✓
Vitamin A supp for children 6-59 mo. (%)	✓
Anemia prevalence amongst pregnant women (%)	✓
Children below age of 5 registered at birth (%)	✓
Children immunized against DPT3 at 12 mo. (%)	✓
Pregnant women who attend at least one antenatal visits (%) (not available for at least 4 visits)	✓
Children enrolled ECE by socioeconomic status (%)	✓

Some data are available to differentiate ECCE access and outcomes for special groups. Data are collected in the Annual Statistics for Education on the enrolment rate by region, gender and socioeconomic status. Data are also collected in the Annual Statistics for Health on usage of health facilities by national, region, local, and urban/rural locations, and by child's age.

Child development is not measured. Data are not collected to measure child development across cognitive, linguistic, physical, or socio-emotional domains. Individual children's development outcomes are also not tracked.

Box 6: Chile Crece Contigo: The Biopsychsocial Development Support Program

Summary: A key accomplishment of *Chile Crece Contigo* is the ability to provide timely, targeted service delivery. A core element that makes this possible is the Biopsychosocial Development Support Program, which tracks the individual development of children. The program commences during the mother's initial prenatal check-up, at which point an individual "score card" is created for the child. Each of the primary actors within the *Chile Crece Contigo* comprehensive service network, including family support unit, public health system, public education system, and other social services, have access to the child's file and are required to update it as the child progresses through the different ECD services. If there is any kind of vulnerability, such as inadequate nutrition, the system identifies the required service to address this issue. Through the integrated approach to service delivery and information system management, these services are delivered at the right time and in a relevant manner, according to each child's need.

Key considerations for the Burkina Faso:

- ✓ Streamlined child monitoring
- ✓ Responsive system that tailors to the individual child's need

Policy Lever 3.2: Quality Standards

Ensuring quality ECD service provision is essential. A focus on access without a commensurate focus on ensuring quality jeopardizes the very benefits that policymakers hope children will gain through ECD interventions. The quality of ECD programs is directly related to better cognitive and social development in children[10].

Certain qualification requirements are established for ECCE professionals as well as some government mandated options for professional development. At present, there are two official diploma-granting training institutes in Burkina Faso for ECD professionals. One is public while the other is private. These are: the National Institute of Social Work Education (*l'Institut National de*

[10] Taylor & Bennett, 2008; Bryce et al, 2003; Naudeau et al, 2011; Victoria et al, 2003

Formation en Travail Social-INFTS) which is a public structure under MASSN. The second is the Center for Educational and Pastoral Formation (*le Centre de Formation Pédagogique et Pastorale-CFPP*) which is a private structure that provides training for ECD educators enabling them to become the equivalent of monitors in the public sector. Regardless of whether students are training to be ECD educators or monitors, the degree is awarded after two years. Graduates of the public structure (INFTS) work primarily in public schools only. Admission to INFTS is based on a national competition and successful entrants have their fees paid for by the government. Upon graduation, the state assigns them as educators in public preschools. In-service training is available but it is only required for public teachers and monitors. The in-service professional development offered to public preschool educators takes two forms. First, teachers have the opportunity to participate in peer learning groups called *Groupe d'Animation Pedagogique* (GAP) which come together only in Ouagadougou and Bobo Dioulasso, the two urban centers in the country. The government also hosts annual conferences in each of the 13 regions and organizes capacity building seminars for educators to learn new practices and connect with their peers.

ECD professionals in the private sector must finance their own in-service professional development. Educators and monitors either pay out-of-pocket or are sponsored by their employers. They can participate in GAPs although few educators in community-based centers do so (perhaps due to the distance). GAPS are financed by individual groups of educators while the conferences are funded by MASSN's regional directorates. In addition, between 2003 and 2008, preschool educators could enroll in MASSN's annual two-week long training course that was modular in design. The trainings were offered in each of the 13 regions of Burkina Faso at the MASSN regional offices. The cost was 15,000 CFA per module; thus, for a 2-3 module course during two weeks the cost was between 30,000 CFA and 45000 CFA.

MASSN via the INFTS regulates pre-service training for ECCE professionals. Pre-service practicum is included in the formal degree program. No practicum is required after degree completion and before formal entry into a paid job.

Health workers are trained in delivering ECD messages. According to the *Plan d'Action de Direction de la Sante de la Famille*, training is required for doctors and nurses, extension health service workers, and mid-wives. Psychologists are not required to be trained.

Standards are established for infrastructure and service delivery for ECCE facilities; however, many of these standards could be strengthened. Infrastructure standards do exist, and cover most areas including space per child, flooring, and structural soundness but they do not include requirements for potable water, or sanitation facilities (toilets) for example. In terms of educator to child ratios, the government has established different requirements based on the age of the child. For 3-5 year olds, the standard child-educator ratio is 35:1. For those children who are between 0-3, the ratio is five children per educator (for those who cannot walk) and eight children per educator (for those who do walk). The international best practice for child-to-teacher ratios is 15:1. The minimum number of hours of preprimary education per week is four hours per day and a minimum of 700 hours per year.

Registration and accreditation procedures for both state and non-state ECCE facilities are available. According to Decree No. 2007-789/PRES/PM/MASSN/MEF/MATD the government is required to monitor the quality of infrastructure, equipment, program content, health, safety and administrative management of preschools in the country. Structures of education and protection of childhood are subject to supervision by technical services of the state. While there are standards for what constitutes quality of service delivery at the preschool level, there is no tool used to measure the improvement of quality of service provision.

Policy Lever 3.3: Compliance with Standards

Latent

Establishing standards is essential to providing quality ECD services and to promoting the healthy development of children. Once standards have been established, it is critical that mechanisms are put in place to ensure compliance with standards.

In Burkina Faso, the majority of ECCE educators do not comply with established pre-service training standards or professional qualifications. The proportion of trained educators in registered preprimary schools is 21.7 percent and the ratio of children to trained educators is 107:1 (UIS).

Data on the compliance of the non- state sector in terms of established service delivery and infrastructure standards is unavailable. MASSN is attempting to increase the number of private ECCE centers that are registered with the government in order to better

monitor compliance of these centers with official standards. At present, registration and accreditation of preschools happens on an ad hoc basis. The government does not have a systematic way of identifying new private preschools for registration. Preschools are currently identified for registration in one of three ways:- through request by a preschool owner; request by MASSN or; a request by parents. According to staff at MASSN, the government is interested in increasing the share of private preschools that are formally registered, and along with this, is considering new penalties for non-compliance with existing standards.

Comparing Official Policies with Outcomes

The existence of laws and policies alone do not always guarantee a correlation with desired ECD outcomes. In many countries, policies on paper and the reality of access and service delivery on the ground are not aligned. Table 10 compares ECD policies in Burkina Faso with ECD outcomes. Some policies reflect the reality for some ECD interventions, such as the fact that in Burkina Faso national policy mandates registration of children at birth while the birth registration rate is 76.9 percent. On the other hand, the exclusive breastfeeding rate of 38 percent does not seem to align with the respective policies given that Burkina Faso's policy complies with that of the International Code of Marketing of Breastmilk substitutes.

Table 10: Comparing ECD policies with outcomes in Burkina Faso

ECD Policies	Outcomes
Burkina Faso's policy complies with the International Code of Marketing of Breastmilk Substitutes	→ Exclusive breastfeeding rate (6 months): **38%**
Preschool/kindergarten is not mandatory for any child age	→ Gross preprimary school enrolment: **3.5 %**
Young children are not required to receive a complete course of childhood immunizations, though they are required to receive DPT	→ Children with DPT (12-23 months): **90%**
National policy mandates the registration of children at birth	→ Completeness of birth registration: **76.9%**

Preliminary Benchmarking and International Comparison of ECD in Burkina Faso

On the following page, Table 11 presents the classification of ECD policy in Burkina Faso within each of the nine policy levers and three policy goals. The SABER-ECD classification system does not rank countries according to any overall scoring; rather, it is intended to share information on how different ECD systems address the same policy challenges.

Table 12 presents the status of ECD policy development in Burkina Faso alongside a selection of regional and global comparators. Sweden is home to one of the world's most comprehensive and developed ECD policies and achieves a benchmarking of "Advanced" in all nine policy levers.

Policy Options to Monitor and Assure ECD Quality in Burkina Faso

- **Data Availability.** The government has a well established centralized system for collecting administrative data on access to essential ECD services. However, data is not tracked on the outcomes of services delivered to beneficiaries. For example, no data is collected at the preschool level to measure individual children's readiness to learn in primary school (i.e. their cognitive, socio-emotional development as a result of attending preschool). As such, the government should consider options to integrate program monitoring metrics into its regular data collection process for the Annual Statistics. The government may wish to consider partnerships with relevant international and civil society organizations that have developed effective tools for M&E for ECD. (For example, Save the Children has developed a tool for measuring child learning in preschool). The government may wish to consider piloting these approaches widely with the goal of identifying appropriate tools for integration into its centralized system.

- **Quality Standards.** The government has established quality standards in a number of key areas. It is currently in the process of revising preschool curriculum to integrate both theory and play-based learning. It has also developed formal standards for the certification of ECCE professionals although few opportunities for professional development exist for teachers in rural areas or for those working in the private sector. The GoBF has also established registration and accreditation procedures for both state and non-state ECCE facilities. Health sector workers are also required to be trained in delivering ECD messages.
- **Compliance with Standards.** While the government has been effective in establishing quality standards in a number of key areas, it has not been as effective in ensuring compliance with those standards. It should consider two streams of action in order to remedy this problem. First, it should review its standards to assess how realistic they are given resources available in country. For example, the requirement of 2 years of formal post-secondary training for certification may be overly demanding given the high cost of training and low wages typical of the ECCE sector. Instead, the government may wish to introduce an alternative short-track certification system that allows for ECCE instructors to gain training in 6-12 months and receive credit for their on-the job experience. This may serve to increase the proportion of teachers currently certified and thus increase the quality of learning in preschool classrooms. In addition to this, the government should consider investing in training its central and regional health and education inspectors to evaluate quality of ECCE infrastructure and compliance, and provide coaching services to ECCE instructors and health workers in order to improve their practice. It should consider providing operating budgets to cover the cost of travel and the purchase of laptops/other technology to support staff in conducting regular site visits to ECCE centers and health care facilities and tracking data collected up to the central level. The government could also consider using its parental education programs and public information campaigns as a means to encourage families to assist in monitoring the standards of ECD service providers.

Table 11: Benchmarking early childhood development policy in Burkina Faso

ECD Policy Goal	Level of Development	Policy Lever	Level of Development
Establishing an Enabling Environment	Emerging	Legal Framework	●●○○
		Inter-sectoral Coordination	●●○○
		Finance	●●○○
Implementing Widely	Emerging	Scope of Programs	●●○○
		Coverage	●●○○
		Equity	●●○○
Monitoring and Assuring Quality	Emerging	Data Availability	●○○○
		Quality Standards	●●○○
		Compliance with Standards	●○○○

Legend:	*Latent* ●○○○	*Emerging* ●●○○	*Established* ●●●○	*Advanced* ●●●●

Table 12: International Classification and Comparison of ECD Systems

ECD Policy Goal	Policy Lever	Level of Development					
		Burkina Faso	Colombia	Jamaica	Mali	Sweden	Turkey
Establishing an Enabling Environment	Legal Framework	●○○○	●●●○	●●●○	●○○○	●●●●	●●●○
	Coordination	●○○○	●●●○	●●●○	●○○○	●●●●	●●○○
	Finance	●○○○	●●●○	●●○○	●○○○	●●●●	●●○○
Implementing Widely	Scope of Programs	●●○○	●●●○	●●●○	●●○○	●●●●	●●●○
	Coverage	●●○○	●●●○	●●●○	●○○○	●●●●	●●○○
	Equity	●●○○	●●○○	●●●○	●○○○	●●●●	●●○○
Monitoring and Assuring Quality	Data Availability	●○○○	●●●○	●●●●	●○○○	●●●●	●●○○
	Quality Standards	●●○○	●●○○	●●●○	●○○○	●●●●	●●●●
	Compliance with Standards	●○○○	●●○○	●○○○	●○○○	●●●●	●●○○
Legend:		Latent ●○○○	Emerging ●●○○	Established ●●●○	Advanced ●●●●		

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Acronyms

BEPC	Brevet d'étude du premier cycle
CFPP	Centre de Formation Pédagogique et Pastorale
ECD	Early Childhood Development
ECCE	Early Childhood Care and Education (used interchangeably with *preprimary* or *preschool*)
GoBF	Government of Burkina Faso
INFTS	Institut National de Formation en Travail Social
LTP	Learn Through Play
MASSN	Ministère de l'Action Sociale et de la Solidarité Nationale
MENA	Ministère de l'Education Nationale et de l'Alphabétisation
Monitors	Teaching assistants
PTME	Prevention de la transmission mere enfant

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This report focuses specifically on policies in the area of **Early Childhood Development**.

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