1. Background

The IPC chronic classification development process started with the preparation of the IPC Manual version 2.0. Since the main focus of IPC has been on classification of acute food insecurity, refining tools for the acute analysis was also the main priority in the new version of the Manual. Draft tools for analyzing chronic food insecurity were included in the Annex of the Manual, and IPC users and field practitioners around the world were encouraged to test the tools and share the feedback with the IPC Global Support Unit for further development of the tools.

Once the Manual was released in October 2012, the chronic development process was able to start in earnest. Plans for piloting the chronic classification tools in five countries were made, and a global Chronic Working Group was formed with members from IPC partner agencies, as well as from other agencies, such as the World Bank, IFPRI, FANTA and ICF.

Due to scheduling conflicts at country level every planned pilot could not be carried out by the deadline of the end of February 2013. However, six pilots did take place between October 2012 and February 2013: (in chronological order) Zimbabwe, Malawi, Lesotho, Nepal, Honduras, and the Philippines. It has to be noted that there were also two earlier pilots: a national pilot in Uganda and analysis of one province of Zimbabwe in 2011. The lessons learned from these earlier pilots are, however, not included in this summary as they already informed the development of the chronic classification tools in the Manual annex.

This report aims at giving an overview of the feedback received and lessons learned during the piloting phase leading up to the first synthesis meeting of the Chronic Working Group in Washington from 11 to 14 March 2013. Sections 2 and 3 pertain to Prototype A, whereas in section 4 the feedback on Prototypes B and D is detailed on basis of the results of the Honduras pilot. Feedback on Prototype A from Honduras is included in section 3.

2. Process – from data preparation to analysis

2.1. Time required for training and analysis

- Time allocated for training and analysis was normally considered too short
- Training should incorporate practical examples and exercises before the analysis, which takes time
Time allocation should also take the extent of the analysis into consideration. If there are a lot of units to be analysed (as is often the case if analysis is done at third administrative level as per recommendation), more time is required for detailed analysis.

Training and analysis altogether can easily take up to six days, instead of the four days planned for the first round pilots.

2.2. Training for the chronic analysis

- Participants should have a preparatory session on understanding of indicators used in the IPC chronic reference table prior to the training and analysis to bring participants to the same level of understanding.
- In some cases the training was inadequate, and the varying capacity of the participants was not properly taken into consideration before the analysis.
- Provide illustrative examples to facilitate the understanding of severity and prevalence, and how the chronic reference table(s) have been constructed.
- Special emphasis should be paid on determination of population numbers under different chronic types. Clear examples on different approaches should be provided.
- More attention in the training should also be paid on inference of outcomes on basis of available indirect evidence, and on proper filling of the analysis worksheets.

2.3. Data preparation and availability

- The data preparation process is a crucial step before the analysis, and in almost all the pilots different gaps were identified in the preparation, in data itself, or both.
- It would be useful to have some TWG members (or people from outside the TWG), who could dedicate some days before the analysis for data preparation, i.e. for identifying suitable data and making it available for the analysis by the units of analysis.
- The data preparation stage could also include trend analysis.
- In most countries data at the 3rd administrative level (preferred unit of analysis according to IPC guidance) is not available, or the sheer amount of the areas to be analysed is overwhelming. These factors meant that analysis in the pilots was normally taken at 2nd administrative level, except in the Philippines, where data was available at 3rd administrative level (however, analysis was limited to one island group out of three as otherwise the number of the units of analysis would have been too high).
- Long term data is preferable for the chronic analysis for several reasons: it enables trend analysis, gives a solid background for analysis, and helps in analysing seasonal food insecurity, and in establishing baseline years. However, data for an extended period is rarely available or it is normally not availed to the participants, which weakens the chronic analysis.
It was also noted that in some cases there were gaps in the data due to haste and inadequate preparation, sometimes related to inadequate guidance on what data would be useful for chronic analysis.

It also became obvious that it would be good to have one person in charge of the data and analysis preparations. When piecemeal action is taken by several parties, there is a risk that something is overlooked and that there are differing views on what needs to be completed before the analysis.

As a general principle it is advisable to organize the analysis workshop in a venue which has an internet connection. If data gaps are identified during the analysis, identification of more data online may be able to fill the gaps.

2.4. Unit of analysis

There seems to be a need to keep the level of analysis flexible, depending on data availability and needs for decision-making, rather than always try to do the analysis at 3rd administrative level. In some countries most of the programming decisions are actually taken at 2nd administrative level, and data is collected at the same level.

In all pilots the analysis was done by administrative units and not by household groups. There is a need for a discussion on whether analysis by household groups, especially if severity aspects are considered, would be required and feasible.

In several countries different types of data were collected at different units. If all data is used in the analysis, there is a need to allocate preparatory time for aggregation and disaggregation of the available data to the same unit of analysis.

Limited evidence standardization for the agreed analysis unit (creation of a database on IPC indicators)

2.5. Timing of analysis

Although in the IPC Manual it is said that chronic analysis should take place in a ‘normal’ year, whether the conditions for this were fulfilled or not was rarely considered in the pilots.

There is also a need to clarify the timeframe of the analysis. Since the chronic analysis addresses also the structural and underlying causes of food insecurity, and uses data for the past 5-10 years when available, chronic IPC analysis is not simple current situation analysis. This question needs to be addressed in guidance on chronic analysis.

The TWG also should ensure that at least a minimum quantity of data is available before calling for the analysis, e.g. by comparing the stock of data generally available in the country to the IPC reference tables and table on indirect evidence

2.6. Participants
For chronic analysis it is pertinent to include some analysts from the development sector in the given country, e.g. from UNDP, the World Bank, or the government agencies or NGOs who work on long-term development programs. That being said, it is also important that the new participants are familiar with the IPC by the time the analysis starts.

Causal analysis in terms of the limiting factors matrix and SWOT analysis requires a lot of background and contextual knowledge. This is usually possessed by analysts coming from the areas analysed, and therefore it is important to ensure that each analysis team includes at least one or two members who come from the area.

3. Technical

3.1. Definition and types of chronic food insecurity

- There is no adequate clarity on the concept of chronic food insecurity, especially as opposed to acute food insecurity. This issue is of primary importance, as the nature of the analysis and characteristics of the classification tools depend on it.
- The different types of chronic food insecurity require further clarification. Moreover, if there is no long term (10 years) of trend data, identification of the types and populations in each type is challenging.
- Some feedback identified a problem with the use of the term ‘ongoing’, on the basis that if we’re analyzing chronic food insecurity all food insecurity taken into consideration is ongoing.
- Chronic food insecurity type 3 was seen as confusing. It is not clearly mentioned that it overlaps with the other two categories and its definition in the reference table and in the text in annex 5 presents contradictions. Also careful communication of type 3 is needed as if added to the other two categories (as suggested in step 4) it provides an overestimation of the population in chronic food insecurity. Nonetheless, for several participants, the number of people in type 3 was considered a useful piece of information for decision making.

3.2. Reference table

- The level descriptions are too tied to acute food insecurity. They should rather refer to the different types of chronic food insecurity. If description is maintained as it appears in the reference table, there is loss of meaning for the long term outcome indicators like stunting.
- Level 2 and 3 descriptions are too similar: in Level 3 it is said ‘less than 20 to 40%’ which corresponds to Level 2 description of ’10 to 20%’.
- The reference table is in many ways rather Africa – specific, especially in terms of the food consumption indicators. A more universal approach is needed, and therefore a wider perspective on data and indicators is required.
The reference table is not very user-friendly. Many of the indicators or elements are rather vague and difficult to analyse, e.g. livelihood change and five capitals. Because they are difficult to analyse and direct indicators/data are lacking, many teams do not do proper analysis on these issues. The indicators for these outcomes should be rethought.

- Need to clarify how the frequency of the acute events is taken into account in the analysis: as an indicator in the reference table or also as a type of chronic food insecurity, with a population number?
- It is also important to clarify how the acute and chronic food insecurity are linked to each other in the analysis and in the reference table.
- Guidance is required on how to establish recurrence of crisis in countries that have not done acute analysis in the past.
- A general conclusion from many pilots was that both severity and prevalence are important in classification of chronic food insecurity.
- Strategic response objectives should be reviewed according to levels of chronic food insecurity with higher levels translating into higher geographic priority and level of investments required.

3.3. Indicators used in chronic analysis

- There is a need to see whether food poverty could be included as an indicator in the reference table.
- At least in Asia there is also data on depth of poverty at sub-national levels, e.g. on poverty gap and poverty squared.
- Affixing population percentage to the Kcal indicator under consumption outcome is difficult, if not impossible.
- Review of the >< signs in some of the indicators under various outcomes.
- Currently there is no mortality outcome, or mortality indicators in the reference table. Some teams felt that inclusion of mortality would be pertinent, but there is no common view of what mortality indicator (or any) would be descriptive of chronic food insecurity. However, mortality of specific age groups could be considered, since chronic food insecurity is a driver for mortality at young age.
- Analysis of Policies, Institutions and Processes (PIPs) contained in the reference table should be explained in more detail in terms of (a) measuring the impact of policies or their influence on food security and (b) identifying regions or population most affected.
- Overall the qualitative indicators, such as PIPs, livelihood change, quantity, and five capitals are too vague and leave a lot of room for interpretation and subjectivity, hampering comparability.
- This is also the case with the use of terms such as “frequent” or “occasional” as thresholds to determine how often hazards occur was found to be subjective. Guidance
on this should be developed. Existing work related to this could be taken advantage of (e.g. Climate Change Index by German Watch)

- Review of the thresholds of the indicators in the reference table. The rationale for selected thresholds should be made explicit
- Different benchmarks are required for water access as the 15% threshold is the emergency threshold. Perhaps for chronic analysis a better benchmark would be the quality, not the quantity (current indicator combines both). The term ‘water safety’ should be included. In Central America there is no data on water availability per se, and a suitable proxy indicator should be developed for this

- Unsustainable strategies / occasional events – lack of common understanding of indicators without thresholds
- Especially in Southern Africa there is a desire to add HIV/AIDS related indicator(s) into the reference table
- Expression of outcome and contributing factors indicators needs to be strengthened in defining the cut-offs especially for indicators that are expressed qualitatively. These include, for instance, quantity (lack of), HEA (deficit), livelihood change (graduate), assets (insufficient) and inadequate availability
- Obesity and overweight in women in fertile age (15 to 49 years) should be included in the nutrition indicators. These indicators may be reflecting inadequate intake and therefore a food security issue. However, identifying contributing factors specific for obesity and overweight was seen by some participants as a challenge. This could be a problem when triangulating during analysis. Also, there is no proof that obesity and overweight are actually reflecting inadequate intake

- Age group for stunting has to be indicated, usually is 0 to 59 or 6 to 59 months. Also, the threshold for stunting in Level 1 (<20%) was found to be very high. It was proposed that it should be 10%

- Indicate population and age group for BMI. The most common is non-pregnant women between 15 and 49

- The same for anemia. It was proposed to use anemia in pregnant women doing a prenatal test

- Age group should also be defined for Vitamin A deficiency. When measured it usually refers to children between 6 and 59 months of age. However given that this indicator is seldom measured, it was suggested that proxy indicators should be defined. There were questions on whether prevalence of fortified food consumption could be such proxy indictor

- Stability should be regarded both inter-annually and within the year

- Some participants thought that a list of possible indicators to understand the status of the pillars should be developed. This in spite having explained the rationale behind not being prescriptive in terms of what indicators should be used to analyze contributing factors.
3.4. Analysis worksheets

- Death rate is one of the elements in Step 3. If mortality is not considered in the IPC chronic analysis, it should be removed.
- The column for key assumptions in Step 3 was found cumbersome and mostly irrelevant by participants. They found it hard to try to identify key assumptions for most of the indicators, with the possible exceptions of vulnerability and livelihood change. The column is more useful for projection analysis, but since the chronic analysis does not incorporate projections the usefulness of the column is questionable. One suggestion was to either remove it, or replace it with further explanations on classification evidence/indicators.
- In many cases the analysis worksheets were not completely filled out. The most common missing sections include: key assumptions, element conclusions (except for the Level classification), reliability scores and confidence levels, parts of the limiting factors matrix or SWOT analysis, and data either in Step 2 or Step 3.
- There is a need to provide more guidance and illustrations on SWOT analysis. Some doubted its relevance, saying that is merely used for planning rather than analysis. The teams, however, found it useful and thought provoking. Evidence may, however, point in different directions for different groups in one unit of analysis. An example of this is a policy which results in different impacts for different groups, like fixing staple food prices may hurt producers, but be a benefit to net buyers. There is necessity to provide definitions/guidance on the SWOT e.g. strengths – full control and internal, opportunity – less control and external.
- Limiting factors matrix focuses on current situation, and cannot be expected to remain valid for 1 – 5 years. It does not correspond to the medium and long-term objectives of the chronic analysis.
- Arrangement of the analysis template for the food security elements should be improved: a separation of contributing factors from outcomes, and also a creation of space under outcomes to affix the indicative phase classification to each of the outcomes.
- A line in Step 3 could be introduced in which all evidence about contributing factors not related to food security could be displayed.
- Removing the reliability score column in Step 2 and allowing determination of these scores at evidence level, similarly to how it is done in the acute analysis.

3.5. Communication template

- A report template should complement the mapping protocol.
- The color scheme of the mapping protocol needs to be revised.
- The “Valid From” date on the communication template should be revised to “Valid For” so that the validity period is known, especially as the “Created On” date implicitly hints on the “Valid From” although it can be the same or different.
- It is confusing to include the level of chronic food insecurity. There is a need to have only one level of chronic food insecurity which is the aggregation of different typologies.

3.6. Analysis

- Relationship between poverty, chronic malnutrition, and food insecurity should be made explicit and linkages explored
- In several cases it seems to be that a high level of chronic food insecurity is actually caused by serious problems with chronic malnutrition, related to poor utilization – difficulties in telling apart food security related causes from non-food security related causes
- Establishing a good reference year for the analysis is difficult. It should be clarified how the baseline or normal year data can be established. Should, for example, all evidence or only a few selected indicators be taken into consideration?
- Gender analysis is largely lacking
- There is also no analysis on specific population groups which may have higher levels of chronic food insecurity
- Accounting for humanitarian assistance: assistance can lower the level of chronic food insecurity in an area, but it is not addressed in the analysis (as opposed to acute analysis)
- It was not clear how to classify when the number of people in type 3 and the number in the other two types point at different levels in the reference table. Should the most severe level prevail?

4. Honduras pilot

General observations

- Cut-offs points for some indicators would need to be revised. For those elements of the reference table containing several indicators such as nutrition or hazards/vulnerability, the indicative level of chronic food insecurity varied depending on the indicator considered. This is a problem when assigning indicative level for outcome elements and for triangulation using contribution factors.

*Indicative chronic level for nutrition outcome by indicator considered and prototype applied to Valle*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Prototype A</th>
<th>Prototype B</th>
<th>Prototype D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Anemia (children)</td>
<td>3 (very close to 4)</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
The issue on whether a severity or a prevalence scale should be included in the future protocol for classifying chronic food insecurity was a central aspect of workshop discussions. Main comments concerning this issue were: (please complete here if you have something else)

a. It was not well understood how populations could show deficits of food consumption chronically as proposed for level 4 in prototype B and for levels 3 and 4 in prototype D. What would be the difference between these levels and the acute phases where food consumption gaps exist?

b. In the severity scales the analysis is centered only in a fraction of population (e.g. poorest tercile in prototype B) and therefore not completely reflecting chronic food security conditions of the whole population in an area.

c. In prototype A (prevalence scale), the description of levels was seen as less useful when doing the classification than description in the severity scales.

d. Most participants concluded that ideally the chronic prototype should be able to capture severity and prevalence, but without proposing ideas on how this could be done.

In the chronic protocol, quantity and quality aspects of food consumption should be emphasized separately. Quality issues such as dietary diversity, quality of protein consumed, levels of consumption of starchy food, and others were seen as key characteristics of the chronic food insecurity problem. Some participants considered that households always sacrifice quality before reducing quantity. Others considered that this is not necessarily a universal rule and therefore should not be an IPC classification criterion. In any case quality and quantity should have a dedicated space in the analysis worksheet when looking at the causes of chronic food insecurity.

Level descriptions are a useful resource when doing the IPC classification. The definitive reference table should include level descriptions that allow identifying the differences between the chronic food insecurity levels. Such description should not only be limited to consumption but also include nutrition and changes in livelihoods, similarly to the acute scale.

Consider increasing the standard for minimum confidence level of analysis given the type of decisions that will be based on a chronic analysis. In this regard the protocol should recommend doing the analysis right after the results of a national household survey are released.
The justification for carrying out the chronic analysis at administrative zone level only was not well understood by some participants. When information allows it, the analysis should be done by household groups too as this is also valuable for program design.

Several participants from the Central American region, including representative from Government of Honduras (GoH), expressed the need to turn IPC into a protocol for classifying food and nutrition security instead of food security only. The main reason seemed to be the work that over the years has been made in this region to sensitize Governments and other stakeholders on the need to take into account food and non-food factors when addressing malnutrition problems. The IPC exclusive focus on food security is perceived as a risk of deviating attention from non-food driving factors.

Participants found that IPC chronic analysis could have an added value as compared to equivalent existing approaches (e.g. poverty indexes, VAM, GHI, etc.). Added value would be the level of disaggregation to which the analysis can be taken, multi-stakeholder participation in the preparation of analyses, the use of all available information sources (providing they fulfill minimum reliability conditions) and the effectiveness of the communication protocol.

The representative from the GoH indicated three possible uses of IPC analysis for decision making: design and management of national aid programs, accountability of entering/exiting government by preparing a map before national elections, organizing the work and responsibilities of the different departments within the GoH.

When analyzing the frequency of high IPC acute phases in the past 5 or 10 years (depending on the prototype considered) it was difficult to determine whether phase 3 or higher had occurred in the area analyzed. Even if for this particular exercise lack of information was evident, there were questions on the feasibility of determining ex-post the occurrence of phase 3 or higher in general.

The prototypes presented are based on the idea of “normal year”. Groups had problems discerning normal year from non-normal years. In Valle, episodes of drought and floods more or less severe are very common, especially in the current climate-change context. Guidance should be developed to help analyst identifying normal years.

There were opinions in favor and against presenting the contributing factors together with the outcomes in the reference table. Those in favor considered that it was a necessary reminder on the need to triangulate outcomes and contributing factors before classifying. Others feared that putting the contributing factors in the reference table could be misleading for analyst who could be tempted to assign indicative levels of food insecurity to the contributing factors.
Some type of guidance would be needed about the minimum information necessary to determine each element of the analytical framework. Such guidance could also orientate analysts on which potential sources of information could be available.

Discussion on the chronic scale should also include the rest of the IPC functions. For example, questions on what additional areas of expertise should be included in the national Technical Working Group for a chronic analysis, or if questionnaires in function 4 should be modified, should also be addressed when thinking about an IPC protocol for chronic food security.

Some participants indicated that the definition of chronic and acute food insecurity should make explicit reference to the occurrence or not of shocks. Also there were opinions in favor of including a reference to the structural nature of factors causing chronic food insecurity. On the other hand definitions based on causal factors bring the challenge of developing an IPC classification with globally standardized thresholds to classify these factors.

Fundamental issues to be addressed by the TWG

1. The issue on whether a severity or a prevalence scale should be included in the future protocol for classifying chronic food insecurity was a central aspect of workshop discussions. Main comments concerning this issue were:

   a. Are there different degrees of severity of chronic food insecurity in the world, or is there just one threshold of food-insecure or not food-insecure? The severity scale assumes the former, and the prevalence scale the latter.

   b. What should the sensitive range of a severity-based chronic scale be? Should it include a separate level? Or subsume within the lowest level household groups or areas that have “no” chronic food insecurity (the “Central Park” case)? Should it include a level of severity for households or areas in livelihood failure that simply cannot survive in a typical year without assistance even in the absence of shocks (the Djibouti-Ethiopia-Somalia case)? It was not well understood how populations could show deficits of food consumption chronically as proposed for level 4 in prototype B and for levels 3 and 4 in prototype D. What would be the difference between these levels and the acute phases where food consumption gaps exist? If the situation was so severe, the area/group would also be classified as being in a phase 4 or 5, thus classifying the area as in acute crises and thus not allowing for chronic classification (as chronic food insecurity has been conceptualized as food insecurity in years without acute crises).

   c. Severity is most easily measured by conducting analysis for a consistent In the severity scales the analysis is centered only in a fraction of the population (e.g. poorest tercile in prototype B or 20% of the population for Prototype D) and therefore not completely reflecting chronic food security conditions of the whole population in an area. If classifying the severity of the entire population is a goal of the chronic analysis, Thus, in order to do a severity based classification it would probably may be necessary to allow for classification of various (or all) HH Analyses Groups and then the area, similarly to the acute scale.
d. In prototype A (prevalence scale), the description of levels is unhelpful in distinguishing between phases was seen as less useful when doing the classification than description in the severity scales.

e. Most participants concluded that ideally the chronic prototype should be able to capture severity and prevalence, but without proposing ideas on how this could be done.

2. Questions were raised about the appropriateness of the IPC analytical framework.

a. Several participants from the Central American region, including representative from Government of Honduras (GoH), expressed the need to turn IPC into a protocol for classifying food and nutrition security instead of food security only. The main reason seemed to be the work that over the years has been made in this region to sensitize Governments and other stakeholders on the need to take into account food and non-food factors when addressing malnutrition problems. The IPC exclusive focus on food security is perceived as taking attention away from non-food contributing factors.

b. The IPC analytical framework specifies livelihood change as an outcome. However, the word “change” refers to responses to shocks and falls under the purview of the acute scale. Does it therefore make sense to refer to typical livelihoods as an outcome for the chronic scale?

3. Should the chronic and acute scale be designed such as to allow for high phases of chronic co-existing with low phases of acute (4 chronic-1 or 2 acute) as well as high phases of acute with low levels of chronic (4 acute-1 chronic in the Japan tsunami case)?

4. Definition and Indicators of chronic food insecurity:

a. Are overweight/obesity or mortality appropriate indicators of “inability to meet minimum quality and quantity of food consumption requirements as is evident even in the absence of a shock/hazard” (chronic food insecurity)? If so, how should they be incorporated?

b. Is the prevalence of acute malnutrition in a typical, non-crisis year relevant to an analysis of chronic food insecurity?

c. Definition of chronic food insecurity to be reviewed. Some participants indicated that the definition of chronic and acute food insecurity should make explicit reference to the occurrence or not of shocks. Also there were opinions in favor of including a reference to the structural nature of factors causing chronic food insecurity. On the other hand definitions based on causal factors bring the challenge of developing an IPC classification with globally standardized thresholds to classify these factors.

d. Typologies: Chronic food insecurity type 3 was seen as confusing. It is not clearly mentioned that it overlaps with the other two categories and its definition in the reference table and in the text in annex 5 presents contradictions. Also careful communication of type 3 is needed as if added to the other two categories (as suggested in step 4) it provides an overestimation of the population in chronic food insecurity. Nonetheless, for several participants, the number of people in type 3 was considered a useful piece of information for decision making.

Comments on prototype B
Strengths:

a. Severity scale consistent with IPC Acute messaging and IPC analytical framework and definition of chronic food insecurity (p. 81 IPC 2.0 Manual)

b. Descriptions very helpful in selecting severity

c. Explicitly includes analysis for a group of households (poorest tercile)

d. Puts chronically poor food consumption into context

Weakness:

a. Is the prevalence of acute malnutrition in a typical, non-crisis year relevant to an analysis of chronic food insecurity?

Opportunities:

a. Although contributing factors were considered they could be incorporated more explicitly in scale/analytical process.

b. Further work on calibration of indicators with descriptions could improve acceptance. Overall, indicators and thresholds need to be better defined to facilitate understanding by the analysts

c. Unit of analysis may be clarified further between the indicators (hh and area) and description (appears more closely related to households).

d. The Combined Index of Anthropometric Failure (CIAF) allows new presentation of known indicators

e. IPC 2.0 Analytical framework includes livelihood change, not livelihoods, as a food security outcome. However, typical livelihoods more accurately reflect chronic conditions and chronic food insecurity than changes in livelihoods (coping strategies); changes in livelihoods more accurately reflect the impacts of shocks appropriate for the analysis of acute food insecurity

Threats:

a. Poor understanding of acute scale, particularly Phases 1 and 2.

On the CIAF:

a. Still too new and poorly understood to be well accepted by the group; created confusion; not yet proven for food security analysis.
b. Duplicates information from acute malnutrition and chronic malnutrition thresholds

c. Includes weight for age, a weak nutrition outcome indicator

d. Includes acute malnutrition; some argue that acute malnutrition is not an outcome of chronic food insecurity under the IPC’s treatment of malnutrition and its various causes, especially in a non-crisis year

e. Despite this, some found the CIAF point of view easy to use and helpful for making comparisons and informing response

f. Most useful when the different categories are detailed. The group found particularly useful the ‘stunting, wasting and underweight’ category, given the combined nature of the problem

g. Appreciate value of having thresholds for various combinations of different levels of acute/chronic rather than thresholds for each individually

- Although description of levels was found to be useful when making the classification, some improvements are necessary:
  a. Difficulty understanding “limited” resilience and “rare acute food insecurity”. “Limited” frequently confused with “non-existent”
  b. Review uses of “and” and “or”
  c. Does frequency of acute food insecurity refer to intra-annual acute, inter-annual acute, or both?
  d. Level 4 “endemic” not understood. Recommend change to “extreme”.

- Other minor issues:
  a. Improve consistency between themes/column headings and the analytical framework
  b. Need to clarify that “Poorest” refers to wealth group/socio-economic status
  c. Data available by quintile not tercile. The tercile is conceptual. If data is available by quintile, the analysis could be done by quintile as a basis for which to infer by tercile
  d. Starchy staples information frequently national, not by tercile or lower admin level
e. FCS: is this a measure of quantity, quality, or both? Same for HDDS

f. MAHFP: Though some argued that this would be difficult to estimate and that data are rarely available, this indicator is no less difficult to measure or infer than many others in Prototypes A and D and may be more available than others as it is a part of the World Bank’s LSMS

g. Anthropometric indicators should be considered nutrition, which should include Anemia and Vitamin A deficiencies. This is particularly the case since Anemia and Vit A may be heavily influenced by health

h. Vitamin A deficiency is measured indirectly

i. Specify age groups for nutrition/quality indicators, clarify which indicators apply

j. Request to include indicators regarding overweight/obesity (should this be included in a CIAF-type indicator?) and mortality

k. Why separate analysis of quantity by part of population and quality for entire population?

Comments on prototype D

- One of the main characteristics of prototype D is its focus on the integrated concept of food and nutrition security. For this reason the prototype is based on a different analytical framework than the one proposed in the IPC manual v 2.0 (see annex). This revised framework proposes that biological utilization is considered as another pillar. It also suggests different terminology for some elements in the current IPC framework to improve understanding in Central America. Participants agreed that the workshop was not the appropriate space for discussing revisions on the analytical framework.

- Another key characteristic of this prototype is the absence of linkage with the acute scale: outcomes are formulated differently, most indicators proposed as direct evidence are not found in the acute scale and type 3 of food insecurity is removed from the chronic analysis.

- For participants with higher level of experience in the use of the acute scale, these fundamental specificities of prototype D where the reason for some criticism. Whereas for other participants, in particular those from the Central American countries, this criticism was biased by a pre-conception that chronic analysis should be based on the acute scale adding the notion of prevalence and recurrence.
The exclusion of type 3 raised concern from some participants who saw a clear linkage between high frequency of high acute phases and structural issues that should be part of a chronic food insecurity analysis.

Level descriptions should be revised. They would be clearer if each level description did not make reference to the previous one. Also reference to marginal levels of availability, access and utilization in level 1 description created confusion. The rationale behind it is that prototype D only includes people in food insecurity and therefore level 1 does not include people that are food secure. Some proposed that in order to avoid misinterpretation on the meaning of Level 1 a Level 0 should be included (meaning food secure). Thresholds for level 0 could be those of the reference population (e.g. <5% for stunting and <2.5% for wasting). Others objected that declaring an area as “food secure” presents important analytical and political challenges.

It was not understood why in Level 4, when there is a “severe insufficiency of food quantity” according to the level description, acute malnutrition is put as part of the indicators of the nutrition outcome.

Purchasing capacity is only one aspect of “livelihood level reduction” therefore this element is insufficiently characterized. Moreover this outcome’s name denotes change but the indicators proposed as direct evidence are static and with a strong focus on poverty.

The introduction of mortality was considered as appropriate. Indicators proposed as direct evidence for this element and for malnutrition were also well received. However the following observations were made:

a. For malnutrition to include: prevalence of non-pregnant women with IMC<18.5 and anemia in pregnant women as there are recent studies that prove its link with chronic food insecurity (Jenny please include reference to the study by Helen Young on this).

b. For mortality, children in the age group of two years should be considered even if this requires looking at primary data (Ricardo please see if this expresses well what you meant in your report).

Some of the indicators proposed as direct evidence can only be measured at national level and therefore present little value in a sub-national analysis (e.g. prevalence of undernourishment). In addition, it was suggested to put the prevalence of undernourishment in the availability pillar and not under the intake outcome.

Some indicators are difficult to obtain at a disaggregated level (e.g. Gini index of caloric consumption). However if the usefulness of higher disaggregation was proved...
(for example through the inclusion of such indicators in a global chronic food insecurity scale widely accepted) then future surveys could be modified to obtain information permitting higher disaggregation levels.

- In the access pillar, the cost of the basic food basket and minimum salary should be expressed in deflated prices. That cost should be referred to the spatial unit of analysis being considered. Some observed that the legal minimum salary is often not respected and thus not representative of real working conditions in the informal sector.

- Participants had difficulties in understanding the Gini indicator for energy consumption. It was suggested to improve guidance or remove it in view of the difficulties to apply it as an indicator of access inequity when the 20% population rule is applied.

- It was suggested to include the Engels Ratio (food expenditure share over total expenditure) as part of the direct reference for access.

- In the utilization pillar it was suggested to include the following indicators as direct evident given their relevance and availability: % of women doing exclusive breast feeding during the first six months of life and extended breast feeding, and introduction of complementary food.

- For the biological utilization outcome, it was proposed to include basic sanitation, health and immunization coverage as well as prevalence of early breast feeding (colostrum), due to its direct relationship to the protection of newborn

- For stability, the analysis should be done not only within the year but inter-annually too. The thresholds proposed would require calibration. Participants considered that in most Central American countries the average number of months with difficult access to food is higher than 4

- The inclusion of direct evidence and thresholds at pillar level could raise issues on whether they are meaningful in all contexts. So far the IPC approach has avoided including such references at contributing factors level due to lack of global standards (except for water availability).

- The need to calibrate direct evidence thresholds for mortality, anemia, obesity and stunting became evident during analysis since it was very difficult to see to which chronic level evidence converged to.

- During the analysis the fact of including pillars but not causal factors in the reference table caused some confusion on whether it was not required to consider these factors. It was clarified that, as in the acute analysis, causal factors were also to be considered.