1. Background

The second round of piloting was conducted between September and November 2013, and consisted of four pilots: Kenya, Bangladesh, Guatemala, and Malawi. The pilots started in the end of September with the Kenya pilot and ended in the second half of November with the Malawi pilot.

This second round of piloting was based on the lessons learned during the first round of piloting from September 2012 to February 2013, and the subsequent work conducted on the draft tools, procedures, and training materials for the chronic analysis. The feedback received from the Kenya pilot was also used to revise the tools and training materials for the later three pilots. The next stage is to make the necessary revisions to the current draft chronic analysis tools and training materials on basis of the lessons learned from all the four pilots, the work done by the sub-working groups, and the discussions in the London meeting. The ultimate goal is to release the version 1.0 of the IPC Chronic Food Insecurity Analysis in early 2014.

2. Organization of the second round of piloting

The pilots were organized mainly by the country IPC Technical Working Groups, assisted by the IPC Regional Coordinators, the GSU members in Rome, and the members of the Chronic Working Group.

There were some difficulties in the organization of the pilots, especially in terms of the timing, location, and length of each pilot. Despite the occasional organizational problems all the pilots were successfully conducted and reached their objectives.

The pilots generally took five days, with the exception of Guatemala which took three and a half days. In other pilots around one day was dedicated to training, three days to analysis, and the last day to wrapping up the analysis, presentations of the analysis teams, and feedback and evaluation.
The detailed agendas, the lists of participants, analysis worksheets, and workshop reports can be found in the Chronic Working Group Dropbox folder¹.

Overall it can be noted that the pilots were quite well attended by the members of the chronic working group, and the rule devised in the Rome meeting of the need to have at least two participants of the Rome meeting in each pilot was respected:

- Kenya: Jenny Coneff and Kaija Korpi
- Bangladesh: Kaija Korpi and Christopher Hillbruner, in addition Laura Glaeser, Siddharth Krishnaswamy and Soo Mee Baumann took part
- Guatemala: Leila Oliveira, Jenny Coneff and Ricardo Sibrian, in addition Jose Veiga took part
- Malawi: Cindy Holleman and Leila Oliveira, in addition Anne-Claire Thomas took part

The experiences from the pilots show that the importance of proper data preparation prior to the analysis cannot be overestimated. The data preparations were mainly conducted by the TWGs, sometimes with the help of external experts. The data mapping matrix shared by the GSU was also used to guide the data preparation. The pilots confirmed that proper data preparation before the pilot, and to the extent possible data reanalysis of existing datasets (e.g. DHS), needs to be well planned and organized.

Recommendations:

- In the chronic roll-out in 2014, it will be important to ensure proper data preparation and possible re-analysis before the pilot. Separate, more detailed guidance will be needed for this purpose

3. Training

As mentioned, the training component generally lasted for about one day. It consisted of different PowerPoint presentations and discussions with the analysis participants. The training was conducted on a premise that the vast majority, if not all, of the participants are familiar with IPC and have already taken part in at least one analysis workshop. Because of this there was no presentation on IPC in general.

In some workshops (esp. Bangladesh and Guatemala), however, there were participants who were not familiar with the IPC. Of the four countries at least Bangladesh also had somewhat limited IPC experience as only two acute analyses had been conducted before the chronic pilot. The presence of participants not familiar with IPC might have necessitated a more thorough introduction to IPC in general during the training. This needs to be taken into

¹ [https://www.dropbox.com/sh/2g6bc7vn9j0zqsp/qGiQWpglHs](https://www.dropbox.com/sh/2g6bc7vn9j0zqsp/qGiQWpglHs)
account in the future roll-out of the chronic analysis, with the option of tailoring the training component to the needs of the participants.

In addition participants expressed a wish to have a more diversified training by e.g. inclusion of exercises and practical components into the training. Another wish was to have an example of a filled-in analysis worksheet which could be shared during the training to the participants.

Conclusions and recommendations:

- Include more exercises and practical examples in the training
- Share a filled-in analysis worksheet from another chronic analysis as an example with the workshop participants
- There is a need to revise the training presentations on this basis, and to increase the length of the training to perhaps two days instead of one
- The training should also be tailored to the needs of the participants, especially if a substantial number are not familiar with IPC

4. Selection of non-exceptional years

The experiences on the identification and use of non-exceptional years in the pilots varied. In the Kenya and Bangladesh pilots there were no considerable problems in the use of the identified approach. In both pilots the shocks relevant to the country were first identified in a plenary session, and subsequently the past ten years from 2003 to 2012 were evaluated year by year in terms of the shocks (extent, national vs. local impact). Ultimately the analysis done led to a conclusion on the non-exceptional years at the national level. These years were then used as the reference years in the analysis, although at times data from other years was also used to support the analysis.

All the groups in Kenya and Bangladesh completed Step 2, validation of the non-exceptional years, and in both pilots there were 1-2 groups who felt that one of the selected years was exceptional in their area. The approach taken by the groups then varied from excluding the year from the analysis to including it but to a lesser degree. Overall in these pilots the approach worked rather well with no major problems, although it was noted that there is a need to have a more standard approach to dealing with identified exceptional years at the local level, and better clarity on what is meant by ‘national impact vs. local impact’.

In the Guatemala pilot the selection of the years was done before the pilot due to time constraints. The selection was validated in the pilot, and the participants agreed with the identified years. The participants suggested, however, that selection of years at area level would be better and felt that the years do not need to be the same for all areas. In Guatemala consumption years (Sept – Aug) were used instead of calendar years.
In the Malawi pilot the analysis team spent a lot of time on the selection of non-exceptional years. First the team tried to identify the years at national level, but this was not successful and finally the years were identified at area level. Even then different teams came up with partially different non-exceptional years for the same area. The participants felt that it was not possible to identify years at national level in a country like Malawi, where conditions can vary widely within the country.

There were a lot of issues raised in the Malawi pilot in connection with the process. For example, the participants thought that the definition of a shock (rare, exceptional, and widespread) was not clear enough and that the impacts of the shocks should be considered in more detail when deciding on non-exceptional years. The participants also preferred use of agricultural years/seasons rather than calendar years, and thought that the word ‘typical’ year would be better than ‘non-exceptional’ year.

Conclusions and recommendations

- The chosen approach worked well in some pilots and less well in at least one pilot. There is a need to focus on the feedback and lessons learned from Malawi to see how the current approach may need to be modified.
- In all pilots more years than two were selected for the analysis and this approach also facilitated data availability. It is recommended to raise the minimum number of years for the analysis from two to 3-4.
- Chronic working group to discuss and decide on the following issues:
  - Calendar year vs. consumption year (current guidance stipulates that consumption years can be used if they are relevant in the country context).
  - National vs. local impact – what criteria to use to determine national impact?
  - Selection of years at national vs. local levels?

5. Reference Tables

The pilots were conducted with two reference tables, the so called Standard Reference Table (based on separation of household and area –based indicators) and the Adapted Reference Table (one table incorporating both household and area –based indicators except for nutrition).

The extent to which specific Reference Tables were used in pilots varied, however, across the pilots. In at least two pilots (Kenya and Bangladesh) most groups used mainly the Adapted Reference Table, whereas a minority of the groups used the Standard Reference Table. Some groups used both to compare the results. In Malawi and Guatemala both Reference Tables were used and results were compared.
In Kenya and Bangladesh the groups that used both tables found no difference in terms of the classification and population estimates. In Malawi and Guatemala differences were evident both in classification and population estimates.

Overall the participants preferred the Adapted Reference Table as they thought that it was easier and clearer to use than the Standard Reference Table. One of the few tangible differences between the two tables is mortality, as there is no mortality indicator included in the Adapted Reference Table. In several pilots participants actually questioned whether mortality is relevant to chronic food insecurity and if it would be better to analyse mortality only in relation to acute food insecurity.

There were several issues raised with regard to the Reference Tables, the indicators and the thresholds used. Some of the issues are outlined below:

- Both tables include three levels, and in several pilots participants indicated that having four or more levels would be more appropriate

- Livelihood change as an outcome of chronic food insecurity: the livelihood change analysis did not work in any of the pilots. This was a matter of poor data, as well as possible lack of analysis skills and inadequate clarity on what the analysis should entail. The relevance of livelihood change to chronic food insecurity was also questioned: how much are the livelihoods expected to change in or due to chronic food insecurity? In some ways livelihood vulnerability analysis seems more appropriate for chronic contexts than analysis of livelihood change

- Lack of data on the relevant livelihood indicators

- Food consumption: the main problems were convergence of evidence and division of indicators under quality and quantity.
  - The convergence of evidence – problem affected the severity classification and the population estimates, as the indicators aligned in different ways. For example, the proportion of children having inadequate meal frequency could be 50-60% indicating Level 3, whereas only <10% of households had poor FCS (Level 3)
  - In the draft reference tables the indicators are divided under quality and quantity. This turned out to be relevant in Bangladesh where data availability was very good, whereas in Malawi there was a lot of uncertainty on whether certain indicators measure better quality or quantity, or both
  - There is also a need to review the thresholds/cut-offs of the indicators due to the problems with the alignment of the data, and due to possible division of the tables into four levels instead of three

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- Description of four pillars in the Reference Table is too vague and needs to be improved

- While using the Adapted Reference Table it was difficult to make food consumption and livelihood change evidence converge with the stunting indicator. In particular it was difficult to establish a correspondence between % of stunted children and % of households. In Bangladesh the participants also expressed reluctance use data on stunting to come up with overall population estimates, and they thought that the indicator is not suitable for the purpose

- Overweight/obesity was considered at least in Guatemala and Bangladesh pilots. In Guatemala some participants felt that it should be included, whereas in Bangladesh the population groups most likely to suffer from chronic food insecurity were the least likely to be overweight or obese. The data available in Bangladesh did not seem to support the presumed connection between chronic food insecurity and overweight/obesity, but this issue needs to be discussed further by the chronic working group

Conclusions and recommendations

- Prepare a prototype Reference Table(s) with four levels and see if it can work conceptually and in terms of the indicators and thresholds
- Need to rethink the livelihood change component of the Reference Table
- The thresholds/cut-offs of the food consumption indicators have to be reviewed
- Need to discuss the use of nutrition information for population estimates both from a conceptual and a practical point of view
- A decision should be taken on whether overweight/obesity is included in the Reference Table and if yes, what are the cut-offs applied across the levels
- A discussion should take place on the relationship between mortality and chronic food insecurity

6. Analysis Worksheets

The same Analysis Worksheets were used in all the pilots, with the exception of using a modified Step 4 partially in Bangladesh and in Malawi pilots.

Overall there did not seem to be any substantial issues or problems with Steps 1-3. However, some groups preferred to just state the titles of their data sources in Step 3 and include all the actual data in Step 4. This has given rise to suggestions of somehow modifying Step 3 in order to reduce potential duplication with Step 4, but no concrete proposals have been presented.
Step 4 in the Analysis Worksheets is the Step where the analysis is conducted and preliminary classification and population estimates are reached. The vertical and horizontal approaches were tested in all the pilots, except for Bangladesh, where only the horizontal approach was used. The experiences from the testing showed that horizontal approach worked better: it allowed better trend analysis and enabled analysis even when data for some selected year was sparse, which was common throughout the pilots. This said, participants did appreciate the vertical approach and could see the value-added of it.

The Adapted Step 4, originally developed by FEWS NET, was partially used in Bangladesh and Malawi. In Bangladesh three groups out of seven used it, and in Malawi it was used as a complementary tool to the original Step 4. In Bangladesh the groups using it felt that it worked better than the original Step 4, as it was clearer, included space for each indicator, was more organized, and facilitated population estimates. In Malawi, however, the participants thought that qualitative information was not reflected well enough in the Adapted Step 4 and that the Adapted Step 4 should be modified further in order to ensure the inclusion of qualitative and contributing evidence.

Probably the most difficult part of the Analysis Worksheets was Step 7. Few groups across the pilots were able to complete this Step fully. In most pilots the data available did not facilitate the division of the population under different types, and it was very difficult to come up with population estimates for Step 7. It also seems that the types are not mutually exclusive, which further complicates the population estimates. Participants questioned the usefulness and value-added of Step 7 and many felt that this information is not required for decision-making. The participants, however, often felt that understanding the seasonality aspects is useful but that the current Step 7 is not appropriate for this. The overall suggestion is to modify Step 7, or to take it out of the Analysis Worksheets completely and incorporate the seasonality information (when available and relevant) somewhere else in the Analysis Worksheets.

Steps 8 and 9 form together the causal analysis component of the Analysis Worksheets. Step 8 was considered rather simple and useful, although many groups did not fully complete it, deciding just to highlight the existing text in the selected box rather than including evidence in the box as per the purpose. Step 9, however, turned out to be more difficult. People who were not familiar with SWOT did not know how to complete the table and what kind of information should be included. Moreover, the information included often had no connection to the data used for the analysis and therefore this step was rather detached from the rest of the analysis. It was also noted that people who might use this information, e.g. response planners and decision-makers, who supposedly are at least somewhat familiar with the areas in question, are not likely to derive any new information from this type of SWOT. One suggestion was to exclude Step 9 as it currently is from the Analysis Worksheets and to develop a separate causal analysis component which could be completed by a separate group of experts on basis of the analysis results either in the chronic analysis workshop or right after it.
Conclusions and recommendations

- Possible revision/merging of Step 3 into Step 4
- Horizontal approach works better than vertical approach in the chronic analysis
- Need to go through Step 4 in detail and see what changes should be made to incorporate the required elements
- Need to rethink Step 7:
  - Exclusion of population estimates
  - Keep a modified version of Step 7 or take it out altogether
- Step 8: better guidance need to be given to groups when they complete Step 8
- Step 9: the role of SWOT has to be reconsidered. How useful is it in the chronic analysis, and can causal analysis be conducted better with another approach?

7. Mapping protocol

Only one chronic pilot map was prepared during the pilots. This happened in Bangladesh, which was the only national chronic pilot of all the four pilots. The group in Bangladesh was asked to provide ideas for the mapping protocol and to experiment with different ways of preparing the map (e.g. colours).

Some of the recommendations of the participants were the following:

- Populations in each level should be indicated with a bar or a pie chart in a call-out box, possibly with the colours of the different levels
- Some symbols can be used to add depth to the map, e.g. to point out areas with particular problems
- In terms of colours a brown scale was tried out but the participants did not like it. Instead they preferred a grey-black colour scale. Some also pointed out that use of colours of the acute scale is not appropriate for the chronic mapping protocol
- Seasonality/typology information does not need to be included in the map

Conclusions and recommendations

- Need to test different colour schemes. The map, overall, is likely to be more eye-catching with four different colours (if four levels are adapted) than with three
- Chronic working group to decide which severity aspects should be highlighted and what the accompanying symbols should be

8. Other issues

Concept of chronic food insecurity:
In general there is considerable clarity on the definition of chronic food insecurity. Certain details, however, still need to be clarified such as the length of chronic food insecurity: how long does a household need to be food insecure in order to be chronically food insecure? There are also outstanding questions in relating to the severity aspects of chronic food insecurity, especially in terms of food consumption (and even livelihood change), which have an impact on the cut-offs used.

**Analytical Framework:**

Some of the choices made and feedback from the pilots also have an impact on the relationship between the IPC chronic food insecurity analysis and the IPC Analytical Framework. The IPC Analytical Framework has four food security outcomes: Food Consumption, Livelihood Change, Nutritional Status, and Mortality. It was realised in the pilots that the livelihood change component of the analysis does not work, and overall there is a question on whether livelihood change is relevant in a chronic context. If the decision is taken that it is not relevant, this will mean that the IPC Analytical Framework as it currently is, is not applicable to chronic food insecurity analysis.

Another issue related to the Analytical Framework is mortality. Currently mortality is not included in the Adapted Reference Table, and in many pilots participants questioned whether mortality should be included at all in chronic food insecurity analysis. If mortality is removed from chronic food insecurity analysis, it again means that the Analytical Framework as it currently stands does not apply to the chronic analysis.

If both of these decisions are taken, it implies that two out of the four outcomes are either not applicable or only partially applicable to chronic analysis. In the Kenya pilot the participants felt that the current Analytical Framework does not suit the chronic analysis, and that there should be a different Analytical Framework for the IPC chronic classification. The chronic working group needs to discuss this and take a decision with appropriate conceptual and practical rationale.

**Acute vs. chronic:**

An issue which has risen in several pilots is the relationship between acute and chronic food insecurity. This issue relates to the question of severity (how severely can a household be chronically food insecure?) and therefore to the indicators used and their cut-offs. In some pilots the participants suggested excluding certain indicators from the Reference Tables either because a) same indicators are in the Acute Reference Table or b) because the indicator indicates such severity that it should be included in the Chronic Reference Table. Another question is the purpose of the chronic and the acute analyses: how are they related, how are they used, and what is the value-added of the chronic approach compared to the acute.