IPC Chronic Food Insecurity Analysis Development Process

Second round of piloting

Kenya pilot 23 – 27 September 2013

1. Background

The Kenya pilot was the first pilot of the second round of piloting, which includes four countries: Kenya, Bangladesh, Malawi/Zimbabwe, and Guatemala. The draft tools tested in Kenya were developed by the IPC Working Group for Classifying Chronic Food Insecurity. The working group developed the new tools on basis of the results of the first round of piloting conducted between September 2012 and February 2013, and the discussions that started in the first synthesis meeting of the chronic working group in Washington in March 2013 and continued up to and beyond the second synthesis meeting in Rome in May 2013.

The Kenya pilot workshop took place in Kitui Cottages & Guest House in Kitui town from 23 to 27 September. There were approximately 20 workshop participants, and 4-5 workshop facilitators. The agenda and list of participants can be found in the annex of this report.

2. Technical development process

The technical development process led to several significant changes in the chronic food insecurity analysis tools, which are briefly explained below as background to the Kenya pilot analysis results and lessons learned.

2.1. Reference Tables

As a result of the feedback from the previous pilots and the discussions of the chronic working group, the draft reference tables were substantially modified. In the first round of piloting three different reference tables were tested: for the second round of piloting the chronic working group agreed on piloting two different reference tables. These are called 1) Standard Reference Table and 2) Adapted Reference Table. The Standard Reference Table is modelled after the IPC Acute Reference Table, and is broken into two sections: the household table and the area table. In the Standard Reference Table only the household table can be used for calculation of population percentages, and both tables are used to estimate the severity of the chronic food insecurity. In the Adapted Reference Table there is

only one table incorporating both area and household –based indicators, and this single table is used for estimating both the severity and the population prevalence. However, the Adapted Reference Table does not include mortality as mortality indicators cannot be used for estimation of population prevalence.

2.2. Selection of non-exceptional years

It was decided to develop a procedure for selecting 2-3 non-exceptional years, which would be the focus of the chronic food insecurity analysis. A matrix was prepared for identification of shocks during the past ten years, and for selection of the reference years for analysis. A non-exceptional year was defined as a year with no unusual shocks.

2.3. Horizontal vs. vertical analysis

The chronic working group also decided to test two different approaches to data analysis. These approaches are called horizontal and vertical, depending on whether the reference years are analysed individually (vertical approach) or by comparing outcomes from one year to another (horizontal approach). The purpose is to see if the approaches yield different results and which approach, if any, is preferred by the pilot participants.

2.4. Nutrition indicators

Nutrition indicator consultations with nutritionists from different organizations yielded some recommendations for the pilots. Data on severe stunting could be used for analysis where it exists and the alignment of severe stunting with the rest of the chronic analysis could be examined. Iron deficiency is best estimated with data on serum ferritin and haemoglobin together – however, both of these rarely exist. In addition prevalence of overweight and obesity (BMI 25 and 30 respectively) should be used as indirect evidence for nutrition. The results of the pilots will be discussed in another teleconference in November with further implications on the nutrition indicators.

3. Analysis preparations

3.1. Preparations before the workshop

The pilot preparations were mainly done by FAO Kenya, especially by the IPC Focal Point Simon Muhindi and Wilfred Oluoch, who took care of the data preparations for the workshop.

The Kenya Food Security Steering Group (KFSSG) made the decision on the workshop location, timing, and the areas to be selected. Members of the group also participated in the pilot workshop. The areas selected for the pilot were Kilifi, Mandera, Turkana, Isiolo, and

Kitui (the county where the workshop was located). The administrative structure of Kenya has recently undergone some changes due to the new constitution of the country. The former districts are now called counties, with some changes in the geographic borders which also affected the analysis, as in some cases there was more data available for one area of the selected county than for the rest of the county. In counties where the geographical borders remained the same as in the former district the problem was avoided.

GSU provided guidance to the workshop organizers for data preparation (e.g. sharing of the data mapping matrix), workshop organization, and the agenda. The workshop facilitators were also briefed on the technical developments since the previous round of piloting, and the tools and approaches to be tested in the second round of pilots.

Re-analysis of data was not performed before the pilot. In principle it would have been possible to do re-analysis of data of the Kenya 2008 DHS but this was not completed. The dataset is available to registered DHS users, but re-analysis requires a separate GPS dataset which enables the identification of households in relevant areas (counties to be analysed). In order to obtain the GPS dataset, however, it is necessary to send a separate request with a justification to the DHS, who evaluate the request and decide whether the permission (and the GPS data) will be granted or not. Due to the complicated nature of the process and lack of time this procedure was not completed for the Kenya pilot.

3.2. Lessons learned and recommendations on preparations

- The data mapping matrix needs to be shared well in advance with the team working on data and pilot preparations
- The IPC TWG (Technical Working Group) needs to convene a few weeks before the pilot to choose the areas to be analysed: this information is required for efficient data preparation
- Data preparation should start early, approximately at least two weeks before the workshop to ensure that enough data, including panel data, is collected and organized
- Need to ensure that the workshop venue has a functioning internet connection in case more data is required during the pilot
- If DHS data is available for the pilot country, the request for the data, as well as separate request for the GPS data has to be done well in advance to the pilot, to enable the processing of the request by DHS and the actual re-analysis of the data before the pilot
- Ensure that there are enough experienced IPC analysts among the facilitators/participants, so that each analysis team has a qualified team leader. The team leaders should also be familiar with the chronic analysis and the tools to be piloted. If required, the pilot facilitators can brief the team leaders before the pilots on the tools and approaches developed.

- In order to ensure that the tools are tested in different circumstances with different data sets, it would be good to select also some relatively food secure areas as well as food insecure areas for the pilot

4. Training

4.1. Chronic analysis training

The training took place on Monday 23 September and lasted for the whole day. The training consisted of seven sessions with PowerPoint presentations, and ensuing discussions with the pilot participants.

Unfortunately the venue had problems with electricity during the first two days of the workshop, which meant that some of the training sessions were done without the accompanying PowerPoint presentation and by only using a flipchart. This may have impacted the understanding of the participants of some of the key concepts and tools to be tested in the pilot (although it is naturally difficult to know to what extent the lack of electricity had an effect).

4.2. Lessons learned and recommendations on training

- Need to ensure that the workshop venue has reliable electricity (and/or a generator)
- The guidance developed by the chronic working group e.g. on non-exceptional years, reference tables, and nutrition indicators could be shared with the pilot participants to facilitate their understanding of the tools and choices made by the chronic working group
- Need to share the reference tables and perhaps also the training presentations with the participants
- The chronic analysis worksheets are gone through in detail in the presentations. Despite of this many teams had problems in filling in the worksheets. If was suggested that in addition to the training, it would be helpful to share an example of a filled-in worksheet for example from another country to workshop participants
- Make sure to emphasize to the participants that their feedback is most useful if they first try the different approaches developed and can therefore base their opinions and suggestions for change on experience
- There may be a need to repeat the concept and logic of the chronic food insecurity and the purpose of the workshop again on the second or third day of the workshop, and perhaps also later on to support the understanding of the participants
- Explain clearly to the teams how the final presentations should be structured and how much time they can take, to keep the focus on the analysis results and feedback on the tools.

5. Analysis

5.1. Analysis process

The analysis took close to three days, and all the teams were able to complete the analysis towards the end of the third day, although some teams were not able to fill in all the sections of the analysis worksheets. This seemed to be less a question of time than a question of complexity of and experience in doing IPC analysis (for example, some teams felt that the data available was not detailed enough to enable population estimates – more detailed explanations are available in the following sections).

5.2. Concept of chronic food insecurity

The concept of chronic food insecurity and the differences between chronic and acute food insecurity were included in the training conducted on the first day of the workshop. Despite this, about half of the participants (on basis of the feedback forms) had difficulties in understanding the difference between chronic and acute food insecurity. Two main issues came out as problematic: first of all, the analytical framework may not suit chronic and acute food insecurity and a separate analytical framework for chronic food insecurity may need to be developed. The second issue concerned the indicators in the reference table. In the view of many participants the indicators in the chronic reference table would need to be reviewed and especially those indicators which are also in the acute reference table (some of the food consumption quantity indicators) would need to be changed.

5.2.1. *Lessons learned and recommendations on the concept of chronic food insecurity*

- Need to make sure that all participants understand how acute and chronic food insecurity are viewed and defined in IPC
- Need to clarify the concept of chronic food insecurity in the training for example by paying more emphasis to discussion on the topic, and perhaps even by including an exercise on acute vs. chronic in the training
- The chronic working group to discuss the issue of the analytical framework and the indicators

5.3. Selection of non-exceptional years

In the beginning of the analysis the reference years for the pilot were selected. In doing this the matrix developed by the chronic working group was used by reflecting it on the screen and discussing the years and shocks with the analysis team. First different shocks were identified and inserted in the matrix. Next different years were discussed starting from 2003, and non-exceptional ones were defined on basis of the shocks that occurred. Since drought is the most common shock, NDVI and rainfall profiles of the selected counties were used to cross-check the conclusions of the discussions.

The team seemed to understand rather well the concept of a non-exceptional year and the process for their identification. Discussion did take place on the significance of given shocks over the years, but overall the group was able to reach an agreement on the non-exceptional years. Four years were selected: 2003, 2008, 2010, and 2012. Most teams did not have data for 2003 so that year was largely excluded from the analysis. Data availability for the remaining years was rather good, which facilitated the analysis.

Two questions were raised by the participants on the process. The first came up during the selection process, and concerned the fact that often the effects of the shocks are felt sometime after the shocks have happened. In Kenya, for example, if the short rains in the end of the year are poor the effects will only be visible in the beginning of the following year. Therefore selection of years on basis of shocks alone may be misleading. The second, albeit related question was mainly raised in the feedback session at the end of the workshop, when some participants thought that the non-exceptional years should be identified on basis of the outcomes rather than on basis of the circumstances (shocks).

5.3.1. *Lessons learned and recommendations on selection of non-exceptional years*

- Need to explain clearly the rationale for selecting non-exceptional years for the analysis
- Need to clarify the reasons for using shocks rather than outcomes for the selection of non-exceptional years
- The chronic working group should discuss further the definition of non-exceptional years and if the effects of the shocks need to be incorporated into the definition

5.4. Analysis Worksheets

Step 1: Area Description and Map

There were no noticeable problems or issues with this step in the pilot.

Step 2: Validation of Analyses of Non-Exceptional Years

This step was largely completed by the teams. Some teams felt that one year of the selected years was somewhat exceptional in their area and took note of that in the analysis, but mostly the years selected seemed to be non-exceptional also in the analysed counties. It was not all clear, however, how possible exceptional years at county level should be treated in the analysis: one option is to ignore them, another to analyse them but give them less value in the overall conclusions and classification.

Step 3: Evidence Repository

This step took one day to complete for all the teams, and some teams continued this step also the following day. Overall there were no problems in completing this step: teams understood the purpose of Step 3 and although completing it took a considerable amount of time, it was done quite well.

Step 4: Evidence Documentation and Analysis

This is the step where evidence was analysed, outcomes were classified, and the vertical and horizontal approaches were tested. Teams took somewhat different approaches to the analysis. Some wrote short conclusions statements without referring to individual pieces of evidence, whereas other teams cited more evidence and had concluding statements at the end. All teams were able to agree on a severity classification for their areas, but some teams were not able to reach conclusions regarding the population estimates. The causes for this varied: some said that there was not enough data to do this, whereas others felt that the evidence was rather conflicting and it was impossible to reach an understanding on population estimates even if it was possible to agree on the overall classification. An additional issue is the timing of data collection: seasonality may have an impact on the resulting population estimates. Due to the differences in data used and expert opinion/judgment on how the population estimates should be calculated, it is quite likely that the population estimates are not comparable from one area to another.

The teams seemed to have a relatively good understanding on the vertical and horizontal approaches, and they understood how the testing of them was done. The groups largely preferred the horizontal approach for the following reasons:

- It enabled trend analysis of different outcomes
- It was easier and possibly also faster
- Possible to use indicators that are 'sensitive' and 'insensitive' to chronic issues
- Lack of data on a certain outcome in a particular year did not compromise the analysis if data was for available for other years

The value of vertical approach was acknowledged as well, and groups found it also useful to do the analysis year by year. However, the majority of the participants preferred the horizontal approach over the vertical.

Step 5: Classification Conclusions and Justification

All groups were able to come up with the overall area classification, even if the confidence level in the analysis varied from high to low (acceptable). However, the justification for the classification was sometimes rather weak: key evidence for outcomes was not cited adequately and conclusions were not always reached properly. Also, it was not always clear that the 20% threshold for classifying the area a certain level was reached in the absence of population estimates.

The estimation of the confidence level was not optimal: it seemed that the guidance given was not always adhered to. There may also be a need to rethink how confidence levels are assigned in the chronic analysis and if the requirements should reflect the ones in the acute analysis or not.

Step 6: Prevalence of Chronic Food Insecurity

In this step groups were asked to identify the population estimates for each of the three chronic food insecurity levels. The groups that had completed Step 4 with population estimates did not find it difficult, but other groups that were not able to identify populations did not complete Step 6.

Step 7: Types of Chronic Food Insecurity

This step turned out to be quite difficult. None of the groups was able to fully complete this step. The main reason for this was that the data available did not allow the separation of the population groups under each type from each other. Also, the annual approach of the analysis was difficult to translate into information on seasonal/cyclical (Type 1) chronic food insecurity. Questions were also raised on the validity of the typology in terms of response differentiation, and the exclusiveness of the types (it may be possible for the same households to experience chronic food insecurity both seasonally and continuously, by having a more severe situation seasonally but still being chronically food insecure also year around).

Steps 8 and 9: Limiting Factors Matrix and Vulnerability SWOT Analyses

All the groups completed these two steps, and felt that they were relevant for the analysis and for decision-making. There was, however, some feedback on the way the Limiting Factors Matrix and SWOT were constructed and used. The participants felt that both tools were somewhat detached from the analysis in a sense that the issues raised in the tools did not necessarily link with the evidence or the analysis findings.

5.4.1. *Lessons learned and recommendations on Analysis Worksheets*

- A lot of emphasis needs to be paid on Step 4 in the pilots. If teams are able to complete this step, including the population estimates, it will greatly facilitate the completion of the rest of the analysis. Facilitators need to make sure that teams understand Step 4 well and provide support to them in the most complicated issues, such as the population estimates
- Analysis teams need to be advised on how to treat possible exceptional years in the analysis
- Clear guidance needs to be developed for estimating populations
- There is a need to rethink Step 7 (typology) and its role in the analysis
- There is also a need to critically review Steps 8 and 9. One recommendation is to ask the participants to link the statements included in the Steps to the evidence used by referring to Documentation Codes. Also, there were suggestions to tie the tools more to the livelihoods rather than to the areas analysed, and to develop stronger guidance and questions to be answered when completing the Steps
- One weakness of the current analysis worksheets was the omission of a separate step to focus on the comparison of the two draft reference tables. Such a step needs to be included in the analysis worksheets before subsequent pilots in order to obtain more information on this aspect

- One suggestion to improve the quality of the analysis is to have minimum evidence requirements. These could include for example information on livelihoods

5.5. Reference Tables

The purpose was to test two different reference tables in the pilot: the Standard Reference Table and the Adapted Reference Table. Both of the reference tables were introduced to the pilot participants during the training, and teams were encouraged to test both and to give their feedback on the tables. The testing was not, however, fully completed as most groups used only one reference table to analyse the data. Out of five teams three used the Adapted Reference Table, one used the Standard Reference Table and one group used both. The main reason for not testing both was probably the lack of a separate section in the analysis worksheets for the comparison of the reference tables (see above for lessons learned on analysis worksheets).

However, on basis of the discussions with the participants it became apparent that most teams preferred the Adapted Reference Table. The main reason for this is that it was deemed clearer as it is just one table instead of two tables. The one group that tested both tables found that regardless of the reference table used, the classification and the population estimates remained the same.

Regarding the indicators, the participants had quite a few concerns on specific indicators and how they capture chronic food insecurity or how relevant they are to the Kenya context. There was also some concern that the indicators do not bring out clearly the differences between the acute and chronic food insecurity, especially as some indicators change seasonally. Sensitivity to short-term changes suggests that these indicators are not suitable for analysing chronic food insecurity. Examples of indicators that were deemed problematic are:

- Indicators that are also in the Acute Reference Table (some food consumption quantity indicators)
- Mortality indicators – some participants thought that mortality was irrelevant to chronic food insecurity and that causality was difficult to establish
- Data on certain indicators is not collected in Kenya and therefore the indicators were irrelevant, e.g. MAHFP, Starchy Staple Ratio, HHS, and even iron deficiency anaemia
- Different mortality indicators suggest different outcomes: for example in DHS mothers are interviewed over the loss of children in their lifetime, whereas in nutrition surveys mortality data is collected over a certain recall period

- Indicators on food consumption of children may reflect more cultural issues and attitudes to child feeding rather than the food consumption of the household in question

Some participants also felt that the indicator thresholds (of certain indicators) were too vague to enable proper analysis and classification. The participants concluded that they would like to provide more recommendations on the indicators to be used in the chronic reference tables, and they agreed on organizing a meeting shortly after the pilot to discuss the topic and to subsequently convey their recommendations to the GSU.

5.5.1. *Lessons learned and recommendations on reference tables*

- Need to incorporate a section for comparison of the two reference tables and their results in the analysis worksheets
- Need to have a plenary discussion with the participants on benefits and disadvantages of the two tables
- The chronic working group should review the indicators and their thresholds, and examine critically whether the indicators provide information on chronic or acute food insecurity

5.6. Value-added to decision-making and food insecurity analysis

This topic was discussed only briefly with the participants in a plenary session. Generally speaking chronic food insecurity analysis was seen very relevant to Kenya, and something that can be used in the decision-making. Moreover, due to the decentralisation process in Kenya counties are getting more resources and authority over them. The increased resources and decision-making powers should be matched by better information on where and how the resources should be used. It was felt that the chronic food insecurity analysis could provide useful information for decision-makers on how to direct funds.

Participants also thought that both severity and prevalence are important, and that decision-makers will need population estimates in order to implement interventions. The challenge, however, is to come up with even somewhat reliable population estimates for the different levels of chronic food insecurity.

6. Conclusions

The Kenya pilot achieved its objectives of piloting the different tools and approaches developed for the chronic food insecurity analysis. Clear feedback was received on many issues, especially on selection of non-exceptional years, and preferences regarding the vertical vs. horizontal approach, the analysis worksheets, and the two reference tables.

The pilot was also able to reveal the most problematic areas that require more work and refinement. These include for example the indicators included in the reference tables, population estimates, and overall the difference between the concepts and analysis of acute and chronic food insecurity.

The Kenya pilot provided many useful lessons learnt and recommendations for future pilots and further development of the chronic food insecurity analysis tools and procedures. It is pertinent to ensure that the lessons learnt and recommendations are taken into consideration in the preparation for the upcoming pilots, and that the testing of the same tools is carried out in order to ensure comparability of results and experiences for further development of the IPC chronic food insecurity analysis.

ANNEX 1: LIST OF PARTICIPANTS

CHRONIC FOOD INSECURITY WORKSHOP -KENYA

KITUI COTTAGES, KITUI

23RD -28TH SEPTEMBER 2013

No.	Name	Gender	Position	Organization	Email	Mobile number
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ANNEX 2: TRAINING AGENDA

Integrated Food Security Phase Classification

Chronic food insecurity analysis pilot in Kitui, Kenya 23 – 27 September 2013

AGENDA

Time	Session #	Session Title	Facilitator/s
Day 1 - Welcome, Introductions, Training, Organization of Teams			
0830 – 0900	1	Welcome, introductions, and opening remarks	
0900 – 0915	2	Objectives and agenda	
0915 - 1015	3	Concepts and rationale for chronic food insecurity analysis and difference between acute and chronic analysis	GSU/Global Partner Facilitator
1015 - 1045		Break	
1045 – 1100	4	Pilot Analysis Overview	GSU/Global Partner Facilitator
1100 – 1200	5	Classifying CFI prevalence and causes: Key Parameters	GSU/Global Partner Facilitator
1200 – 1300		Lunch	
1300 – 1430	6	Classifying CFI prevalence and causes: Reference Tables	GSU/Global Partner Facilitator
14:30 – 15:30	7	Classifying CFI prevalence and causes: Selection of Non-Exceptional Year	GSU/Global Partner Facilitator
1530 – 1600		Break	
1600 - 1700	8	Classifying CFI prevalence and causes: Analysis Worksheets	GSU/Global Partner Facilitator

1700 - 1730	9	Classifying CFI prevalence and causes: Classification & Mapping Protocols	GSU/Global Partner Facilitator
Day 2 – Analysis			
0830 – 1030	10	Selection of Non-exceptional Years at National Level	GSU/Global Partner Facilitator
1030 – 1100		Break	
1100 – 1300	11	Analysis: Step 1 Background, Step 2 Validation of Non Exceptional years, Step 3 Data Repository	Team Leaders / Facilitators
1300 – 1400		Lunch	
1400 – 1730	12	Analysis: Step 3 Data Repository (cont.)	Team Leaders / Facilitators
Day 3 – Analysis			
0830 – 1030	13	Analysis: Step 4 Review/input of evidence statements	Team Leaders / Facilitators
1030 – 1100		Break	
1100 – 1200	14	Analysis: Classification of CFI Using the Vertical Approach: Steps 4, 5, 6 and 7	Team Leaders / Facilitators
1200 – 1300		Lunch	
1300 – 1500	15	Analysis: Classification of CFI Using the Horizontal Approach: Steps 4 and 6	Team Leaders / Facilitators
1500 – 1530		Break	
1530 – 1730	16	Group discussion on findings, focusing on Horizontal Approach vs. Vertical Approach	Team Leaders / Facilitators
Day 4 - Analysis			
0830 – 1000	17	Analysis: Classification of CFI Using the Standard Reference Table: Steps 4, 5, 6 and 7	Team Leaders / Facilitators
1000 – 1030		Break	
1030 - 1300	18	Analysis: Classification of CFI Using the Adapted Reference Table: Step 4 and 6	Team Leaders / Facilitators
1300 – 1400		Lunch	
1400 – 1530	19	Group discussions of findings, focusing on Standard vs. Adapted Reference Table	Team Leaders / Facilitators
1530 – 1600		Break	
1600 – 1730	20	Cushion Time	
Day 5 – Analysis, Group Presentations, Feedback and Evaluations			
0830 – 1000	21	Review of analysis results	Whole team
1000 – 1030		Break	
1030 - 1130	22	Discussions on the chronic analysis process and tools – Selection of Non-Exceptional Years	Whole team
1130 - 1230	23	Discussions on the chronic analysis process and	Whole team

		tools – Vertical vs. Horizontal Approaches	
1230 – 1330		Lunch	
1330 - 1500	24	Discussions on the chronic analysis process and tools – Standard vs. Adapted Reference Tables	Whole team
1500 – 1530		Break	
1530 – 1630	25	Discussions on the chronic analysis process and tools – Analysis Worksheets	Whole team
1630 – 1700	26	Outstanding Issues	Whole team
1700 – 1730	27	Evaluation and closing	Whole team