IPC Chronic Food Insecurity Analysis Development Process

Second round of piloting

Bangladesh pilot 3 – 7 November 2013

1. Background

The Bangladesh pilot was the second pilot of the second round of piloting, which includes four countries: Kenya, Bangladesh, Malawi, and Guatemala. The draft tools developed for the second round of piloting by the chronic working group were first used in the Kenya pilot in September, and thereafter revised for use in Bangladesh and Guatemala, as both pilots took place during the same week in early November.

The pilot was well attended by different members of the IPC Technical Working Group. Around 30 different organizations took part in the pilot, and altogether there were >40 participants.

The Bangladesh pilot workshop took place in Sarina Hotel in Dhaka from 3 to 7 November 2013. The pilot was originally scheduled to take place in Cox's Bazar from 3 to 8 November, but the location was changed and the time allocated was shortened due to the security problems caused by the approaching elections in mid-January and tensions between the Government and opposition forces. The three-day shutdown ('hartal') imposed by the opposition took place during the workshop, but this fortunately did not have any major impact on the workshop. The pilot did, however, end a little earlier than previously thought on the last day of the workshop due to a large demonstration in Dhaka.

The pilot was organized by the IPC Technical Working Group in Bangladesh, and the IPC Focal Point Feroz Ahmed was the main person behind the successful organization of the pilot. The lead facilitator for the workshop was Kaija Korpi, and co-facilitators were Laura Glaeser (FANTA), Christopher Hillbruner (FEWS NET), Soo Mee Baumann (WFP) and Siddharth Krishnaswamy (IPC FAO). All the facilitators are also members of the global IPC Working Group on Classifying Chronic Food Insecurity.

2. Tools and procedures used in the pilot

Analysis tools developed for the second round of piloting, i.e. Analysis Worksheets and two Reference Tables were first used in the Kenya pilot. Experiences on them were gathered in

the Kenya pilot, and subsequently a new version of Step 4 in the Analysis Worksheets was proposed for testing in the Bangladesh pilot. Eventually the adapted Step 4 was used by three different groups in the Bangladesh pilot. The adapted Step 4 does not follow the original vertical vs. horizontal approach of Step 4, but provides separate space for the values of individual indicators, and for overall conclusions of food security outcomes and population estimates.

Some changes to the previous approach used were also made in the Bangladesh pilot. Instead of testing both vertical and horizontal approaches, it was decided to test mainly the horizontal approach. Also, the groups were asked to use primarily the Adapted Reference Table, and if time allowed, also the Standard Reference Table. These changes in the pilot approach were made to accommodate better the needs of the Bangladesh TWG, who wanted to have a relatively straightforward piloting process and a product at the end of the pilot. The simplification of the pilot allowed the analysis to be completed in time (pilot was shortened by >1 day due to the security concerns), as well as the preparation of the draft chronic map of Bangladesh.

There were no changes to the process of selecting or using non-exceptional years, and they were selected and validated as in the previous pilot.

3. Analysis preparations

3.1. Preparations before the workshop

The pilot preparations were mainly done by FAO Bangladesh, especially by the IPC Focal Point Feroz Ahmed, assisted by Mahabubul Hasan. Feroz coordinated the work for the organization of the pilot. The initial data organization was done already in March by the Economic Research Group (ERG) of Bangladesh, on basis of the Nepal pilot. The Bangladesh TWG finalised the data preparations on basis of the work done by ERG and the data mapping matrix shared by GSU for the pilot. Some supplementary data analysis of the Bangladesh Demographic and Health Surveys and of NDVI data was conducted by FEWS NET. Overall the amount of data available for the analysis (including outcome data) was high, and especially data on food consumption and nutrition (and mortality) was excellent whereas there were some gaps in the data on livelihoods.

The Bangladesh TWG also made the decisions concerning the location and timing of the workshop (both were impacted by security considerations as noted above) and the areas selected for the analysis. Initially the purpose was to select a few districts for the pilot, but it turned out that data availability at district level was relatively poor compared to divisions, and therefore the seven divisions of Bangladesh were eventually chosen for the pilot. The decision also enabled the team to prepare a national product (communication template) at the end of the workshop.

3.2.Lessons learned and recommendations on preparations

- Data preparation should start early to ensure that enough data, including panel data, is collected and organized. There may be a need to provide more detailed guidance (besides sharing the data mapping matrix) on the data preparations, including the re-analysis that needs to be conducted especially on the potentially available DHS data. Need to review the data requirements for analysis of livelihood change.
- Need to ensure that the workshop venue has a functioning internet connection in case more data is required during the pilot. Some additional data was accessed through internet during the pilot.
- If DHS data is available for the pilot country, the request for the data has to be done in advance of the pilot, to enable the request to be processed and the actual re-analysis of the data before the pilot. It is also pertinent to see if there are other data sources that could be re-analysed for the pilot: in the Bangladesh pilot it turned out that some large datasets were available and could have been reanalysed for the pilot if this only had been thought of earlier
- Populating the analysis worksheets with data (Step 3) is a time-consuming process in the beginning of the analysis. If resources allow, the data organized by the TWG could be entered into the worksheets before the analysis to speed up the process and to leave more time for actual analysis

4. Training

4.1 Chronic analysis training

The training took place on Sunday 3 November and lasted for the whole day after the opening ceremony, and part of the following day. The training consisted of seven sessions with PowerPoint presentations, and discussions with the pilot participants. The training overall went well, and participants seemed to understand the main concepts and analysis tools without major difficulties. A couple participants had problems in understanding some issues, mainly the types of chronic food insecurity, and the vast majority felt that the concepts and types were relatively easy to understand. No-one reported any problems in understanding the Reference Table or Analysis Worksheets.

It has to be noted, however, that the pilot participants also included some people who were not familiar with the IPC or with food security analysis overall. Six participants (out of >40) had never done IPC analysis before. As they were a small minority, this did not have any negative impact on the analysis process or results.

4.2. Lessons learned and recommendations on training

- The presentations should be shared with the participants (done electronically in Bangladesh)

- The chronic analysis worksheets are gone through in detail in the presentations. Also an example of a filled-in worksheet was shown to the participants, and that seemed to increase the understanding of the analysis worksheets and different steps to be completed
- If there are people present in the workshop that have no prior experience of IPC, they could be gathered together for mini-training on IPC.
- During the workshop some participants expressed a wish to have exercises during the training. The need to include exercises and real-life examples e.g. from prior chronic analysis should be taken into consideration when the training materials are finalised for the roll-out of the chronic analysis. Also the appropriate and feasible length of the training needs to be determined

5. Analysis

5.1. Analysis process

The analysis took close to three days. As mentioned above, the seven divisions of Bangladesh were analysed by seven groups, one group for each division. The five facilitators were assigned to five different groups, whereas two groups did not have external facilitators. All the teams were able to complete the analysis, although some teams were not able to fill in completely all the sections of the analysis worksheets. In the Bangladesh pilot all teams did prepare population estimates, although it has to be noted that in some cases contradicting evidence weakened the reliability of the estimates.

5.2.Concept of chronic food insecurity

There were no major issues related to the concept of chronic food insecurity, which seemed to be rather well understood by the majority of the participants. It, however, has to be noted that some of the more problematic questions relating to the relationship between chronic and acute food insecurity were not discussed in great detail. It is recommended that in future chronic analysis trainings, time is taken to explain the linkages between chronic and acute in more detail. For example, the thresholds of the food consumption quantity indicators included in both acute and draft chronic reference tables were referred to but not widely discussed, and the same applied to the tentative extent of the severity of chronic food insecurity in relation to the acute reference tables (Phases 1 and 2).

Certain aspects of chronic food insecurity seemed to resonate well with the Bangladeshi participants, for example the focus on both quantity and quality of food consumption, and the fact that chronic food insecurity should be conducted over a longer time period.

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

- Need to make sure that all participants understand how in IPC acute and chronic food insecurity are defined, and how acute and chronic analysis and findings relate to each other. The implications for decision-making also need to be discussed
- Chronic working group to further discuss the thresholds of food consumption indicators and the severity of chronic food insecurity in relation to the acute reference table, as well as the overall similarities and differences of chronic and acute food insecurity

5.4. Selection of non-exceptional years

The non-exceptional years were selected in the beginning of the analysis. There was a lively discussion on the different shocks and their character (national vs. local impacts), which eventually led to a consensus on the shocks selected for the matrix and the potential reference years for the pilot. After some identified shocks were deemed local in character, seven years out of the last ten were rated non-exceptional. Since it was impossible to conduct analysis of all the seven years identified, it was decided to take the three most recent non-exceptional years also due to the fact that data availability on those years was relatively good. It was further agreed that the dataset can be, if required, complemented with data from other years. The reference years selected were 2010, 2011 and 2012.

The decision to focus on the three latest non-exceptional years was well founded, but did have some drawbacks as well. Proper trend analysis could not be conducted one basis of these successive years, which may have had an impact on the overall findings. On the other hand, according to the participants (and some longer term data), the situation at least in certain divisions had changed quite substantially in the last ten years. This may support the decision of doing the analysis on more recent years, at least in the Bangladesh context. This, however, invites a discussion on how long does a situation need to be prevalent in order to be defined as chronic.

5.5 Lessons learned and recommendations on selection of non-exceptional years

Overall, facilitation and explanation of this section was weak, for some of the reasons outlined below. However it is also clear that this would improve in future trainings as this was a learning experience for both participants and trainers.

- It is important to explain clearly the rationale for selecting non-exceptional years for the analysis
- Need to clarify guidance on the selection of the years when the situation has changed substantially within the past ten years
- Time dimension of chronic food insecurity needs to be discussed and clarified
- Also to clarify better how to define ‘national impact’ of the shock

- It is recommended not to do this exercise in an ad-hoc plenary session in the beginning of the analysis, but rather to do it prior to the workshop itself with a smaller group in order to save time

5.6. 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 Analysis of Non-Exceptional Years

This step was completed by all teams. One team (Sylhet) noted that 2010 was an exceptionally bad year for the area due to extensive flash flooding. In other areas the years chosen were considered to be non-exceptional.

Step 3: Evidence Repository

Entering the data in the Analysis Worksheets took a considerable amount of time: the teams spent a large part of day two on the data and most teams had to continue the work also the following morning. Some teams did not complete Step 3 according to instructions which encourage analysts to put all raw data (e.g. tables, statistics, graphics and report quotes) from different data sources in Step 3. These teams cited the sources in Step 3 but included the more specific data only in Step 4.

Step 4: Evidence Documentation and Analysis

In this step evidence was analysed and the teams came to a conclusion on the area classification and population estimates. A decision was taken before the pilot to use only the horizontal approach instead of testing both horizontal and vertical approaches. In addition a different version of Step 4 produced by FEWS NET was tried out. Initially the purpose was to use the FEWS NET Step 4 only in one group, but eventually two other groups also decided to use it. As a result three groups used the FEWS NET Step 4, and four groups used the horizontal approach. One group of the first three switched from the standard Step 4 to FEWS NET Step 4 during the analysis, thinking that it was clearer and more structured. Other teams only used one version of the Step 4, so there was no proper comparison of the two approaches.

All teams were able to reach a severity classification for their area, as well as population estimates. The process, however, was not easy. Many teams struggled especially with the population estimates due to somewhat conflicting data – often prevalence of inadequate food

consumption would not correspond with the prevalence indicated by livelihood change indicators or chronic malnutrition indicators, and there were also differences between the prevalence indicated by food consumption quantity vs. quality. Some data on quality was only available for different parts of the population, esp. children and women.

The difference between quality and quantity of food consumption came out very clearly in the Bangladesh pilot, also due to the fact that data available on food consumption was very comprehensive. In all areas analysed around half or more of the population had inadequate food consumption in terms of quality, whereas a minority of the population (around 20-30%) had gaps in quantity (again some of the data is on women and children, as per the indicators in the draft Reference Table). Practically all analysis teams calculated the population estimates separately for quality and quantity. It also became evident that the internal alignment of the indicators in the reference table may need a revision: for example the available data on FCS and HHS indicated consistently that only a very small part of the population has poor food consumption (max 5-10%) whereas a lot higher proportion of children were not able to get the required meal frequency. Interestingly also IDDS, but no HDDS, was available in Bangladesh and it was included in the analysis with somewhat modified thresholds compared to the HDDS (thresholds of the source, the IDDS analysis report, were used).

A particularly problematic area in the analysis was livelihood change. As in many other countries, there was very little information available on livelihoods, apart from the primary income-generating activities of households from two surveys, and some information on assets from one survey. Also, the timeframe of three years (in terms of the reference years) was rather limited in order to detect any wider changes in livelihoods. Overall it could be noted that a vast part of the population has marginal livelihoods (e.g. casual labour), which indicated vulnerability to food insecurity. The weakness of the livelihood analysis raised questions on whether the approach adopted in the current chronic analysis tools is feasible: Can livelihood change analysis be conducted with inadequate data? If not, what are the options? Is livelihood change analysis appropriate if the analysis focuses on chronic food insecurity, with the implication that the situation is relatively static over the years? Should livelihood change analysis be replaced by livelihood analysis?

There was a wealth of information available on nutrition. The data, however, did not always converge with the other indicators and some (but not all) teams needed to make a choice on whether they should use the nutrition information for population estimates or leave it out. Some participants also raised questions on the suitability of nutrition information for population estimates. On the other hand in Bangladesh there was also data available for example on the nutritional status and inadequate height of adolescent girls and adult women, which could be used as complementary information for nutrition and population estimates.

The information on nutritional status also included the proportion of overweight and obese women, an issue that the Chronic Working Group agreed on looking into whenever possible in the pilots (a recommendation made in the nutrition consultations). At the national level in Bangladesh the proportion of overweight and obese women is gradually rising, whereas the proportion of women who are chronically energy deficient (CED) is shrinking. The proportion

of maternal overweight and obesity increases with wealth, and is largest in the two highest wealth quintiles (as well as among the business and salaried occupational groups). The situation is the reverse for maternal CED, which peaks in the lowest wealth quintiles (and in the unskilled labour and fishermen occupational groups).

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. Moreover, the groups generally did not allocate reliability scores as in this particular training and analysis much of the data was provided in excel sheets to all. Thus the entire group was using one data set and could complement that by using other data pertinent only to their area. This was the reason reliability scores were not used all the time – a lot of the data was sourced, cleaned, sorted and then given to participants. In principle, however, according to the analysis guidance reliability scores should be assigned in every analysis. This could be done either by the people who prepare the data and are familiar with it, or the analysts themselves.

Step 6: Prevalence of Chronic Food Insecurity

All groups completed this step on basis of the prevalence estimates reached in Step 4.

Step 7: Types of Chronic Food Insecurity

Only a couple of groups completed this step of the Analysis Worksheets. Most groups felt that the information available did not enable the division of the chronically food insecure population to different types. In addition it was already mentioned in the training that this step may be difficult and that groups may give it less attention if they feel that they cannot reasonably fill it in. The usefulness of the step was also discussed – the participants felt that it was not always clear how this information would be useful for decision-making and response.

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

All the groups did at least some work on these steps, although some groups did not fully complete them. Despite instructions, a few groups just chose the appropriate box for each limiting factor in Step 8 but did not elaborate on the reasons for choosing that box. Overall the participants felt that both steps are useful for contextualisation of the situation and for possible response planning. It was also noted, however, that information recorded in the steps was rather superficial and often would not provide much new information to anyone even somewhat familiar with the areas in question.

5.7 Lessons learned and recommendations on Analysis Worksheets

- Chronic working group needs to discuss Step 4 and revise it so that it is user friendly, enables trend analysis from one year to the next, and facilitates the calculation of population estimates
- Guidance needs to be developed for estimating populations – especially in situations where evidence is not converging.
- 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. Despite people finding them useful, there is a question on the value they bring to response planning.

5.8 Reference Tables

It was decided before the pilot that only the Adapted Reference Table would be used in Bangladesh, on basis of the experiences in Kenya. The teams were also instructed that if there is time, they could also try to use the Standard Reference Table and see if it would make any difference to the classification.

Overall there were no problems in understanding the Reference Table and the indicators. Most of the participants found both valid to analysing chronic food insecurity, although certain issues were raised. Quite a few participants would like the Reference Table to be more specific to country context in terms of incorporating locally appropriate indicators.

As noted above, there seems to be a need to rethink the livelihood change section of the Reference Table. The indicators should be reviewed and the whole livelihood change analysis approach has to be rethought so that it fits better into the overall chronic analysis process. In Bangladesh the livelihood change analysis was barely conducted due to lack of data but probably also because the teams focused more on the analysis of vulnerability to food insecurity in terms of livelihoods, rather than the livelihood change itself. Also, often there was little convergence of the information available with the other outcomes, which hampered classification and population estimates – especially when analysing possible livelihood changes.

The teams that tried out both reference tables noted that the inclusion of mortality data did not change the classification to any direction – rather it confirmed the existing classification.

5.9 Lessons and recommendations learned

- Need to review the alignment of the indicators and thresholds. Review of indicators is crucial for the livelihood change indicators, whereas the thresholds of the food consumption indicators have to be examined critically to improve alignment
- Inclusion/exclusion of mortality does not seem to affect the overall classification
- May need to add IDDS to the Reference Table

- Chronic working group also to discuss the possible need to add another level into the Reference Table (from three to four levels)

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 relevant to Bangladesh, and something that can be used in the decision-making. Some requests for use of the analysis results for information and potential programming came from the participants already at the end of the workshop.

It was noted several times that the analysis at division level, however, masked many differences within the divisions. For this reason, and for better targeting, it would be recommended to conduct any further chronic analysis at district level. This is nevertheless likely to pose challenges in terms of data availability. The possibility of doing further analysis at district level incrementally was also briefly highlighted, allowing the work to be more spread out. This might also forego the need to convene a large analysis workshop, rather a smaller group could conduct the analysis and a larger meeting could be organized at the end of the process for review and validation of the results.

The participants overall thought that the chronic food insecurity analysis is useful and provides a different angle to food insecurity in the country. Also the participants who had not done IPC before indicated that they had learned a lot and would be happy to be part of future IPC processes in Bangladesh.

7. Feedback from participants

The pilot feedback form was distributed to the participants the last day of the workshop and 24 participants provided feedback. The participants did not note any major issues with the chronic analysis or the tools used. Overall the feedback was positive, and the participants felt that the concept of chronic food insecurity, the Reference Table and the indicators, and the Analysis Worksheets were clear and served well their purpose. As noted above, some participants wanted to include indicators that are more specific to the country context, e.g. indicators relating to fisheries and salinisation.

Several participants also mentioned the need for proper data preparation and possible re-analysis before the workshop. Many participants equally thought that the length of the workshop (5 days) was not adequate for detailed analysis and discussion, and that at least 2-3 extra days would have been required.

More feedback from the participants was received in the plenary discussion after the analysis results were presented on the last day of the workshop. The participants recommended a review of the indicators and indicator thresholds (as discussed above) and paid attention to the

extensive data requirements for proper analysis. Some participants also inquired whether it would be possible to increase the resolution of the Reference Table by adding one or two more levels, which would also be helpful in bringing out the differences between the areas more clearly.

The mapping protocol was also discussed, and the participants agreed that both the severity and the prevalence should be highlighted in the map. The population percentages could be presented in a bar or in a pie next to the area analysed. There was no particular support for the inclusion of typology prevalence in the map, but there were some ideas for including different legends to highlight various aspects of the severity situation.

8. Conclusions

The Bangladesh pilot was able to achieve its objectives of testing different chronic food insecurity analysis tools and reaching a draft classification of the seven divisions of Bangladesh. This was possible even with the adverse external conditions, which forced the organizers to change the workshop location and to shorten the length of the pilot. The positive results of the workshop were largely due to the preparations done before the workshop (especially by Feroz Ahmed and his colleagues), and the participants who remained committed and engaged throughout the process and provided many helpful comments and suggestions.

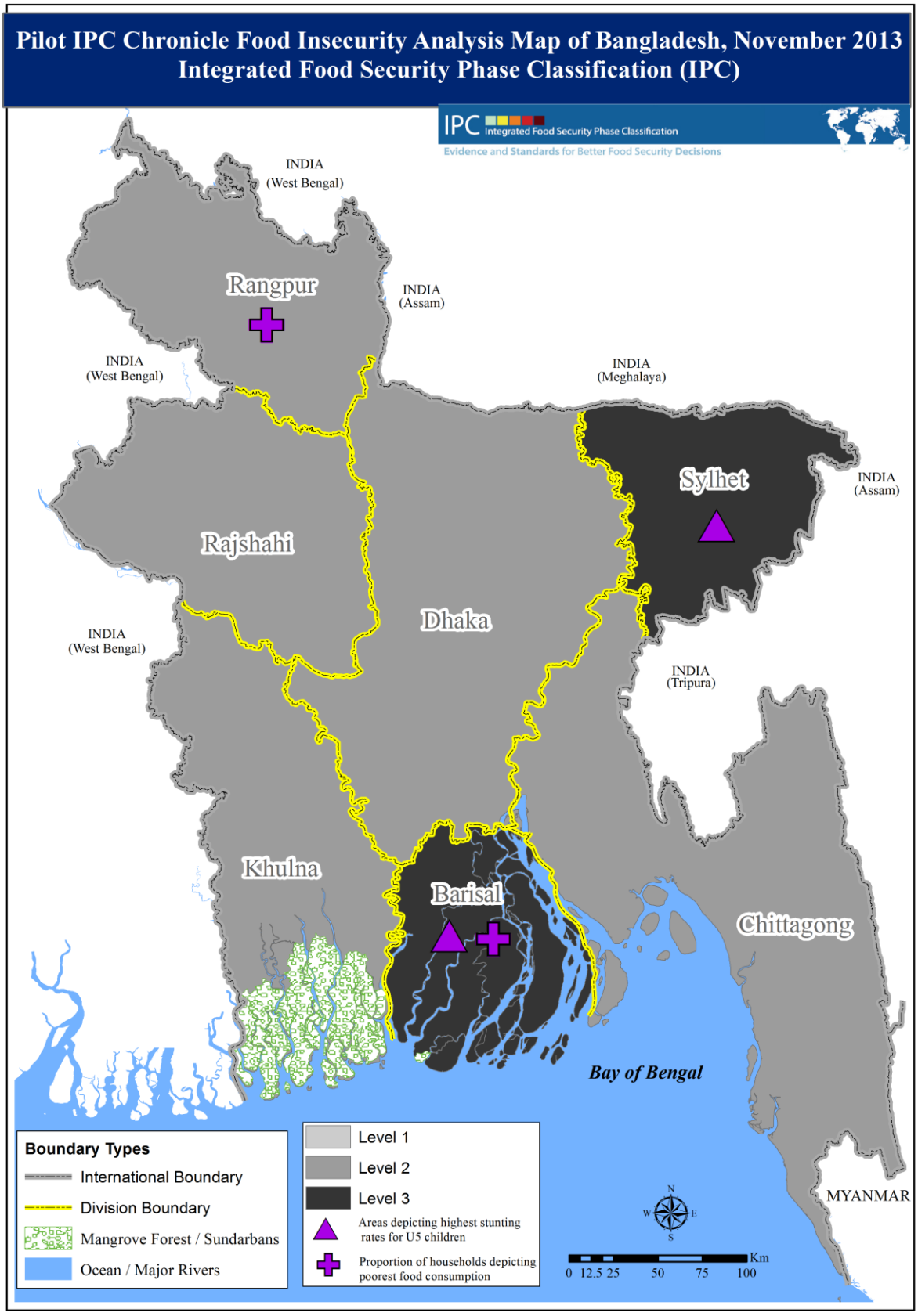
The Bangladesh pilot was very useful for further development of the chronic analysis, especially due to good data availability which allowed the review of the convergence of evidence and the alignment of indicators. The pilot, once again, also underlined the need for proper data preparation prior to the workshop. It is also pertinent to strengthen the training component by adding exercises and using examples from chronic contexts and different chronic analyses.

The feedback from the participants underlined that chronic analysis is valuable and useful for programming. However, there is a need to see how the causal analysis tools can serve the purpose of decision-making better, and to ensure the linkages between the chronic analysis and response. There is also a need to review and document the value-added of chronic compared to acute analysis, and how both can be used in a complementary way for decision-making. In summary, the Bangladesh pilot showed that the approach chosen (analysis done on non-exceptional years, Reference Table and Analysis Worksheets) to a large extent works as expected. There are, however, still several issues to be sorted out, in particular:

1. Clarification of the rationale for and linkages between the two tools. This is not to be confused with the concepts of Acute & Chronic Food Security, as the question is rather how exactly do these two tools link and exist together?
2. Worksheets need to be simplified.
3. Trainings need to be more interactive and work with real data / on ground realities

It should also be noted that all of the above are being addressed and many improvements / changes have already been made in the present period between the completion of the Bangladesh pilot and finalization of this report.

Annex 1: Draft Chronic Food Insecurity Map of Bangladesh



Annex 2: List of Participants

List of Participants in Bangladesh Chronic pilot 3 – 8 November 2013

No.	Name	Organization
1	Mohammed Shafiqur Rahman	DLS
2	Omar Farook	WFP
3	Soo Mee Baumann	WFP
4	Farhana Sharmin	UNICEF
5	Kayenat Kabir	WFP
6	Toufique Ahmed	Save the Children
7	Nushrat Rahman Chowdhoury	Islamic Relief Bangladesh
8	Tapan Chakrabaryt	ACF
9	Kazi Soyeb Fokrul	SACO
10	Noor Ahmed	SI
11	Shafiqur Rahman	CARE Bangladesh
12	A. Awal	ECHO
13	Mamtaz Uddin	Concern Worldwide
14	Ranajit Das	Oxfam
15	Atal Majumdar	ESDO
16	Dr. Mohammed Shahe Alam	NFPCSP-FAO-FPMU
17	Santosh Kumar Roy	Eco Social Development Organization
18	Bijoy Chandra Sarker	World Vision
19	Nusha Choudhury	WFP
20	Kaija Korpi-Salmela	FAO
21	Koyela Sharmin	CU
22	Tanvir Elahi	Muslim Aid
23	Sukamar Datta	SPARRSO
24	Mohammed Rafiqul Hasan	DAE
25	Mohammed Shameen Hassan	BMD
26	Farzana Bilkes	WHO
27	Afroza Taznim	HKI
28	Abdul Wadud	Shushilan
29	Mohamuad Ismail Mia	FPMU
30	Mohammed Abdullah Al Mustasim Billah	Ministries of Fisheries and Livestock
31	Mohammed Mahabubul Hasan	FAO-BD
32	Abul Kashem Mohammed Jahangir Hossain	Laison Officer IADPPGB DAE, Khamarbari Dhaka
33	Feroz Ahmed	FAO-IPC
34	Chris Hillbruner	FEWS NET
35	Laura Glaeser	FANTA
36	Rosanne Marchesich	FAO
37	Nusrat Shahin	FAO
38	Sarowar Hossain	FAO
39	Feroz Al Mahmud	FPMU Ministry of Food
40	Krishnendu Saha	Department of Fisheries

41	Moyen Uddin Ahmmed	BRAC
42	Amnasir Uddin	AAB
43	Dr. Mohammed Abdul Razzaque	DG Health
44	Mohammed Saidur Rahmann	BBS
45	Siddarth Krishnaswamy	FAO
46	Mohammed Mahabubul Alam	WFP
47	Mohammed Mezbanur Rahman	FAO
48	Tanzina Tarlim	FAO
49	Gazi Ismail Hossain	FAO

Annex 3: Agenda

Integrated Food Security Phase Classification

Chronic food insecurity analysis pilot

Dhaka, Bangladesh 3 – 7 November 2013

AGENDA

Date	Time	Activities	Remarks
1st Day: Chronic Analysis training			
3rd of November	8.15-9:00 am	Registration and snacks	All participants
	9:00-10:00 am	Opening ceremony of Chronic Analysis training and workshop.	
	10:00-10:20am	Break	
	10:20-10:45 am	Objectives and agenda	
	10:45-11:45 am	Concepts and rationale for chronic food insecurity analysis and difference between acute and chronic analysis	
	11:45-12:00 pm	Pilot analysis overview	
	12:00-1:00 pm	Classifying CFI severity and causes: Key Parameters	
	1:00 -2.00 pm	Lunch Break & prayer	
	2:00-3:00 pm	Reference Tables	
	3:00-4:00 pm	Selection of Non-Exceptional Years	
	4:00-4:30pm	Snacks	
	4:30-5:00pm	Feedback	
2nd Day: Chronic Analysis training and analysis			
4th November	8:00 -9:00am	Day 1 recap	
	9:00-9:30 am	Morning Snacks	
	10:00-11:00 am	Analysis Worksheets	
	11:00-11:30 am	Classification & Mapping Protocols	
	11:30 -11:45am	Break	
	11:50-1:00 pm	Selection of Non-Exceptional Years at national level	
	1:00-2:00 pm	Lunch Break & prayer	
	2:00-2:30pm	Group formation and data review	
	2:30-4:00pm	Analysis: Step 1 Background, Step 2 Validation of Non Exceptional Years, Step 3 Data Repository	
	4:00-4:30pm	Snacks	
	4:30-5:00pm	Feedback	
3rd Day : Chronic Analysis			
5th November	8:00 -9:00am	Analysis: Step 3 Data Repository (cont.)	
	9:00-9:20am	Tea Break	
	9:20-10:30am	Analysis: Step 3 Data Repository (cont.)	
	10:30-11:30am	Overview: Step 4 of the Analysis Worksheets	
	11:30-11:45am	Break	

	11:45-1:00pm	Analysis: Step 4 Review/input of evidence	
	1:00-2:00p-m	Lunch & prayer	
	2:00-4:00pm	Analysis: Step 4 Review/input of evidence	
	4:00-4:30pm	Snacks	
	4:30-5:00pm	Feedback	
4th Day : Chronic Analysis			
6th November	8:00 -9:00am	Previous day discussion	
	9:00-10:30am	Analysis: Classification of CFI Using the Vertical Approach: Steps 4, 5, 6 and 7	
	10:30-10:45am	Break	
	10:45-1:00pm	Analysis: Classification of CFI Using the Horizontal Approach: Steps 4, 5 and 6	
	1:00-2:00pm	Lunch & prayer	
	2:00-4:00pm	Overview: Standard Reference Table and Steps 4, 5, 6, and 7	
	4:00-4:30pm	Snacks	
	4:30-5:00pm	Feedback	
5th Day : Chronic Analysis, Presentations and Feedback			
7th November	8:00 -9:00am	Previous day discussion	
	9:30-9:30am	Tea Break & snacks	
	9:30-10:30am	Analysis: Classification of CFI Using the Adapted Reference Table: Steps 4 and 6	
	9:30-11:30am	Analysis: Steps 8 and 9	
	11:30-11:45am	Snacks	
	11:45-1:00pm	Group presentations	
	1:00-2:00pm	Lunch & prayer	
	2:00-3:30pm	Discussions on the chronic analysis process and tools	
	3:30-4:00pm	Evaluation and feedback	
	4:00-4:30pm	Snacks	
	4:30-5:00pm	Closing of the workshop	