# IPC Chronic Food Insecurity Development Process

## Second round of piloting – Guatemala City, November 4th – 7th

### Background

- In consultation with several IPC partners with presence in Guatemala, the GSU decided to propose the Government of Guatemala (GoG) to host an IPC Chronic pilot in Guatemala. The GoG gave green light to the pilot in September, indicating its preference for a 3 - 3.5 days workshop and for three specific areas to be analyzed. These areas were municipalities with prevalence of stunting among school children considered to be low, medium and high as compared to the national average. These municipalities were: Asunción Mita, San Luis Jilotepeque y Tajumulco. The choice for the municipalities to be analyzed was also defined by their geographic location, with one in the western highlands and two in the East. This differentiation was aiming to evaluate how the scale behaves in different settings within the country.
- There were 3 areas to analyze and five sub-groups of 4 to 6 people were formed to do it. Two areas (Tajumulco and Asunción Mita) were analyzed by two groups each and the third area (San Luis Jilotepque) could only be analyzed by one group. The idea was to test how replicable analysis results were using current tools. Classification results for each of the sub-groups can be found in annex 2.
- Workshop's participants were divided into five sub-groups for the testing of the two approaches. Sub-groups composition included one facilitator, one person with local knowledge of the area to be analyzed[1], a nutritionist and a person knowledgeable about agriculture. Other participants were distributed according to the type of organizations they represented (government, NGOs, UN and specialized institutions).
- Logistics costs were mainly covered with funds from the PESA project run by FAO Guatemala. FEWSNET kindly agreed to host the workshop for half a day on the 7th. ICFI was strongly engaged in the preparation of information prior to the workshop. Facilitation was provided by a team of four people: Jenny Coneff (FEWS NET), Ricardo Sibrián (PRESANCA – PRESISAN) and Leila de Oliveira and José Manuel Veiga (IPC GSU).
- A coordination group was created on the last week of September. This group was formed by organizations working in Guatemala that wanted to contribute to the preparation of the pilot. Stakeholders taking part in this coordination group were: Action Against Hunger, FANTA, FAO, FEWS NET, ICFI, IPC GSU, PRESANCA, SESAN[2], WFP. The group worked through email exchanges and periodic teleconferences.

[1] Not all the groups counted with a person with local knowledge for the entire duration of the workshop.
[2] Secretaría de Seguridad Alimentaria, this is the GoG's body responsible for food and nutrition security.

- The coordination group developed an agenda for the workshop taking into account the duration proposed by the GoG (3 days + 0,5 extra day if necessary). No government representatives participated in the additional half day. This was less time than was required for the pilot, so a number of tasks normally to be done during the workshop had to be completed before. These were the selection of non-exceptional years and the pre-completion of step 1, 3 and 4, under the assumption that participants would have the chance to revise these steps during the workshop. Agenda of the workshop can be found annexed to this report.
- The coordination group also agreed on a list of participants. Government institutions were the most represented in this list. It was agreed that the SESAN would send the invitations on behalf of the coordination group. Invitations were sent a few business days prior to the workshop. This delay could have been insufficient for some of the stakeholders that were invited. In spite of that, the number of participants was close to what was recommended by the TWG for the chronic scale. However, the requirement concerning the amount of previous IPC experience of participants was not fulfilled by a considerable number of them. List of participants is included in annex 1.
- Guiding materials were made available before the workshop. They included the latest modifications based on the experience of the Kenya pilot. These materials were translated to Spanish by GSU and FEWS NET and distributed to the coordination group between one and three weeks before the workshop. These guidance materials were shared with the Technical Working Group by Kaija Korpi on October 31st.
- The following report contains lessons learnt during the pilot. They have been divided in two categories: “Main issues” and “Other issues”. The first group corresponds to key messages that the facilitators consider as most important based on the level of consensus among workshop´s participants and the relevance that may have for the discussions of the Technical Working Group on the IPC Chronic Scale. The second contains ideas, comments and other messages produced during the workshop´s discussions which reflect individual’s opinions rather than views shared by the majority of participants. In annex 3 it has been included additional notes on the workshop prepared by some of the facilitators.

**Non-exceptional years**

- Prior to the workshop, the coordination group completed the matrix for selecting non-exceptional years. It also prepared an excel spreadsheet in which duration of the impacts of the different shocks was estimated. Both, the matrix and the spreadsheet, will be shared with the Technical Working Group. Years selected for the analysis were those within the period 2005 – 2013 not considered as exceptional and that had the sources of information considered to be most relevant.
- During the workshop a session was dedicated to explain the selection of non-exceptional years and participants had the opportunity to provide feedback on this process. The next session was dedicated to validate the selection made for the three areas of analysis (step 2).

- The coordination group agreed to work with the concept of consumption year. Therefore, selected years actually covered the period going from September of the year before until August of the selected year.

*Main issues*

1. All participants were in agreement with the identification of exceptional years done before the workshop. This could mean that the current definition of exceptional/non-exceptional years is appropriate. However, this definition needs to include whether a calendar or a consumption year is to be considered, and that the timing of the exceptionality should be based on the impact of a shock is felt and not when the shock actually happened.
2. The process of identifying reference year for the analysis should be flexible and allow the use of as many sources of information as possible.
3. Several ideas were suggested with respect to non-exceptional years:
    a. Select non-exceptional years by area, not at national level.
    b. Reference years don't need to be the same for all units of analysis.
    c. Identify exceptional years at an intermediate, regional level between the national level and the analysis area level. This intermediate level could be defined by livelihood zones in order to make a better selection of what shocks are likely to have an exceptional impact on food security conditions.
    d. Identifying 6-7 non-exceptional years at a national level for which at an area level the group could choose 3-4 (or more if they like) depending on data availability and non-exceptionalness. There appeared to be more consensuses for this option.
    e. A full year (consumption or calendar) may be a too long period to exclude from the analysis. This can lead to exclude an information source of a year considered as exceptional, when in reality data collection took place in non-exceptional period within the year considered as exceptional.
4. During the selection of exceptional years, participants felt the need for more guidance to determine the duration of the impacts of certain events not directly linked with the production of staple foods (e.g. non-normal high food prices or coffee rust).

*Other issues*

1. The process of how to validate step 2 at an area level was unclear. For example, one group attempted to re-write the matrix at an area level; this was extremely time consuming, and since the group was required for this pilot to use the national level non-exceptional years anyway, it was not a productive use of time. Most other groups simply added any additional notes in the Step 2 summary table.
2. There was a question as to whether or not in Step 2 years identified as exceptional at a national level should be allowed to be considered as non-exceptional for the area of analysis. This would be equivalent to do selection of non-exceptional years at area level; as

such, what would be the purpose of national identification of non-exceptional years? Moreover, it would mean that for a map of a country, the analyst/decision-maker would have no idea or guidance as to which years the colors in the map represent; they might be totally different and not sharing similar contexts at all.

3. An exceptional year may not cover all the period in which the impact of an extraordinary shock is felt. The impact could last longer than a year, in particular after the occurrence of several years considered to be exceptional.
4. Basic general information (e.g. population and crop areas), about the area is needed in order to assess whether the shock can cause a year to be considered as exceptional.

**Vertical and horizontal approaches**

- All groups added additional information to steps 3 and 4Besides from to adding information from other reports, participants contributed expert knowledge of the area, when possible.
- The horizontal approach was tested first with the standard reference table and after with the adapted one.
- Three of the five groups found the vertical approach (standard reference table) impossible due to a lack of data. Two groups attempted the vertical approach; however, they did so with data from only one year, which was not the way the approach was intended.

*Main issues*

1. *Main issues*The horizontal approach was more suitable for the analysis, taking into account available information. Sub-groups that tried the vertical approach were able to classify only one year out of the four non-exceptional years considered, and this was only possible thanks to the existence of a baseline study that provided many direct evidences. IPC had intended classification of a minimum of 2 non-exceptional years for the vertical approach to be viable.
2. The degree of flexibility that analysts can apply when using thresholds in the IPC (including the 20% rule) during the convergence of evidence needs clarification. Sub-groups analyzing Tajumulco did not reach similar conclusions in terms of area classification due to a rigid interpretation of the 20% rule by one of the sub-group. Some participants thought that flexibility opened room for subjectivity. Others considered that flexibility was necessary given the margin of error inherent to any measure of a given indicator.
3. The process of inferring outcomes using indirect evidence was considered to be very challenging and a source of subjectivity. This probably was the cause of the divergence found in the classifications of Tajumulco, where the difference in the percentage of households found to be in level 3 was a 100% difference. And same for Asunción Mita where percentages of households in each chronic level were very different and area classifications were clearly in different levels. For the group doing San Luis this was also problematic, especially when trying to come up with percentage of households in each

level. **As a result, the pilot found that the methods applied are not yet reliable/replicable.**

4. Availability of adequate household information (disaggregated at the area level, reliable, and covering all elements of the analytical framework) was considered to be the main limiting factor for the chronic analysis. This was very clear when determining % of households in each food insecurity level. It is important to bear in mind that information made available for the analysis does not always include all information actually existing. There is data collected al local level which is difficult to retrieve at the central level. Identifying this type of information could be facilitated if people based in the areas of analysis participated in the analytical workshop.
5. The worksheet should include a specific space for putting evidence of contributing factors not specifically related with food security ("grey box" elements of the IPC analytical framework). This could help analysts to pay due attention to this type of information when doing analysis.
6. Health factors can also influence food consumption. This is the case of people that eat less because are sick.
7. The horizontal approach using the adapted table yielded less divergent results than when the standard one was used. The two groups doing Tajumulco classified phase 3 for the area and presented closer results with regard the % of population in each level. Results for Asunción Mita still presented important differences between the two groups that analyzed it, although the gap decreased comparing to the standard table. Many participants found that it was easier to determine % of households using the reference adapted table thanks to the additional data point facilitating classification of households. However, improvement in convergence could also be caused by reciprocal influence between groups after presentation of results for the standard table.

*Other issues*

1. All participants agreed on the need for people with the appropriate local knowledge of the areas of analysis in analysis groups.
2. Some participants appreciated the rationale for the vertical approach and the possibility of checking inter-annual variation of food insecurity levels it offers. They considered that the possibility of following both approaches for the same analysis should be allowed.
3. For some it was difficult to see a difference between the household group analysis proposed in the acute scale and classifying % of households in the chronic scale. It was proposed to strengthen the guidance about this in the chronic materials to be developed.
4. A discussion within multi-disciplinary sub-groups for interpreting the evidence was considered as very useful by some participants.

**Reference tables**

*Main issues*

1. Observations about indicators in the tables:
    a. Participants found it difficult to compare indicators for minimum diet quality in children with the rest of food consumption indicators that are expressed in % of households.
    b. Some were not sure that mortality could be linked to chronic food insecurity. Mortality may be more important in acute food insecurity. However, mortality by age might be informative. To identify the causes of mortality is very challenging, even with quantitative data and especially with qualitative approach like IPC.
    c. To include indicators to assess the continuity of water supply and quality during the reference years, as indicators related to access to water do not reflect conditions throughout the year.
    d. Consider removing HHS from the chronic scale since it is more relevant in an acute context. Or if not at least revise the cut-offs. Any HHS score >0 already indicates a situation of hunger more severe than implied by Level 1 and 2 descriptions.
    e. Guidance on how to measure livelihood change in the chronic analysis is needed. This is a dynamic element and it is not clear how it has to be assessed when considering multiple reference years. There are questions/confusion as to whether or not livelihood change or "livelihoods" are more appropriate to analyze in chronic analysis.
    f. Total income as a percentage of survival needs should go in access instead of Hazards & Vulnerability.
2. In 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. This brought up a question for the Chronic TWG to debate: can HHs be chronically food insecure and have children not stunted?
3. People found that putting area and household indicators together (adapted table), made it easier to understand.
4. Several indicators proposed as direct evidence for food consumption, were available for Tajumulco. However, it was difficult for the sub-groups analyzing this area to determine the preliminary % of households in each level for food consumption, because % of households (and children) showed important differences depending on the food consumption indicator considered. Consider revising the calibration of the different indicators´ cut-offs.

*Other issues*

1. The way indicators for children´s diet quality are defined, was seen as confusing by some participants.

2. ELCSA[3] was not used as direct evidence for food consumption, despite participants' comfort with the indicator as a measure of food consumption. Clear guidance and training about how to infer food consumption outcomes from available evidence is needed.
3. The tables should explicitly indicate to which population group anemia and malnutrition refer.
4. Stunting in school children can be misleading since, given cumulative nature of growth retardation, it can reflect conditions of a period far away in the past. However for a horizontal approach stunting data for school children from a recent year can be used to infer what the situation was in the 5 to 7 years before the measurement took place. This relation is not evident if people have no knowledge on nutrition; it would be a good idea to have a guiding statement on this, since this indicator might be the only one for a chronic analysis.
5. Some thought that countries where food is fortified with vitamin A might systematically not get level 3 as preliminary classification for food consumption according to current indicators of dietary quality of children's need.

6. Some participants agreed that obesity needs to be included in the chronic scale. However there was no time to discuss how this could be done.

**Analysis of causes and types of chronic food insecurity**

- All sub-groups completed step 8 but only one was able to complete step 9. Results for step 8 from each group can be found in annex 2.
- On day 4, a fraction of participants from previous days took part in a brief session to test step 7. Three sub-groups, one per municipality, were formed. Therefore, for step 7, it was not possible to compare results between different sub-groups.

*Main issues*

1. Differences found in limiting factor matrix for the same area of analysis, could be a sign of subjectivity when using the tool. Further guidance on how to complete it could be necessary. The questions and statements in the matrix were not clear and useful enough.
2. It was difficult to understand the concept of stability in step 8. What is meant by "short term" in the guiding question? Is it stability between the reference years or within the years? How is it possible to assess stability for access, availability or utilization?
3. In all areas of analysis the whole population identified in chronic food insecurity, was classified as being Type 2. This was because even when conditions permitted access to an adequate diet, dietary quality was too poor as to put them in level 1. Some of these

[3] Escala Latinoamericana de Seguridad Alimentaria

people have insufficient dietary quantity during the lean season; if dietary quality were sufficient otherwise, these households would be classified as type 1.

4. After completing step 7 some participants felt that decision makers did not really need to know whether chronically food insecure population is type 1 or 2. What is more important is to know how many people are affected by a given limiting factor, to what degree and during which period of the year. Introduce an improved limiting factors matrix, that is able to answer these questions and eliminate step 7 should be considered. In this new matrix stability could be approached as the study of the evolution of the other three pillars throughout the year.
5. Group that attempted to do step 9 found that more guidance would be necessary on SWOT analysis and also on how to assess the five capitals.

*Other lesson learnt*

1. The information that is provided by the limiting factor analysis is key for decision making and may be as important as the classification of severity.
2. Is it possible to consider two pillars as a complete limiting factor? Shouldn't be the objective to establish which pillar should be a priority in the response? Is it necessary to do this matrix for areas classified as level 1?
3. Consider other ways of communicating the limiting factor matrix (e.g. a map).

**General comments**

- The following are observations that don't refer specifically to one of the topics mentioned above, but rather apply in general to the entire chronic prototype.

*Main issues*

1. Decision-makers in Guatemala have a strong preference and political culture in favor of quantitative, statistical, and representative information. For many, there is not advantage in using the IPC chronic scale as compared to using stunting in school children as the indicator to establish geographical priorities for intervention. Stunting is a statistical, representative indicator, and it is available at municipal level. However, the IPC has a potential added value in informing decision makers about the causes, the percentage of population affected and the nature of the problem. There was a perception that the amount of work and dedication that the IPC chronic analysis requires may not be compensated by the added value that supposedly can bring.
2. It was not clear how the IPC chronic is able to inform on who is chronically food insecure when it provides % of households in different levels of chronic food insecure, without describing the characteristics of these households. This may be due to incomplete testing of the Limiting factors matrix and causal analysis or because those tools are not sufficiently responding to IPC chronic's analysis and communication needs.

3. As seen in previous comments, the need for better guidance for the use of the tools and procedures of the IPC chronic protocols was constantly demanded by participants. In addition to what has been indicated above, this guidance would also include the standardization of concepts that are to be used during the analysis and the establishment of criteria permitting to filter information that is really required to do the analysis.

## Annex 1: Workshop's agenda and list of participants

| Duración | Sesión | Título[4] | Facilitador |
|---|---|---|---|
| | | **Día 1** | |
| 0800 | 1 | Bienvenida e introducción | FAO/SESAN |
| 0815 | 2 | Explicación de objetivos y agenda | CIF USG |
| 0835 | 3 | Conceptos y justificación del análisis de inseguridad alimentaria crónica y diferencia entre el análisis agudo y crónico. Introducción a los parámetros clave y herramientas principales para clasificar la inseguridad alimentaria crónica | CIF USG |
| 1000 | | *receso* | |
| 1030 | 5 | Presentación de municipios a analizar y de la información disponible: Pasos 1 y 3 | CIF USG |
| 1100 | 6 | Clasificar la severidad de la inseguridad alimentaria crónica: años no excepcionales. Selección de años no-excepcionales en Guatemala para el piloto. | CIF USG / FEWS NET |
| 1215 | | *almuerzo* | |
| 1315 | 7 | Paso 2: validación de los años no - excepcionales para las áreas a analizar. | CIF USG / FEWS NET / PRESANCA |
| 1415 | 8 | Discusión sobre el proceso de selección de años excepcionales. | FEWS NET |
| 1545 | | *receso* | |
| 1615 | 9 | Clasificando la severidad de la inseguridad alimentaria crónica: hojas de análisis y tabla de referencia. | CIF USG |
| 1645 | 10 | Análisis de áreas – Paso 4: elaboración y revisión de los enunciados de evidencia (tabla de referencia estándar y enfoque vertical). | CIF USG / FEWS NET / PRESANCA |
| 1745 | | *Fin de jornada* | |
| | | **Día 2** | |
| 0800 | 11 | Análisis de áreas – Paso 4: elaboración y revisión de los enunciados de evidencia (tabla de referencia estándar y enfoque vertical) – *cont.* | CIF USG / FEWS NET / PRESANCA |
| 1015 | | *receso* | |
| 1030 | 12 | Análisis de áreas – Paso 4: elaboración y revisión de los enunciados de evidencia (tabla de referencia estándar y enfoque horizontal). | CIF USG / FEWS NET / PRESANCA |
| 1230 | | *almuerzo* | |
| 1330 | 13 | Discusión plenaria sobre los enfoques horizontal y vertical. | CIF USG |
| 1500 | | *receso* | |
| 1515 | 14 | Análisis de áreas – Paso 4: elaboración y revisión de los enunciados de evidencia (tabla de referencia adaptada y enfoque horizontal o vertical). | CIF USG / FEWS NET / PRESANCA |
| 1730 | | *Fin de jornada* | |
| | | **Día 3** | |
| 0800 | 15 | Discusión plenaria sobre las tablas de referencia estándar o adaptada. | FEWSNET |
| 0900 | 16 | Análisis de áreas – Paso 6: determinación de prevalencia. | CIF USG / FEWSNET / PRESANCA |
| 1000 | 17 | Discusión plenaria sobre paso 6 | PRESANCA |
| 1100 | | *receso* | |
| 1115 | 18 | Análisis de áreas – Pasos 8 y 9: matriz de factores limitantes y análisis DAFO. | CIF USG / FEWS NET / PRESANCA |
| 1300 | | *almuerzo* | |
| 1400 | 19 | Discusión plenaria sobre pasos 8 y 9. | CIF USG |
| 1500 | 20 | Análisis de áreas – Pasos 5 y 7. | CIF USG / FEWS NET / PRESANCA |
| 1615 | 21 | Discusión plenaria sobre pasos 5 y 7[5]. | FEWS NET |
| 1700 | | *receso* | |
| 1715 | 22 | Discusión abierta sobre herramientas y procedimientos de la escala CIF crónica. | CIF USG |
| 1815 | | *Evaluación y cierre* | |
| | | **Día 4** | |
| 0800 - 1300 | | *Este espacio se usará para finalizar lo que no se haya podido concluir en los días anteriores según convenga.* | |

**Pilotaje de la Escala de Clasificación de la Inseguridad Alimentaria Crónica de la CIF**

**Ciudad de Guatemala del 4 al 7 de noviembre de 2013**

[4] La facilitación de las sesiones estará a cargo de miembros del GTT que participarán en el taller.

[5] Las sesiones 21y 22 podrán eliminarse en caso de falta de tiempo.

**LISTADO DE PARTICIPANTES: TALLER ENSAYO ESCALA DE CLASIFICACIÓN CRÓNICA**
**4-6 de noviembre 2013**

**Grupo Asunción Mita, Jutiapa**

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**Annex 2: Classification results.**

| Horizontal Approach - Standard Reference Table | | | | |
|---|---|---|---|---|
| **Municipality** | **Area Classification** | **% Level 1** | **% Level 2** | **% Level 3** |
| Tajumulco (1) | 2 | 30% | 50% | 20% |
| Tajumulco (2) | 3 | 20% | 36% | 44% |
| A. Mita (1) | 2 | 20-50% | 50-80% | 0% |
| A. Mita (2) | 1 | 80% | 15% | 5% |
| San Luis J. | 2 | 10% | 20-50% | 40-60% |

| Horizontal Approach - Adapted Reference Table | | | | |
|---|---|---|---|---|
| **Municipality** | **Area Classification** | **% Level 1** | **% Level 2** | **% Level 3** |
| Tajumulco (1) | 3 | 30% | 45% | 25% |
| Tajumulco (2) | 3 | 7-33% | 35-44% | 25-49% |
| A. Mita (1) | ? | >50% | 15-50% | 0% |
| A. Mita (2) | 1 | 80-85% | 10-15% | <5% |
| San Luis J. | 3 | 30% | 35-45% | 25-35% |

| Step 8: Limiting Factor Matrix | | | | |
|---|---|---|---|---|
| **Municipio** | **Food Availability** | **Food Access** | **Food Utilization** | **Stability** |
| Tajumulco (1) | Not a limiting factor | Major limiting factor | Minor limiting factor | Minor limiting factor |
| Tajumulco (2) | Minor limiting factor | Major limiting factor | Major limiting factor | Minor or Major limiting factor |
| A. Mita (1) | Not a limiting factor | Major limiting factor | Minor limiting factor | Major limiting factor |
| A. Mita (2) | Minor limiting factor | Major limiting factor | Major limiting factor | Minor limiting factor |
| San Luis J. | Not a limiting factor | Complete limiting factor | Complete limiting factor | Major limiting factor |

Annex 3: Notes from Jenny Coneff (FEWSNET) and Ricardo Sibrián & Patricia Palma (PRESANCA).

**Jenny Coneff's trip report summary**

Executive summary:

- Ambitious schedule due to IPC's decision to accept GoG request for a 3-day pilot instead of 5-day pilot.
    - The following components were successfully tested: Step 2 (validation of non-exceptional years), Step 4: standard and adapted reference tables, Step 7 (typology).
    - The following components were not tested sufficiently: confidence levels and causal analysis (Steps 6, 8 and 9). Not testing the confidence levels was a detriment to the pilot given Guatemala's significant preference for statistically valid methods and statements of confidence. The vertical approach for Step 4 was considered impossible due to insufficient inter-annual data availability.
    - FEWS NET's proposed "alternative" Step 4 table was not tested systematically.
- The choice of municipalities enabled piloting of the methods over a range of severities and information levels. In addition, having 5 groups working with 3 municipalities enabled reliability testing.
- The pilot suggested a few major hurdles for the IPC Working Group:
    - The tools, guidance, and technical capacity of IPC staff and working group are not yet sufficient to produce replicable (reliable) analytical results.
    - Three levels are very few. In the face of analytical inflation, there's a high risk of using only 2 out of the 3 levels in many exercises, significantly reducing the value of the scale for decision-makers.
    - In Guatemala in particular, there is a political culture strongly in favor of statistical methods and precise results/recommendations. The IPC's prioritization of consensus-based, qualitative analysis and ranges will be a difficult sell to decision-makers and therefore to the technicians that support them.
    - Ensuring incorporation of livelihood information. This means understanding the differences between livelihoods vs. livelihood change as an element and the consequences for information and data re-analysis needs.
- The evaluation form was sent via email and is unlikely to be returned. The evaluation portion was verbal, with the substantive, big-picture evaluation on day 4 with an incomplete group. Fundamental questions the pilots should address were not raised during the evaluations. As a result, feedback from pilots may not be as effective, as complete, or as productive as it could be.

**GENERAL FEEDBACK**

*Major concerns for the Chronic working group to address*

- The tools, guidance, and technical capacity of IPC staff and working group are not yet sufficient to produce replicable (reliable) analytical results.
- Three levels are very few. There's a high risk of using only 2 out of the 3 levels in most exercises, making the scale less useful for decision-makers. For example, if the tool can't clearly identify places like Asunción Mita as Level 1, then this is a significant risk.
- In Guatemala in particular, there is a political culture strongly in favor of statistical methods and precise results/recommendations. The IPC's prioritization of consensus-based, qualitative analysis, and ranges will be a difficult sell to decision-makers and therefore to the technicians that support

them. For example, one excellent nutritionist said that in Guatemala there is a preference among technicians to use chronic malnutrition as the one and only proxy for chronic food insecurity because it's a statistically valid point value with a confidence interval, and the decision-makers won't rest until that's what they get.

- Livelihoods vs. livelihood change: understanding the differences in the choices, their consequences for information and data re-analysis needs. Data availability is scarce and relies heavily on expert judgment; acquiring data for this element, particularly across different years, is fundamental to the exercise.

*Major structural recommendations, issues*

- Recommendation without complete consensus: Eliminate step 7, incorporating relevant elements into other steps. (see Feedback specific to steps section below)
- Overhaul Step 8 (see Feedback specific to steps section below)
- Set a standard for minimum information requirements to complete chronic analysis as distinct from (or more precise than) existing "confidence level" specification.
    - JC proposes for discussion 1 piece of direct evidence each for food consumption (quantity or quality), livelihoods, and malnutrition over the past 10 years. Evidence need not be from non-exceptional years or from the same year. Additional clarification of minimum information standard for livelihoods needed. Perhaps, with some specific re-analysis methods for specific types of indirect information (e.g. admissions of malnourished children, retail prices and income, etc.), the resultant indirect evidence may also be considered sufficient to meet a minimum standard.
    - Another person recommended research into most determinant variables to help establish this guidance.
- Are there cases of sufficient quality with insufficient quantity? Not among food-insecure people and not relevant for the population analyzed by the IPC.
- Can people change chronic food insecurity level within a year? No; food consumption may change within a year, but chronic food insecurity severity does not.

*Process recommendations*

- Groups need people with local knowledge; Lorena and Gilda were able to contribute key details to inform analysis. Few other invitees had their level of local knowledge.
- More emphasis should be given to explaining the value of convergence of evidence and analysis of qualitative data during trainings and/or at the beginning of the analysis process, particularly in settings strongly in favor of quantitative/statistical methods. The general idea in a group with a lot of quantitative data and 'statistics persons' was: why try to infer information from other variables or different years or do a convergence of evidence when you have facts about food consumption?
- The evaluation form was sent via email and is unlikely to be returned. The evaluation portion was verbal, with the substantive, big-picture evaluation on day 4 with an incomplete group. Fundamental questions the pilots should address were not raised during the evaluations. As a result, feedback from pilots may not be as effective, as complete, or as productive as it could be. For example, I would expect the GSU to explain more clearly the logic of the choices the working group has made (pros and cons) within the context of the guiding principles of the IPC as a part of the training/orientation and to present these decisions to participants for comment as appropriate as the main substance of the evaluation. Fundamental question examples:
    - The purpose of the pilot is to test whether or not the tools are sufficient to meet chronic food insecurity severity classification and prevalence identification needs for decision-

makers. Did the pilot sufficiently test the tools for this purpose? Do the groups find that the tools are sufficient or not? What are the main issues?

- The IPC is designed to be both rigorous and simple. Assuming a more robust 2-3 day training with formal guidance, is there sufficient balance between the two given the current procedures and tools?
- IPC decided to respond to decision-makers' demand for prevalence. The only way the IPC could think of doing this was by classifying households in levels of food insecurity. Do you agree that decision-makers need prevalence to act? Needed or not, is it something the IPC should provide? Is there any other way to estimate prevalence of chronic food insecurity other than the way the IPC has proposed?
- What is the value added of X step or indicator to decision-making within the context of the other steps? Do any changes need to be made (or guidance notes) to improve sensitivity to chronic issues and ease of convergence of evidence/ achievability?
- Do steps 7-9 sufficiently respond to the causal analysis needs of decision-makers for chronic food insecurity? Are there other tools/processes that may be more appropriate?
- Are there minimum information needs or participant needs required for IPC chronic analysis?
- The question: "is there a different food consumption cutoff between the minimum kcal/person/day required for a healthy and active life and minimum survival need" may not be an appropriate evaluation question for the pilots because:
  - The idea that the food consumption cutoffs in chronic are higher than those for the acute scale is too fundamental to change.
  - The appropriate group to present this question to would be a group of nutritionists prepared for the discussion, not a mixed group or a group of generalists.
  - It's my understanding that the working group already presented this question to a group of highly-qualified nutritionists, and that they supported the working group's conclusion that there should be a difference, even if no threshold for acute was specified. Therefore, it seems unnecessary to re-open the question.

*Guidance/training needs*

- How to estimate % households.
- Guidance on appropriate ranges, if ranges are appropriate at all. For example, ranges of >50% and <50% are not sufficient. Concern was expressed that decision-makers will be unhappy with ranges; decision-makers want a precise number to act upon. Others expressed a desire to provide approximate information to decision-makers because the IPC analytical process is by its very nature qualitative and imprecise.
- How to translate data for children to data for hh
- How to converge evidence and make inferences
  - How to consider food consumption and livelihoods
  - How to weight micro-nutrient indicators appropriately (2 groups expressed that because sugar and salt are fortified (vit. A and iodine), no households could be severely chronically food insecure)
  - 1 group didn't use information from exceptional years to make inferences for non-exceptional years (for which information was very limited)
  - 1 group had "too much" info for 2013 but didn't use this information + data points from other years to make inferences about indicators for other years
  - Suggestion that the IPC produce at least 2 examples of worksheets/classification, one for a data-rich area, and one for a data-poor area to illustrate convergence of evidence and inference.

- How to incorporate morbidity in the analysis of chronic food insecurity.
- How to do SWOT analysis. SWOT is general and chronic is general, so it may be difficult for analysts to understand the direction of the approach and the specific types of questions the product should answer. For example, should the SWOT already begin to address recommendations for action or not?

*Minor suggestions/issues*

- Consider adding indicator for water quantity seasonality.
- One group, when discussing Step 7, expressed concern about sub-standard food consumption among middle-income households as a result of shocks ("increasingly frequent"). This population wouldn't really show up in a chronic scale as they are not food insecure in a non-exceptional year and as the acute scale may not be very sensitive to their issues.
- How long do you have to have a problem in order to be food insecure? For example, if you usually have a quantity problem of 2 weeks is that enough to make it phase 3? Desire for specification of a minimum number of months.
- Mortality is still a variable not entirely accepted as a valid one for a chronic analysis.
- Piloted tables still don't include obesity.
- Steps 7-9: instead of these rather open-ended tables, perhaps simple, guiding questions may be more appropriate.

*Ideas to explore*

- Perhaps the levels of chronic include seasonality of food consumption in the description:
    - Level 1: Sufficient quantity and quality possible year-round
    - Level 2: Sufficient quantity possible year-round; seasonal quality deficits.
    - Level 3: Sufficient quantity year-round; permanent quality deficits
    - Level 4: Insufficient quality year-round; seasonal quantity deficits
    - Level 5: Insufficient quality year-round; near-permanent quantity deficits
- In several cases, the results showed populations >20% with severity levels higher than the area severity level (i.e. household classification of 1/2/3=70/20/10 and area classification of 1). After reconsidering the methodology, this result was determined to be appropriate for the scale as developed. However, it appears to result in giving more weight to malnutrition and mortality than food consumption and livelihoods. Is this appropriate? If area classification can't be better than the lowest level experienced by at least 20% of the households, then what is the point of doing a separate area classification at all?

**FEEDBACK SPECIFIC TO STEPS**

*Step 2: non-exceptional years. Options discussed regarding identification of non-exceptional (NE) years at local vs. regional vs. national levels, ranked in order of JC's perception of expressed preference*

- Recommendation 1: At national level make a broad pre-selection of NE years (ex 6-7/10) and municipalities can choose 3-4 from among them based on local NE and info avail. There seemed to be broad, though not complete support for this option.
- Recommendation 2: Use all of the data and just adjust it if it was influenced by shock.
- Recommendation 3: Do NE process at all levels. JC: why do it at a national level at all if you're not going to use the national level?
- Recommendation 4: must use same years in all municipalities.
- NE definition talks about "adverse" shocks rather than just shocks. This needs to be modified to take into account positive shocks.

*Step 4*

- Hybrid tool with mutual purpose to both facilitate analysis and communicate may end up not doing a great job of either.
- Vertical approach: Not tested in most groups due to lack of info. One/two groups had complete info for 2013 but did not infer complete info for other years and therefore essentially did vertical for 2013 only, which is not a viable test of the vertical approach.
- Household classification was more difficult in vertical because different years had different data with larger variations.
- There was general consensus that the adapted reference table was preferred to the two separated ones because it added additional support to the classification of households. It should be noted that for one group this table/information resulted in more, rather than less, confusion about classification of households. For the people not familiar with the IPC acute protocols, the two tables and the separated classification for households and area were confusing.

*Indicators*

- Need research into cutoff alignment
- HHS of 1 implies already a quantity deficit, which implies that quality is already compromised. This suggests that HHS cut-offs may not match descriptions/other indicators. Does HHS apply to chronic or is it more appropriate for acute? Do the cutoffs correspond with other indicators? (you don't have "hunger" unless quality is already compromised; 1 = severe)
- The group is comfortable with ELSA data; however, despite being informed that it's ok to draw inferences from other indicators, this data was not used. Guidance about how to infer from non-standard indicators is needed.
- Still no definition of applicable group for anemia or for chronic malnutrition
- Acquiring appropriate information on livelihoods is extremely difficult.
    - If in Tajamulco with the Title II baseline they still didn't have enough info to analyze livelihoods, then perhaps the livelihoods info the IPC is looking for is too specific. On the other hand, potential livelihood (strength) information derivatives from Title II baseline were discussed. This re-analysis was not done, likely due to time limits. Livelihood "change" information may or may not be available from just 1 year of data.
- Mortality is included in the adapted reference table descriptions, even though there are no mortality indicators in the adapted reference table.

*Step 7 should be eliminated; any relevant concepts should be incorporated in other steps*

- LO expressed Step 7's purpose as: synthesis of analysis through step 6 and to help identify "who" is chronically food insecure.
- Step 7 assumes that responses would differ between types, an assumption that may or may not be justified. Even if food insecurity may be more acute at certain times of the year, the solutions to chronic food insecurity are long-term, not seasonal. Responses also may be more appropriately differentiated by limiting factors than by temporality of food insecurity.
- Contrary to stated purpose, step 7 clearly requests new analysis. It is not adequate as a description of the food-insecure population or to identify "who" is food insecure.
- Several groups were unable to distinguish between typology and chronic food insecurity severity, making the step both redundant and confusing. This is particularly the case as insufficient quantity of food was regarded as a seasonal rather than permanent issue.
- There was strong consensus that:
    - Chronic analysis should assess and document seasonality of food insecurity/food consumption, but not necessarily as Step 7 does.
    - Chronic malnutrition and mortality aren't seasonal. "Livelihoods" can't be seasonal, (group did not discuss whether or not "livelihood change" could be seasonal). Food consumption can be seasonal, but that is not the same as chronic food insecurity. Therefore, typology doesn't fit the definition of chronic food insecurity.
    - Households can't be part of the year in chronic level 3 and part of the year in chronic level 1. The level of chronic food security is stable intra-annually, despite seasonal changes in limiting factors/food consumption/typical household behavior.
    - If step 7 is to be maintained, it should include all mutually exclusive types of chronic food insecurity, currently identified as permanent only, permanent + seasonal, seasonal only.

*Step 8 needs an overhaul*

- Criteria for selecting between levels unclear.
- Method for prioritizing one pillar (constraint) over another unclear.
- Pilots use of numbers for limiting factors unclear.
- Unclear whether stability refers to inter-annual or intra-annual.
- Limiting factors should explicitly address seasonality of limiting factors, not just in stability column.
- Level of limiting factor appeared to be preferred product. However, several issues may be identified in each cell. Can a large number of issues that are individually minor limiting factors constitute as a whole a major or complete limiting factor?
- Value of final result is unclear due to high subjectivity resulting from insufficient guidance.
- Is it possible to have "completely limiting" for chronic?
- Should matrix be for entire population or for only part of the population? Which part? If you should analyze different populations separately, do you discuss both within the same tool or do you copy the tool and re-analyze when evaluating multiple populations?

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# Added value of the Chronic IPC in Guatemala



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The Integrated Food Security Phase Classification (IPC) as a standardized protocol may provide a common procedure using evidence for classifying the severity and magnitude of food and nutrition insecurity among countries and lower level administrative units in emergency situations. This may not be the case in chronic situations where actions are aiming at preventing likely crisis from chronic stress and promoting better food and nutrition conditions.

These conditions may include contributing factors, non-food or food-based, with different levels of positive or negative impact on results of food and nutrition security as defined in the IPC approach, that is, shortage of food intake, deterioration of positive and appearance of negative livelihoods at first stage and nutritional problems due to deficiencies or excess related to the food systems and mortality linked to nutrition such as infectious diseases in young children as outcomes at a final stage.

The proposed objective of the ongoing development of the Chronic IPC using basic characteristics of the Acute IPC approach of classifying low level administrative units may be just not enough. The Chronic IPC may be successful in obtaining consensus-building among decision makers in arriving to a classification of these administrative units, in particular when resources are not enough and prioritization is a most. However the Government of Guatemala has made efforts to classify administrative units by ranking them in Phases for Actions using existing information. For example, the current Government has defined 5 Phases for Actions with respective 8, 25, 50, 83 and 168 administrative units based on the prevalence of growth retardation (moderate and severe) of school children attending first grade of elementary schools (2008).

The questions are: What value adds Chronic IPC classification to this classification scheme? Is there any other element in the Chronic IPC that may be a plus in the Government effort?

This technical note addresses these aspects as a contribution for the development of an improved Chronic IPC.

**The classification of low administrative units by the Government**

Based on the National Height Census of First Grade School Children carried out in 2008 and using the prevalence of moderate and severe growth retardation, the Government of Guatemala classified municipalities (administrative units of level 2) with legal and budgetary autonomy for the implementation of the Municipal Development Plans (PDM) in Phases 1 to 5 from highest priority to lowest priority. Municipalities of Phase 1 have received extra-budgetary funds through health, education and social development institutions for implementing actions. Currently the 5 Phases for Actions include respectively 8, 25, 50, 83 and 168 administrative units and available financial, human and operating resources are assigned by phases.

**The classification of low administrative units by the proposed Chronic IPC approach**

One of the end products of the Chronic IPC approach is classifying administrative units in severe or moderate food insecurity or absence of food insecurity based on a four-model conceptual framework. In achieving this classification an in-depth analysis of the elements of the four-model is performed. This exercise of in-depth analysis is costly and complex. It is a time-consuming exercise, even if it systematized using information technology, in a country interested in second level administrative unit analysis, for example in Guatemala there are more than 330 units to analyze. This situation may preclude government efforts for implementing such a big task for the purpose of classification as in the case of Guatemala where there is a scheme classification.

In a recent exercise for the purpose of testing a proposed Chronic IPC, three municipalities were tested and the end point classification was similar to the ranking of the Guatemalan classification scheme, one as severe, one as moderate and one as without food insecurity.

**The classifications by the proposed Chronic IPC approach and Government**

If the information on growth retardation split in moderate and severe as part of the response subject to classification in the proposed Chronic IPC approach converge with the rest of the elements of the response (mortality, food intake and change in livelihoods), one could group municipalities based on both approaches as shown by Table 1.

**Table 1: Number of municipalities by phase and chronic IPC level**

| Guatemala classification | Chronic IPC level | | | |
|---|---|---|---|---|
| Phase and category of the prevalence of growth retardation – moderate and severe (%) | Without CFI | Moderate CFI | Severe CFI | **TOTAL** |
| 1) 77.7 and over | 0 | 0 | 8 | **8** |
| 2) 70 to 77.6 | 0 | 0 | 25 | **25** |
| 3) 60.1 to 69.9 | 0 | 21 | 29 | **50** |
| 4) 42.9 to 59.9 | 0 | 83 | 0 | **83** |
| 5) 42.7 or less | 32 | 133 | 0 | **168** |
| **TOTAL** | **32** | **237** | **62** | **331** |

**Sources:**
**1) SESAN (2013).** Sistema de Información Nacional de Seguridad Alimentaria y Nutricional **(SIISAN). Guatemala;**
**2) SESAN / Ministry of Education (2008). National Height Census of First Grade Elementary School Children. Guatemala.**

**The classification including trend analysis**

The classifications above are based on information of 2008. However some units have performed better than others within a long or middle time frame. If the information on response elements were available this type of analysis would be possible.

If one estimates the annual percentage change of growth retardation, both moderate and severe, as part of the response as in the proposed Chronic IPC approach, and the other elements of response converge, one could group municipalities based on the trends of the prevalence of growth retardation and the trend in the number of school children with growth retardation as shown by Table 2.

Based on the estimates of the annual percentage change of the prevalence of growth retardation, none of the municipalities showed a significant increase, 30 increased slightly, 141 reduced slightly and 160 showed significant reductions; however, based on the estimates of the annual percentage change of the number of growth retarded children, 88 municipalities showed a significant increase, 65 increased slightly, 86 reduced slightly and 92 showed significant reductions.

Among 92 municipalities classified as best performers, based on a reduction in number of children with growth retardation, most of them (84) showed effects of both reduction population and increasing food and other better non-food policies, 8 showed reductions linked to effects of population reduction policies only. Among 160 municipalities classified as best performers, based on a reduction in the

prevalence of growth retardation, 50 (less than one third) showed reductions linked to effects of increasing food and other better non-food policies only. That is, efforts for growth retardation reductions were more effective by increasing food and other better non-food policies while reduction population policies were less important between 2001 and 2008.

**Table 2: Number of municipalities by categories of change in prevalence and number of school children with growth retardation**

| | Trend of number of school children with growth retardation | | | | |
|---|---|---|---|---|---|
| Trend of prevalence of growth retardation | Increase by 2.5% and above | Increase by less than 2.5% | Decrease by less than 2.5% | Decrease by 2.5% and above | **TOTAL** |
| Increase by 2.5% and above | 0 | 0 | 0 | 0 | **0** |
| Increase by less than 2.5% | 28 | 2 | 0 | 0 | **30** |
| Decrease by less than 2.5% | 52 | 45 | 36 | 8 | **141** |
| Decrease by 2.5% and above | 8 | 18 | 50 | 84 | **160** |
| **TOTAL** | **88** | **65** | **86** | **92** | **331** |

**Sources:**

1) **Ministry of Education (2001). National Height Census of First Grade Elementary School Children. Guatemala.**
2) **SESAN / Ministry of Education (2008). National Height Census of First Grade Elementary School Children. Guatemala.**

Among 88 municipalities classified as worst performers, 8 showed high increase in numbers in spite of the high decrease in prevalence as result of increasing food and other better non-food policies counteracted heavily by the effects increasing population policies, while 52 municipalities counteracted mildly the effects of these increasing population policies. The remaining 28 showed a mild increase the prevalence of growth retardation between 2001 and 2008.

**Usefulness of classifications**

By providing more information on the nature of the evolution in terms of change in the prevalence of growth retardation and in the number of children with growth retardation, more informed and better decisions may be obtained.

**Added value of in-depth analysis**

An in-depth analysis as suggested by the proposed Chronic IPC of the different classification groups of municipalities based on estimates of growth retardation and trends complementing with other response elements as well as contributing factors may provide more insights of causality of food and nutrition insecurity for a better response analysis for policy design, planning, programing, actions and monitoring achieved progress.

**Referencias**

Guatemala (1987). Primer censo nacional de talla en escolares de primer grado de primaria de la República de Guatemala 1986. Informe Final. Ministerio de Educación, Guatemala.

Guatemala (2002). Segundo censo nacional de talla de escolares de primer grado de primaria de la República de Guatemala: 16 al 20 de julio, 2001. Informe Final. Ministerio de Educación, Guatemala.

Guatemala (2009). Tercer censo nacional de talla en escolares del primer grado de educación primaria de la República de Guatemala: 4 al 8 de agosto, 2008. Resumen Ejecutivo. Informe Final. Ministerio de Educación / Secretaría de Seguridad Alimentaria y Nutricional de la Presidencia de la República, Guatemala.

Guatemala (2013). Sistema de Información Nacional de Seguridad Alimentaria y Nutricional (SIISAN). Secretaría de Seguridad Alimentaria y Nutricional (SESAN). (http://www.siinsan.gob.gt/

**Annex**

The rates of change of growth retardation (prevalence or numbers) can be obtained using the exponential model $N_t = N_0$ x delta$^t$, where $N_0$ = initial growth retardation and $t$ = number of years between initial and latest years.

The exponential equation is expressed with natural logarithm as $\ln[N_t] = \ln[N_0] + t$ x ln[delta] where the annual change rate r = ln[delta] is the slope and $\ln[N_0]$ the intercept of $\ln[N_t] = \ln[N_0] + rt$, so that r = $\ln[N_t/N_0] / t$.