Second Synthesis Meeting of IPC Working Group on Classifying Chronic Food Insecurity

Rome 6 – 10 May 2013

Meeting minutes

1. Introduction

The second synthesis meeting of the chronic working group took place approximately two months after the first meeting from 11 to 14 March in Washington, which was hosted by the World Bank. As a result of the discussions in the Washington meeting, it was decided that two of the original four prototypes for classifying chronic food insecurity would be developed further with the aim of testing them and finding a consensus on the principles for a joint prototype in the Rome meeting. These two prototypes were the so called 'severity' prototype, prepared by FEWS NET, and the 'binomial' prototype, developed by IPC GSU. It was also agreed in Washington that members of the chronic working group would be welcome to participate in the further development work of either or both of the prototypes together with the people originally responsible for them.

During the period between the two meetings the prototypes were refined and discussions were held with the whole chronic working group and within the sub-groups focusing on the draft prototypes. The FEWS NET team working on the severity prototype also had consultations with external experts and decision-makers.

In the Washington meeting it was also decided that part of the second synthesis meeting would be used to do a real data analysis with the two prototypes. The country selected for the real data exercise was Kenya, for the following reasons: good data availability, data available in English, high variability of food security from one area to another and long history with IPC. As a result the Rome meeting was divided into two parts: 6 and 7 May for the real data exercise, and 8 to 10 May for the technical discussions.

The list of participants, agenda, and other related documents of the meeting are found in the annex of the minutes.

2. Real data exercise

As mentioned, the real data exercise on Kenya data was conducted on 6 and 7 May. The severity scale was used for the testing on 6 May, whereas the binomial scale was tested on 7 May. The data for the analysis was collected mainly beforehand from different reports and databases. Some gaps which became evident during the analysis were filled by sourcing for relevant data from WFP (FCS database) and FEWS NET (Kitui county short and long rains assessment reports). In addition the analysis team had access to Kenya food security analysts

through Skype (Francis Wambua from the Ministry of Health and Sanitation and Justus Liku from CARE), who kindly answered questions posed by the team.

Only one county, Kitui, of Kenya was finally analysed due to extensive discussions throughout the real data analysis and subsequent lack of time. Instead of dividing the group in two sub-groups for analysis, it was decided to keep the group together in order to facilitate the sharing of questions and comments and to keep everyone on the same page.

2.1. Real data exercise with the 'severity' reference table

The severity scale incorporated two reference tables: a household-based reference table, and an area-based reference table. The analysis started from the household-based reference table, as that formed the basis for the classification. After the household-based analysis, the area-based indicators were reviewed. The analysis raised a lot of questions on the severity approach, especially regarding the household component. The main questions and comments are below:

- ✓ Difficult to do analysis on livelihoods, especially when no baseline data is available
- ✓ When selecting a HH group there is a possibility that no data is available at that level for analysis
- ✓ National poverty line is not comparable across all countries. Maybe we could use DHS wealth index (the new, comparable version?) instead
- ✓ Issue with poverty gap & % below poverty: inconsistency with cut-offs. Needs to also look at food poverty line
- ✓ The severity table has none, low, moderate, and high levels, but none and high are rare and thus the difference is basically between two levels
- ✓ Resiliency is a too complicated to analyse
- ✓ What to do when >1 livelihood is one admin zone?
- ✓ Resilience measurement
    - Looking back at recurrence at crises might be easier and more accurate than modelling
    - What does it mean to model? Is it to project into future?
    - Are specific shocks comparable?
    - Is it worth going into detail in resilience now/with IPC or should this be done by the resilience group?
    - The resilience model would depend on external expertise, which is inconsistent with the IPC approach
- ✓ Difficult to apply kcal necessary for age, gender and activity level
    - Issue of overweight
    - Average
    - 2,100 kcal is ideal or minimal?
    - Should the acute vs. chronic be the same threshold
    - How to get the activity level? Need to average?
- ✓ Data availability in a non-crisis year

- ✓ Indicators included under quantity and quality are very similar, but one is for children whereas another is for HHs, why are they different?

There were fewer issues raised in relation to the area-based reference table, although some of the issues listed above apply to the overall analysis. The most challenging question in relation to the severity scale was, however, the analysis of livelihoods and resilience. The severity approach required modelling of resilience on basis of information on households groups, livelihoods, and shocks. This, however, turned out to be very difficult and the results remained uncertain, raising questions on the feasibility of this type of analysis by IPC country Technical Working Groups.

2.2. Real data exercise with the 'binomial' reference table

The analysis with the binomial scale focused on analysis of general and severe chronic food insecurity, as per the reference table on general chronic food insecurity, and a separate tool with cut-offs for severe chronic food insecurity. The main questions relating to the analysis are listed below:

- ✓ Type 3 (recurrence of acute crises) in the reference table
- ✓ 'Persistence' in the table/indicators/analysis
- ✓ Cut-offs for chronic analysis are different from acute analysis
- ✓ Definitions
  - Type 1
  - Type 2

  } CFI

  Not only focus on food consumption
- ✓ IYCF (Infant and Young Child Feeding) indicators –where do they fit? Food utilization? Proxy for dietary quality
- ✓ What if humanitarian (or developmental) assistance is ongoing?
- ✓ The binomial scale seems to imply acute food insecurity every year, is that what we want to say?

Some of the questions raised and listed above pertain also to the severity approach. One of the main questions discussed was the role of recurrence of acute crises in the analysis: is it an outcome of chronic food insecurity, an indicator of it, a cause of chronic food insecurity, or a type of chronic food insecurity? Given the many implications of the recurrence of acute crises, it was considered as a necessary element of the analysis even if the exact angle of the analysis remained somewhat unclear.

An issue specific to the binomial analysis was convergence of evidence. It was quite difficult to decide on a final level classification, as evidence pointed to two levels. However, an even more challenging issue was the determination of the percentage of population who were severely chronically food insecure. The percentages ranged by indicator from 3 to 61, which rendered the analysis inconclusive (and the group did not even try to estimate the overall percentage of severely chronically food insecure).

2.3. Summary of severity and binomial scales

The summary feedback on the real data exercise is available in the table below. The colours indicate similarities between the raised questions, which enabled the team to regroup the questions into five different issues which were discussed later on in the meeting.

Table 1: Summary table of feedback on real data exercise

	What worked well	What did not work well	Vital issues

Severity prototype	- Structure worked well, mimics the acute approach (HH and area)
	  ○ Binomial and severity scales measure different things
	  ○ Worksheets ask more analytical questions than the binomial analysis worksheets
		- A lot of time spent on discussing the approach – limited time for analysis
		- Analysis takes a lot of time
		- Data available does not correspond to requirements (e.g. resiliency)
			- **3.** What is the threshold for chronic food insecurity, and is it the same or different from acute scale
			  ○ Minimum vs. ideal, saving livelihoods vs. building livelihoods
			- **2.** If both prevalence and severity are important to chronic analysis, why don't we use the same approach?
			- **1.** What is the vision for the chronic process in terms of time, personnel resources, and consensus required?
			- Who are the users/analysts?

Binomial prototype	- Data available - No complicated analysis or modelling - Forces to think of contributing factors - Simple and direct	- Not easy to identify years for analysis - U5MR is not a %, but a rate per 1000 - Many indicators were between 3 and 4 - Classification of contributing factors?	- **3.** What is the cut-off in relation to the acute scale? Linkages between the two scales - **4.** What is the cut-off for severe - **1.** Simplicity, applicability, empowering - **5.** Non-exceptional year - **5.** Trend data vs. one-off surveys and data sets - Looking at snapshot data – needs to be validated

3. Technical discussions

3.1. Pertinent issues

As per the summary table presented above, five issues for further discussion were identified. These five issues were: 1) Chronic analysis process, 2) Binomial and severity approaches (conceptual differences), 3) Link between acute and chronic, 4) Identification of cut-off for severe chronic food insecurity, and 5) Identification of a reference year/reference years for analysis.

All issues, except issue 4 were discussed separately. Issue 4 was noted to link to issue 3 (link between acute and chronic) and therefore it did not merit a separate discussion. In order to clarify the different points of view and the extent of agreement, it was decided to write down statements on the issues and gauge the level of agreement/disagreement on each statement among the group. If the level of agreement remained uncertain, the second column was left empty. The tables constructed in this manner are presented below. In cases where there was no definitive agreement on statements at the time of the discussions but an agreement was reached later, the * sign after the table indicates the brief summary of the agreement.

Table 2: Issue 1

1. What is the vision for the chronic process in terms of time, personnel resources, and consensus required? Who are the users/analysts? Simplicity, applicability, empowering

Statements	**Agreed/not agreed**
Acceptable level of confidence should be higher than in acute analysis	Agreed
Minimum requirements for analysis (established guidance)	Agreed
TWG can do their own chronic analysis without external support (from regional or global IPC)	Agreed
Detailed data preparation is required	Agreed
TWG can do chronic analysis on their own without external consultants	Agreed
Chronic analysis provides an opportunity for more investment in the process than acute	Agreed
Users are government, NGOs, UN, donors…	

Table 3: Issue 2

2. If both prevalence and severity are important to chronic analysis, why don't we use the same approach?

Statements	Agreed/not agreed
% of population who are chronically food insecure indicates the severity of the situation	
Prevalence is more important for decision-makers than severity, i.e. the size of the gap	
Even the prevalence scale is a severity scale in a sense that a cut-off is required	
Not possible to do detailed HH group analysis at the required level	

*By the end of the meeting an agreement had been reached on these issues: both severity and prevalence are important and the reference table should capture both. The requirement to do detailed HH group analysis was left out.

Table 4: Issue 3

3. What is the cut-off for chronic food insecurity, and is it the same or different from acute scale: Minimum vs. recommended/ideal, saving livelihoods vs. building livelihoods. What is the cut-off in relation to the acute scale? Linkages between the two scales

Statements	Agreed/not agreed
Binomial cut-off is equivalent to Phase 2 of the acute scale, complemented with stunting and other chronic indicators	
Binomial cut-offs follow int'l standards to the extent possible	
Binomial cut-off is above minimum (adequate)	
Three groups: minimally or not chronically food insecure, moderately chronically food insecure, and severely chronically food insecure	
Severity scale cut-offs refer to resilient and sustainable livelihoods and acceptable food consumption	
Acute scale cut-offs refer to maintaining the status quo in terms of consumption and livelihoods	
If thresholds are tied to acute phases, in case there is no acute food insecurity there would not be any chronic food insecurity	
Cut-offs for short-term decision-making can't be the same as for medium and long-term decision-making	
Tying the binomial scale to acute scale prevents all four typologies of chronic-acute food insecurity combinations from materialising	

The cut-off for chronic food insecurity is whether or not the households have ideal/recommended diet	

*The discussion focused to a large extent on the 2,100 kcal/day cut-off. It was agreed that it is not a survival threshold, but neither does it represent the ideal or recommended intake. The acute cut-off eventually settled around phase 2, although there are variations depending on the indicator and also due to the fact that the chronic reference table has three levels (instead of previous four levels in some draft reference tables, and five phases of the acute scale).

Table 5: Issue 5

5. Trend data vs. one-off surveys and data sets. Non-exceptional year, looking at snapshot data – needs to be validated

Statements	**Agreed/not agreed**
One year is sufficient as a reference year for chronic analysis	Not agreed
Ideally the chronic analyses would be based on multiple non-exceptional years	Agreed
One year is sufficient as a reference for indicators that reflect persistent conditions - such as stunting and maybe extreme poverty	

*Eventually it was agreed that one year as a reference year is the required minimum for the analysis, although several reference years and panel data are preferable.

3.2. Indicator cut-offs and points of convergence/divergence

After reviewing the issues and feedback from the real data exercise, it was decided to identify the commonalities between the two scales especially in relation to indicator cut-offs. The table below details the cut-offs for both prototypes and the points of convergence and divergence. The first drafts for the joint prototype were developed on basis of this table and the ensuing discussions.

Table 6: Cut-offs for chronic food insecurity

	Binomial approach	**Severity approach**	**Convergence (or not)**
Food consumption	inadequate for a healthy and active life FCS: borderline HHS: 1 HDDS: smaller or equal to 4 Minimally acceptable diet for children:	less than something greater than 2,100 kcal FCS: borderline HHS: 1 HDDS: ? HEA: - MAHFP: 1 Minimally acceptable	Food consumption indicators have largely similar cut-offs There is an agreement that we refer to an active and healthy life. There is no agreement

	minimum meal frequency, minimum dietary frequency Share of food expenditure out of total expenditure: 50% (no int'l standards) Starchy Staple Ratio: ?	diet for children: Not achieved Starchy Staple Ratio: ?	on kcal cut-off in relation to acute. No capacity/possibility to come up with a different cut-off from 2,100 kcal
Livelihood (change)	HH is engaging in unsustainable (harmful) strategies to meet food needs regularly or seasonally: <5% of HHs	Share of food expenditure out of total expenditure: ? Depth of poverty: something comparable at sub-national level Value of total cash and food income as a proportion of survival needs: 150%	Share of food expenditure not under the same outcomes in the two scales
Nutritional status	Height for age -2 SD: 10% Anaemia: 5% Vitamin A deficiency: 2%	Height for age -2 SD: 20% CIAF: 20% Wasting: 5% Anaemia: 5% Vitamin A deficiency: 2% Iodine: ?	General agreement, except for CIAF and wasting
Mortality	U5MR: 40/1000	U5MR: 40/1000	Agreement
Recurrence of acute food insecurity/ instability	Frequency of IPC Phases 2+?	Impact of a moderate shock on livelihoods protection: 1% Time required to recover from a moderate shock: ? Frequency of IPC 1+ >0 over 5 years	We agree that frequency of acute is an indicator for chronic
Contributing factors	<u>Hazards and vulnerability</u> Below national poverty line: tbd (10%) Livelihoods are marginal or HHs have limited resilience to shocks: 5%		Contributing factors are important in the analysis and for classification
	<u>Availability, Access, Utilization, and Stability</u> Inadequate to meet food consumption		

	requirements of a diet of acceptable quantity and quality: 5% of HHs		
	<u>Water</u> HHs rely on non-improved sources: 5% of HHs		

3.3. Pertinent questions

Many issues were discussed several times during the meeting, and often no definitive conclusion was reached. Instead, different points of view were presented for discussion. Some of these issues with the points of view offered, and tentative agreements where possible, are detailed below:

1. 2,100 kcal/day cut-off
   - Is 2,100 kcal/day a general, a survival or minimum requirements cut-off? The agreement on this question was that is it not a survival threshold, but neither does it represent an ideal diet in terms of energy or micronutrient requirements
   - No minimum or maximum requirements in nutrition community
   - Captures energy requirements but no micronutrient requirements
   - Nationally determined cut-offs exist for some countries – can be more applicable than the standard 2,100 kcal/day
   - Short-term vs. long-term requirements
   - Energy requirements vary by age, sex, health status, and activity levels
   - Data problems – the kilocalorie cut-off is rather meaningless as an indicator in the reference table in a sense as there is almost never data on the kilocalories eaten by different population groups. The indicator could perhaps be replaced with a qualitative description?
   - Need to have it in the table as it is the basis for other food consumption indicators

2. Prevalence and severity
   - It is agreed that both prevalence and severity are important, and that the chronic analysis should be able to provide information on both to decision-makers
   - The issue is, however, on whether the classification will be conducted on basis of prevalence or severity
   - One option is to do classification on basis of both, and to communicate it to decision-makers by using two different maps
   - Use of two maps will be tried in the pilots
   - The topic will also be raised with decision-makers to see what they prefer

3. Reference years for analysis
   - Use of non-exceptional year(s) instead of non-crisis year(s) preferred because of potentially having very good years which might distort the analysis
   - Option of not choosing years but using panel data? Or having to do both?

- Ideally panel data is used, especially for analysis of food consumption indicators
- Practical guidance required before the pilots, has to be consistent with the conceptual approach
- Issues of comparability of analysis as people have different ideas on what is non-crisis or non-exceptional
- Indication of level of confidence in the analysis
- Should chronic scale only have indicators which are sensitive to time changes? Or only having structural indicators?

4. Joint prototype

On basis of the discussions and the identified commonalities between the two approaches a compromise was reached and a joint prototype was produced (pages 13-14). The joint prototype is based on agreements on many of the outstanding issues which were the reason for originally having several prototypes for the first round of piloting. The agreements are briefly explained below:

1. Severity scale vs. prevalence scale

   It was confirmed that both are important, and should be incorporated in the reference table. However, a question remained on whether the classification and mapping should be based on severity, or prevalence. This was solved by adding two sub-tables to the chronic reference table which allows classification and mapping according to the preferences of the analysts (and decision-makers). The feasibility and practicality of the sub-tables will be tested during the second round of the pilots and further adjustments will be made accordingly.

2. Relationship between the acute and chronic

   It was agreed that there would be two cut-offs for the chronic reference table: moderate chronic food insecurity and severe chronic food insecurity. As a result the chronic reference table has three levels: food secure, moderate chronic, and severe chronic. The basic cut-off for different food consumption indicators is phase 2 of the acute scale, albeit with some variation (e.g. the approach to HHS is somewhat different in the chronic scale compared to the acute scale). The division of the chronic scale into three levels is thought to make the analysis and the classification simpler rather than retaining more levels or having separate scales.

   It was also decided to separate the chronic from the acute to the extent possible, especially by removing the only acute indicator from the chronic reference table: the frequency of acute crisis. It was agreed that the chronic food insecurity would refer to continuous and cyclical food insecurity, without an explicit reference to (repeated) acute shocks as a form of chronic food insecurity.

3. Household analysis as a prerequisite for chronic analysis

   It was noted that requiring the analysts to perform HH group analysis as an integral part of the chronic analysis is unsustainable: it requires a lot of data and is rather complicated. Since most IPC TWGs do not conduct acute analysis by household groups, it would not be practical to require them to perform chronic analysis by household groups.

4. Structure of the reference table

   Since it was decided to incorporate severity and prevalence in the same reference table and to leave out analysis by household groups, it became possible to have just one reference table (even though with two sub-tables for classification and mapping purposes).

   The joint reference table includes the four food security outcomes as per the IPC Analytical Framework. This means that mortality was also included in the reference table, as opposed to the previous versions of the draft table. As mentioned earlier, frequency of the acute crises was removed from the reference table. Since there was no agreement on the inclusion of wasting and CIAF in the reference table, they are not included in the joint prototype. It was also decided to keep the contributing factors in the reference table in order to complement and deepen the analysis, and to encourage the analysts to think through the impact of the contributing factors during the analysis.

Although major breakthroughs were achieved during the meeting regarding the understanding of chronic food insecurity and the structure of the reference table, at the end of the meeting there were still some issues which required further clarifications. Most of the problematic questions relate to the indicators of the reference table and they are listed below.

Indicators:

1. Livelihood change: the indicators currently pertaining to livelihood change are more likely to measure livelihood strength rather than livelihood change. Further research is required on suitable indicators
2. Micronutrients: the issues relating to the two micronutrient deficiency indicators (Vitamin A and anaemia) are their cut-offs, thresholds, and unit of analysis.
    - The specific cut-offs are often based on separate population groups, e.g. children and pregnant women. Equally data is normally collected from these groups rather than the whole population. Is it not clear whether the rates received can be aggregated to the whole population (as stunting rates commonly are) or not.
    - The thresholds for these two indicators have been defined by WHO on basis of the public health significance of the problem and therefore the thresholds do not have any explicit relationship with food insecurity. Moreover, the thresholds do not converge with the thresholds of other

indicators used in the chronic reference table. The question is whether there is a possibility, and a rationale, for changing the thresholds for food security purposes. Consultations with public health specialists and nutritionists are needed to clarify this.

- Until the issues related to the two micronutrient indicators are solved, the reference table cannot be called a 'HH reference table'.

3. Mortality: the main problem with the mortality indicator (U5MR) is that it does not provide a % of children, but rather a rate per 1,000 children. As other indicators provide a % of population, it is difficult to calibrate the mortality indicator especially to the prevalence classification. Another problematic issue is the fact that there is no established cut-off to indicate the severity of under-5 mortality. Further research into the issues is required, as well as consultations with mortality experts.

At the end of the meeting the following list was prepared on agreed issues:

- Sub-working group to look into micronutrient indicators and examine how they can be aligned to food consumption indicator cut-offs/thresholds
- HH will be put back into the title of the reference table if the indicators can be sorted out
- Contributing factors stay on the reference table
- Analysis focuses on recent non-exceptional years. Minimum is one year. If possible, trend analysis of these years will be conducted
- Within the non-exceptional year the analysis will be done on the worst time period of the year
- We will keep livelihood change as an outcome in the reference table (vis-à-vis livelihood)
- Sub-working group will prepare a definition of livelihood change and choose appropriate indicators to reflect livelihood change. If this turns out not to be possible, two different versions will be prepared and piloted
- Guidance on analysing livelihood change will be available before piloting
- We will keep to the plan of releasing version 1.0 of the chronic scale by January 2014

Draft joint reference table for classifying chronic food insecurity

Chronic Food Insecurity Reference Table for Severity Classification

PURPOSE: To guide decision making with medium and/or long-term strategic objectives. Should be accompanied with analysis of Acute severity when appropriate.

USAGE: Estimation of prevalence of Moderate and Severe Chronic Food Insecurity

		Food Secure	Moderate Chronic	Severe Chronic
Level Description		*(Considering recent non-exceptional years, and without any assistance)* HHs are able to access an acceptable quantity and quality diet throughout the year and maintain a sustainable livelihood which is resilient to shocks. Prevalence of chronic malnutrition is low.	*(Considering recent non-exceptional years, and without any assistance)* HHs are not able to access an acceptable quantity and quality diet throughout the year and maintain a sustainable livelihood, or resilience to shocks is limited. Prevalence of chronic malnutrition is moderate.	*(Considering recent non-exceptional years, and without any assistance)* HHs have significant quantity and quality deficits regularly with very marginal livelihoods resulting in severe chronic malnutrition. Resilience to shocks is very limited and can result in recurrent experience of acute food insecurity
Outcomes	**Food Consumption**	**Quality**: Adequate nutrient intake **Starchy Staple Ratio (SSR) >TBD** **Children eating minimal dietary diversity**	**Quality**: Moderately inadequate nutrient intake **Starchy Staple Ratio (SSR) TBD** **Children NOT eating minimal dietary diversity**	**Quality**: Very Inadequate nutrient intake **Starchy Staple Ratio (SSR) TBD** **Minimum acceptable diet of children lacking diversity & frequency**
		Quantity: Adequate caloric intake for a healthy and active life **HDDS >4** **FCS acceptable** **HHS 0** **Children eating minimal meal frequency**	**Quantity**: Moderately inadequate caloric intake for a healthy and active life **HDDS 3-4** **FCS borderline** **HHS 1-3** **Children NOT eating minimal meal frequency**	**Quantity**: Very Inadequate caloric intake for a healthy and active life **HDDS ≤2** **FCS Poor** **HHS ≥4**
	Livelihoods	HHs not engaging in unsustainable/harmful strategies to meet food needs regularly or seasonally **Share of food expenditure of total expenditure** <50% **Value of total cash and food income** as a proportion of survival needs > 150%	HHs engaging in unsustainable/harmful strategies to meet food needs seasonally **Share of food expenditure of total expenditure** >50% **Value of total cash and food income** as a proportion of survival needs < 150%	**HHs engaging in unsustainable strategies** to meet food needs regularly **Share of food expenditure of total expenditure** >66% **Value of total cash and food income** as a proportion of survival needs < TBD%
	Nutritional Status	**Stunting > -2sd** **No (or mild) Anaemia** **No (or mild) Vit. A deficiency**	**Children are moderately stunted** **Moderate Anaemia** **Moderate Vit. A deficiency**	**Children are severely stunted** **Severe Vit A deficiency** **Severe Anemia**
	Mortality	**U5MR: <**40	**U5MR:** 40	**U5MR:** TBD

		For Contributing Factors, most indicators and cut-offs to infer Chronic Level need to be determined and analyzed according to the livelihood context of the area.		
Contributing Factors	**Hazards & Vulnerability**	**Above Nat'l Poverty Line** **Livelihoods** are sustainable and resilient to shocks	**Below Nat'l Poverty Line** **Livelihoods** are marginal or HHs have limited resilience to shocks	**Below Extreme Nat'l Poverty Line** Livelihoods are very marginal and of very limited resilience to shocks
	Availability, Access, Utilization,	**Adequate** to meet food consumption requirements of a diet of acceptable quantity and quality	**Inadequate** to meet food consumption requirements of a diet of acceptable quantity and quality	**Very Inadequate** t o meet food consumption requirements of a diet of acceptable quantity and quality
	Stability/Recurrence of Crises	**Recurrence of Acute crises 2+ seen less than 2 times in previous 10 years**	**Recurrence of Acute crises 2+ seen more than 2 times in previous 10 years**	**Recurrence of Acute crises 3+ seen less than 2 times in previous 10 years**
	Water	**HHs rely on non-improved sources:** < 5% of HHs	**HHs rely on non-improved sources:** < 5% of HHs	**TBD**

Chronic Food Insecurity Reference Table for Area Severity classification (MAP)

	Food Secure/Low	Moderate Chronic	Severe Chronic
Level Description	(Considering recent non-exceptional years, and without any assistance) HHs are able to access an acceptable quantity and quality diet throughout the year and maintain a sustainable livelihood which are resilient to shocks. Prevalence of chronic malnutrition is low.	(Considering recent non-exceptional years, and without any assistance) HHs are not able to access an acceptable quantity and quality diet throughout the year and maintain a sustainable livelihood, or resilience to shocks is limited. Prevalence of chronic malnutrition is moderate.	(Considering recent non-exceptional years, and without any assistance) HHs have significant quantity and quality deficits regularly with very marginal livelihoods resulting in severe chronic malnutrition. Resilience to shocks is very limited and can result in recurrent experience of acute food insecurity
Area cut-off	>80 % of HH are food secure	>20% of HH are moderately chronically food insecure or worse	>20% of HH are severely chronically food insecure or worse

Chronic Food Insecurity Reference Table for Area Prevalence classification (MAP)

	Very Low Prevalence of Chronic FIS	Low Prevalence of Chronic FIS	Medium Prevalence of Chronic FIS	High Prevalence of Chronic FIS
Prevalence	>5%	5-20%	20-40%	>40%

5. Next steps

It was decided to establish a sub-working group of the chronic working group in order to solve the remaining issues and questions relating to the joint prototype (indicator cut-offs detailed above). This group is coordinated by Kaija Korpi and it includes members who will address the issues relating to the nutrition, mortality, and livelihood indicators by literature review, internal consultations, and by referring to external experts. The deadline for inputs from the sub-working group is 7 June.

After the deadline the inputs will be consolidated and a new draft of the reference table will be released for a round of comments from the chronic working group. It is hoped that an agreement on the joint draft reference table can be reached in June – early July, so that the pilots can resume in late July – August.

Regarding the pilots, the following principles were agreed:

- There will be (at least) three pilots: one in Africa, one in Asia, and one in Central America
- Each official pilot will require the presence of minimum two members of the chronic working group (esp. those who took part in the Rome meeting)
- Each pilot will be preceded by a thorough preparation period especially in terms of data gathering and organisation

The lessons learned from the pilots will be documented and proposals for subsequent revisions of the reference table and associated tools will be prepared. These will be reviewed in the third synthesis meeting of the chronic working group, which is likely to take place around October 2013. The exact timing and location of the meeting are to be decided. It was also agreed that the original objective of finalising the version 1.0 of the chronic reference table and tools by the end of the year is still valid. This means that the chronic reference table and tools can be rolled out for country use by early 2014.

These decisions were included in a list of next steps, available below:

- Forming the sub-working group (Kaija the focal point. Group includes Chris (micronutrients), Ricardo (micronutrients), Jenny (livelihoods), Leila, Jose. The sub-working group will circulate their results and products to the wider group by Friday 7 June
- Preparation of the tools in June
- Piloting starts in July-August
- Countries:
    - Criteria: one with a lot of information and one with little information
    - In every pilot at least 2 people from the Rome meeting
    - One in Asia, one in Latin America, one in Africa
    - One of the countries (Africa) should also have HEA livelihood data
- Preparation of some training materials to be used in every pilot

Annexes

Annex 1: List of participants

IPC Working Group on Classifying Chronic Food Insecurity

6 – 10 May synthesis meeting

List of participants

No.	Name	Agency	Contact	Days
1	Nicholas Haan	IPC GSU	Nicholas.haan@fao.org	3 (8-10)
2	Leila de Oliveira	IPC GSU	Leila.oliveira@fao.org	5
3	Oriane Turot	IPC GSU	Oriane.turot@fao.org	5
4	Kaija Korpi	IPC GSU	Kaija.korpi@fao.org	5
5	Cindy Holleman	IPC GSU	Cindy.holleman@fao.org	5
6	Kay Sharp	SC	k.sharp@savethechildren.org.uk	3 (8-10)
7	Jose Cuesta	World Bank	jcuesta@worldbank.org	4 (7-10)
8	Ricardo Sibrián	PRESANCA	rsibrian@sica.int	5 (6-10)
9	Christopher Hillbruner	FEWS NET	chillbruner@chemonics.com	5
10	Tharcisse Nkunzimana	JRC	Tharcisse.nkunzimana@jrc.ec.europa.eu	5
11	Alexis Hoskins	WFP	Alexis.hoskins@wfp.org	5
12	Jenny Coneff	FEWS NET	jconeff@chemonics.com	3 (8-10)
13	Kate Ogden	WFP	Kathryn.ogden@wfp.org	3 (8-10)

Annex 2: Agenda

IPC Working Group on Classifying Chronic Food Insecurity
Second Synthesis Meeting
FAO, Rome 6 – 10 May 2013
Draft Agenda

Time	Session title	Facilitators (tbc)
Day 1		
08:30-09:00	Welcome, introductions, & objectives	Cindy Holleman
09:00- 10:00	Review of bivariate prototype and tools	Leila de Oliveira, Kaija Korpi
10:00-10:30	Preparations for Kenya real data exercise (groups, data, areas to be analysed)	Kaija Korpi
10:30-10:45	Coffee break	
10:45-13:00	Real data exercise – bivariate scale	
13:00-14:00	Lunch	
14:00-15:30	Real data exercise (cont.)	
15:30-15:45	Coffee break	

15:45-16:30	Real data exercise (cont.)	
16:30-17:30	Wrapping up of analysis and conclusions	Leila de Oliveira, Kaija Korpi
Day 2		
08:30-09:30	Review of severity prototype and tools	Christopher Hillbruner
09:30-10:30	Preparations for Kenya real data exercise (groups, data, areas/HH groups to be analysed)	Christopher Hillbruner
10:30-10:45	Coffee break	
10:45-13:00	Real data exercise	
13:00-14:00	Lunch	
14:00-15:30	Real data exercise (cont.)	
15:30-15:45	Coffee break	
15:45-16:30	Real data exercise (cont.)	
16:30-17:30	Wrapping up of analysis and conclusions	Christopher Hillbruner
Day 3		
08:30-09:00	Welcome, introductions and review of agenda	Nicholas Haan
09:00- 10:30	Review of lessons learned from real data exercise	Leila de Oliveira, Kaija Korpi, Christopher Hillbruner
10:15-10:45	Coffee break	
10:30-12:30	Identification of common ground and points of divergence	Chair: tbd
12:30-13:30	Lunch	
13:30-15:30	Technical discussion	Chair: tbd
15:30-15:45	Coffee break	
15:45-16:30	Technical discussion (cont.)	Chair: tbd
16:30-17:30	Synthesis	Chair: tbc
Day 4		
08:30-9:00	Stock taking & remaining priorities	Cindy Holleman
9:00-10:15	Technical discussion (tbd)	Chair tbd
10:15-10:45	Coffee break	
10:45-12:30	Technical discussion (tbd)	Chair tbd
12:30-13:30	Lunch	
13:30-15:30	Technical discussion (tbd)	Chair tbd
15:30-15:45	Coffee break	
15:45-17:30	Technical conclusions & synthesis	Nicholas Haan
Day 5		
08:30-09:00	Stock taking & remaining priorities	Nicholas Haan
09:00-10:30	Common ground for development of a joint prototype	Chair tbd
10:30-10:45	Coffee break	
10:45-13:00	Common ground for development of a joint prototype (cont.)	Chair tbd
13:00-14:00	Lunch	
14:00-15:30	Common ground for development of a joint prototype (cont.)	Chair tbd
15:30-15:45	Coffee break	

15:45-17:00	Next steps: development process, pilots, next synthesis meeting, and stakeholder participation	Kaija Korpi
17:00-17:30	Concluding remarks and closure	Nicholas Haan and Cindy Holleman