IPC Working Group on Classifying Chronic Food Insecurity
Third Synthesis Meeting, London 9-13 Dec 2013
Meeting report

1. Background

The meeting in London was the third meeting of the IPC chronic working group after the previous meetings in Washington (March 2013) and Rome (May 2013). The meeting was preceded by the second round of piloting of chronic food insecurity analysis tools and procedures, which consisted of four pilots (Kenya, Bangladesh, Guatemala, and Malawi) between September and November 2013.

The meeting was hosted by Save the Children, and the following agencies were represented: FANTA, FEWS NET, JRC, PRESANCA, Save the Children, WFP, and the World Bank. The list of participants and the meeting agenda are available in the annex of the report.

2. Meeting structure

The meeting lasted for five days (9-13 Dec) and rather than having a very detailed agenda, it was decided to focus the discussions on different topics, called tasks. The tasks were the following:

Task 1: Pilot Learning & Agreement on IPC Chronic Definitions and Approach

Task 2: Pilot Learning and Agreement on Non-Exceptional Years

Task 3: Pilot Learning & Agreement on Reference Table

Task 4: Pilot Learning & Agreement on Analysis Worksheets

Task 5: IPC Mapping Protocols

Next Steps

One-page briefs on each task were prepared on basis of the feedback from the pilots and the work done by a sub-working group of the chronic working group before the meeting. These briefs were shared with the participants and they were used as the basis for discussion on each task. In addition to the tasks above issues related to the process for undertaking chronic

analysis (e.g., data preparation, convening an analysis workshop, validating the findings of the analysis) were also discussed briefly.

The sections of this report follow the same structure and summarise the main discussions and decisions on each task.

3. IPC Chronic Definition and Approach

The first task that was discussed by the participants was the definition of chronic food insecurity within the IPC context, and the relationship between chronic and acute food insecurity.

A crucial feature of chronic food insecurity is time. In relation to this, it was agreed that operationally IPC defines persistence as 'food insecurity that exists even in non-exceptional years'. On basis of this the group reformulated the definitions of chronic and acute food insecurity so that they mirror each other, and are directly comparable (for definitions see agreements below).

One question raised in the pilots was whether the IPC Analytical Framework should be changed for the chronic analysis. One reason for this is that not all four of the outcomes listed in the IPC Analytical Framework are directly applicable in chronic analysis. For example, mortality is excluded as a potential direct outcome of chronic food insecurity (and therefore from the chronic analysis), albeit for reasons that relate more to the character of the mortality indicators than to relationship between mortality and chronic food insecurity (discussed below in the Mortality –section). In addition, revisions to the livelihoods change outcome indicators (discussed below in the section on Livelihood change) raise the question of whether this element should remain an outcome or be moved to contributing factors. The participants felt, however, that the Analytical Framework should not be changed and that the differences between the acute and chronic analyses can be addressed with footnotes and explanations in the Reference Table, the training materials, and the upcoming Chronic Manual.

Another significant topic of discussion was the 2,100 kcal threshold. Currently this applies both to acute and chronic analysis, which is somewhat contradictory when the phases and levels are reviewed. Whereas the chronic working group is not the group to change the kcal threshold of the Acute Reference Table, a preliminary agreement on the kcal threshold was required for making progress with the draft Reference Table. The 2,100 kcal threshold is the only internationally accepted and widely used threshold. It is also the basis for the FCS and the HEA indicators (not necessarily for the other food consumption indicators), both of which are used in the Acute and Chronic Reference Tables. Currently in the Acute Reference Table the 2,100 kcal threshold distinguishes between Phases 2 and 3, whereas it fell between Levels 2 and 3 of the piloted, 3-level draft Chronic Reference Table.

The group overall thought that the 2,100 kcal threshold is applicable to chronic food insecurity, but that the thresholds for acute food insecurity would probably need to be lower. However, another option would be to simply move the 2,100 kcal threshold from Phase 3 to Phase 2 in the Acute Reference Table, which would mean that the 2,100 kcal could still be kept in the Acute Reference Table. In this case the thresholds for the higher phases would either need to be revised qualitatively or by finding new quantitative thresholds. The decision on this, as well as on other food consumption indicators and the alignment of their thresholds, should be taken during the discussions on revisions to be made to the IPC Manual 2.0, probably in late 2014 or early 2015.

There was a consensus that average household kcal consumption can be persistently (slightly) below 2,100 kcal. It was also established that in terms of food consumption, households can persist in Phase 3 (as in the current IPC Manual 2.0, at least seasonally). There was, however, no certainty if this persistence can happen with regard to other outcomes and indicators. The working group agreed that 2,100 kcal should be the threshold for food consumption quantity deficits referenced in the Chronic Reference Table.

In order to avoid any confusion on the indicators and language in the Reference Table, the participants recommended that the food consumption indicators should be clearly explained in the training materials and special emphasis should be given to those indicators that are in both tables. The current language used, for example 'minimally adequate' and 'borderline adequate', is not very clear in terms of the possible kcal deficit, and the language should be revised to address this concern.

Agreements:

Definition of chronic and acute food insecurity:

➢ Definition of chronic and acute food insecurity as they are used in IPC:

- Chronic Food Insecurity (CFI) = Persistent food insecurity due to structural and underlying causes

  o IPC classification informs medium- to long-term development objectives

- Acute Food Insecurity = Food insecurity at a specific point in time and of a severity that threatens lives and/or livelihoods, regardless of the causes, context or duration

  o IPC classification informs short- and medium-term responses that focus on protecting/saving lives and livelihoods

Persistence of food insecurity:

➢ How many years are required for food insecurity to be persistent? In chronic IPC analysis, persistent food insecurity is defined and measured based on food insecurity

that exists across a selection of *non-exceptional* years. (Not an average over time and not simply IPC acute over time)

➢ Intra-annual food insecurity: Any food insecurity within a non-exceptional year is considered chronic food insecurity, even if it occurs seasonally or for a short period during the year, so long as it persists across a number of non-exceptional years (repeats each non-exceptional year)

Analytical Framework:

➢ Analytical Framework: Non-food –related elements (e.g. health – see IPC Analytical Framework) will be reviewed as we move forward with fuller F & N security IPC (through the establishment of the Nutrition Working Group in 2014)
➢ Analytical Framework itself is not going to be changed or revised for the chronic analysis

Relationship of chronic and acute food insecurity:

➢ 2100 kcal is the threshold for food consumption deficits for chronic insecurity
➢ Agreed that somewhat below 2100 kcal and >15% acute malnutrition related to Phase 3 of Acute IPC is possible persistently
➢ Persistence of Acute Phases in non-exceptional years: having Phases 4 & 5 of acute food insecurity persistently is not possible
➢ Food consumption quantity: Proposed chronic food quantity deficit cut-off between Levels 3-4 is 2100 kcal, to correspond to proposed revised Acute Phase 1-2 food consumption quantity cut-offs (to be discussed and decided later)
➢ Indicator for IPC Acute Phase 2 food consumption quantity i.e. minimally adequate (Phase 2 Acute) is interpreted as slightly less than or equal to 2100 kcal.
➢ This will require a review of the food consumption indicators of IPC Acute V2.0, but there is no agreement whether changes of indicator thresholds of Phase 2 of IPC Acute would be necessary.

Training materials and Chronic Manual:

➢ The relationship between acute and chronic needs to be clearly explained in the training materials and the Chronic Manual
➢ Food consumption indicators need special emphasis, especially those which are the same in the Acute and Chronic Reference Tables

4. Non-exceptional years

The experiences on the use of the non-exceptional year approach in the pilots were reviewed, and the most problematic issues were discussed in more detail by the meeting participants. One of the issues was the number of years to be analysed, and the length of the reference

period. According to the previous guidance prepared by the chronic working group at least two non-exceptional years should be selected for the analysis. In all pilots, however, more than two years were identified and analysed, and it was acknowledged that selection of more years allows the use of more data, makes the analysis more robust, and assists in conducting the analysis even if some of the outcome data is missing. It was eventually agreed that two years could be maintained as the minimum criterion for an analysis to take place (i.e. there should be at least two non-exceptional years within the past ten years before an analysis can be conducted). However, it would be better to have 3-4 years or even more, depending on the country context. Guidance will also be developed on the minimum data that should be available for an analysis. There has been some uncertainty on how to treat data that is not collected in a non-exceptional year in the analysis, and in different pilots this was perceived in various ways, even though the chronic working group had issued some guidance on the topic for the pilots. After further discussion, the group agreed that guidance should recommend the use of such data for interpolation when comparable data is not available from a non-exceptional year.

The purpose of the chronic analysis was also briefly discussed, especially the question on whether the analysis is supposed to inform the current situation, or situation during non-exceptional years. It was agreed that the analysis should inform the current situation (by looking at past non-exceptional years).

The length of the reference period is 10 years. The discussion focused on the question on whether 10 years is too long, as the situation in many developing countries can change substantially within 10 years. In addition many of the indicators used in the chronic analysis were not available (at least in their current form) 10 years ago. Improving and deteriorating trends should be considered as normal factors that are included in any chronic analysis. More profound structural change requires a different approach, as data collected before the change is not likely to be very relevant to the situation afterwards. In case of a structural change, the years before the change should not be included in the reference period. There was also some discussion on the definition of a structural change. In econometrics, structural change is a change in a trend. In the case of IPC, the decision on structural change is likely to depend largely on the expert opinion of the analysis participants. It may also help to discuss if the frequency of shocks (positive or negative) in the country has changed to an extent that the concept of non-exceptional year needs to be revisited (i.e. that X type and magnitude of shock is no longer unusual). In the identification of exceptional years the indicators of the outcomes used to classify food security situations should not be used.

The last major issue discussed was whether the years should be selected at national or area level. In Kenya, Guatemala, and Bangladesh, non-exceptional years were selected at a national level and validated at a sub-national level. In Malawi, different groups proceeded with different processes for identifying non-exceptional years. In Malawi the groups also found it difficult to identify the non-exceptional years. In general, the group agreed that if the selection process is only done at the local level, there is a danger of too much subjectivity (i.e. every group defining non-exceptional/exceptional events differently), which would endanger the comparability of the analysis results within the country.

It was thought that in order to address this issue, and to include the required amount of flexibility in the process, it would be best to divide the selection of non-exceptional years into two parts:

- National level identification of shocks with national-level food security impacts
- Selection of non-exceptional years at the local level would consider years without major impacts of nationally-relevant shocks or additional, similar, locally-relevant shocks.

This only works as long as every participant is clear on the concept and definition of a non-exceptional year and what constitutes a (positive/negative) shock, which is why a lot of emphasis has to be paid to this in the training and the plenary discussions.

Agreements:

➢ Clarification: Chronic FIS informs current non-exceptional situation
➢ Reference time period to identify the non-exceptional years:

- Recommend 10 years (if stable, assuming no structural change)

  o If significant structural change is clear from the data/expert opinion, choose the non-exceptional years from the latest period since structural change. However, it may take some time (up to 2-3 years) for the situation to stabilise after structural change, which would impact the amount of years available for selection

  o Guidance for identification of structural change – a significant sustained shift in one or more of the key underlying drivers of food insecurity whether quick or slow onset.

➢ Guidance is to identify all non-exceptional years within the past 10 years

➢ A minimum of 2 years is required for chronic analysis, however, in the absence of shocks we would expect to see a greater number of non-exceptional years

➢ Definition of non-exceptional year:

- Identification of occurrence of shocks: Group discussions to:

  • Identify what kinds of shocks are relevant for food security in the country

  • Identify when in last ten years major shocks at any level, including regional and international levels, impacting food security occurred that are relevant to the chronic analysis. List shocks in the table and identify year and geographical area where the food security impact of the shock occurred. Need to explain the process and the concepts of the shocks properly in the training on selection of non-exceptional years

- Identification of non-exceptional years is done through group discussions of sub-national areas to identify non-exceptional years, using the national table and

additional information on relevant shocks if impact was significant and unusual for the four pillars of FS. Exceptional years are identified based on when the impacts of the shocks are felt. Where relevant, consumption years can be used instead of calendar years.

➢ Guidance will be developed on the data required for the analysis (i.e. minimum evidence requirements)

5. Reference Table

First the experiences from the pilots were briefly reviewed. The experiences from the pilots seem to show that the main issues with the reference table are not technical but rather relate to the guidance given (e.g. the way the population estimates are done) However, according to the feedback from the pilots, most participants preferred the Adapted Reference Table over the Standard Reference Table. In the end it was agreed that the Adapted Reference Table should be the basis for the eventual Chronic Reference Table version 1.0. It was also suggested, and preliminarily agreed, that issues that are not compatible with the Adapted Reference Table (especially mortality – see sections below) and potential other issues that should be highlighted can be included in a mapping protocol that will accompany the Reference Table.

There was a short discussion on using phases or levels in the Chronic Reference Table. Phases are used in the Acute Reference Table, and it is important to make the distinction between the classification systems, as otherwise it may be confusing to the practitioners and decision-makers. Another reason to use levels in chronic classification is that level implies a more static situation, whereas phases refer to a dynamic situation with movement up and down in a sequence. It was agreed to keep levels in the Chronic Reference Table.

On the basis of the feedback from the pilots, the chronic working group, before the London meeting, started to develop a new version of the draft Reference Table that included four levels instead of three. In the London meeting it was agreed that four levels were preferred. This required looking at how different indicators align and what the thresholds should be.

The different elements of the Reference Table were discussed over the course of a couple of days. Below is a recap of the discussions by elements, including the food security outcomes and contributing factors.

The following table is a result of the discussions on the relationship of the different food security elements to the four levels of the Reference Table: It was agreed to see if the indicators of the outcome indicators could be aligned according to the table below, and work on the level descriptions on basis of the results.

Table 1

	Not CFI	Mild	Moderate	Severe
Food consumption quality: Duration of the gap (short period/or continuous) is/may not be measured with the indicators	Ok	Yes – small continuous or moderate deficit for short period	Yes – moderate or severe continuous deficit or severe for short period	
Food consumption quantity	Ok		Yes –small continuous or moderate deficit for short period	Yes – moderate deficit continuous or severe for short period
Risk to go into Acute FI crises given a moderate shock (resilience)	Low risk	Moderate risk	High risk	Very high risk
Chronic malnutrition	Ok	Mild	Moderate	Severe

The concept of resilience was also discussed, and some participants alerted the group to be careful about the language used, as there is a lot of ongoing work on resilience at the global level and many concepts, indicators etc. are not yet clear. It was agreed that the word 'resilience' can be used if it is defined within the IPC perspective.

Food consumption indicators:

Quality

The draft Reference Table refers to 'adequate' quality of food consumption, which was briefly discussed and agreed that adequate does not mean optimal, but adequate for an active and healthy life.

The issue of adding new macronutrient indicators into the Reference Table was also discussed. Currently the Reference Table does not include macronutrient indicators, whereas the indicators and the thresholds are available from WHO. It was agreed that some key macronutrient indicators could be added to the Reference Table, and that the chronic sub-working group would address this issue in more detail later. Ricardo agreed on identifying suitable macronutrient indicators and their thresholds.

Some of the key indicators on food consumption quality are the indicators on dietary intake of children of 6-23 months (age to be specified in the Reference Table). In addition to the current indicators it was suggested to add an indicator on calcium–rich foods. In principle it would be possible to get this data from the DHS dataset, but there is no specific indicator for this, nor

are there thresholds. It was eventually agreed that information on calcium–rich foods can be used as indirect evidence of food consumption quality if the information on it exists, but that it should not be added to the reference table. The main source of information on dietary quality of children is DHS. This poses some problems regarding the time sensitivity of the level descriptions, as DHS data is typically collected over an extended period of time (often over six months) and it is not possible to know at what point in time data for a particular area was collected. Therefore it cannot be known if the data was collected during a lean season or a harvest period. This is an issue in a sense that chronic analysis should preferably be conducted with data collected during the lean season of the non-exceptional years.

IDDS is not currently included in the Reference Table, but it was used in the Bangladesh pilot. IDDS informs on dietary quality and can therefore make a suitable indicator in the quality section of the food consumption outcome. There are no international thresholds for IDDS, and therefore it was decided to use the Bangladesh thresholds at least for the time being. This decision can be revisited once more experience on IDDS is available. There are certain things to note regarding the use of IDDS. It is a quick-changing indicator and values can change a lot, for example at the peak of the lean season. This needs to be indicated in the explanation of the indicator and in the footnotes of the Reference Table. IDDS can be collected for anyone, but is often collected on women, which means that the indicator provides only indirect evidence on the food security status of the whole household. This needs to be taken into account when using IDDS for population estimates.

The indicator on use of negative food consumption –based strategies (related to quality of food consumption) needs to be clarified. As per the discussions, this indicator refers to the following three questions: use of cheaper/less preferred foods, use of socially unacceptable foods, and use of foods with less variety (questions 2-4 from FANTA HFIAS guide, version 3). The weakness of the indicator is in the fact that the poorest households cannot often change their consumption and therefore the indicator may not reveal the true extent of food insecurity. There is a need to clarify the language of the thresholds in the footnotes of the Reference Table: what actual frequency does e.g. 'rarely' refer to?

Iodized salt is the only indicator on food fortification in the Reference Table. There are at least two reasons for this: iodine deficiency is the most serious micronutrient deficiency worldwide, and data on iodized salt is available in different household surveys, e.g. in the DHS. Data on other fortified food items is less frequently available. Sometimes there is also data available on other fortified foods, which can be used as indirect evidence (e.g., availability of fortified food items and vitamin supplementation programmes are also included in the chronic data mapping matrix as indirect evidence). One issue raised was that the presence of iodized salt is sometimes a result of a government policy and may therefore not reflect the food security situation of households. It was also noted that sometimes the salt is iodized but not to an adequate degree, which means that the mere presence of iodized salt does not indicate adequate supply of iodine. Presence of iodized salt is also a binary indicator, which poses challenges to its positioning in the Reference Table. The role of fortification was also discussed: adequate supply of iodine can be reached through dietary diversity (i.e. seafood or sufficient soil salinity) and salt iodization is not always required. It was decided to

keep the indicator in the Reference Table because insufficient iodine intake (either through fortification or through diet) is an indicator of poor dietary quality, and to note in the materials that both fortification and dietary diversity can contribute to the adequacy of the diet.

The last quality indicator discussed was SSR, i.e. Starchy Staple Ratio. This indicator is rarely available, and it does not have any international thresholds. However, it collects information on relative share of different macronutrients, unlike the other quality-related indicators. In order for the indicator to be useful, thresholds need to be developed. Data on the indicator is available in some countries, for example in Central America. Jose agreed on using the available datasets which have both some food consumption indicator(s) and SSR, and to run a correlation analysis to identify usable thresholds with ranges for different levels in the Reference Table.

Quantity

In the pilots there were some issues with the alignment of different food consumption quantity indicators, for example with FCS and children having minimum meal frequency. Another more general issue was the idea of preparing minimum data requirements for the chronic analysis.

HDDS indicator is a measure of access to food that focuses more on food quantity than quality. There are no accepted thresholds for HDDS and therefore no certainty over the appropriate HDDS thresholds for the Chronic Reference Table. However, because the current acute table references an HDDS level of ≤4 the chronic tables should reference a higher cut-off. For the time being it was decided to use the following cut-offs: Levels 1-2: ≥9, Level 3: 6-8, Level 4: <6. Some members of the group expressed concern that specifying cut-offs other than possibly for the Severe category may be misleading; for example, it is highly unlikely that a moderately chronically food insecure household would be able to achieve dietary diversity of 6-8 out of 12 groups during the lean season. Yet inclusion of a cut-off only for one level out of four would be problematic in terms of the usefulness of the indicator in the analysis and would not be very helpful for population estimates. It was agreed that FANTA and the World Bank would look into conducting some analysis on existing data on HDDS and other food consumption indicators, in order to suggest possible thresholds and ranges. Therefore, the thresholds decided in the meeting are placeholders that may be changed as a result of additional analysis and/or when feedback from future chronic analyses is available. It was also agreed to indicate the limitations of the indicators in future guidance materials.

FCS, similarly to HDDS, is more related to food consumption quantity than quality, even though it also gives some indication on quality. WFP is currently reviewing the FCS thresholds, and there is also an ongoing study of different food consumption indicators by FANTA and FEWS NET, in technical collaboration with WFP and the IPC GSU. It was decided to keep the current thresholds of FCS for the time being, and to wait for the results of the two processes before revising the thresholds.

There was a discussion on the severity of the HHS and if it is suitable for the chronic analysis. HHS is based on three questions, and it was thought that some of the questions might indicate

too severe situation to fit with lower levels of chronic food insecurity. The questions also seem to differ somewhat in terms of the severity they indicate. After a discussion on the questions and the thresholds it was, however, decided to keep the thresholds as they are (Levels 1-2: 0, Level 3: 1, Level 4: ≥2).

MAHFP is a relatively simple indicator, and a rare indicator in a sense that it reveals information on the chronic food insecurity situation of households with its 12-month timespan. Unfortunately it is not often available, although this may change in the future. It was decided to use the following thresholds for the indicator: Levels 1-2: 11-12, Level 3: 9-10, Level 4: ≤8.

The quantity-related coping strategies in the draft Chronic Reference Table are divided into moderate and severe. These need to be defined in the footnotes of the Reference Table and also in the upcoming guidance materials. It was decided to follow the thresholds of the Coping Strategies Index Manual, and to keep the thresholds consistent with the quality thresholds: quality and quantity move in the same direction but not together. The thresholds also need to be explained in the guidance materials, by indicating that the moderate strategies can take place from Level 1 to Level 4, whereas the severe strategies are likely to take place in the higher end of the Reference Table. If there is a high frequency of severe strategies, it is likely that the non-exceptional year/years have not been chosen correctly. The CSI Manual has a table which divides the coping strategies in four different groups. It was decided that strategies in group 4 would be included under food consumption quantity.

Children eating minimum dietary frequency is one of the standard IYCF indicators. Since it is a binary indicator, it is challenging to decide where in the Reference Table the cut-off should go. After a discussion, and given the group's agreements on how food quality and quantity move across the chronic levels (see Table 1, above) it was decided to put the cut-off between Levels 2 and 3. The fact that there are four levels instead of three, and that the cut-off is between Levels 2 and 3 should also help in aligning the indicator better with other food consumption indicators.

The recently introduced food gap indicator can be based on HEA data, but also on other data. One of the main concerns raised was that the indicator can be somewhat confusing as it may be understood as a food availability indicator. The group also concluded that there was insufficient documentation and international recognition of this indicator at present. As a result it was decided to not to use it in the Reference Table. An HEA-based food gap indicator (survival deficit) may, however, be included in the Reference Table, similar to what is included in the Acute Reference Table. This indicator measures the potential of households in principle to satisfy their food needs (2,100 kcal) with the cheapest cereal. Since this kind of a food gap induced by an income deficit in a non-exceptional year indicates a rather severe situation, the food gap would only be relevant in Level 4. Inclusion/exclusion of aid in the analysis of a survival deficit was also discussed, and it was decided that emergency aid would be excluded from the analysis of a survival deficit, whereas developmental aid and inter-annual aid would be included.

There was also a discussion on the MDER indicator, which is currently not in the draft Reference Table. There are MDER thresholds for every country, which are updated annually (by FAO). The MDER thresholds could in principle be used with kcal thresholds for all levels, but this requires more discussion by the chronic working group.

It was also discussed that there may be a need to revise the language of the Reference Table by adding '% of households' to indicators to make it clear that what is needed is the prevalence in each level in order to estimate the overall severity level and related population figures.

Livelihood change:

The analysis of livelihood change was quite challenging in the pilots for two main reasons: there was not much data available on livelihood change indicators and even when there was, no large changes could be detected across non-exceptional years. The relevance of livelihood change in a chronic context was questioned in the pilots, and as a result it was clear that the livelihood change analysis would need to be considerably revised. In the London meeting the group agreed that in a non-exceptional year, it makes sense that basic livelihoods would look like basic livelihoods without "livelihood change". It was agreed that livelihood change is of interest only to the degree that it reflects a change in food security (i.e. that it is the *outcome* of a food security issue).

If a HH changes livelihood strategies as a result of a shock and then returns to the previous livelihood strategies, this reflects a transitory shock and possibly exceptional livelihood behaviours (coping strategies). Since chronic analysis concerns non-exceptional years, coping strategies in response to a shock would not be directly included in the chronic analysis.

But if, after a shock or for continuing shocks, the HH does not return to its prior livelihood strategies, then there may have been a structural change in the livelihoods; the new livelihood behaviours since the structural change would be considered as the livelihoods for the chronic analysis.

One suggestion was to use livelihood change only in identification of Level 4. It was, however, also noted that the worst-off groups may not change their livelihoods, as they have few opportunities to invest in new livelihoods. It would also be difficult to know how to classify the rest of population.

Eventually it was decided to remove livelihood change indicators from the Reference Table, but to leave the outcome in the Reference Table with an explanation that in a chronic food insecurity context, analysis of livelihoods is more relevant than analysis of livelihood change. The livelihood indicators would be placed in contributing factors, under the heading 'livelihoods'. This revision entails the removal of those indicators that refer to livelihood change (the first two) and retention of the other two indicators. It was decided that strategies in groups 2 and 3 of the coping strategies table in the CSI Manual would be included under livelihood.

Nutrition:

The proposed thresholds for stunting are >-2 SD for Levels 1 and 2, <-2 SD for Level 3, and <-3 SD for Level 4. The thresholds are meant for the analysis of individual children, not the overall child population. Therefore, there is a need to add a text on top of the Reference Table which specifies that the nutrition indicators refer to prevalence of each SD cut-off within the larger population. It was also noted that prevalence works in a relatively large area/community, but it is not very informative in small areas where there are few children. This may pose problems in Central America, where most IPC analysis is conducted at municipality level, depending on the size of the municipality.

The current anaemia indicator in the Reference Table measures women of reproductive age. It was agreed that both anaemia of children and of women is important, but inclusion of both would complicate population estimates. It was agreed to leave anaemia of women in the Reference Table and to include anaemia of children in the indirect evidence, with thresholds for each Level.

Possible inclusion of wasting was also discussed. Wasting in some areas (Somalia, Western Africa) is high year after year and in this sense reflects a chronic situation. Stunting and anaemia are, however, better indicators of chronic malnutrition. It was agreed to include wasting as indirect evidence for Level 4, with the cut-off of ≤ -2 SD.

Overweight and obesity have been discussed intermittently throughout the development process but there has been no agreement on how the indicator should be addressed in the chronic analysis. In principle the presence of overweight and obesity signifies that these people get too much energy from their diet. There are, however, no thresholds to indicate the extent to which overweight/obesity reflects a problem with quantity. There is some evidence that overweight and obese people often suffer from micronutrient deficiencies, but this does not mean that it is always the case, or that overweight/obesity is an indication of inadequate dietary quality. These issues mean that it is rather difficult to develop any universal indicator or thresholds for overweight/obesity. As a solution is was agreed to document existing overweight/obesity and to interpret it within the country context to understand whether it is related to chronic food insecurity. The group agreed that overweight/obesity should be re-evaluated in the next version of the chronic scale.

Mortality:

Mortality is not included in the current draft Reference Table as it is measured as a rate (per fixed population) rather than as a prevalence for an area's population. It is also an area-based indicator and cannot be used to classify households. That is, a household cannot have less severe mortality or more severe mortality. As a result mortality data cannot be used to assist with population estimates. Yet it is known that mortality and chronic food insecurity are linked, and mortality is relevant in the analysis. There are also problems with the existing data sources, as DHS data is often used but unfortunately DHS does not collect comprehensive

mortality data (e.g., it is not possible to discern from the data collected what portion of the mortality rate is due to food security-related issues and what is due to non-food security-related issues). It was agreed to conduct more research into mortality indicators to see if there are indicators or derivatives of indicators that can be used in chronic analysis. It was also agreed to indicate high mortality levels as a mapping protocol – exact indicator and threshold to be agreed by the chronic working group.

Contributing factors:

Hazards and vulnerability

Contributing factors are currently not properly analysed due to at least two reasons: The text and indicators in the draft Reference Table are rather vague, and analysts do not often know how to perform the analysis.

It was suggested to include livelihood strategies, assets and PIPs into the contributing factors. It was, however, also thought that PIPs would bring in too many elements for proper analysis and that analysis of PIPs is area-specific instead of household-specific. Inclusion of assets in the analysis is important, but assets are also context-specific and therefore difficult to use for classification. It was eventually decided that livelihood strategies, assets and PIPs would be included by mentioning them in the text.

There are two indicators in the draft Reference Table, which were proposed by FEWS NET and tested with data on Zimbabwe. The first of the two indicators is the household income as a % of household survival needs. The indicator is derived from HEA data and in principle can be available in many countries with HEA baselines. In principle the indicator is closely related to poverty indicators (as poverty indicators are also based on minimum food needs), as are FCS and HDDS. This indicator can and should be validated within countries. It was agreed to keep it in the Reference Table and to explain in the footnotes and the Chronic Manual that the indicator is being tested in the upcoming chronic analysis workshops.

The second indicator on household resilience, defined as the ability of a household to recover from a defined shock, is more challenging, as it effectively cannot be tested, and it provides information through a simulation (as opposed to the observed measurements of the other indicators). Classification on the basis of a simulation is rather difficult, also because simulation is not likely to be equivalent to an observed outcome resulting from the same defined shock, due to assistance and other factors. On the other hand, simulation is likely to be the only way to understand resilience as defined by the IPC. There is a large, ongoing global effort to define and promote resilience, and to find indicators for measuring it. Care should be taken to avoid IPC being drawn into the resilience debate in ways that could impede or delay the adoption of the Chronic FIS. If the indicator is included, clear guidance has to be attached in order to clarify how resilience is understood in this context (resilience to what), and how it is measured in IPC chronic analysis. Due to these complications, it was eventually decided to keep the indicator in a qualitative form in the Reference Table, and continue

testing it in the upcoming chronic analyses. It also was remarked that use of these two indicators requires HEA expertise and, especially for the second one, also access to data for re-analysis before the workshop. This may limit the use of the second indicator.

Cost of the Diet (CoD) is a new method which may provide appropriate information on households' economic access to a nutritious diet to be included in the Reference Table. CoD is increasingly being used in different countries of the world, and it could potentially provide valuable information on the food and nutrition security status of households. Since Save the Children originally developed the Cost of the Diet tool, it was agreed that SC would look into the feasibility of including a CoD indicator in the Reference Table, and propose appropriate thresholds if such an indicator is agreed.

Food security dimensions

Currently food security dimensions are just mentioned in the Reference Table without specifying any indicators. There was some discussion as to whether indicators should be added, which however is rather challenging due to the context-specific nature of the food security dimensions. It was agreed that in version 1.0 of the Chronic Manual there would be no specific indicators for food security dimensions, but guidance will be provided on different potential indicators to be used and how the analysis could be conducted. If appropriate universal indicators can be identified, those could be included in version 1.1.

Stability

The Reference Table includes stability as the recurrence of acute crises. There are, nevertheless, numerous conceptual issues with the indicator and with linking it to stability.

- Conceptually, stability is a cross-cutting dimension of food security that refers to the stability of the food security pillars (access, availability and utilization) over time. Stability as a pillar of food insecurity cannot at the same time refer to trends in food insecurity as a whole over time (as it is used in the piloted Reference Tables).
- The chronic analysis process involves an analysis of food insecurity across non-exceptional years. If acute crises only occur in exceptional years, then including exceptional years in the chronic analysis would be technically inconsistent with the analytical parameters of the chronic analysis.
- The frequency of acute crisis is an area-based measure. As such, it does not help an analyst classify households between the chronic levels.
- The indicator is also inconsistent with the typology of acute and chronic food insecurity: high frequency of acute crises in the Reference Table implies high chronic food insecurity, whereas according to the typology the two do not have to move together but are rather independent of each other.
- The interpretation of the indicator in chronic analysis is challenging: for example, it is not clear how the frequency of acute crises should affect stability of food

security pillars in non-exceptional years, and what the analysts should infer from it in order to analyse the outcomes

As such, though the indicator did not raise many concerns in the chronic pilots, its usefulness may be limited due to associated conceptual problems.

It was agreed that the frequency of acute crises is nevertheless important, and the group decided that it should be indicated in mapping. This means that it would be presented simultaneously with the chronic analysis, allowing a decision-maker to compare chronic and acute food insecurity within the same map. It was also noted that even if the indicator is just included as a mapping protocol, it still needs to be analysed and some thresholds have to exist for mapping purposes.

Further discussions on how to potentially include stability of availability, access and utilization in the Reference Table are required.

Level descriptions:

The level descriptions are intended to clarify the relationship between different levels. They therefore need to be logical, and also conceptually sound. Food consumption in terms of quantity and quality is the key factor in the level descriptions, and a time element of the deficits was also considered. The main element of the level descriptions is the increasing severity of the gap in food consumption quality as the household moves 'up' the scale. In higher levels, there is also a gap in quantity. This is based on the understanding of the following pattern of behaviour of households when they face a food security problem: first households start cutting quality, followed by quantity. It was acknowledged that in practice it may be difficult to separate the different levels of quality and quantity consumption from each other, but that conceptually the sequencing makes sense and can be justified.

Agreements:

Food consumption:

➢ Adequate nutrient intake is not necessarily an optimal diet but enough for an active and healthy life

➢ Agree to input key nutrient indicators & thresholds (e.g. share of energy from macronutrients)

  o Action: Requires references at adequate level to establish qualitative thresholds; chronic working group to review and include in V1.0

➢ Agreed that both diet diversity and micronutrient fortification can contribute to micro-nutrient adequacy. Micronutrient adequacy can be achieved through diet diversity or fortification or both.

- Agreed to retain iodized salt in the Reference Table for now. Any nutrient-specific indicators, including iodized salt, should not be weighted as much as other quality indicators

➢ The three quality-related coping will be included in the Reference Table, and the indicator thresholds will be clarified in guidance to be provided

➢ Values of quick changing indicators can change significantly over the consumption year, therefore analysts should consider whether the indicator values could change significantly over the analysis year(s)

➢ Correlation between Starchy Staple Ratio and other indicators, such as IDDS, FCS and others should be analysed to provide clearer guidance and references for the qualitative levels

- Action: Jose to do this analysis & provide to the working group for review to be included in V 1.0.

➢ Agreed to keep HDDS, but to acknowledge considerable problems in setting the thresholds, though research is ongoing. All agree on less than 6 for Level 4,

- Action: Jose will analyze HDDS data to feed back to the working group, in order to help determine/better calibrate the range for caloric intake. Analysis required to identify the patterns, to identify peaks, or changes. For release of V1.0.

➢ FCS and HHDS thresholds can be revised and recalibrated once more research is done (e.g. FANTA-FEWS NET-WFP Correlations Study of FC indicators).

➢ Revised Reference Table Indicators and Thresholds as per the changes made to the table in the meeting, with footnotes (see discussions above for more details)

Livelihood change:

➢ Livelihood change is not used in the IPC chronic analysis as livelihoods should not change in a non-exceptional year. But livelihood strategies within the year are important and are included in the Reference Table.

➢ Livelihood strategies and livelihood assets to be explicitly mentioned in the Reference Table

➢ Those coping strategies that are in categories 2 & 3 in the CSI manual are included in the livelihood analysis

Nutrition:

- ➤ Agreed as per the changes made in the meeting to the Reference Table (see discussions above for more details)

  - o Action: We will continue to review/analyze the issue of obesity for future versions of the Chronic Manual (e.g., for Version 1.1)

Mortality:

- o Action: We will continue to look into mortality to see if there are mortality indicators or derivatives that can be used to classify households into different levels (for V1.1)

Contributing factors:

- ➤ Agree: Income as a % of survival needs will be included in the section on Hazards and Vulnerability

  - o Action: Chris to validate the thresholds before V1.0.

- ➤ Agree: No agreement on having stability in the Reference Table.

  - o Actions: Chronic working group still to review and decide

- ➤ Agree: to include the frequency of IPC Acute Phase X Classification as a mapping protocol, though the mapping protocol needs to be developed for v1.0.

- ➤ Cost of diet:

  - o Action: Request Kay to provide further information on potential cost of diet indicators and propose thresholds. If adopted it would go in the Reference Table in the section on vulnerability/hazards.

- ➤ Livelihoods:

  - o Action: Reference Table will be updated to include livelihood assets, strategies, and PIPS related to vulnerability

- ➤ Resilience indicator:

  - o Action: Resilience will be looked at in general terms in the Reference Table. Its meaning for the purposes of IPC analysis will be clearly explained in the manual, with references.

6. Analysis Worksheets

Due to lack of time the analysis worksheets were not addressed in the meeting. It was only largely agreed that the most problematic sections are Steps 4, 7, 8 and 9. The chronic working

group will discuss the analysis worksheets and find solutions to possible problems in telecons over the coming weeks.

Agreements:

- ➢ Chronic Working Group to discuss the Analysis Worksheets in the upcoming teleconferences
- ➢ In addition a couple of action points were agreed on during the discussion on the Reference Table:
    - o In case trend analysis is included an additional step for that may need to be added in the analysis worksheets as currently there is no particular section in the worksheets where trends are considered
    - o Depending on the decisions taken regarding the mapping protocol, there has to be space for analysis of the specific issues included in the mapping protocol

7. IPC Mapping Protocols

Unfortunately there was not much time to discuss this topic, and just the experiences from Bangladesh (the only pilot where a map was produced) were briefly reviewed. In Bangladesh the participants thought that it would be useful to indicate the population prevalence in a call-out box next to each area analysed, either with a bar or a pie chart. In addition they welcomed the idea of using different symbols to indicate special issues, such as high chronic malnutrition, high mortality or frequency of acute crises. There was no clear preference of one colour scheme over another, and different colour schemes will need to be tested before one is adopted. It was, however, pointed out that the colours should not be the same as in the acute maps as that would create confusion.

One issue that was introduced but not widely discussed was the 20% rule, and either keeping it or changing it in the chronic analysis.

Agreements (tentative):

- ➢ Chronic working group to discuss the mapping protocol further
- ➢ Different symbols can be introduced – decision pending on the issues and symbols to be included
- ➢ Colour scheme also to be decided
- ➢ Population prevalence to be indicated with a bar or a pie chart

8. Process issues

One of the lessons learned from the pilots was that the preparations required for the chronic analysis are more detailed and take longer than those for the acute analysis. The preparations include the search for and compilation of available data, and potential re-analysis of the data. Re-analysis is required at least for DHS data, and possibly for other household data sets. It was also noted that in any future technical development initiatives there has to be a readiness to pilot in terms of the maturity of the tools and process in order to use the human and financial resources efficiently and to avoid excessive rounds of piloting.

The detailed preparation period and re-analysis of the data require guidance from the GSU and the chronic working group. Another area where guidance is required is in the different indicators used in the chronic analysis and their interpretation, including examples of time periods and severity levels especially of the food consumption indicators.

Another issue discussed was the validity period of the analysis. The standard validity period for chronic analysis is estimated at 1 to 5 years, depending on the country context. The participants thought, however, that the validity period should be longer than 1 year, due to the chronic nature of what is measured, and also because the additional investment made in the preparation and analysis should enable a longer validity period. If circumstances change significantly the year after a chronic analysis and a country would like to re-do its analysis, it would still require data from a minimum of 2 non-exceptional years after/since the year of the shock/change to have enough data to produce a new chronic analysis. As such, it was agreed that the standard validity period of the analysis should be from 3 to 5 years, with the following qualifiers:

➢ The validity period is 3 to 5 years if there is no structural change before or after the analysis
➢ If new data is made available after the analysis without structural change, the Technical Working Group (TWG) of the country may want to update the analysis before three years have passed

Agreements:

Training materials and Chronic Manual:

➢ Chronic Manual to include guidance on the preparations required for the chronic analysis
➢ Chronic Manual to include guidance and examples of the use and interpretation of different indicators included in the Reference Table

Validity period of chronic analysis:

➢ The objective is to have chronic analysis which is valid for 3 to 5 years, provided that there is no structural change right before or after the analysis. The TWG may also want to update the chronic analysis with new data before three years have passed

9. Next steps

➢ To share and review the agreed, revised Reference Table and decisions taken (recorded in the PowerPoint presentation) with the meeting participants
➢ Analysis Worksheets and Mapping Protocol will be discussed and decided on
➢ Process issues will also be discussed further and decided on
➢ The meeting report/minutes will be prepared and shared with the meeting participants for review and comments
➢ Key components of the meeting minutes will be shared with the SC for endorsement
➢ Weekly, half-day teleconferences will be arranged between 19 Dec – 23 Jan, with finalisation on 30 Jan (Christmas holiday from 20 Dec to 6 Jan)
➢ The second round of nutrition consultations will not be held
➢ There is a need to start working on the Chronic Manual and training materials shortly. Existing drafts will be the basis for the work.
➢ The Chronic Working Group will continue in the current form in order to help with the finalisation of the training materials and the Chronic Manual, and with the incorporation of the lessons learned from the past and upcoming chronic analyses
➢ WG needs to be informed of the plans for the future analysis workshops and technical support required well ahead – working group members to discuss the support to be provided

Annexes:

Annex 1:

Third synthesis meeting of the IPC Chronic Working Group

London 9 – 13 December 2013

List of participants

No.	Name	Organization
1	Jose Cuesta	World Bank
2	Laura Glaeser	FANTA
3	Felix Lee	FEWS NET
4	Christopher Hillbruner	FEWS NET
5	Jenny Coneff	FEWS NET
6	Cindy Holleman	IPC GSU
7	Leila Oliveira	IPC GSU
8	Kaija Korpi	IPC GSU
9	Anne-Claire Thomas	JRC
10	Alexis Hoskins	WFP
11	Kay Sharp	SC
12	Ricardo Sibrián	PRESANCA

Annex 2:

IPC Working Group on Classifying Chronic Food Insecurity

Third Synthesis Meeting

London 9 – 13 December 2013

Agenda

Time	Session title	
Day 1		
09:00-09:30	• Welcome • Objectives & Agenda	Kay Sharp Cindy Holleman
09:30-10:30	**Task 1: Pilot Learning & Agreement on IPC Chronic Definitions and Approach**	(Cindy will chair the meeting. Facilitators to individual

	1. *Definition of Chronic;* 2. *Relationship/Difference Between Acute and Chronic* 3. *Chronic in IPC Analytical Framework* o *Livelihood Change & Mortality*	sessions will be allocated in the meeting)
10:30-11:00	Coffee break	
11:15-13:00	**Task 1: Continued** ➢ *Conclusions & Agreements*	
13:00-14:00	Lunch	
14:00-15:30	**Task 2: Pilot Learning and Agreement on Non-Exceptional Years**	
15:30-16:00	Coffee break	
16:00-17:30	**Task 2: Continued** ➢ *Conclusions & Agreements*	
Day 2		
08:30-10:30	**Task 3: Pilot Learning & Agreement on Reference Table** 1. *Structure: Standard vs. Adapted*	
10:30-11:00	Coffee break	
11:00-12:00	➢ *Continue Standard vs. Adapted & Agreement*	
13:00-14:00	Lunch	
14:00-15:30	2. *Number of Levels: 3 or 4* ➢ *Conclusions and Agreements*	
15:30-16:00	Coffee break	
16:00-17:30	3. *Reference Table Indicators- food consumption*	
Day 3		
08:30-10:30	**TASK 3: Pilot Learning & Agreement on Reference Table – continued** 4. *Reference Table Indicators – food consumption continued* ➢ ***Conclusions and Agreements***	
10:30-11:00	Coffee break	
11:00-13:00	5. *Reference Table Indicators- Livelihood Change* ➢ ***Conclusions & Agreements***	
13:00-14:00	Lunch	
13:30-15:30	6. *Reference Table Indicators – Contributing*	

	Factors & Stability
15:30-16:00	Coffee break
16:00-17:30	➢ *Continued Contributing Factors* ➢ ***Conclusions & Agreements***
Day 4	
08:30-10:30	**TASK 3: Pilot Learning & Agreement on Reference Table – continued** 7. *Reference Table Indicators – Nutrition, Mortality & Stability*
10:30-11:00	Coffee break
10:45-13:00	➢ *Continued Nutrition & Mortality* ➢ ***Conclusions & Agreements***
13:00-14:00	Lunch
14:00-15:30	**TASK 4: Pilot Learning & Agreement on Analysis Worksheets** 1. *Step 4, 7, 8 & 9*
15:30-16:00	Coffee break
16:00-17:30	**TASK 4: continued**
Day 5	
08:30-10:30	**TASK 4: continued** ➢ ***Conclusions & Agreements***
10:30-11:00	Coffee break
11:30-13:00	**TASK 5: IPC Mapping Protocols**
13:00-14:00	Lunch
14:00-15:30	Task 5: continued ➢ **Conclusions & Agreements**
15:30-16:00	Coffee break
16:00-17:00	**Next Steps:** 1. Review of Task Agreements 2. Actions Needed to Finalize & Clear V1.0 IPC Chronic Food Insecurity Phase Classification 3. Development of Chronic Manual version 1.0 & Training Materials
17:00-17:30	Concluding remarks and closure