

- Burden of Disease Group: advisory role on study methods and processes, integration and extrapolation of study results as inputs to FERG regional and global estimates.
- Knowledge Translation and Policy Group: advisory role on policy situation analysis and 'knowledge translation' methods and processes, provision of technical guidance on how to produce information that is useful and meaningful for policy makers.

*Process and timeline:*

1. Initial workshop: Before the study begins there will be initial engagement (probably in the form of a workshop) with government and scientific stakeholders and end users within the country to:
  - Discuss the purpose of the study;
  - Develop a shared understanding for the need for FBD burden data; among key food safety stakeholders;
  - Outline the burden of disease and policy situation analysis protocols; and,
  - Create a work-plan and timetable.

Specific topics that should be discussed at this initial workshop are:

- available country specific sources of data;
- core syndromes and hazards to be addressed by the study;
- relevant data available from publicly available databases that WHO has assembled;
- identification of scientists from the country to conduct the study, as well as additional experts for a future expert elicitation process;
- engagement with stakeholders, particularly those from the food industry, agriculture and consumers; and,
- language/translation issues.

Prior to the initial workshop as much preliminary data and information as possible will be gathered by a team composed of staff from both FERG/WHO and the participating country. Concurrent with this process will be the development of a policy situation analysis (the policy situation analysis may commence prior to this initial workshop). The policy situation analysis should involve independent reviewers as well as involving government and scientific parties.

2. The study process will be guided by a detailed protocol currently being developed by FERG. A draft for use with pilot studies is expected to be completed by late 2010 (with revisions to be made after pilot studies). This protocol will largely be adapted from the Global Burden of Disease Study Operations Manual (final draft Jan. 2009) with specific modifications to apply to foodborne diseases/source attribution and policy situation analysis. A brief overview of the study elements is provided below.
3. To provide estimates of source attribution that are otherwise unavailable, and collate additional unpublished data, at least one expert elicitation meeting will be

held during the study. The meeting will generate quantitative estimates of parameters appropriate to each relevant hazard according to protocols being developed by FERG (by late 2010).

4. The timeframe for each country study is anticipated to be 1-2 years. The country studies will be conducted in two stages:
  - Pilot studies (probably six): commencing early 2011.
  - After the pilot studies the process and protocols will be reviewed, to be completed by mid 2011.
  - Full country studies (potentially twelve or more, including if appropriate countries who have conducted pilot studies), to commence in late 2011.

#### *Pilot Studies:*

The primary purpose of the pilot studies is to act as a test of feasibility and the draft protocol for the country burden of disease studies. Consequently they are likely to address only a selection of hazards, and some aspects (e.g. source attribution and expert elicitation) will only be undertaken in a preliminary way (if at all). Participation in a pilot study does not mean that a country will not be able to undertake a full burden of illness study after the pilot.

#### *Expert elicitation:*

It is anticipated that an expert elicitation process will be undertaken to provide source attribution estimates on a regional basis. A protocol for this process is under development (to promote consistency) but will not be available for the pilot country studies. Regional source attribution estimates will be used to generate global burden of disease estimates, as these data will only be reported on a regional basis. The regional source attribution estimates may then be used by individual countries for their own estimates, or an expert elicitation for the specific country may be undertaken.

The expert elicitation process will be a parallel work stream to the country studies. Piloting of the expert elicitation protocol will occur separately from the pilot country studies.

#### *DALY calculations:*

These will not be undertaken as part of the pilot studies. There are a number of issues for FERG to work through before these calculations can be undertaken; once these are resolved, countries undertaking burden of disease studies will be offered training and assistance with performing these calculations.

#### *Principles:*

1. The national burden of disease study will, to the greatest extent possible, be conducted by scientists from the country itself. Capacity building and training are important objectives of the country study.

2. The scope of the study must include a core set of foodborne hazards and associated diseases identified by FERG and its Task Forces (see Table below), but there will be the opportunity for the country to discuss which additional hazards and/or diseases which it considers relevant and might be added to ensure that the burden assessment is as demand-driven as possible.
3. The national burden of disease will largely be estimated from existing data; if this is not available at the national level, extrapolation from alternative sources will be considered. The suitability of these alternative sources will be subject to review using analyses that the CSTF has already initiated. The only aspect of the study where new data may be generated is for chemical hazards, where measurement of suitable biomarkers may be needed to estimate exposure. Resources for research to generate new data will be negotiated between WHO and the participating country.
4. Planning of the national burden of disease study should be undertaken in a participatory manner, involving key food safety stakeholders.
5. Ownership of the study and results: The data and results of the study will belong to the participating country, and scientific staff at country level are encouraged to publish the results in the peer-reviewed literature. All original data will be sent to WHO upon completion of the study. The country will grant WHO full and non-exclusive, royalty-free and perpetual license for analysis and publication of the data (publication only in aggregated regional format) in the FERG Global Atlas and Report. For the purposes of coordination the country should agree not to publish any results without consultation with WHO
6. The need for regional (within the country) as well as national estimates will be considered.
7. An important consideration will be the collation of information that describes the representativeness of the data for the national population.
8. Foodborne disease will be attributed to specific foods/commodities as much as possible, to enable policy development. However, the available data may only permit identification of high risk foods, rather than quantitative estimates of attribution to those foods.
9. The primary aim is to estimate the disease burden such that the disability adjusted life years (DALY) metric can be derived. However, the research effort will aim to respond to policy-makers' and end-users' data requirements, maximise the relevance and usefulness of the research results and create a robust, accessible and contextualized knowledge base. Such supplementary data may be important in providing cost-effectiveness information, which is crucial to the translation of results into practice. Examples of this type of data are: health system costs, costs to agricultural sector through lost production/poor animal health.
10. The reference year for the study will be 2005 (this is the year for which the burden will be estimated; data from earlier studies may need to be updated or adjusted).
11. Extrapolation of partial or incomplete datasets to national and regional estimates, as well as the use of indirect indicators, will be performed according to protocols developed by FERG.
12. Attribution estimates will be universally applied at the point of consumption, but source/reservoir/processing points of attribution will also be considered where they inform risk management. While the risk factor of interest to FERG is exposure to the hazard through food it will be essential for the study to gather data that also allows risk factor analyses from exposure via other pathways within the remit of the Source Attribution Task Force (water, animal contact, person to person etc.).

Data that may be useful for source attribution include: food categorisation system, food consumption data, prevalence of hazards in the food supply, incidents and outbreaks of foodborne disease, dietary patterns, data that indirectly informs estimates of the prevalence and burden of foodborne disease (e.g. presence/absence of animal reservoirs, food preparation practices, domestic production versus food importation etc.). These data should be collated during the course of the study for analysis during the calculation of the burden estimates.

13. Throughout the study, collaborative approaches and regular interaction between researchers and research users will be fostered at country level, and local capacity to create and respond to opportunities of bringing research into policy-making strengthened.

Contributions to the country study:

*From WHO and FERG:*

Protocol for foodborne disease burden of disease study: to ensure alignment of the study to the overall goals of FERG

Global and regional context: information generated from systematic reviews and other deliberations conducted by FERG. Information relevant to the specific country that is identified during FERG activities will be collated and provided to the country at the commencement of the study.

Ongoing communication: with WHO and FERG during the FBD study

Assistance: with statistical/epidemiological analyses and 'knowledge translation' as required

Tools for facilitating the transfer of research into policy-making, including a protocol for policy situation analysis, implemented by policy experts in the participating country and supported by the context mapping subgroup of the Country Studies Task Force

*From the participating country:*

Human resources: staff with previous experience of conducting burden of disease studies OR staff with expertise in epidemiological methods to be trained in burden of FBD methodology and 'knowledge translation' approaches, staff to commit to undertaking a burden of FBD study (1-2 years of commitment), a policy situation analysis as well as other activities aiming to promote research utilisation.

Infrastructure resources: needed to complete a burden of FBD study and related 'knowledge translation' activities.

Country infrastructure: laboratory capacity to generate relevant data, relevant country-level data for burden studies e.g. vital registration; household surveys;

other sources of data or good infrastructure for collecting such data, established links with potentially useful networks<sup>1</sup>.

*Elements of a country specific burden of disease study*

(adapted from WHO National Burden of Disease Study Manual: <http://www.who.int/healthinfo/nationalburdenofdiseasemanual.pdf>)

Major tasks to be undertaken

- (i) Demographic baseline: population and total mortality by age, sex, and geographical region for the reference year. These data are already available for each country at the UN Population Division.
- (ii) Cause of death analysis: based on vital registration data, verbal autopsy data, sentinel surveillance sites and others. This information is usually sent to WHO by most countries.
- (iii) Description of non-fatal outcomes: acute diseases and sequelae to be defined by FERG Task Forces. Incidence data preferably to come from representative community-based studies. Available country specific surveillance data to be assessed and if necessary fitted into an estimated surveillance “pyramid” for relevant illnesses, or (if possible) hazard specific pyramids.
- (iv) Review of Internal Consistency of Disease Estimates
- (v) Source/food attribution analysis including expert elicitation (replaces Comparative risk assessment: risk factor analysis)
- (vi) Calculation of YLDs and YLLs leading to DALYs. These calculations to be undertaken in close collaboration with scientists at WHO and FERG, according to procedures as specified in the detailed protocol being prepared by FERG (specific training may also be provided by FERG for this part of the burden of disease study process). WHO and FERG guidance on this part of the study is essential to ensure that the DALY estimates are internally consistent and in line with global mortality and morbidity estimates.
- (vii) Sensitivity Analysis
- (viii) Draft report and external peer review/quality assurance processes
- (ix) Final Report
- (x) Dissemination of results

---

<sup>1</sup> For example INDEPTH DSS (Demographic Surveillance Systems); Measure DHS (Demographic and Health Surveys); Health Metrics Network (WHO); World Health Surveys (WHO); Global Salm-Surv (WHO) now GFN)

### *Elements of policy situation analyses*

To identify pathways of influence and determinants favourable for research up-take, national policy situation analyses will comprise:

Major tasks to be undertaken

#### **1. Systematic analysis of the political context:**

##### **1.1 Analysis of the international food safety political environment:**

analysis of factors external to a country which affect policy-makers and food safety policy processes within the country, such as:

- international integration of the country, export and import from and to the region and internationally, activities of multinational food corporations, aid dependency, aid priorities and donor policies,
- activities of foreign governments and international food safety bodies relevant to domestic food safety e.g. the Codex Alimentarius Commission.

##### **1.2 Analysis of the national political context:**

analysis of:

- structural factors, including national political, social and economic trends and pressures, culture and value systems which shapes the food safety policy-making process,
- health system structures, surveillance systems and the integration of food safety health promotion strategies.
- the domestic food safety system, its institutions and management system, operations and capacity as well as resource allocation to food safety.
- SWOT of food safety and food security/agricultural production.
- food related customs.

#### **2. Development of a policy process matrix:**

assessment of country-specific food safety policy-making processes and mechanisms, i.e.:

- the way national policy agenda setting, formulation, adoption, implementation and evaluation takes place,
- opportunities and timing for food safety research input into formal policy processes.

#### **3. Mapping of information sharing and access mechanisms**

- analysis of current practices of information sharing, access and utilisation of food safety actors and other relevant food safety stakeholders.
- identification of institutional and technical obstacle of knowledge sharing, access and utilization.

**4. Stakeholder analysis and political interest map**

analysis of:

- actors, organizations and mediating agents involved (food safety) policy-making and their interests with regard to supporting/resisting the development of effective food safety policies, their capacity and degree of power/influence in food safety policy-making, and their reasons and resources for exerting influence (incl. the identification of drivers of change),
- actual and potential alliances and links among actors.

**5. Identification of pathways of influence and outreach strategies**

**Table of hazards and syndromes to be addressed by the study**

**N.B. This table represents a preliminary list. It is expected that topics will be amended as studies progress, and as health outcomes of importance are clarified by individual Task Forces (e.g. sequelae).**

Hazard	Information Needed	Method Of Obtaining Information
<b>Chemicals</b>		
Aflatoxin	<ol style="list-style-type: none"> <li>1. Incidence studies of acute aflatoxicosis (by age and sex);</li> <li>2. Longitudinal study to assess sex-specific risk of developing HCC (relative and absolute), accounting for confounding (alcohol consumption etc) including settings where Hep B absent;</li> <li>3. Diet studies assessing intake of aflatoxin against validated exposure biomarkers and in countries with high rates of HCC;</li> <li>4. Ecological study to explore association between stunting in children and aflatoxin exposure;</li> </ol>	<ol style="list-style-type: none"> <li>1. Existing study to be identified OR original (community-based) cohort study</li> <li>2. Existing study to be identified OR retrospective cohort study</li> <li>3. Direct diet studies (including laboratory assessment of contamination) - China?</li> <li>4. Regression analysis of country data on stunting (WHO nutritional database) with country level aflatoxin exposure</li> </ol>
Cassava Cyanide	<ol style="list-style-type: none"> <li>1. Diet studies assessing levels of cassava in food (including effects of processing) and intake of cassava cyanide by age groups;</li> </ol>	<ol style="list-style-type: none"> <li>1. Existing study to be identified OR direct diet studies (including laboratory assessment of contamination)</li> </ol>
Peanut Allergens	<ol style="list-style-type: none"> <li>1. Incidence studies of adverse reactions to peanut consumption (by age and sex from developing countries);</li> </ol>	<ol style="list-style-type: none"> <li>1. Existing study to be identified OR direct diet studies (including laboratory assessment of contamination)</li> </ol>
Dioxins Etc	<ol style="list-style-type: none"> <li>1. Studies assessing levels of dioxins in human milk</li> </ol>	<ol style="list-style-type: none"> <li>1. Conduct human milk survey OR obtain data from global survey of human milk (WHO/UNEP) for all persistent organic pollutants</li> </ol>
Lead	<ol style="list-style-type: none"> <li>1. Studies assessing levels of lead in food in comparison to total lead exposure (in developing countries)</li> </ol>	<ol style="list-style-type: none"> <li>1. Existing study to be identified OR direct diet studies (including laboratory assessment of contamination)</li> </ol>
Ciguatera	<ol style="list-style-type: none"> <li>1. Incidence studies of acute fish and shellfish poisoning (by age and sex);</li> </ol>	<ol style="list-style-type: none"> <li>1 a. Existing study to be identified OR original (community-based) cohort study</li> <li>1 b. Obtain outbreak information collated by FERG Enteric Diseases Task Force</li> </ol>
Methyl mercury	<ol style="list-style-type: none"> <li>1. Information on levels of methylmercury in hair</li> </ol>	<ol style="list-style-type: none"> <li>1. Existing study to be identified OR community-based studies collecting human</li> </ol>

	and blood in populations with well-characterized fish consumption	samples (including laboratory assessment), especially in women of child-bearing age
Cadmium	1. Information on levels of urinary cadmium in rice-eating nations where rice grows in volcanic soil (China, Indonesia, Japan & Philippines)	1. Existing study to be identified OR community-based studies collecting human samples (including laboratory assessment)
Organophosphate pesticides	1. Incidence studies of acute organophosphate poisoning (by age and sex); 2. Diet studies assessing levels and types of OPs in food and intake;	1. Existing study to be identified OR retrospective cohort studies (incl. assessment of poison centre records) 2. Direct diet studies (including laboratory assessment of contamination)
<b>Parasites (all studies)</b>		
Intestinal protozoa ( <i>G. lamblia</i> , <i>E. histolytica</i> , <i>Cryptosporidium</i> )	1. Incidence / prevalence studies at community level (by age and sex); 2. Proportion of patients with infections, who develop sequelae 3. Proportion of infections that are foodborne 4. Extent of co-morbidity between cryptosporidiosis and HIV infection	1-4. Review of all available literature and reports in country, and surveillance/lab data, cohort studies, population-based and lab-based studies 3. Expert elicitation at national level?
Toxoplasmosis	1. Incidence / prevalence studies at community level (by age and sex); 2. Proportion of patients with infections, who develop sequelae 3. Proportion of infections that are foodborne	1-4. Review of all available literature and reports in country, and surveillance/lab data, cohort studies, population-based and lab-based studies 3. Expert elicitation at national level?
<b>Parasites (if relevant i.e. endemic within the country)</b>		
<i>Fasciola hepatica</i>	1. Incidence / prevalence studies at community level (by age and sex); 2. Proportion of patients with infections, who develop sequelae 3. Proportion of infections that are foodborne 4. Extent of co-morbidity between fasciolosis and other parasitic infections	1-4. Review of available literature and reports in country 3. Expert elicitation at national level?
Alveolar echinococcosis	1. Hospital based incidence of AE in endemic countries 2. Population prevalence of AE in endemic	1. Review of hospital records / registers; 2. Review of available literature and reports on mass surveys 3. Cross sectional surveys? Expert elicitation?

	countries 3. Proportion of infection that is foodborne	
Cystic echinococcosis	1. Hospital based incidence of CE in endemic countries 2. Population prevalence of CE in endemic countries 3. Proportion of infection that is foodborne	1. Review of hospital records / registers; 2. Review of available literature and reports on mass surveys 3. Cross sectional surveys? Expert elicitation?
Cysticercosis	1. Incidence / prevalence studies at community level (humans and pigs; cysticercosis and taeniosis) 2. Hospital/slaughterhouse based incidence / prevalence of NCC/subcutaneous cysticercosis and porcine cysticercosis 3. Proportion of epilepsy cases with NCC (attribution?)	1. Review of available literature and reports on mass surveys; 2. Review of hospital (epilepsy/neuroimaging)/slaughterhouse records (porcine cysticercosis) / registers; 3. Cross sectional surveys?
Any other parasite XX of concern in the country	1. Hospital based incidence / prevalence of XX in endemic countries or incidence / prevalence studies at community level (by age and sex) 2. Population prevalence of XX in endemic countries 3. Proportion of infection that is foodborne	1. Hospital based incidence of XX in endemic countries or incidence studies at community level (by age and sex) 2. Population prevalence of XX in endemic countries 3. Proportion of infection that is foodborne
<b>Enterics</b>		
Bacterial toxin-based illnesses	1. Incidence of toxin-based outbreaks of gastroenteritis due to <i>C. perfringens</i> , <i>B. cereus</i> & <i>S. aureus</i> , to identify patterns of morbidity and mortality 2. Foodborne causes of toxin-based outbreaks in terms of specific food vehicles	1. Surveillance of foodborne disease outbreaks at country or sub-country level
<i>Clostridium botulinum</i>	1. Hospital based incidence of botulism in endemic countries (by age and sex) 2. Foodborne causes of botulism in terms of specific food vehicles	1. Review of hospital records in country 2. Literature review of incidence in country 3. Conduct surveillance of outbreaks to identify food vehicles
<i>Listeria monocytogenes</i>	1. Incidence from hospitalization records (by age, sex and	1. Review hospital records in country for listeriosis 2. Literature review of incidence and food contamination in country

	presentation)	
Hepatitis A	<ol style="list-style-type: none"> <li>1. Incidence from hospitalization records (by age and sex)</li> <li>2. Proportion of infections that are foodborne</li> </ol>	<ol style="list-style-type: none"> <li>1. Review hospital records in country for hepatitis and related presentations</li> <li>2. Conduct seroprevalence study, if not done</li> <li>3. Literature review of incidence in country</li> <li>4. Conduct surveillance of outbreaks to identify food vehicles</li> </ol>
Norovirus	<ol style="list-style-type: none"> <li>1. Incidence studies at community level (by age and sex)</li> <li>2. Proportion of norovirus infections that are foodborne</li> </ol>	<ol style="list-style-type: none"> <li>1. Microbiological study of detection of strains in faeces in either inpatient or community-based studies</li> <li>2. Conduct surveillance of gastroenteritis outbreaks to identify proportion that is foodborne and potential vehicles of infection.</li> <li>3. Expert elicitation at national level?</li> </ol>
Enteric infections of concern in the country	<ol style="list-style-type: none"> <li>1. Incidence studies at community level (by age and sex) using a cohort study approach for enteric pathogens, such as <i>Vibrio</i> spp., <i>Campylobacter</i>, <i>Salmonella</i>, pathogenic <i>E. coli</i>, noroviruses, and rotaviruses.</li> <li>2. Proportion of infections that are foodborne and specific food commodities causing illness</li> </ol>	<ol style="list-style-type: none"> <li>1. Microbiological study of detection of strains in faeces in either inpatient or community-based studies</li> <li>2. Conduct surveillance of outbreaks to identify food vehicles</li> <li>3. Expert elicitation at national level?</li> </ol>

### 3. FERG : Situation Analyses Manual

**The Foodborne Disease Burden Epidemiology  
Reference Group (FERG)  
Situation Analyses Manual**  
*working draft 2*  
May 25, 2012



# World Health Organization

## Table of Contents

<b>1.0 Overview</b>	<b>2</b>
1.1 The Three Situation Analyses	2
1.2 Timing considerations	2
<b>2.0 Task Force Formation</b>	<b>2</b>
2.1 Step One: The Senior Advisory Team	2
2.2 Step Two: Determining Task Force Structure and Terms of Reference	2
2.3 Specific Task Force Dialogue Modalities	2
2.3.1 <i>Expert Witness Panels</i>	2
2.3.2 <i>The Chatham House Rule</i>	2
2.3.3 <i>Visualization in Participatory Planning</i>	2
2.3.4 <i>Concept Mapping</i>	2
<b>3.0 Situation Analysis I: Stakeholders</b>	<b>2</b>
3.1 Stakeholder Analysis: major concepts and approaches	2
3.2 Brainstorming Sessions	2
3.2.1 <i>The Purpose, Plan and Process</i>	2
3.2.2 <i>Brainstorming</i>	2
3.2.3 <i>Subsequent Tasks</i>	2
3.3 Key Informant Interviews	2
3.4 Power vs. Interest Grid	2
3.5 Stakeholder Influence Mapping	2
3.6 Stakeholder-issue Interrelationship Diagram	2
3.7 Core Package of Stakeholder Analysis Tools	2
3.8 Synthesis	2
<b>4.0 Situation Analysis II: Political Context</b>	<b>2</b>
4.1 Brainstorming the Political Context	2
4.2 Key Informant Interviews	2
4.3 Force-Field Analysis	2
4.4 Power Analysis	2
4.5 Core Package of Political Context Analysis Tools	2
4.6 Synthesis	2
<b>5.0 Situation Analysis III: National Policy</b>	<b>2</b>
5.1 Brainstorming the Policy Process	2
5.2 The Policy Process Matrix	2
5.3 Network Analyses	2

*FERG Situation Analyses Manual*

5.4 Problem-Driven Analysis	3
5.5 Core Package of National Policy Analysis Tools	3
5.6 Synthesis	3
<b>6.0 Conclusions</b>	<b>3</b>
6.1 Final Evaluative Reports	3
<b>7.0 Glossary</b>	<b>3</b>
<b>8.0 Resources</b>	<b>3</b>
<b>9.0 Annex I: Key-Informant Interview Questions</b>	<b>3</b>

This manual was written by Sandy Campbell. Tanja Kuchenmüller and other FERG colleagues provided strong feedback throughout the writing process. All feedback to this manual should be addressed to: [kuchenmullert@who.int](mailto:kuchenmullert@who.int).

## 1.0 Overview

This manual presents a menu of possibilities in conducting several different types of situation analyses. Recognizing the many knowledge gaps in food and food safety issues, this manual seeks to assist country teams in filling those gaps, with particular emphasis on increasing country-level knowledge of stakeholders, power dynamics, relationships, networks, and policy processes.

The manual is structured in nine different sections. The analysis tools are presented largely in theoretical terms; they are not definitive or prescriptive, and are for guidance purposes only. Teams may decide to combine aspects of different tools, deem some irrelevant, or employ other tools not discussed here. As this is a pilot exercise, the experience of the four participating country teams (Albania, Japan, Thailand and Uganda) are crucial to informing and shaping the eventual scale up of these analyses across the six WHO regions, and thus documenting the lessons and the processes arising from this work is imperative.<sup>1</sup>

The unit of study for these analyses is the nation-state. The analyses are intended to capture the perspective of countries from the national level – more meta than micro, more oriented to the regional and global dynamics than the local. These analyses are designed above all to complement the accompanying country-based burden of foodborne disease studies, working to position these studies as comprehensive inputs to the wider policy-making processes within countries, regions and at the global level.

While many different approaches and tools have been outlined here, this manual is not designed to align a situation with a tool to magically produce a complete analysis. In every case, a good opening discussion and understanding of the situation – through collective, often facilitated brainstorming – will suggest the tools that should be used, typically in combination, and typically tailored to context, to arrive at a thorough analysis of the situation. This manual recommends the creation of participatory, multi-stakeholder, multi-disciplinary, multi-sectoral Task Forces to lead all analyses, and specifies in *Section Two* how countries may form these bodies.

**This manual is a working draft, and will be finalized by May 2012.**

### *1.1 The Three Situation Analyses*

Country teams are expected to use or modify the tools and approaches described here to execute three separate yet connected situation analyses. These analyses will provide largely qualitative “snapshots” of complex and overlapping processes, allowing country teams to better understand the actors, dynamics, actions, structures and processes surrounding priority food safety issues and policies at a national level. While country teams may approach these three analyses separately, they are inherently connected and may each be done simultaneously, in combination, or tailored to match specific contexts and opportunities.

These analyses will assist each Task Force in producing:

---

<sup>1</sup> Monitoring and evaluation guidelines will be developed and distributed to country teams at the end of November, 2011.

- a peer-reviewed document analyzing the actors, context and dynamics of food safety within their particular country, how this has changed over time, and what prospects the future holds. This will also assess which stakeholders, structures and processes may support or impede changes towards evidence-informed policy and practice in food safety at the national level.
- a national-level strategy positioning foodborne disease-burden data as a comprehensive input into national policy-making. Such a strategy may take many different forms, from cabinet recommendations to an evidence-informed policy brief and deliberative dialogue to an op-ed piece.
- synthesis documents reflecting the Task Force's work in each of the three analyses. These may be published online as grey literature.
- evaluative reports reflecting experience, data and recommendations arising from the conduct of these situation analyses to better assist the programme's eventual scale up across all WHO regions.

Central to all analyses is the creation of a national-level Task Force with the necessary skills and perspectives to lead the work. While the Task Force may commission other groups or individuals to undertake some of the suggested tasks, a key recommendation for the formation and eventual operation of a Task Force is the use of brainstorming techniques. Sometimes facilitated, sometimes structured using different dialogue modalities, this brainstorming will provide much of the preliminary raw data that individual situation analysis tools can then review, evaluate, and add value to.

The first analysis is a **stakeholder analysis**, where the Task Force will work to understand the positions, interest, power and dynamics among global, regional and national stakeholders relevant to food and food safety. This should begin with facilitated brainstorming to define and describe the major actors, their positions vis-à-vis food safety, the dynamics among them, and their interests, capacities, power and influence in food and food safety policy-making. The manual contains several different stakeholder analysis tools that will assist Task Forces in this work.

The second analysis is designed to create a systematic overview and analysis of the **political context** of food and food safety, with respect to the global, regional, and national levels. While connected to the stakeholder analysis above, this is more intended to document the political and policy environment surrounding food and food safety issues. This may include: understanding the factors external to a country that affect national policy-makers and food safety policy processes (from international food safety bodies to foreign aid organizations); structural factors within the national food industry, from economic parameters (e.g. subsidies, food handling regulations) to unique political-social trends, customs and pressures (e.g. common hand-washing practices); the degree of integration of food safety strategies in the health system; and a general understanding of the domestic food safety system, its institutions and management system, operations and capacity, as well as the resources allocated to food safety.

The third and final analysis aims to sketch and assess **national policy processes** and mechanisms related to or affecting food safety, including food safety policy. While clearly connected to the first two analyses, this is a much more focused investigation of national processes and

mechanisms. This includes a description and analysis of all national policies relevant to food safety and how they have changed over time; how previous policy agendas related to food safety issues have been set, formulated, adopted, implemented and evaluated; and an analysis of current or future opportunities for influencing policy and policy processes with food safety research evidence. This last variable is critical in terms of understanding how knowledge can inform and influence change. Studying this variable must include attention to the ways and means stakeholders currently access research evidence on food safety; the overall capacities of policy-makers to access, assess, adopt and apply research evidence in food safety; the national-level mechanisms in place to encourage the sharing and dissemination of relevant research evidence;

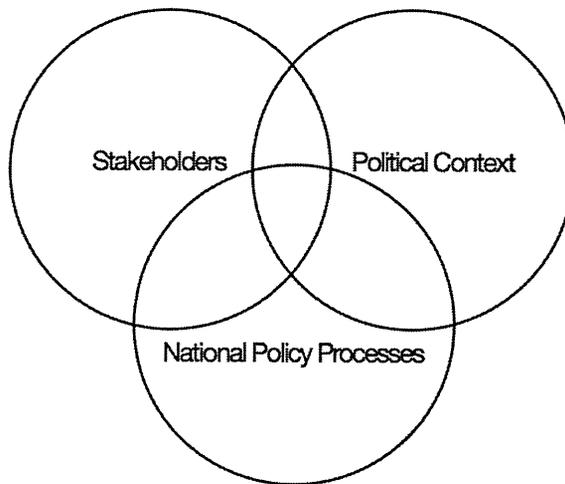


Diagram 1: Three Situation Analyses

and the individual and institutional obstacles to knowledge sharing, access and utilization.

### **1.2 Timing considerations**

In light of the timeframe for completing the national burden of foodborne diseases study, it is hoped that country teams will complete this work by the end of May 2012. How country teams divide the work over this period depends on the context – some Task Forces will take longer on particular tools than others; some may use a skeleton set of tools, while others will find tools not described in this manual to be of use. WHO will provide limited technical assistance during this period to address any questions, challenges or problems individual teams may have, while also serving to connect focal individuals across the four pilot countries to encourage learning and collective problem solving.

Note that in light of timing considerations, and in recognition of resource limitations and constraints, this manual provides, at the end of *Sections Three, Four and Five*, a minimum set of tools required to complete each situation analysis. While this minimal approach is not the recommended one, it will certainly provide a fair baseline of understanding for each analysis.

## 2.0 Task Force Formation

Central to these analyses is the formation of a national Task Force. The Task Force will coordinate and/or undertake all analyses, commission the work where appropriate, promote the involvement of key stakeholders, and oversee the production of the final outputs. There are many different approaches for forming, appointing or electing a Task Force, but the composition of each should reflect a wide sample of national food safety and policy stakeholders. Members of the Task Force need to possess not only knowledge of the country's food safety context, but must also have the abilities and time to perform, manage and/or review these analyses.

Each Task Force should be composed of 5-10 members. As there is a limited timeframe to conduct these activities (2-6 months), it is suggested that the Task Force form its geographic base where the majority of its members are located. This may exclude some individuals deemed essential to the Task Force's operations, but as described in *Section 2.3.1* below, there are other means for adopting their perspective and expertise into the Task Force.

In some countries, there may already exist a legitimate and capable body or entity that could either become or oversee the creation of the Task Force. However, in other countries, *how* the Task Force is created, and who sits upon it, are critical variables. As these situation analyses are inherently political – with an end goal being eventual policy influence and an understanding of policy pathways relevant to foodborne disease data – caution must be applied in the creation of a Task Force. In order to ensure that every Task Force possesses the necessary skills (in food safety and in situation analysis) *and* the required political support and acceptance among all major stakeholders, this manual recommends countries follow a number of connected steps that will, in the end, create a participatory, multi-stakeholder, multi-disciplinary, multi-sectoral group incorporating a range of voices.<sup>2</sup> If this is done poorly or exclusively or arbitrarily, the abilities of the Task Force to execute its mandate may be strongly impaired, with any of its eventual recommendations perceived as biased, untrustworthy or incomplete.

### Task Force Endorsement and Oversight

Given the clear political mandate of a Task Force – to discuss and analyze issues with obvious political, economic and/or cultural sensitivity – every Task Force requires deep political roots and support. And the higher the level of national endorsement the better. For instance, if a Minister of Health were to declare the need for such a Task Force, this would likely carry greater weight than the assertions of a mid-level ministry bureaucrat. As a non-binding, voluntary entity, its legitimacy is directly tied to this kind of endorsement and support. In terms of oversight, as the Task Force limits itself to providing recommendations for the way ahead, it may in fact require little active oversight. However, its operations and outputs should be evaluated upon conclusion, to document lessons learned if nothing else.

### 2.1 Step One: The Senior Advisory Team

Each country team likely already has a champion in food safety issues, and he or she may well be a participant in the FERG's foodborne disease study. Assuming a wide knowledge of the food safety arena in his/her country, this individual can begin the process by selecting three other individuals to jointly create a Senior Advisory Team (also called in other contexts a *Council of*

<sup>2</sup> These steps are an amalgam of those outlined in the priority-setting literature (see, for instance Campbell 2010), the deliberative dialogue literature (see McDonald, Bammer and Deane 2009), in Tuckman (1965), in programmatic decisions supported by international entities (see, for instance, UNICEF 2003), and in Dodge and Bennett (2011).

Elders). These four members should all be senior individuals with long experience in domestic food safety issues and processes; they should have experience in the public sector – at various

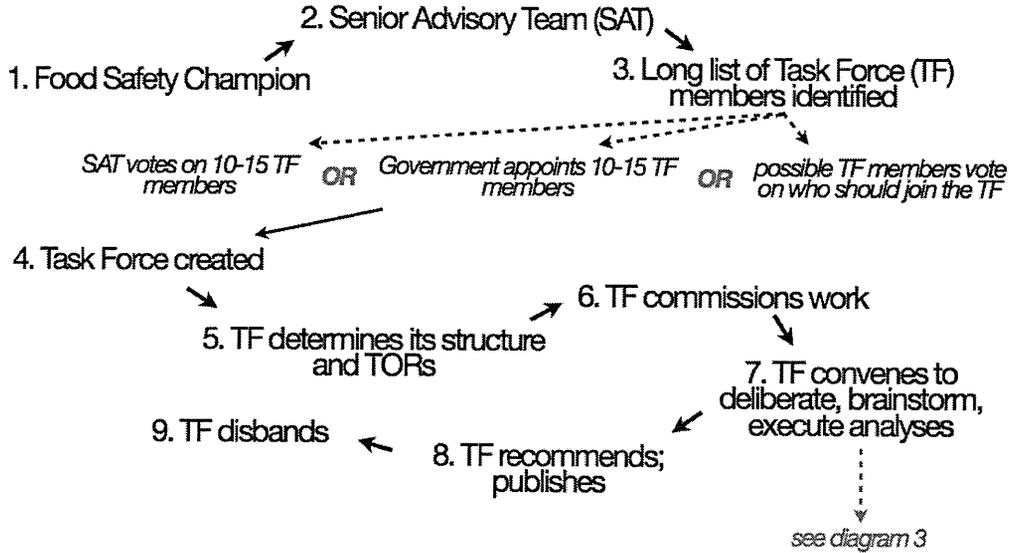


Diagram 2: Steps to complete the Situation Analyses

levels, domestic and international – civil society, and possibly the private sector.<sup>3</sup> The role of this Senior Advisory Team is to brainstorm a long list of individuals who could be part of the Task Force. It must discuss and take into consideration a range of variables for each candidate, including: relevant experience in the area; food safety knowledge; potential situation analysis skills; educational background; realistic availability; gender; age; and sector of expertise (among others). Upon completion of this long list (which may indeed include members of the Senior Advisory Team), the Senior Advisory Team may vote on the possible members, with those 5-10 individuals receiving the most votes becoming members. Or, following discussion, they may arrive at a consensus on who should serve as members. A third alternative would be to submit the long list of individuals to the identified individuals themselves, explain the overall goal and processes of the analyses, and have them vote on who should participate as a member of the Task Force.

Possible Task Force Members
<ul style="list-style-type: none"> <li>• environmental health officers involved in food safety assurance</li> <li>• federal, state, district government officials with responsibilities in health, agriculture and/or commerce (assuming routine interaction with food safety issues); this may include representatives from ministries of health, agriculture, commerce, etc.</li> <li>• members of non-governmental organizations involved in health action or food safety</li> <li>• representatives of consumer health groups</li> <li>• academics researching/teaching food safety issues</li> </ul>

<sup>3</sup> Importantly, there may already exist an in-country arrangement or group similar to this Senior Advisory Team or the Task Force itself. If that is the case, then this Team or Task Force could certainly proceed in its current composition.