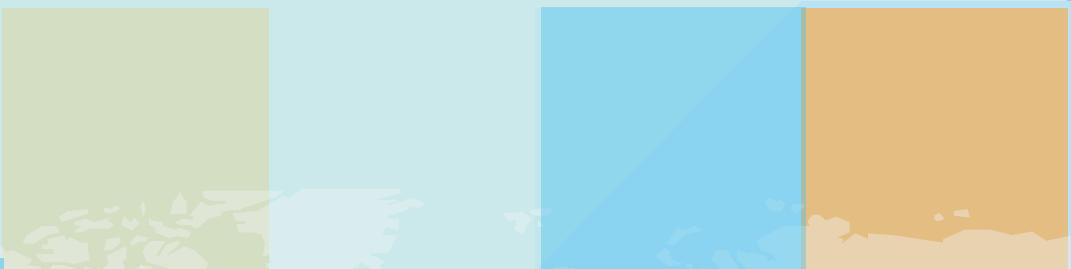




Integrated Food Security Phase Classification
Evidence and Standards for Better Food Security and Nutrition Decisions



Technical Manual Version 3.1

**Evidence and Standards for
Better Food Security and Nutrition Decisions**



The Integrated Food Security Phase Classification (IPC) Global Partners



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TECHNICAL MANUAL VERSION 3.1

Evidence and Standards for Better Food Security and Nutrition Decisions

The IPC Global Partners



IPC Funding Partners



Rome, August 2021

The IPC Partnership is a group of 15 organizations and intergovernmental institutions including: Action Against Hunger, CARE International, Comité Permanent Inter-États de Lutte Contre la Sécheresse au Sahel (CILSS), Food and Agriculture Organization of the United Nations (FAO), Famine Early Warning Systems Network (FEWS NET), the Global Food Security Cluster, the Global Nutrition Cluster, Intergovernmental Authority on Development (IGAD), Joint Research Centre (JRC) of the European Commission, Oxford Committee for Famine Relief (Oxfam), Southern African Development Community (SADC), Save the Children, Sistema de la Integración Centroamericana (SICA), World Food Programme (WFP) and United Nations Children's Fund (UNICEF).

Version 1.0 of the IPC Technical Manual was originally prepared in 2006 by FAO/Food Security and Nutrition Analysis Unit – Somalia (FSNAU) under the leadership of Nicholas Haan.

The formal citation for version 1.0 of the manual is:

FAO/FSNAU 2006. Integrated Food Security and Humanitarian Phase Classification: Technical Manual Version 1.0. Nairobi. FAO/FSNAU Technical Series IV.

A revised Version 1.1 was published by the same authors in 2008. This version is referred to as:

IPC Global Partners. 2008. Integrated Food Security Phase Classification Technical Manual. Version 1.1. FAO. Rome.

Version 2.0 of the manual was then prepared in 2012 by the IPC Global Partnership. This version of the manual transformed the IPC from a local classification scheme to a global classification scale. The IPC analytical framework was presented for the first time and the IPC Reference Table was reorganized. This version was prepared by the IPC Global Support Unit under the leadership of Nicholas Haan, with full engagement of partners.

Version 2 of the IPC Manual is cited as:

IPC Global Partners. 2012. Integrated Food Security Phase Classification Technical Manual Version 2.0. Evidence and Standards for Better Food Security Decisions. FAO. Rome.

In 2019, a comprehensive revision and update of the IPC Technical Manual Version 2.0, was published. This version 3.0 focused on expanded explanations of the IPC protocols and processes. For the first time, the three scales (acute food insecurity, chronic food insecurity, and acute malnutrition) were presented together and harmonized. More comprehensive protocols for Famine classification and classifications of areas with limited humanitarian access were added. This version was prepared by the IPC Global Support Unit under the leadership of Leila Oliveira, with the full engagement of the Technical Advisory Group and the Food Security and Nutrition Working Groups.

That manual is cited as:

IPC Global Partners. 2019. Integrated Food Security Phase Classification Technical Manual Version 3.0. Evidence and Standards for Better Food Security and Nutrition Decisions. Rome.

In 2021, Version 3.0 was upgraded with the following supplemental information included in the current document, Version 3.1: the inclusion of the Food Insecurity Experience Scale (FIES) in the Acute Food Insecurity Reference Table. Editorial changes for better usability. Version 3.1 represents the most up-to-date version of the IPC Technical Manual. Pending the future publication of any further revisions, Version 3.1 should be applied to all analyses going forward; previous versions of the manual should be considered obsolete.

Please cite this version as:

IPC Global Partners. 2021. Integrated Food Security Phase Classification Technical Manual Version 3.1. Evidence and Standards for Better Food Security and Nutrition Decisions. Rome.



FOREWORD

The IPC Technical Manual Version 3.1 is the culmination of a collaborative process between key agencies and stakeholders dealing with food insecurity and malnutrition. IPC has been designed to expand both the reach and scope of the classifications.

The IPC Manual provides a comprehensive guide for new and experienced IPC practitioners, including an overview of the IPC as an approach for decision-makers' use, supplemented by the technical sections of interest to the IPC analyst.

The expansion of the IPC scales from one to three indicates the dynamic evolution of the IPC. The IPC Acute Food Insecurity scale have been joined by the Chronic Food Insecurity and Acute Malnutrition scales. With analytical approaches and protocols shared across all three scales, an analyst proficient in one scale will immediately be familiar with the other scales. Going forward, it is anticipated that in the next iteration of the IPC Technical Manual, a fully integrated analytical approach across the different scales will be introduced.

Further refinements to particular tools and procedures are also included in this manual, notably as regards famine classification, classification in areas with limited or no access for collecting evidence, and evidence reliability. Taken together, these upgrades support the dual purpose that has been at the core of the IPC since its inception: a technically rigorous approach that is feasible at the field level.

As an indication of the increasing global interest in the IPC and its institutionalization, we note with satisfaction that the formal structures supporting it have grown to keep pace accordingly. The composition of the IPC Global Steering Committee has expanded from 8 to 15 global partners to include Action Against Hunger, United Nations Children's Fund (UNICEF), Global Nutrition Cluster, and four regional intergovernmental bodies: *Comité Permanent Inter-États de Lutte Contre la Sécheresse dans le Sahel* (CILSS), Intergovernmental Authority on Development (IGAD), *Sistema de la Integración Centroamericana* (SICA) and the Southern African Development Community (SADC). This expanded global partnership is reflected by the presence of, *inter alia*, the Technical Advisory Group and the Working Groups on Food Security and Nutrition, all of which played key roles in the preparation of this manual. This Manual is representative of our shared, collective commitment to addressing food insecurity and malnutrition wherever they occur, using the IPC to enable consensus-led, evidence-driven decision-making.

The IPC Global Steering Committee

ACKNOWLEDGEMENTS

In keeping with the IPC's commitment to consensus, the development of the IPC Technical Manuals Version 3.0 and 3.1 involved a collaborative process that examined every detail of the IPC. This as a necessary step, because an increasing number of countries have moved to adopt the IPC and the scope of the IPC has grown: with this, valuable lessons have been learned. The process of upgrading the IPC Technical Manual Version 3.0 and 3.1 required the collective efforts of food security and nutrition professionals from across the world, working in institutions such as intergovernmental organizations and United Nations agencies, non-governmental organizations (NGOs), donor representatives and academics. For all those individuals who generously gave their time and insight, and who worked to find solutions to some of the most complex questions that food security and nutrition analysts currently face, the IPC Global Support Unit would like to express its appreciation and gratitude.

The development of the IPC Technical Manual Versions 3.0 and 3.1 has been overseen by the IPC Global Support Unit under the leadership of Leila Oliveira, with the full engagement of the Technical Advisory Group and Food Security and Nutrition Working Groups which comprised the following partners: Action Against Hunger, CARE, CDC, CILSS, FAO, FEWS NET, gFSC, GNC, IGAD, JRC, Oxfam, SADC, Save the Children, SICA, UNICEF, the University College London and WFP.

Specifically, this manual is the result of the efforts of the following individuals: Mohammed Addum, Claudia Ah Poe, Dalmar Ainashe, Lorena Auladell, Issoufou Baoua, Lisa Biblo, Oleg Bilukha, Carlo Cafiero, Estefania Custodio, Matthew Day, Panduleni Elago, Gwenaelle Garnier, Valerie Gatchell, Megan Gayford, Valentina Giorda, Christopher Hillbruner, Tim Hoffine, Cindy Holleman, Alessandro Iellamo, Josephine Ippe, Damien Joud, Gertrude Kara, Pardie Karamanoukian, Domitille Kauffmann, Cyril Lekiefs, Grainne Moloney, Louise Mwirigi, Chris Newton, Tharcisse Nkunzimana, Kathryn Ogden, Danka Pantchova, Saeed Rahman, Sergio Regi, Katie Rickard, Joysee Rodriguez-Baide, Magalie Salazar, Mohammed Salem, Andrew Seal, Ricardo Sibrián, Ruth Situma, Darana Souza, Laura Swift, Peter Thomas, Marina Tripaldi, Massaoud Williams, Hailu Wondim Yismaw and Anna Ziolkovska

From the IPC Global Support Unit, Douglas Jayasekaran and Kaija Korpi-Salmela co-chaired the working groups and supported the drafting of the Manual; Sophie Chotard and Rachele Santini drafted specific parts; and Jannie Armstrong, Barbara Frattarulo, Quraishia Merzouk, Manuel Veiga, Kamau Wanjohi, Frank Nyakairu and Lisa Zammit provided invaluable contributions. Our sincere thanks go to Nicholas Haan, who conceived the IPC's vision during the development of the IPC Technical Manual Version 1.0 and the IPC Technical Manual Version 2.0, and continued to provide strategic guidance during the development of Version 3.0 and 3.1.

The IPC Global Steering Committee, which provided guidance throughout this process, was composed of the following individuals: Guleid Artan, Emily Farr, Cyril Ferrand, Yvonne Forsen, Laura Glaeser, Joanne Grace, Amador Gomez, Bruce Isaacson, Baoua Issoufou, Davina Jeffery, Mahalmoudou Hamadoun, Diane Holland, Justus Liku, Bruno Minjauw, Thierry Negre, Patricia Palma, Silke Pietzsch, Luca Russo and Jessica Saulle.

The development of the IPC Technical Manual Version 3.0 is also the result of deep collaboration with the Technical Committee of the *Cadre Harmonisé* in order to harmonize tools and procedures to the highest extent possible. The IPC and the *Cadre Harmonisé* have never collaborated more closely, and we would also like to sincerely thank our friends and colleagues from West Africa and the Sahel for their engagement in this process.

Jose Lopez
IPC Global Programme Manager

WHAT IS NEW IN THE IPC TECHNICAL MANUAL VERSION 3.1

The IPC Technical Manual v3.1 includes a complete range of classification scales: Acute Food Insecurity, Chronic Food Insecurity and Acute Malnutrition. Each scale informs specific types of action needed, thus providing decision-makers with invaluable information for the strategic design of actions to address food insecurity and malnutrition. The scales have been fully harmonized, thus enabling:

- new scales to be applied more easily at the country level as protocols are shared across all scales, allowing analysts greater fluidity across the entire IPC portfolio;
- the path for integration of the three scales, with similar analytical parameters and a consolidated conceptual framework, increasing the ability to compare and establish linkages between the three conditions.

In addition, the Manual includes the most up to date reference tables, including the newly added Food Insecurity Experience Scale. The IPC Technical Manual Version 3.1 also includes elaborated communication protocols, with more informative and adaptive modular communication templates. Throughout the manual, guidance to users is included in order to promote higher-quality analysis and global comparability. The manual includes also protocols for:

- **Famine classification:** Protocols for use in the most severe crisis contexts, setting the global benchmark for declarations of famine. These have been updated since version 3.0 to allow rigorous and accountable classifications to be done even in context of inadequate data availability.
- **Classification of areas with limited or no humanitarian access to collect evidence:** Specific protocols for classification under extreme circumstances, maintaining IPC standards through adherence to recommended minimum parameters.
- **Evidence reliability assessments:** More specific criteria providing better guidance on the use of evidence for classifications.

The IPC Technical Manual Version 3.1 is organized into two parts:

- **Part I** provides the general user, including donors, implementing partners and governments, with adequate information to understand and critically utilize IPC products.
- **Part II** provides the analyst with the protocols, including tools and procedures, to conduct the classification.

A number of Guidance Notes and Working Papers covering specific aspects of the IPC were developed. These are part of IPC Resources and provide useful supporting guidance for this Manual, which will be of particular interest to advanced analysts, trainers and facilitators. The IPC Resources can be accessed through the IPC website (www.ipcinfo.org).

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PART 1

IPC OVERVIEW

1.1 WHAT THE IPC IS

Figure 1: What the IPC is

The IPC is:

- a process to build an **evidence-based technical consensus** among key stakeholders;
- an approach to consolidate wide-ranging evidence to **classify the severity and magnitude** and to identify the key drivers of food insecurity and malnutrition;
- a path to provide **actionable knowledge** for strategic decision-making;
- a platform to ensure a **rigorous, neutral analysis.**

The Integrated Food Security Phase Classification (IPC) is a **common global scale** for classifying the severity and magnitude of food insecurity and malnutrition. It is the result of a partnership of various organizations at the global, regional and country levels dedicated to developing and maintaining the highest possible quality in food security and nutrition analysis. Increasingly, the IPC is the international standard for classifying food insecurity and malnutrition.

The IPC is a ‘big picture’ classification focusing on providing information that is constantly required by stakeholders around the world for strategic decision-making. Nuanced information may also be needed to inform particular decisions or answer certain questions. The IPC provides the essential information needed in a wide range of contexts in consistent, comparable and accountable ways.

The IPC communicates actionable information for strategic decision-making. It analyses and consolidates complex food security and nutrition information and presents it in a simple and accessible form. The IPC provides the evidence base for assessing the situation by asking the following questions: **how severe, how many, when, where, why, who, as well as the key characteristics.** Together, these questions form the basis for situation analysis and help inform decision-making, which is the focus of the IPC (Figure 1).

The IPC estimates the number of people affected at different severities of food insecurity and malnutrition and communicates the key drivers and characteristics of the situation, providing decision-makers with key information to support response-planning.

The IPC distinguishes between acute food insecurity, chronic food insecurity and acute malnutrition since different interventions are needed to address each situation. Furthermore, understanding their co-existence and relationship is invaluable for strategic decision-making. The IPC is a platform for presenting the linkages between food insecurity and malnutrition, as well as acute and chronic food insecurity, to support more integrated and better coordinated response-planning. Figure 2 details the focus of each classification scale and the action that they inform.

Figure 2: What the three IPC scales do

IPC Scale	Identifies areas and populations with:	Identify the need for urgent action to:
Acute Food Insecurity 	food deprivation that threatens lives or livelihoods, regardless of the causes, context or duration.	decrease food gaps and protect lives and livelihoods.
Chronic Food Insecurity 	persistent or seasonal inability to consume adequate diets for a healthy and active life, mainly due to structural causes.	address underlying factors and potentially implement safety net programmes.
Acute Malnutrition 	a high prevalence of acute malnutrition accompanied by high or increasing levels of morbidity or individual food consumption gaps.	scale up acute malnutrition treatment and prevention for affected populations.

IPC protocols are not designed – nor should they be used – to assess the impact of humanitarian or developmental assistance on food security and nutrition, nor to monitor the achievement of goals, which require separate monitoring and evaluation methods.



1.2 WHY IT IS NEEDED

Within the inherently complex, multidisciplinary and cross-sectoral fields of food security and nutrition, there was a widespread need for an analytical approach that would be **robust and transparent, comparable and applicable across locations, and relevant for decision-making**. To meet this challenge, the IPC has become a global reference for the classification of food insecurity and increasingly for acute malnutrition because it is:

- **Generic** enough to be utilized in an array of food security and nutrition situations and contexts;
- **Simple** enough to be practical and understandable at field level, making it useful for multiple stakeholders;
- **Rigorous** enough to become an international standard.

1.3 HOW IT WORKS

The **IPC makes the best use of the evidence available** through a transparent, traceable and rigorous process. Evidence requirements to complete classification have been developed taking into consideration the range of circumstances in which evidence quality and quantity may be limited while ensuring adherence to minimum standards. To ensure the application of the IPC in settings where access for collecting evidence is limited or non-existent, specialized parameters have been developed. The IPC provides a structured process for making the best assessment of the situation based on what is known and shows the limitations of its classifications as part of the process.

There are three IPC scales: Acute Food Insecurity, Acute Malnutrition and Chronic Food Insecurity. Each scale classifies a specific condition that is linked to particular responses. The uses and analytical differences for each of the scales are described in Figure 3.

Figure 3: The three IPC scales – An Overview

	Acute Food Insecurity	Chronic Food Insecurity	Acute Malnutrition
IPC definitions of food insecurity and malnutrition			
Informs action with specific strategic objectives	Food insecurity found at a specific point in time and of a severity that threatens lives or livelihoods, or both, regardless of the causes, context or duration.	Food insecurity that persists over time mainly due to structural causes, including intra-annual seasonal food insecurity.	Global Acute Malnutrition (GAM) as expressed by thinness of individuals or presence of oedema.
Severity categories	Short-term objectives to prevent or decrease acute food insecurity that threatens lives or livelihoods.	Medium- and long-term improvement of the quality and quantity of food consumption for an active and healthy life.	Short- and long-term objectives to prevent or decrease high levels of acute malnutrition.
Analytical focus	Five Severity Phases: 1. Minimal/None 2. Stressed 3. Crisis 4. Emergency 5. Catastrophe/Famine	Four Severity Levels: 1. Minimal/None 2. Mild 3. Moderate 4. Severe	Five Severity Phases: 1. Acceptable 2. Alert 3. Serious 4. Critical 5. Extremely Critical
	Identifying areas with a large proportion of households with significant food energy gaps or livelihood change strategies that can endanger lives or livelihoods.	Identifying areas with a large proportion of households that have long-term inability to acquire adequate food requirements both in terms of macro- and micronutrients.	Identifying areas with a large proportion of children wasted or with oedema.

The IPC consists of four functions that must be followed to conclude classification and to generate IPC information products. Each function has a specific purpose and a set of protocols to guide analysts. The completion of all protocols is fundamental to the IPC as they ensure that analyses are rigorous, neutral and accountable. The four Functions are detailed in Figure 4 and include:

- **Function 1:** Build Technical Consensus
- **Function 2:** Classify Severity and Identify Key Drivers
- **Function 3:** Communicate for Action
- **Function 4:** Quality Assurance

All three scales follow exactly the same protocols within the functions but contain adapted tools and procedures to allow analysts to untangle the different conditions. By sharing the same protocols, the IPC promotes the application of multiple scales in the same country.

Figure 4: The four IPC Functions – An Overview

IPC Function	Purpose	Protocols
I. Build Technical Consensus	To enable technical consensus between multi-sectoral experts.	1.1 Compose the analysis team with relevant sectors and organizations. 1.2 Conduct the analysis on a consensual basis.
II. Classify Severity and Identify Key Drivers	To critically analyse complex information, classify areas in severity categories, estimate magnitude, and identify key drivers and characteristics of the condition.	2.1 Use Analytical Frameworks to guide the convergence of evidence. 2.2 Compare evidence against the Reference Tables. 2.3 Adhere to parameters for analysis. 2.4 Evaluate evidence reliability. 2.5 Meet minimum evidence and analysis requirements. 2.6 Methodically document evidence and analysis and provide them upon request.
III. Communicate for Action	To communicate core aspects of the situation in a consistent, accessible and timely manner.	3.1 Produce the IPC Analysis Report. 3.2 Adhere to mapping standards. 3.3 Strategically share communication products in a timely manner.
IV. Quality Assurance	To ensure technical rigour, neutrality and self-learning for future improvements.	4.1 Conduct a self-assessment of the analysis. 4.2 Request and engage in an external quality review if necessary.

Note: Special protocols have been developed for the IPC Famine Classification and classifications in areas that have scarce evidence due to limited or no access. They are detailed in Part 2A, Acute Food Insecurity Classification. .



1.4 ADDED VALUE

The IPC process begins with the formation of an in-country Working Group, referred to as the IPC Technical Working Group, hosted by the government where feasible and composed of relevant national stakeholders, and usually including representatives of the government, United Nations agencies and NGOs. These Technical Working Groups can be either new groups or embedded within existing coordination structures. The Technical Working Groups are the foundation of country-level implementation and are crucial for ensuring the consistency, sustainability and use of the IPC.

Since its introduction in 2004, the IPC has become the internationally accepted reference for analysis of food security and, increasingly, for acute malnutrition crises. **The IPC has considerable advantages** for both analysts and decision-makers, including:

- **Setting of the global standard:** The IPC provides a common language for classifying the severity and magnitude of acute and chronic food insecurity and acute malnutrition. It is applicable across and between regions and countries over time.
- **Global and national applicability:** The IPC can be applied in almost any situation and is supported by rigorous protocols that allow the use of a wide range of evidence. The evidence is framed in the applicable national context and analysed against global references through a consensus-based approach led by teams of experienced analysts.
- **Convergence of evidence:** The IPC is a way of consolidating complex evidence from different methods, sources and periods, following a set of specific protocols. Although the IPC identifies selected indicators, it also requires the inclusion of other supporting evidence and consideration of local and historical contexts.
- **Technical consensus:** Situations involving food insecure and malnourished populations are multifaceted and complex, subject to interpretation by multiple stakeholders at the macro, sectoral and local levels. The IPC serves as a platform to bring together stakeholders from all levels in order to facilitate a consensus-based approach to understanding the problem. One of the hallmarks of the IPC is multi-sectoral cooperation and technical consensus, which ensures that the results of the analysis are widely accepted and acted upon, thus promoting responses that are better coordinated and targeted, and more effective.
- **Comparability over space:** Decision-makers need to be able to compare the situations from one area to another, both within and across countries. The IPC facilitates such a comparative analysis by providing globally accepted and widely adopted criteria for food security and nutrition classification.
- **Comparability over time:** The IPC allows time series-based trend analysis to facilitate an understanding of the evolution of situations as they unfold in order to determine the short- and medium-term strategic response priorities.
- **Effective early warning:** Decision-makers need forecasts of the potential timing, severity and magnitude of any forthcoming crisis. Without a common technical understanding to describe crises, early warning messages can be ambiguous and go unheeded. The IPC provides clear protocols for projecting and communicating potential critical situations, informing early relief planning to prevent or limit the severity of forecast acute food insecurity and acute malnutrition.
- **Transparency through evidence-based analysis:** IPC food security and nutrition situation analyses are fully transparent as to how findings were reached and conclusions made, ensuring credibility at every stage of the process. The IPC establishes clear protocols to support and guide high standards of transparency and rigour. As the IPC draws on existing evidence in the public domain, all underlying data should be accessible to anyone. Furthermore, analysis worksheets should be provided upon request.
- **Better accountability:** In an IPC analysis, a meticulous process tracks every decision (and the data supporting it) from start to finish. Findings are based on consensus, ensuring ownership throughout the classification process. The IPC therefore provides high levels of both credibility (i.e. the analysis process can be clearly followed) and dependability (i.e. open to external checks and review), reinforced by a comprehensive Quality Assurance process.
- **Identification of data gaps:** Although the IPC is not a data collection tool, it can help identify critical data gaps or quality issues, encouraging investments and improvements in future data collection (Figure 5).

1.5 KEY FEATURES

Figure 5: What the IPC isn't

- **A methodology for directly measuring food insecurity or malnutrition** – it draws from multiple methodologies and secondary sources;
- **Limited to particular analytical methodologies** – it calls for a critical review of all the relevant evidence;
- **An information collection tool**, although it may inform data collection and highlight information gaps;
- **An information system** – it is a complementary add-on to existing systems;
- **A response analysis tool nor is it intended to be one** – it provides key information to support response analysis;
- **A tool for monitoring and evaluating the impact** of humanitarian or developmental assistance on food security and nutrition, nor for monitoring the achievement of programmatic goals – it classifies the current and projected situation considering the inherent complexity of food security and nutrition analysis. Also, although valuable for informing response analysis, the findings are not adequate for monitoring and evaluating responses or the achievement of development goals.

- **The IPC is based on consensus-building.** Building a technical consensus is important for two main reasons. First, food security and malnutrition analysis requires expertise from a wide range of disciplines (food security, livelihoods, nutrition, markets, agriculture and others, depending on the situation) as well as in-depth knowledge of the local context. The consensus-based process brings together experts from different disciplines and perspectives to evaluate and debate the evidence culminating in the final classification. Second, bringing technical experts from key stakeholder organizations together in the analysis process ensures that the analysis results will be more widely accepted and acted upon in a coordinated manner. Thus, consensus-building is key to promoting rigorous and unbiased food security and nutrition classifications.
- **The IPC uses a convergence-of-evidence approach.** IPC analyses are prepared with a range of data and information from a variety of sources across multiple sectors. This approach requires analysts to critically evaluate the body of evidence in terms of both content and reliability, using the IPC protocols to guide analysis and classification.
- **The IPC can be used at low levels of disaggregation.** The IPC can be used for classifying food insecurity and malnutrition in any administrative unit or geographical area, provided that minimally adequate and representative evidence is available. However, it should be noted that because IPC classification is based on consensus-building and convergence of evidence, the efforts required in terms of human and time resources to classify multiple small areas are substantial. Hence, decisions regarding the level of geographic disaggregation of IPC analyses need to take into account decision-makers' needs but also data availability, feasibility of implementation, resources and logistical aspects.
- **The IPC can be applied with minimally adequate evidence.** Reliable, good-quality data are vital for well-informed, rigorous food security and nutrition analyses and classifications. The IPC strongly recommends that national data collection systems adhere to global standards for the collection and analysis of food security and nutrition indicators. However, because such data are often unavailable for the geographical unit under analysis, the IPC allows classification to be carried out with somewhat reliable evidence, provided that there is a minimum set of data and that all IPC protocols are followed. It is the four IPC Functions and their methodological protocols that allow classifications to be carried out even when only limited evidence is available.



- **The IPC can be used to classify acute food insecurity and acute malnutrition in areas with limited or no humanitarian access.** The IPC classification is often conducted in situations where limited access prevents humanitarian organizations from reaching certain areas. This is especially the case in situations of conflict and large-scale natural disasters. In fact, areas that cannot be reached are often those most affected by food insecurity and acute malnutrition, and for which available data are limited. To support response planning, IPC classifications can be performed under these conditions, provided that minimum evidence is available, with the recognition that this analysis will provide less specific and less accurate information as a result.
- **The IPC can be used in rural and urban settings.** While food security analysis is often biased towards rural settings, food insecurity in urban areas can also be a major concern. This is increasingly the case as a result of growing urbanization and global market integration. The overall IPC approach, including the IPC Analytical Framework and other protocols, is equally applicable to urban settings; however, tools and procedures may need further adaptation for urban contexts.
- **The IPC Information Support System (ISS) allows more efficient, accountable and mainstreamed classifications to be made.** The ISS is an innovative Internet platform designed to facilitate the creation, storage and dissemination of IPC classifications. The ISS includes the tools necessary to complete the 13 protocols used for classification and enables documentation and analysis of evidence. The ISS can greatly reduce the time it takes to complete an IPC analysis by enabling the pre-organization of evidence, allowing simultaneous work by multiple users, and automatically creating population tables and communication templates. The ISS is a country tool owned and managed by the national Technical Working Group. The Technical Working Group can decide to make the analysis results available for the general public, including the map, the population table and the communication brief, or can share them among technical personnel.
- **The IPC sets the global standards for Famine classification.** Famine is the most severe phase of the IPC. It exists in areas where at least one in five households has or is most likely to experience an extreme deprivation of food. Starvation, death, destitution and extremely critical levels of acute malnutrition are or will likely be evident. Significant mortality, directly attributable to outright starvation or to the interaction of malnutrition and disease, is occurring or is likely to be occurring. Given the severity and implications of classifying Famine, specific IPC protocols have been developed, and special considerations are identified in Figure 6.

Figure 6: Famine classification – An Overview

- **The IPC only permits the classification of Famine when all regular IPC protocols and special Famine protocols are met.** The special protocols are:
 - The requirement of reliable evidence on the three outcomes – food consumption or livelihood change, global acute malnutrition (GAM), and crude death rate (CDR), all of which are either currently above or projected to be above Famine thresholds (>20% of households with extreme food gaps, >30% of children acutely malnourished, and CDR> 2/10,000/day).
 - Undergoing a Famine review process to validate the classification.
 - Development of the IPC Famine Alert adhering to pre-determined standards.
- **The IPC permits the classification as Famine Likely when all regular and special protocols are met, except for the existence of reliable evidence for the three outcomes.** Areas can be classified as Famine Likely if minimally adequate evidence available indicates that a Famine may be occurring or will occur. When an area is classified as Famine Likely, it should trigger prompt action by decision-makers to address the situation while calling for urgent efforts to collect more evidence.
- **Famines should be avoided at all costs.** Although further deaths can and should be prevented by urgent action, it is evident that these actions will be, de facto, a late response because many will have died by then. The IPC supports Famine prevention by highlighting the following:
 - **IPC Phase 4 Emergency is an extremely severe situation** where urgent action is needed to save lives and livelihoods.
 - **Households can be in Phase 5 Catastrophe even if areas are not classified as Phase 5 Famine.** This indicates that households in Phase 5 Catastrophe experience the same severity of conditions even if the area is not yet classified as Famine. This can occur due to the time-lag between food insecurity, malnutrition and mortality, or in the case of a localized situation.
 - **A projection of Famine can be made even if the current situation is not yet classified as Famine,** thus enabling early warning.



1.6 KEY CHALLENGES AND LIMITATIONS

- **Consensus-building is a time-consuming process, and agreement is not always reachable.** Consensus-building represents the cornerstone of every analysis exercise, and as an approach, sets the IPC apart. However, it is time-consuming and requires careful stewardship to mitigate against bias, encourage openness, and in some cases, resolve interpersonal conflict. In contexts in which rigid hierarchies are the norm, this process can prove complex to navigate and remains an ongoing challenge. The time required to build a technical consensus and the contextual factors at play need to be well understood from the onset.
- **The ‘convergence of evidence’ approach often identifies contradictory evidence.** IPC Reference Tables provide commonly accepted thresholds, cut-off values and approaches. Although they guide convergence, they do not provide a definitive classification, as there is no guarantee that indicators will align. Analysts commonly have to deal with divergent and contradicting data due to context-specific issues, indicator validity and reliability of evidence. Divergent data can lead to differences of opinion: although the IPC has been developed precisely to embrace and identify reasons for divergence, lack of convergence can result in failing to attain consensus, making the process more time-consuming.
- **IPC classification is only as robust as the evidence used and how it is analysed.** The IPC does not collect primary data and relies on existing evidence. It may provide a useful platform for identifying critical data gaps, but it does not have the means to directly address them. The IPC can thus act as a stimulus to improve data availability and quality, but this depends on the efforts of external parties. The usual limited data availability for vulnerable subgroups, such as refugees, displaced populations and marginalized groups, as well as for areas with limited access for collecting evidence is of particular concern in this regard. In addition, high-quality data do not guarantee accurate classification, since the information available must be critically analysed.
- **Analysis of drivers does not always meet decision-makers’ needs.** Although the IPC supports the identification of key drivers, it does not provide the details required to develop sector-specific response plans, especially those focusing on addressing the structural causes of food insecurity and malnutrition. In this regard, the food security and nutrition context at the subnational level may require additional, in-depth analyses that provide greater details on causality, drivers and structural factors that contribute to food insecurity and malnutrition.
- **Analysis planning is not always aligned with country response processes.** The IPC’s relevance for informing decision-making depends on the ability of countries to align data collection and analyses processes with decision-making processes. When not aligned, evidence generated by the IPC may not be used optimally for programming and policy decision-making.
- **In-country resourcing of the IPC is variable.** IPC implementation is contingent on time, place, and available human and financial resources. IPC global partners’ representation at the national level may not have the required resources or skills set to support the introduction or institutionalization of the IPC in the countries. At the planning stages, it is essential to ensure that the overall resources required are well identified and that solutions for any major gaps are sought. In the planning process, care should be taken to consider: (i) availability of requisite financial and human resources to conduct analysis at the level of the intended unit of analysis; and (ii) the feasibility of the number of units to be analysed and classified. The scope of analysis should be adjusted based on what is affordable and feasible.
- **The IPC is not a guarantee that the requisite action will follow.** The IPC is a basis for providing information for decision-making, but decisions taken as a result of IPC classification are a separate and distinct process.

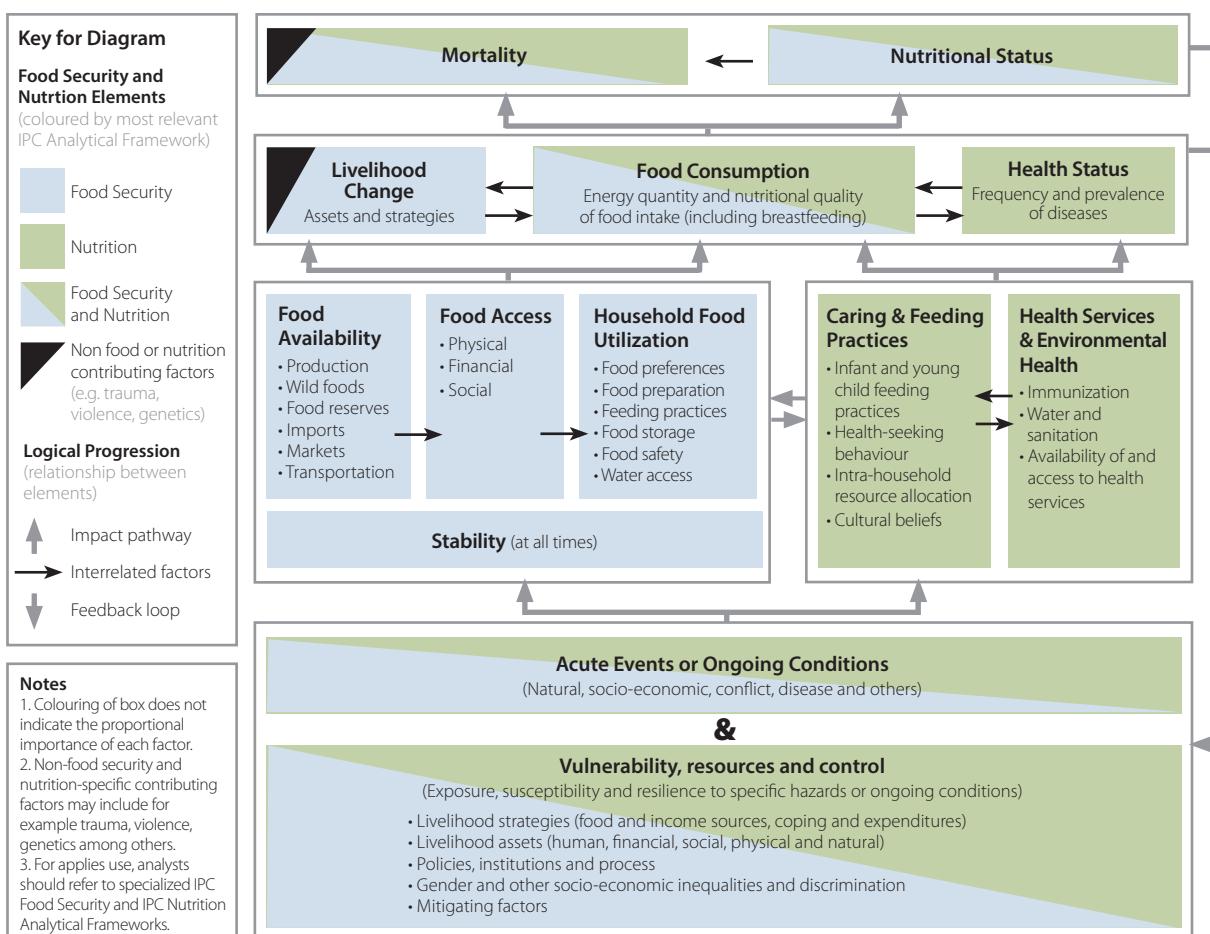
1.7 THE IPC INTEGRATED FOOD SECURITY AND NUTRITION CONCEPTUAL FRAMEWORK

The IPC Integrated Food Security and Nutrition Conceptual Framework expands on the well-known IPC Analytical Framework for Food Security and the UNICEF Analytical Framework for Malnutrition to contribute to a better understanding of the linkages between food security and nutrition (Figure 7). Because classifications are made separately for food insecurity and malnutrition, albeit considering their linkages, this Conceptual Framework should not be used to guide IPC analysis, but rather to inform further analysis of linkages between the different conditions. Specific IPC Analytical Frameworks to guide food security and nutrition analyses are included in the IPC Technical Manual Version 3.1 under Part 2, Function 2.

The IPC Integrated Food Security and Nutrition Conceptual Framework considers the following:

- The basic causal factors of food insecurity and malnutrition are common, and thus the responses addressing structural causes need to be well integrated.
- Suboptimal caring and feeding practices, together with low food availability, access, utilization and stability, directly impact the food consumption of households and individuals.
- There is a reciprocal and complex relationship between food consumption and health status. It is expected that people who live in households that have an inadequate quantity or quality of food for consumption are more likely to become ill. Furthermore, they are more likely to eat less, while their disease can impact the ability of household members to access and utilize food, either because of their weakened immune system or because of their weakened ability to engage in productive activities.
- Food insecurity and malnutrition outcomes will contribute to overall vulnerability or may be a shock on their own, following the cyclical nature of food insecurity and malnutrition.

Figure 7: The IPC Integrated Food Security and Nutrition Conceptual Framework (Tool 1)





1.8 RELEVANCE FOR DECISION-MAKERS

The IPC is designed to provide evidence-based analysis to **guide strategic decision-making**, providing decision-makers with clear, well-presented information on food security and nutrition situations in a reliable, consistent and accessible form. The IPC provides a general classification of the severity and magnitude of food insecurity and acute malnutrition and identifies key characteristics and drivers.

The IPC follows a rigorous and globally comparable approach and has proven **valuable for awareness-raising and advocacy, and for informing strategic response planning** in the fields of food security and nutrition, as in the case of Humanitarian Needs Overview and Response Plans. The IPC responds to the six key questions of **how severe, how many, when, where, why and who**, and identifies the key characteristics of the situation, as described in Figure 8

Figure 8: The key questions the IPC answers (Tool 2)

Decision-makers ask:	The IPC provides:
<i>How severe</i> is the situation?	Classification by phases/levels is made to identify urgency and inform the strategic priority objectives of interventions.
<i>How many</i> people are currently affected?	Estimates of the number of food insecure or acutely malnourished people in need of action are provided to inform decisions on the scale of the responses.
<i>When</i> will people be affected?	Estimates of the number of food insecure or acutely malnourished people who will be in need of action during a future period are provided to inform contingency planning, mitigation and prevention.
<i>Where</i> is response most required?	Classification of areas by highest severity of food insecurity that affects at least 20 percent of households, or classification of areas by prevalence of acute malnutrition is aimed at informing decisions on the location of the responses.
<i>Why</i> is this occurring?	Key drivers of the situation under review are identified to inform response analysis for strategic design of interventions.
<i>Who</i> are those most affected?	Key characteristics of those who are most food insecure or acutely malnourished are provided to inform general social targeting.
<i>What</i> are the key characteristics of the situation?	<p>Classification is provided individually for each scale in accordance with key characteristics so as to inform response analysis for the strategic design of interventions as follows:</p> <ul style="list-style-type: none"> • Acute Food Insecurity Classification focuses on identifying food insecurity of a severity that requires urgent action with short-term objectives to protect or save lives and livelihoods. • Chronic Food Insecurity Classification focuses on identifying persistent food insecurity that limits an active and healthy life and thus requires urgent action with medium to longer-term objectives to address persistent food insecurity. • Acute Malnutrition Classification focuses on identifying areas with a high prevalence of children who require urgent short- and long-term action to decrease acute malnutrition. <p>Classifications can and should be linked to inform better coordinated response.</p>

The IPC provides decision-makers with an analysis of the fundamental aspects of a current or projected situation. Hence, although the IPC supports response analysis by providing invaluable information on complex food security and nutrition conditions, the subsequent stages of response planning and implementation should also consider other issues, such as operational and financial constraints.

Furthermore, although the IPC provides general estimates of the extent of food insecurity and malnutrition to support a more strategic response analysis, the scope, methods, purpose and meaning of the figures are not to be used to monitor and evaluate responses and the achievement of development goals. Instead, the overall goal of the monitoring and evaluation systems is to assess achievements based on a precise detection of changes in certain key indicators that should be used to assess impact and achievements. The IPC Acute Food Insecurity Analysis may identify areas that receive or are likely to receive significant humanitarian food assistance. The identification of these areas aims to raise awareness of decision-makers on the presence of significant humanitarian food assistance that may be affecting phase classification.

The situation analysis provided by the IPC and the consequential and circular stages of response analysis, planning, implementation, and monitoring and evaluation are all indispensable for more strategic, responsible and timely action.

Figure 9 indicates where the IPC is located within the analysis-response continuum.

Figure 9: The IPC analysis-response continuum

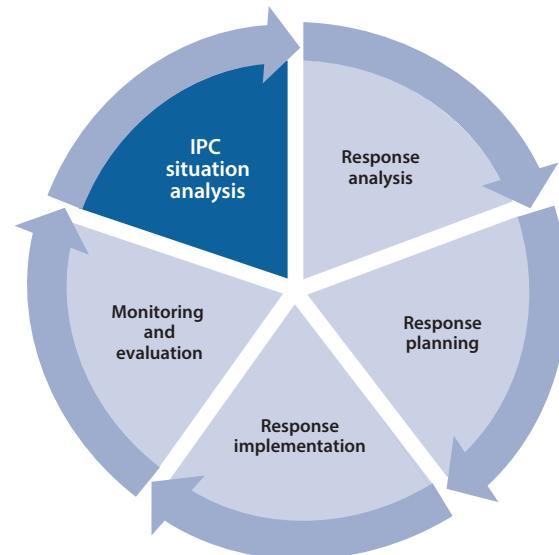
The aim of the IPC situation analysis: To identify the fundamental aspects of the current or projected situation (e.g. severity, magnitude, nature and drivers). The IPC provides the invaluable and rigorous evidence-based information that is constantly needed for response analysis.

The aim of response analysis: To identify where assistance should be continued, scaled up or down, terminated or initiated, and the most effective and efficient responses. Although based on a situation analysis, it also considers other issues, such as operational, logistical, financial and security constraints and opportunities, as well as an analysis of the most appropriate modalities for response.

The aim of response planning: To identify and put in place operational requirements and systems to enable an effective and efficient response. These include logistics, financing, institutional partnerships, advocacy and training.

The aim of response implementation: To implement multiple operational modalities for an effective and efficient response.

The aim of monitoring and evaluation: To determine degrees of desired impact and/or achievements towards goals of policy, programme and/or project outputs and overall impact, and to inform adjustments to the response as necessary.





1.9 RELEVANCE FOR ANALYSTS

At the country and professional levels, the IPC has a number of advantages, including:

Country level

- The IPC promotes country leadership and ownership. It engages with and relies on country-based experts. It builds in-country capacity for trainers, analysts and decision-makers through a wide-ranging portfolio of capacity development initiatives, including training, cross-country learning and certification, with the aim of producing quality IPC analysis.
- The IPC promotes among both analysts and decision-makers, a cross-sectoral engagement between different stakeholders from relief and development, including governments, donors, United Nations agencies, NGOs and more. It promotes a holistic, wide-ranging consideration of multiple topic domains relevant to food security and nutrition.
- The IPC also promotes analysis that is consistent with global standards, thus allowing countries to make best use of global practices and generate better quality products.

Professional level

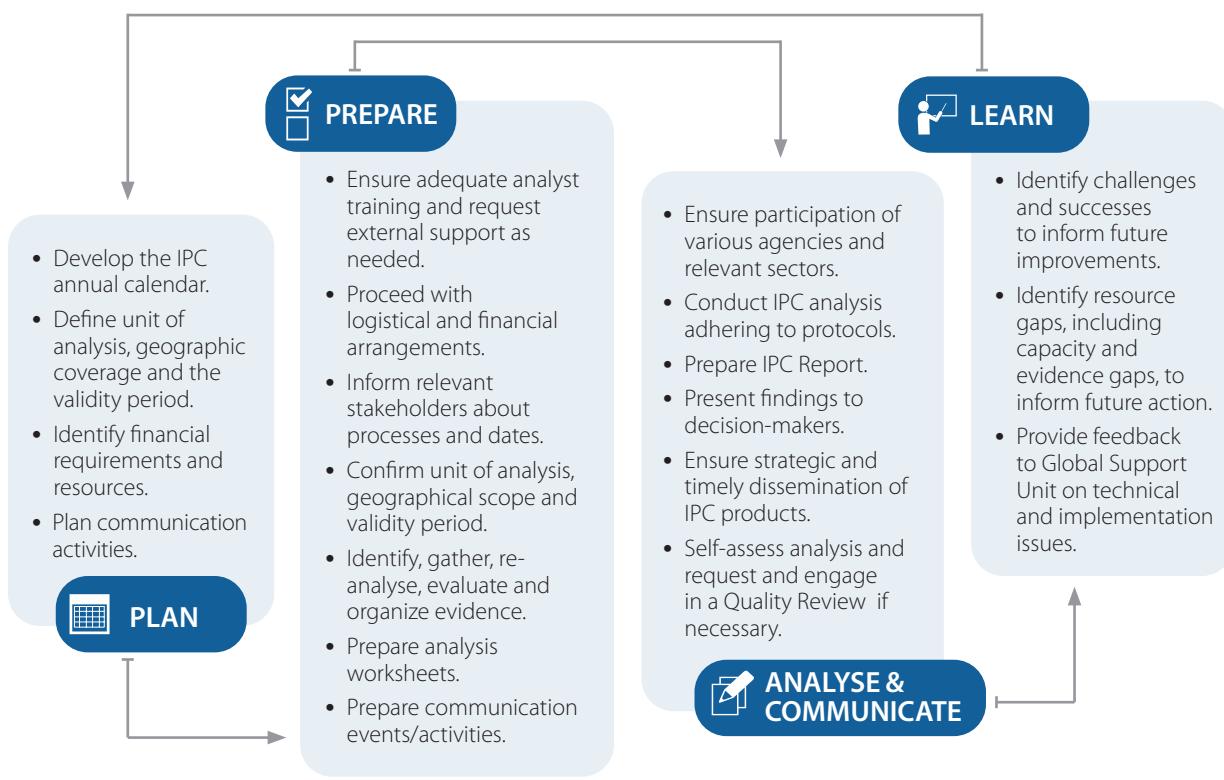
- The IPC provides visibility to the conceptual approach and the overall Analytical Framework of the IPC, supporting the development of a set of skills applicable in any food security or malnutrition context, and providing food security and malnutrition analysts with a standard knowledge base.
- IPC implementation is built on a solid training and certification strategy with opportunities for being certified as Analyst (Level 1), Advanced Analyst and Co-Facilitator (Level 2) and Lead Trainer and Analysis Facilitator (Level 3). As part of the certification process, analysts engage in the IPC as both participants and facilitators, which provides them with valuable professional skills. Capacity-building opportunities through cross-country learning provide analysts with international experience in food security and malnutrition analysis outside of their own countries.
- The IPC facilitates access to all the basic templates, guidelines, procedures, supporting documentation and remote support necessary to undertake a full analysis that meets global standards.
- Through its Community of Practice platform and professional formal and informal networking, the IPC fosters a global community of food security and nutrition analysts, which promotes one-to-one technical support, professional opportunities and information exchanges across and between individual analysts.

Finally, both at the country and professional levels, the IPC is accessible, free and easy to use. Understanding of the IPC is supported by a range of structures, including support provided by the Global Support Unit, IPC partner organizations, and the global and regional networks of IPC certified trainers/facilitators.

1.10 ANALYSIS CYCLE

The IPC Analysis Cycle includes four inter-linked stages that need to be followed for each IPC analysis in order to provide high-quality products and effectively communicate results (Figure 10). An analysis cycle, excluding planning, usually takes between one and three months, although Chronic Food Insecurity analyses may take longer, depending on the analysis coverage and other parameters.

- **Plan:** Technical Working Groups should develop annual calendars, taking into account seasonal considerations and decision-makers' needs. Since IPC Acute Classifications are based on recent data, the calendar should foresee that IPC analyses are preceded by data collection. At this stage, the Technical Working Group should define the unit of analysis, geographic coverage and validity period for each planned analysis. Together with the calendar, the financial requirements and resources for IPC implementation should be identified. At this stage, a communication plan should be developed to ensure that IPC findings are timely and efficiently communicated. For Acute classifications, annual planning should be directly linked to the Humanitarian Programme Cycle – including the development of the Humanitarian Needs Overview/Humanitarian Response Plan – when the cluster system is operational. The Technical Working Group should thus plan IPC activities in close collaboration with both the Food Security and Nutrition Clusters when present. IPC planning should be flexible enough to allow IPC acute analyses to be carried out in response to unforeseen events (e.g. a sudden onset crisis).
- **Prepare:** Preparation includes activities to ensure that analysts are adequately trained and that requests for external technical support, including for communication, are made as needed. At this stage, the Technical Working Group should proceed with logistical and financial arrangements and ensure that the relevant stakeholders are informed about the analysis process and dates. During preparation, the Technical Working Group should confirm the unit of analysis and geographic scope foreseen in the planning stage as well as identify, gather and re-analyse evidence as needed and as is feasible. During this process, analysts should ensure that minimum evidence requirements are met. At this stage, all evidence should also be evaluated against the reliability criteria and organized and included in the analysis worksheets. Preparations should also extend to communication activities, such as preparing dissemination events. Preparation can take from one week to a few months depending on the scale used and the amount of data re-analysis needed.
- **Analyse and communicate:** At the core of IPC analysis is the workshop, where the Technical Working Group convenes analysts from the relevant agencies and sectors to undertake the convergence of evidence following the IPC protocols, agree on classification and population estimates, draft the IPC Analysis Report, conduct a self-assessment and request a Quality Review if needed. The process typically includes a week-long analysis workshop, which can be followed by other supporting activities. Once the analysis has been completed, the Technical Working Group is encouraged to hold a meeting with decision-makers to present and discuss the findings. Subsequently, IPC communication products are prepared and strategically disseminated as soon as possible after completion of the IPC analysis.
- **Learn:** Learning ensures constant self-improvement by informing the action needed before the next analysis. Technical Working Group members are required to reflect on the challenges encountered, such as inadequate evidence, unsuitable timing of analysis, and resource and capacity gaps, and are encouraged to develop a plan to address them. Furthermore, lessons learned from the country analysis are also fed back to the Global Support Unit for the development and review of technical guidance and training materials, as well as for adjustments in global coordination and country support.

**Figure 10: The IPC analysis cycle**

1.11 GOVERNANCE STRUCTURE

Country level

At the country level, Technical Working Groups are the foundation of the IPC governance structure (Figure 11). These are composed of experts representing key stakeholder institutions/organizations who are responsible for leading the planning, coordination and implementation of IPC activities in the country. Where considered appropriate and feasible, IPC Technical Working Groups can be supported by other bodies, such as a senior management group, equivalent in composition and function to a steering committee at the country level.

Although not strictly part of the governing structure, the IPC analysis team conducts the actual IPC analysis and typically includes all the Technical Working Group members, as well as other experts whose knowledge or skills are relevant for the analysis. Membership of the analysis team may vary between analyses, depending on the focus of analysis at hand. The analysis team is led and coordinated by the Technical Working Group.

Commonly, during combined Acute Food Insecurity and Acute Malnutrition analysis, there are two interlinked analysis teams. Coordination and collaboration between the two teams is ensured by the Technical Working Group.

Organizations that need to classify acute food insecurity independently from the national IPC partnership may use IPC protocols to develop IPC-compatible classifications. In such cases, agencies follow all protocols except those for Function 1 (Protocols 1.1 and 1.2). With regard to Function 4, the only protocol that applies is the external quality review when the Technical Working Group of the country subject to IPC-Compatible Classification expresses concerns about a lack of adherence to protocols in the IPC-Compatible Classification with regard to Phase 4 classification. The resulting Compatible Classification is the sole responsibility of the individual organization and includes the following disclaimer or similar text: "This is an IPC-Compatible Classification, which uses key IPC protocols but is not built on multi-partner technical consensus". Should IPC-compatible analyses include a Famine classification, specific protocols for Functions 2 to 4 for Famine should be applied, including the Famine review process.

Figure 11: IPC Technical Working Groups - Basic principles

- There can be regional, national and/or subnational IPC Technical Working Groups, depending on needs and context. As much as possible, the IPC Technical Working Group should be hosted within an existing structure, instead of creating a parallel single-purpose coordination body.
- Whenever applicable and feasible, and especially important in countries where food insecurity or acute malnutrition crises occur frequently, a combined IPC Food Security and Nutrition Technical Working Group should be formed, with the responsibility for implementing both types of classifications in a coordinated manner. In combined Technical Working Groups, there should optimally be a co-chair from the nutrition sector.
- The members of the IPC Technical Working Group are technical officers with different sectoral expertise, typically from government branches, United Nations agencies, international and national NGOs, civil society groups, technical agencies and academic institutions. They are technically proficient in their sector, and most of them must be trained and have experience in conducting food security or malnutrition analysis.
- The IPC Technical Working Group should include communication experts from relevant institutions with the specific role of supporting IPC-related communications.
- The chairperson is a senior officer from a member organization, from the government where feasible. To facilitate inclusiveness and the overall buy-in of the IPC analysis at all levels, the IPC Technical Working Group must be co-chaired by a representative from another member organization from the IPC Global Partnership, present at country level.
- The permanent members of the IPCTechnical Working Group are designated by their organization to plan, manage and coordinate IPC processes in the country, including the production of IPC products. A larger group of individuals (i.e. the IPC analysis team) is responsible for conducting IPC analyses and ideally includes all members of the IPC Technical Working Group as well as other experts whose knowledge and/or skills are relevant for the IPC analysis.
- The IPC Technical Working Group ensures that most of the individuals conducting an IPC analysis have adequate IPC training and, as much as possible, are IPC-certified analysts. In addition, there should be at least three certified IPC trainers/facilitators in the country so that the IPC Technical Working Group can implement IPC activities without necessarily relying on external support.
- Members of the IPC Technical Working Group and other analysts participating in the IPC analysis must commit to conducting evidence-based, unbiased analysis using the IPC protocols, concerned only with classifying and describing food security and malnutrition conditions as accurately as possible.
- The IPC Technical Working Group should develop Terms of Reference which describe its purpose and membership; the roles and responsibilities of the chair, co-chair and members; its structure (including the broader IPC governance structure in the country, if applicable) and working modalities; and reflect the parameters described in this Box.
- To ensure commitment to the IPC partnership and promote ownership, formal agreement or signing of the IPC Technical Working Group Terms of Reference by the senior management of all member organizations is strongly encouraged.



Figure 12: IPC Global Steering Committee members

1. Action Against Hunger
2. CARE International
3. Comité permanent Inter-États de Lutte contre la Sécheresse dans le Sahel (CILSS)
4. Food and Agriculture Organization of the United Nations (FAO)
5. Famine Early Warning Systems Network (FEWS NET)
6. Global Food Security Cluster (gFSC)
7. Global Nutrition Cluster (GNC)
8. Intergovernmental Authority on Development (IAD)
9. Joint Research Centre of the European Commission (JRC)
10. Oxfam
11. Save the Children
12. Sistema de la Integración Centroamericana (SICA)
13. Southern African Development Community (SADC)
14. United Nations Children's Fund (UNICEF)
15. United Nations World Food Programme (WFP)

Regional level

In most regions, regional IPC working groups composed of representatives from key stakeholders are usually established to support the funding, implementation and institutionalization of IPC at the country level, and dissemination of IPC results and advocacy at the regional level. IPC regional coordinators and trainers, who are part of the Global Support Unit, also play a key role in the coordination of IPC activities within the region and provide direct support to regional and country stakeholders for IPC implementation.

Global level

The IPC is a multi-agency initiative governed by the **IPC Global Steering Committee**, which is composed of senior officers representing the partner organizations. The Steering Committee is responsible for strategically guiding and positioning the IPC globally (see Figure 12 for the Steering Committee composition as of April 2019).¹

The **Technical Advisory Group** is responsible for advising the Steering Committee on technical matters. This group is made up of high-level technical experts from the IPC Steering Committee agencies. If necessary, the Technical Advisory Group can invite experts from any relevant agencies to form working groups to work on specific topics.

The **Global Support Unit** is the operational arm of the IPC Global Steering Committee. Hosted at FAO, the IPC Global Support Unit is in charge of promoting the IPC within global decision-making structures and developing and updating IPC protocols and technical guidance based on inputs from the Technical Advisory Group. It also provides capacity development and technical support to countries, as well as quality assurance oversight, among other things.

¹ The Global Nutrition Cluster and Southern African Development Community joined the IPC Global Partnership in November 2018.

1.12 INTRODUCTION AND INSTITUTIONALIZATION AT COUNTRY LEVEL

Introduction of the IPC at the country level starts with various **awareness-raising activities**, led by IPC global partners and/or the Global Support Unit, including events targeted at decision-makers (managers, senior officials) as well as technical officers.

Once the country formally declares an interest in implementing the IPC, the process of institutionalization starts with the **identification of the IPC's institutional home** and the establishment of the Technical Working Group, through a consultative and inclusive process.

Full institutionalization can take years to be completed. When institutionalization is fully achieved, the IPC is embedded in national food security and nutrition structures and systems.

IPC institutionalization promotes ownership, accountability and sustainability, considering existing structures and processes at the national level. Key guiding principles are:

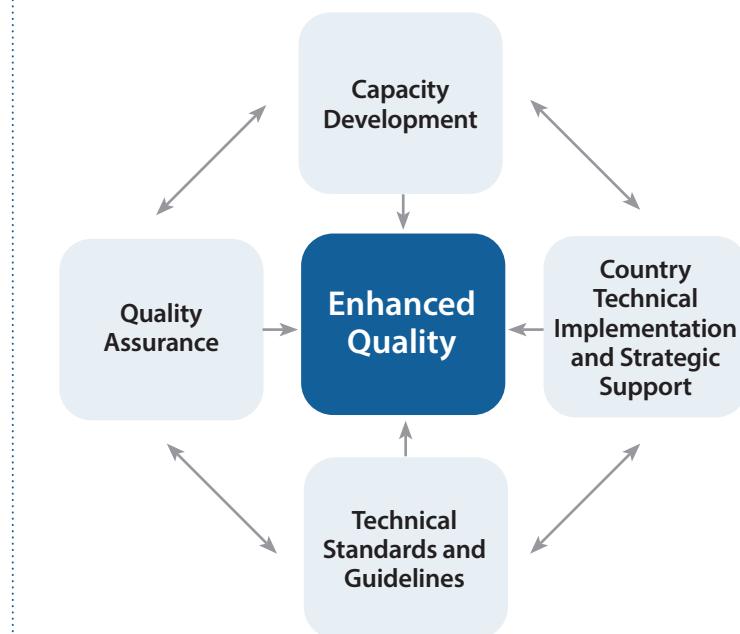
- The implementation of IPC processes should be demand-driven, ideally by the government where feasible.
- The leadership of IPC processes depends on the country context, comparative advantages and responsibilities. All efforts should be made to engage and build the capacity of national stakeholders, promote ownership and strengthen the institutional process.
- Agencies commit to a multi-year process.
- The IPC analysis is conducted in a timely manner.
- Organizations participating in the IPC commit to sharing data.
- The IPC should be applied as an iterative learning process.

1.13 QUALITY AND SUPPORT STRATEGY

The rapid expansion of the IPC worldwide and the increased use of its findings for decision-making underscore the need to ensure the overall quality of IPC processes and products.

The IPC initiative, through the global partners and the Global Support Unit, is committed to supporting this process through implementation of the comprehensive IPC Quality and Support Strategy. The Strategy aims to ensure that IPC products meet global standards and respond to the needs of decision-makers. The strategy has four components: (i) capacity development; (ii) country technical, implementation and strategic support; (iii) technical standards and guidelines; and (iv) quality assurance (Figure 13), as follows:

Figure 13: Quality and support strategy





- **Capacity development:** Capacity development is the stepping-stone of Quality Assurance and aims to ensure the professionalization, decentralization and sustainability of IPC technical capacity. It entails developing capacities at the country and regional levels, as well as at the global level, to implement and support the IPC in line with global standards. Modalities include standard and tailored training, cross-country learning exchanges and a certification programme, among other things.
- **Country technical, implementation and strategic support:** This entails providing real-time remote and in-country technical support to the various stages of the IPC implementation process (both ex ante and ex post support), depending on the Technical Working Groups' needs. This includes systematic in-country facilitation during analyses in various contexts. It also entails providing strategic guidance for future improvements and monitoring quality enhancements over time. Ensuring that good practices related to IPC governance and IPC implementation processes are identified, documented, promoted and replicated also contributes to the greater quality of IPC analytical and communication products across countries and regions.
- **Technical standards and guidelines:** These are a pre-condition to ensuring high-quality IPC analyses and related products. The IPC Quality Assurance Strategy thus includes feedback mechanisms to ensure that learning from IPC application feeds into IPC normative work at the global level (e.g. The IPC Technical Manual and IPC Resources).
- **Quality Assurance (Function 4 of IPC protocols):** This refers to mechanisms that foster technical rigour and neutrality of analysis and self-learning for future improvements. To this end, tools and procedures have been included under Function 4 to allow country Technical Working Groups to assess to what extent they followed the protocols in their ongoing analyses and learn from the exercise to inform future improvements by using the self-assessment tool. Still under Function 4, if necessary, the Technical Working Group may also request and engage in an external quality review, which serves to strengthen the quality of the IPC products prior to their release.

1.14 TECHNICAL DEVELOPMENT

The IPC partnership is committed to ensuring that protocols draw from the latest global standards and research, and to better utilizing technological advances while also learning from field applications. Continuous learning for technical development is embedded in the IPC and is the responsibility of the Technical Advisory Group, which considers the latest advances and users' feedback to recommend updates to protocols as needed.

Ongoing technical development is especially important to refine the parameters stipulated by the IPC on topics where there is a clear lack of an authoritative agreement on the part of the relevant global community. Examples of areas where the partnership had to make decisions in the absence of agreement among the global community include parameters for using Mid-Upper Arm Circumference (MUAC) for classifying acute malnutrition and cut-offs for identifying significant humanitarian food assistance for classifying acute food insecurity. Accordingly, IPC updates are not only expected, but also desired. Updates may take the form of forthcoming versions of the IPC Technical Manual such as the IPC Technical Manual Version 3.2 or the IPC Technical Manual Version 4.0, or as addenda to the IPC Technical Manual Version 3.1. Specifically, the IPC Reference Tables may be updated as new indicators or cut-offs are identified by the global community.



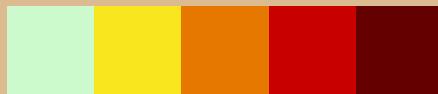
PART 2

IPC PROTOCOLS



PART 2A

ACUTE FOOD INSECURITY CLASSIFICATION





Functions

1**Build Technical Consensus****2****Classify Severity and Identify Key Drivers****3****Communicate for Action****4****Quality Assurance**

This module describes the **Protocols for the Integrated Phase Classification of Acute Food Insecurity**

These protocols are organized and presented according to the **four IPC Functions**: (i) Build Technical Consensus; (ii) Classify Severity and Identify Key Drivers; (iii) Communicate for Action; and (iv) Quality Assurance.

Additional and supporting protocols have been developed for **areas with limited access** and for **Famine classifications**.

All protocols can and should optimally be completed in the country-owned and -managed **ISS** to mainstream the analysis and facilitate recurring classifications.

Important note for using Part 2A:

1. This Part is an **integral part of the IPC Technical Manual Version 3.1**, which also includes an Overview of the IPC (Part 1), Protocols for Chronic Food Insecurity Classification (Part 2B) and Protocols for Acute Malnutrition Classification (Part 2C).
2. This module focuses on providing succinct and clear guidance on how to complete the Protocols. It includes the 13 tools that are required for Acute Food Insecurity Classification as well as a brief overview of the procedures for completing them. Additional guidance, the reasoning behind technical decisions and other relevant issues are included as **IPC Resources** on the IPC website.



FUNCTION 1: BUILD TECHNICAL CONSENSUS

Function 1 promotes a neutral and participatory process to build a technical consensus by ensuring that classifications are carried out through multi-agency and multi-sectoral analysis teams and by providing general guidelines for achieving a consensus.

Protocols for Completing Function 1

There are two protocols for completing Function 1, which, when correctly followed, will ensure that the analysis includes the necessary variety of experts from relevant institutions and organizations, and that it is conducted following a consensus-based and unbiased approach. Figure 14 provides an overview of these protocols; specific tools and procedures are provided below for each protocol.

Figure 14: Protocols for Function 1

Protocols	Procedures	Tools
1.1 Compose the analysis team with relevant sectors and organizations.	Complete IPC Analysis Team Matrix and ensure representation of relevant stakeholders.	Tool 1: IPC Analysis Team matrix <p>The table is titled 'Tool 1: IPC Analysis Team matrix' and has a subtitle 'Stakeholders representation across presentation, classification and analysis phases and relevant skills'. It has three columns: 'Stakeholder', 'IPC Core analysis team (relevant skills)', and 'National and Sectoral analysis and presentation (relevant skills)'. The 'Stakeholder' column lists 'Food security and nutrition' (highlighted in orange), 'Agriculture', 'Health', 'Economy', 'Environment', 'Geopolitics', 'Other', and 'Civil society'. The 'IPC Core analysis team (relevant skills)' column has four rows: 'Data collection and analysis', 'Facilitation', 'National and Sectoral analysis and presentation', and 'Interpretation and synthesis'. The 'National and Sectoral analysis and presentation (relevant skills)' column also has four rows: 'Data collection and analysis', 'Facilitation', 'National and Sectoral analysis and presentation', and 'Interpretation and synthesis'.</p>
1.2 Conduct analysis on a consensual basis.	Follow good practices for consensus-building, such as strong facilitation, adequate analytical capacity of analysts, vetting of results, and preliminary presentation to decision-makers.	Refers to good practices (no specific tools)

PROTOCOL 1.1: COMPOSE THE ANALYSIS TEAM WITH RELEVANT SECTORS AND ORGANIZATIONS

The **IPC analysis team** should include representatives from different institutions/organizations and sectors so as to create the inclusive environment needed for an unbiased consensus-building analysis (Figure 15).

The composition of the **IPC analysis team** may vary from one analysis event to the next, since different expertise may be needed for specific analyses. When planning the analysis and forming the analysis team, the following should be considered:

- There is a need to raise awareness of and interest in the IPC's Acute Food Insecurity classification among country-level stakeholders prior to the actual analysis.
- There is a need to inform partners at the country level in advance of forthcoming analysis activities.



Figure 15: The IPC analysis team – Examples of members

- members of the national IPC Technical Working Group;
- food security analysts and nutritionists who are not part of the Technical Working Group but can contribute to the analysis;
- officers who can support contextualization and interpretation of evidence;
- sectoral experts (e.g. livestock experts, conflict analysts) depending on the key drivers of acute food insecurity;
- communication officers to support the development of communication products.

- The analysis team should include members of the national IPC Technical Working Group, which has the overall task of coordinating and implementing the IPC in-country, and other experts whose knowledge or skills are relevant for the specific IPC analysis, including knowledge of local conditions and context.
- The Technical Working Group should ensure that most analysis team members have adequate IPC Acute Food Insecurity training and have passed the IPC test prior to the analysis.

The **Composition matrix for the analysis team** needs to be completed for each analysis (Figure 16). If correctly used, it provides a clear visualization of the diversity achieved. The matrix should identify:

- the Technical Working Group chairperson and hosting organization;
- analysis facilitator(s);
- all analysis participants, including their name, title, organization, area(s) of expertise and IPC training/certification status. Analysts may have advanced knowledge of different sectors, and thus the same person may appear more than once in the matrix.

When **Acute Food Insecurity** and **Acute Malnutrition classifications** are performed simultaneously, either one common or two individual matrices can be completed, depending on the approach used during the analysis.

Figure 16: Composition matrix for the analysis team (Tool 1)

Chairperson: Hosting organization: IPC Analysis Facilitators:	Stakeholder organization representation (Indicate the name, title, organization and IPC training/certification status of each analyst in the relevant cells)				
	National government (at all relevant levels)	National NGOs/ civil society/the private sector	Technical agencies/ academic institutions	International NGOs	United Nations agencies
Area of expertise (include as relevant for analysis)	Food security/ livelihoods				
	Nutrition				
	Markets				
	Agriculture				
	Livestock/ fisheries				
	Climate				
	Health				
	Water/sanitation				
	Gender				
	Statistics				



PROTOCOL 1.2: CONDUCT THE ANALYSIS ON A CONSENSUAL BASIS

The analysis team members must commit to conducting an evidence-based and unbiased analysis, with the objective of classifying and describing food insecurity conditions as accurately as possible through mutual agreement.

The formulation of a mutual understanding and agreement is one of the central tasks of IPC Technical Working Group leadership and IPC facilitators, and a range of strategies may be applied to this end.

Consensus does not necessarily imply unanimity, since some disagreement or dissent is common. Nevertheless, consensus should leave all parties in a better position than when they started, thus adding trust and credibility among themselves and in the public's eye. Common ground between the analysts can be sought by carrying out a joint analysis and critical review of the data available, and through a good understanding of the context of the area analysed. However, since arriving at a consensus is complex, it requires the support of a qualified facilitator. One of the initial tasks of IPC Technical Working Group leadership and IPC analysis facilitators is to define the ground rules for building a consensus with the participating analysts (see examples in Figure 17).

Consensus-building is dependent on the ability of analysts to critically analyse and discuss evidence. Hence, it is imperative that members have a strong understanding of their sector(s), food security and IPC protocols. Furthermore, in order to ensure that adequate time is devoted to critically reviewing evidence and achieving a consensus on classification, it is imperative that evidence be well organized for and prior to the analysis.

Consensus is not always achieved. Disagreements may relate to a particular area or analysis overall. In these situations, the best approach is to address the disagreements within the analysis team through neutral facilitation and seek an agreement at the country level to avoid delays. If this is not possible, the dissenting organization(s) can decide to disagree with the analysis results, in which case the minority view may be documented and communicated to decision-makers. However, if the disagreement relates to classification in IPC Phase 4, an external quality review of the alternative analysis (reflecting the minority view) may be requested by the Technical Working Group or partner(s) supporting the minority view.

Vetting of classification and population estimations is also good practice for IPC consensus-building. Although the IPC does not define the process for reaching a consensus, it recommends that some form of vetting be carried out. Vetting usually takes place after preliminary classification and population estimates have been performed, and it typically consists of sessions during which IPC analysts who participated in the analysis review, discuss and debate the preliminary IPC classifications and population estimates resulting from the exercise, reach consensus and agree on the final results.

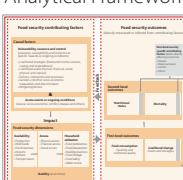
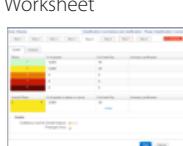
Presentation of IPC results to key decision-makers before public release is another recommended activity. This achieves two objectives: (i) it is a double-check on the results, allowing for open discussion as necessary, which may in some instances lead the Technical Working Group to revisit the analysis if supported by evidence; and (ii) it promotes ownership of the findings by key stakeholders before the results are presented to the public.

Figure 17: Consensus-building - Examples of ground rules

- Identify the modalities of the analytical process (e.g. subgroups conduct preliminary analyses and present their findings to the larger group for vetting).
- Agree on how decisions will be made (e.g. based on full consensus or majority view) and how minority views will be documented and communicated.

FUNCTION 2: CLASSIFY SEVERITY AND IDENTIFY KEY DRIVERS

Figure 18: Protocols for Function 2

Protocols	Procedures	Tools
2.1 Use the Analytical Framework to guide convergence of evidence.	Analyse evidence following the IPC Food Security Analytical Framework.	Tool 2: IPC Food Security Analytical Framework 
2.2 Compare evidence against the Reference Table.	Use the IPC Acute Food Insecurity Reference Table for the characteristics of phases and thresholds of the selected international standards.	Tool 3: Reference Table 
2.3 Adhere to parameters for analysis.	Respect the key parameters as the rules for classification.	Tool 4: Analytical Parameters 
2.4 Evaluate evidence reliability.	Assess the soundness of methods and the time relevance of all evidence following stipulated parameters.	Tool 5: Evidence Reliability Scores 
2.5 Meet the minimum evidence and analysis requirements.	Present evidence and analysis that adhere to minimum requirements.	Tool 6: Evidence-level Criteria 
2.6 Methodically document evidence and analysis and provide them upon request.	Use an Analysis Worksheet preferably in the Information Support System (ISS).	Tool 7: Minimum Analysis Requirements  Tool 8: Analysis Worksheet 

Function 2 promotes a meticulous analysis of complex information to classify populations and areas into meaningful categories to guide decision-making. Classification of Acute Food Insecurity focuses on identifying areas with significant food gaps that require urgent action to save or protect lives and livelihoods.

By completing Function 2 for the classification of Acute Food Insecurity, the IPC analysis should answer the following questions:

- **How severe** is the situation?
- **When** will populations be acutely food-insecure?
- **Where** are the most acutely food-insecure people located?
- **How many** people are acutely food-insecure?
- **Why** are people acutely food-insecure?
- **Who** are those most acutely food-insecure?

Protocols for Function 2

In order to complete Function 2, analysts need to follow six protocols, as briefly introduced in Figure 18 and further explained below.

While this section only focuses on the protocols followed during the actual analysis, the completion of the entire analysis cycle, including the preliminary planning and preparation activities, is of utmost importance. Especially important is the preparation of evidence, including the identification and gathering of evidence and ensuring that it aligns with the IPC Reference Table and unit of analysis before the actual analysis stage.



PROTOCOL 2.1: USE THE ANALYTICAL FRAMEWORK TO GUIDE CONVERGENCE OF EVIDENCE

Figure 19: The IPC Food Security Analytical Framework – Elements for analysis

• Contributing factors

Causal factors

- Vulnerabilities
- Hazards (acute events or ongoing conditions)

Food security dimensions

- Availability
- Access
- Household utilization
- Stability

• Outcome elements

First-level outcomes

- Food consumption
- Livelihood change

Second-level outcomes

- Nutritional status
- Mortality

The purpose of the Food Security Analytical Framework (Figure 19) is to guide the convergence of evidence through a logical outline of acute food insecurity. The same framework is used for the outline of chronic food insecurity. The framework is divided into ‘contributing factors’ and ‘outcomes’ (Figure 19). While contributing factors include causal factors and food security dimensions, outcomes include the expected manifestation of food insecurity at the household and individual levels. These are related to inadequate food consumption, negative livelihood change, acute malnutrition and mortality.

Causal factors: vulnerabilities and acute events or ongoing conditions

According to the IPC, the interaction between hazards and vulnerabilities drives food insecurity. Thus, analysis of these interactions identifies the key drivers of food insecurity. Vulnerability is defined as a household’s exposure, susceptibility and resilience to specific hazards. According to the IPC, vulnerability analysis is mainly driven by an understanding of: the livelihood strategies of households (how they obtain food and income, their common coping strategies, and expenditure patterns); the livelihood assets that households can rely on including financial, physical, human, social, and natural assets; and how policies, institutions and processes, gender, and mitigating factors positively or negatively affect or could affect their ability to successfully respond to shocks and ongoing conditions. Once the vulnerabilities are clearly understood, the impacts of shocks are assessed based on their severity, magnitude and occurrence or probability of occurring. Shocks can be phenomena that have occurred or may occur in the future. They include acute events or ongoing conditions that can be natural or human-made, including but not limited to droughts, floods, earthquakes, tsunamis, sharp price increases, energy or food shortages, war, civil unrest, and disease epidemics.

The concept of resilience is explicitly included in the IPC Analytical Framework, since resilience is acknowledged as a factor that, together with exposure and susceptibility, determines the vulnerability of households to specific acute events and ongoing conditions. Consideration of resilience is ensured through the examination of livelihood strategies, assets and policies, institutions and processes. IPC analyses can contribute to and benefit from more comprehensive analyses of resilience.

Figure 20: Limiting dimensions to food security – Examples

- Lack of rainfall and heavy reliance on rainfed agriculture are likely to affect food production levels, thus limiting food availability.
- Households' access to food will be limited since their harvests for own consumption will be small so that reliance on food purchases needs to be increased; however, purchases are likely to be low due to the low purchasing power of the households as a result of high prices and few income opportunities.
- In addition to limited access to food, inadequate storage capacity, which results in high post-harvest losses, and high reliance on staples typically coupled with low dietary diversity, will limit the full utilization of food, and therefore food security.
- Due to the high severity and volatility of the situation, it is likely that future food insecurity will be even more severe. However, the extent of food insecurity will depend on the following year's rainfall and harvest seasons.

Food security dimensions: availability, access, household utilization and stability

The four food security dimensions (food availability, access, utilization and stability) are directly impacted by the results of the interactions between shocks and vulnerabilities. Analysis of how each of the dimensions limits food security is important to confirm and contextualise outcome indicators (Figure 20). This information enables a better design of interventions, which may differ depending on what is limiting food security (i.e. food availability, access, utilization or stability). These dimensions interact in a sequential and systematic manner as follows:

- Food availability addresses whether food is actually or potentially physically present for purchase or acquisition for consumption, including: aspects of production, food reserves, imports, markets and transportation, and wild foods.
- Once analysis on the presence of food has been conducted, the next question is how households will access food through different sources and whether this will be sufficient. The ability to access enough food will depend on physical access (e.g. crop/livestock production, gathering, fishing, and distance to markets), financial access (e.g. purchasing power, and access to credit) and social access (e.g. social networks, gifts, and family support).
- If food is available and households have access to it, the next question is whether households are fully utilizing the accessible food for an adequate nutrition and energy intake. Food utilization is usually a factor of food preferences, preparation, storage and access to an adequate quantity and quality of water.
- Once the dimensions of availability, access and utilization are understood, the next question is whether the whole system is stable. A stable system should ensure that the households are and will be food-secure at all times, including during future forecasts. Stability problems of specific interest include those that have or will impact food security in the short term. Climatic, economic, social and political factors can all be a source of instability.

First-level outcomes: food consumption and livelihood change

If food availability, access, utilization and stability are inadequate, a household's consumption is also likely to be inadequate. The severity of the inadequacy of food consumption is dependent on how inadequate one or more elements are, and to what extent households are resorting to an unsustainable livelihood change to decrease food gaps. In this regard, it is important to note that if



food consumption gaps have been mitigated by unsustainable coping strategies, for the IPC, households are food insecure. For IPC Acute Food Insecurity analysis, the severity of the inadequacy of energy intake is key for classification and not necessarily the adequacy of the micronutrient intake, which is important for classifying chronic food insecurity.

If households have difficulties in securing enough food, they may engage in unsustainable strategies, such as selling assets, decreasing expenditure on education and health, and consuming seeds. Livelihood changes need to be carefully contextualised, since households may engage in activities for reasons other than food insecurity. Livelihood changes that are not driven by food insecurity (e.g. seasonal migration) may not be evidence of outcome-level changes; nevertheless, the impacts of these changes on the food security dimensions should be considered. See Figure 21 for examples of first-level outcomes.

Figure 21: First-level outcomes – Examples

- The proportion of households unable to consume adequate diets, such as those with a poor Food Consumption Score (FCS) or a Household Hunger Scale (HHS) > 3;
- The proportion of households resorting to strategies to cope with a shortage of food, such as those engaging in crisis or emergency livelihood coping strategies;
- How the current or projected situation compares with previous years and non-exceptional conditions, as well as with other areas and other indicators.

Second-level outcomes: nutritional status and mortality

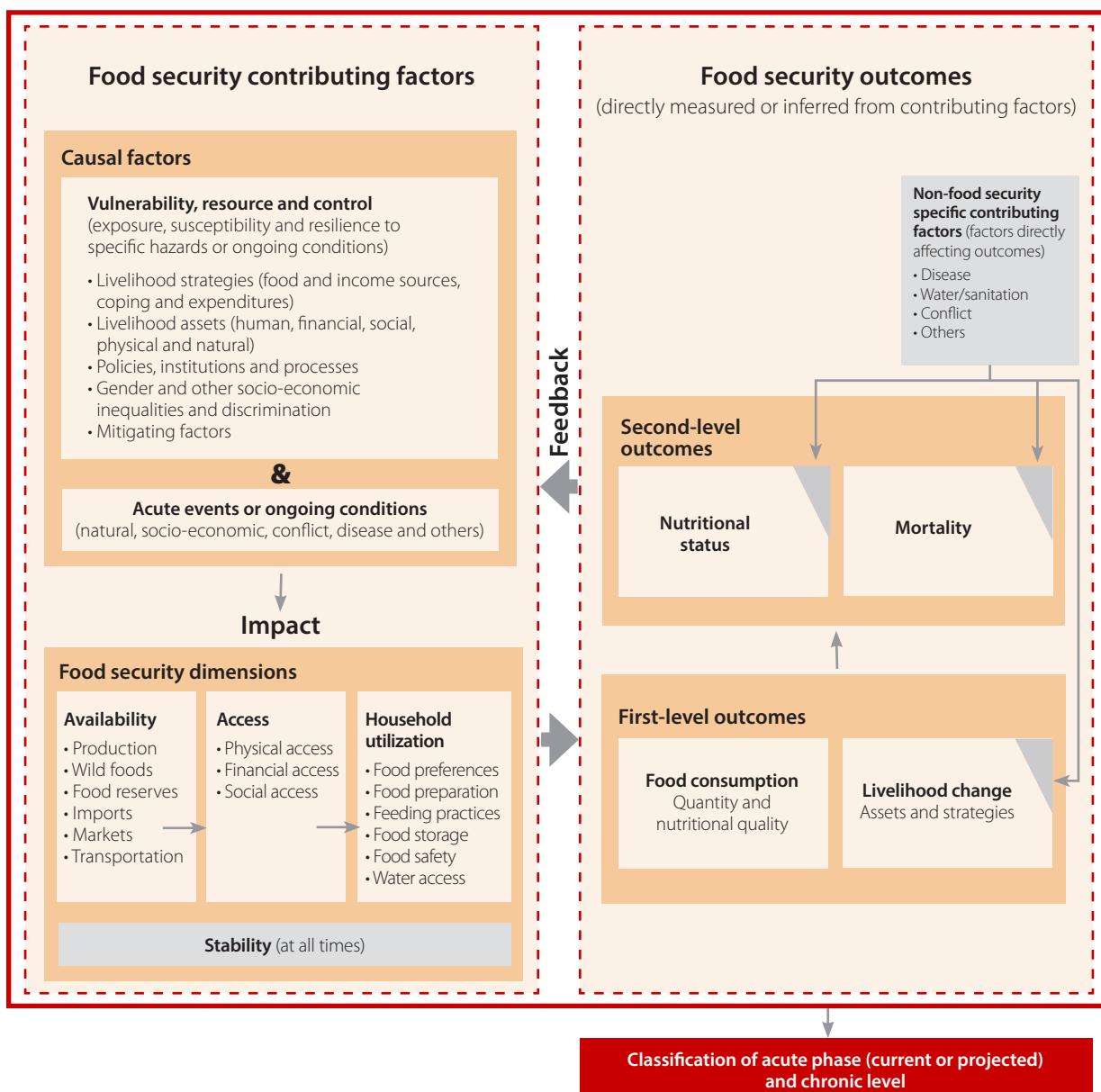
Inadequate food consumption and negative livelihood changes to cope with shortages of food, together with other non-food security-specific factors such as inadequate access to health services are expected to increase malnutrition and mortality levels (Figure 22). At the area level, high or increasing levels of acute malnutrition and mortality could be expected if severe energy gaps are found within a large proportion of populations, since the interaction of dietary consumption and disease have a direct impact on malnutrition and eventual death. The interaction is usually consequential, and some time-lag is often noted with dietary intake and health conditions being impacted first, followed by acute malnutrition, and finally ending in mortality.

Figure 22: Second-level outcomes – Examples

- If food consumption is inadequate, it is more likely that people will be malnourished. In areas where at least 20 percent of households have large food consumption gaps (i.e. IPC Phase 4 Emergency cut-off), it is expected that acute malnutrition is between 15 percent and 30 percent or significantly greater than baseline levels. In these areas, Under-Five Death Rates (U5DRs) are expected to be between two and four deaths per 10,000 children per day.
- Livelihood change can also have an impact on nutrition and mortality. Households that decrease expenditure on health and increase engagement in casual underpaid labour are more likely to limit their caring practices and health-seeking behaviour. Also, households may increase their risk of mortality if they engage in risky activities, such as illegal mining, prostitution and migration.

Because the contributing factors to malnutrition and mortality may not be specific to food security, evidence of them is not to be used to drive classification, but rather to support and confirm (or question) food insecurity classifications. Thus, it is essential for analysts to carefully examine whether these are the result of food security drivers or non-food security drivers, by following evidence-based consensus-building. Although it is best to have some evidence of the statistical correlation between malnutrition, mortality, inadequate food consumption and negative livelihood change, even when there is no proof of it, the linkages between these different elements can be assessed qualitatively.

Figure 23: The IPC Food Security Analytical Framework (Tool 2)





PROTOCOL 2.2: COMPARE THE EVIDENCE AGAINST THE IPC ACUTE FOOD INSECURITY REFERENCE TABLE

The purpose of the IPC Acute Food Insecurity Reference Table is to guide convergence of evidence by using generally accepted international standards and thresholds.

The Acute Food Insecurity Reference Table is organized according to the IPC Analytical Framework – i.e. outcomes (food consumption, livelihood change, nutrition and mortality) and contributing factors (vulnerabilities and hazards, and the four dimensions of food security (Figure 23)), so that evidence can be critically evaluated, contextualized and related to different severities of food insecurity.

The Acute Food Insecurity Reference Table is organized into five severity phases (Phase 1: Minimal/None; Phase 2: Stressed; Phase 3: Crisis; Phase 4: Emergency; and Phase 5: Catastrophe/Famine). The Table provides a description of the typical characteristics for each phase and assumes that populations of households in each phase are likely to share the same general characteristics (Figure 24).

Each phase is linked to priority response objectives. While the Reference Table links response objectives with each phase, it is necessary to conduct a response analysis subsequent to the completed analysis to effectively determine which particular interventions and activities are best suited to mitigate or prevent food insecurity.

The Acute Food Insecurity Reference Table identifies generally comparable cut-offs for key food insecurity outcome indicators so that populations of households can be commonly distributed across the five phases (Figure 25). Evidence for these indicators is taken by the IPC as direct evidence. Although the IPC identifies 'generally globally comparable' cut-offs of indicators, it acknowledges that they may not always align due to context issues and indicator characteristics. Thus, while the Reference Table provides general guidance for evidence alignment, it is the convergence of evidence based on critical contextualization and understanding of indicator use and limitations that will allow analysts to decide on a classification. Analysts will be required to explain their reasoning for classification, including reference to supporting and contradictory evidence. Figure 25 summarizes the key expected characteristics of indicators for each phase, organized by food security elements.

Figure 24: The IPC Reference Table – Example of contents for Phase 4

Each IPC Phase has a description, priority response objective, and a set of common characteristics expected among households. Below is an example of how this is presented for Phase 4.

- **Phase description.** Households experiencing Phase 4 conditions typically have large food consumption gaps, which are reflected in very high acute malnutrition and excess mortality, or are partially able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation that threaten future food security.
- **Priority response objective.** Households experiencing IPC Phase 4 should be targeted with responses that focus on saving their lives and livelihoods. Activities such as food assistance, cash assistance and asset redistribution, together with an analysis of key drivers and limiting factors, should be optimally considered during the response analysis.
- **Common characteristics.** Populations of households experiencing large food consumption gaps (IPC Phase 4) are also more likely to be engaging in crisis or emergency livelihood coping strategies, such as eating seeds intended to be used for next season, selling the last adult female livestock or selling land. In addition, households in these conditions are also more likely to have been affected by shocks and have some dimensions of food availability, access, utilization and stability that are limited. If areas have at least 20 percent of households experiencing these conditions, acute malnutrition and mortality should be relatively high or increasing.

Figure 25: The IPC Reference Table – General profile of the elements for each Phase

		Phase 1 None/Minimal	Phase 2 Stressed	Phase 3 Crisis	Phase 4 Emergency	Phase 5 Catastrophe/ Famine
First-level outcome	Food consumption (focus on energy intake)	Adequate	Minimally adequate	Moderately inadequate	Very inadequate	Extremely inadequate
	Livelihood change (assets and strategies)	Sustainable	Stressed	Accelerated depletion	Extreme depletion	Near collapse of strategies and assets
Second-level outcome	Nutritional status	Minimal	Alert	Serious	Critical	Extreme critical
	Mortality	CDR: <0.5 / 10,000 / day	CDR: <0.5 / 10,000 / day	CDR: 0.5 - 0.99 / 10,000 / day	CDR: 1 - 1.99 / 10,000 / day or >2 x reference	CDR: >2 / 10,000 / day
Contributing factors	Food availability, access utilization and stability	Adequate	Borderline adequate	Inadequate	Very inadequate	Extremely inadequate
	Hazards and vulnerability	None or minimal effects	Stressed livelihoods and food consumption	Results in assets and food losses	Results in large food assets and food losses	Results in near complete collapse of livelihood assets



Although the IPC Reference Table (Figure 27) only identifies selected indicators as direct evidence, it does not preclude the use of **information from other indicators not included in the Table** during the analysis (Figure 26). In fact, IPC encourages the inclusion of other relevant indicators in the analysis. The IPC Reference Table is not for review at the country or regional levels. However, it may be updated by the global IPC partnership through the Technical Advisory Group, considering users' feedback and the latest technical developments.

Indirect evidence includes all relevant evidence not listed in the IPC Reference Table, including locally specific indicators on outcomes and most indicators on contributing factors. Indirect evidence is usually available at subnational levels with greater frequency, since it often contributes to national monitoring systems. Furthermore, some of these locally specific indicators may have been calibrated for local conditions. Since the Table does not identify globally applicable cut-offs for indirect evidence, they need to be interpreted and analysed within their context. If, however, locally applicable cut-offs have been developed, analysts may refer to them. In the absence of locally applicable cut-offs, it is the task of the analysts to understand and infer the meaning of the evidence, and to relate it to the phase descriptions and other indicator cut-offs.

Figure 26: Combining the Reference Table with analytical reasoning – Context and critical thinking is key

Evidence should be analysed against the IPC Reference Table within the context and by using critical reasoning. Below is an actual example from Tete, Mozambique, IPC 2016.

"44 percent of households had a poor Food Consumption Score (i.e. FCS ≤21); and 42 percent had a borderline score (i.e FCS between 21.5 and 35). The analysis team noted that, even in a normal year, at the end of the post-harvest season, 13 percent of households had a poor FCS and 31 percent had a borderline FCS (data from November 2013). They also noted that a poor FCS includes scores referring to eating cereal or tubers and vegetables daily, but nothing else. The analysis team therefore concluded that the FCS was probably overestimating the problem due to the traditional heavy reliance on cereals and vegetables as the basis of diet during the lean season."

By converging this analysis with information on livelihood coping, it was noted that only 33 percent were engaging in crisis or emergency livelihood coping, with less than 10 percent engaging in emergency strategies. Finally, based on the whole body of evidence and contextualization of indicators and also relying on information on contributing factors that were not showing any IPC Phase 4 characteristics, the area was classified as Phase 3."

Figure 27: The IPC Acute Food Insecurity Reference Table (Tool 3)

Purpose: to guide convergence of evidence by using generally accepted international standards and cut-offs. The classification is intended to guide decision-making aiming at short-term improvements in food security.

Phase name and description	Phase 1 None/Minimal	Phase 2 Stressed	Phase 3 Crisis	Phase 4 Emergency	Phase 5 Catastrophe/ Famine
	Households are able to meet essential food and non-food needs without engaging in atypical and unsustainable strategies to access food and income.	Households have minimally adequate food consumption but are unable to afford some essential non-food expenditures without engaging in stress-coping strategies.	Households either: <ul style="list-style-type: none"> Have food consumption gaps that are reflected by high or above-usual acute malnutrition; or Are marginally able to meet minimum food needs but only by depleting essential livelihood assets or through crisis-coping strategies. 	Households either: <ul style="list-style-type: none"> Have large food consumption gaps which are reflected in very high acute malnutrition and excess mortality; or Are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation. 	Households have an extreme lack of food and/or other basic needs even after full employment of coping strategies. Starvation, death, destitution and extremely critical acute malnutrition levels are evident. (For Famine Classification, an area needs to have extreme critical levels of acute malnutrition and mortality.)
Priority response objectives	Action required to build resilience and for disaster risk reduction	Action required for disaster risk reduction and to protect livelihoods	Urgent action required to: Protect livelihoods and reduce food consumption gaps	Save lives and livelihoods	Revert/prevent widespread death and total collapse of livelihoods

First-level outcomes refer to characteristics of food consumption and livelihood change. Thresholds that correspond as closely as possible to the Phase description are included for each indicator. Although cut-offs are based on applied research and presented as global reference, correlation between indicators is often somewhat limited and findings need to be contextualized. The area is classified in the most severe Phase that affects at least 20% of the population.

Food security first-level outcomes	Food consumption (focus on energy intake) Quantity: Adequate energy intake	Quantity: Minimally Adequate	Quantity: Moderately Inadequate – Moderate deficits	Quantity: Very Inadequate – Large deficits	Quantity: Extremely Inadequate – Very large deficits
	Dietary energy intake^{vii}: Adequate (avg. 2,350 kcal pp/day) and stable	Dietary energy intake: Minimally adequate (avg. 2,100 kcal pp/day)	Dietary energy intake: Food gap (below avg. 2,100 kcal pp/day)	Dietary energy intake: Large food gap; well below 2,100 kcal pp/day	Dietary energy intake: Extreme food gap
	Household Dietary Diversity Score^{vi}: 5-12 food groups and stable	Household Dietary Diversity Score: 5-6 FG but deterioration \geq 1 FG from typical	Household Dietary Diversity Score: 3-4 FG	Household Dietary Diversity Score: 0-2 FG (NDC to differentiate P4 and 5)	Household Dietary Diversity Score: 0-2 FG
	Food Consumption Score^{viii}: Acceptable and stable	Food Consumption Score: Acceptable but deterioration from typical	Food Consumption Score: Borderline	Food Consumption Score: Poor (NDC to differentiate P4 and 5)	Food Consumption Score: Poor (NDC to differentiate P4 and 5)
	Household Hunger Scale^{vii}: 0 (none)	Household Hunger Scale: 1 (slight)	Household Hunger Scale: 2-3 (moderate)	Household Hunger Scale: 4 (severe)	Household Hunger Scale: 5-6 (severe)
	Reduced Coping Strategies Index^{vii}: 0-3	Reduced Coping Strategies Index: 4-18	Reduced Coping Strategies Index: \geq 19 (non-defining characteristics (NDC) to differentiate P3, 4 and 5)	Reduced Coping Strategies Index: \geq 19 (NDC to differentiate P3, 4 and 5)	Reduced Coping Strategies Index: \geq 19 (NDC to differentiate P3, 4 and 5)
	Household Economy Analysis^{vii}: No livelihood protection deficit	Household Economy Analysis: Small or moderate livelihood protection deficit <80%	Household Economy Analysis: Livelihood protection deficit \geq 80%; or survival deficit <20%	Household Economy Analysis: Survival deficit \geq 20% but <50%	Household Economy Analysis: Survival deficit \geq 50%
	Food Insecurity Experience Scale^{vii}: (FIES 30 days recall): <-0.58	FIES: Between -0.58 and 0.36	FIES: $>$ 0.36 (NDC to differentiate between Phases 3, 4 and 5)	FIES: $>$ 0.36 (NDC to differentiate between Phases 3, 4 and 5)	FIES: $>$ 0.36 (NDC to differentiate between Phases 3, 4 and 5)
Livelihood change (assets & strategies)	Livelihood change: Sustainable livelihood strategies and assets	Livelihood change: Stressed strategies and/or assets; reduced ability to invest in livelihoods	Livelihood change: Accelerated depletion/erosion of strategies and/or assets	Livelihood change: Extreme depletion/ liquidation of strategies and assets	Livelihood change: Near complete collapse of strategies and assets
	Livelihood coping strategies^{viii}: No stress, crisis or emergency coping observed	Livelihood coping strategies: Stress strategies are the most severe strategies used by the household in the past 30 days	Livelihood coping strategies: Crisis strategies are the most severe strategies used by the household in the past 30 days	Livelihood coping strategies: Emergency strategies are the most severe strategies used by the household in the past 30 days	Livelihood coping strategies: Near exhaustion of coping capacity

Food security second-level outcomes	Nutritional status^x	Acceptable: <5%	Alert: 5-9.9%	Serious: 10-14.9% or > than usual	Critical: 15-29.9%; or > much greater than usual	Extremely Critical: \geq 30%
	Global Acute Malnutrition based on Weight-for-Height Z-score (WHZ)^{xii}	<5%	5-9.9%	10-14.9%	20-39.9%	\geq 40%
	Global Acute Malnutrition based on Mid-Upper Arm Circumference (MUAC)^{xii}					
	Body Mass Index (BMI) <18.5^{xii}	<5%	5-9.9%	10-19.9%, 1.5 x greater than baseline	20-39.9%	\geq 40%
	Mortality	Crude Death Rate^{xiii}: <0.5/10,000/day	Crude Death Rate: <0.5/10,000/day	Crude Death Rate: 0.5-0.99/10,000/day	Crude Death Rate: 1-1.99/10,000/day OR $>$ 2x reference	Crude Death Rate: \geq 2/10,000/day
		Under-five Death Rate^{xiv}: <1/10,000/day	Under-five Death Rate: <1/10,000/day	Under-five Death Rate: 1-1.99/10,000/day	Under-five Death Rate: 2-3.99/10,000/day	Under-five Death Rate: \geq 4/10,000/day
	Food security contributing factors	For contributing factors, specific indicators and thresholds for different phases need to be determined and analysed according to the livelihood context; however, some general descriptions for contributing factors are provided below.				
	Food availability, access, utilization, and stability	Adequate to meet short-term food consumption requirements	Borderline adequate to meet food consumption requirements	Inadequate to meet food consumption requirements	Very inadequate to meet food consumption requirements	Extremely inadequate to meet food consumption requirements
		Safe water ^{xv} \geq 15 litres pp/day	Safe water marginally \geq 15 litres pp/day	Safe water > 7.5 to 15 litres pp/day	Safe water > 3 to <7.5 litres pp/day	Safe water \leq 3 litres pp/day
	Hazards and vulnerability	None or minimal effects of hazards and vulnerability on livelihoods and food consumption.	Effects of hazards and vulnerability stress livelihoods and food consumption.	Effects of hazards and vulnerability result in loss of assets and/or significant food consumption deficits.	Effects of hazards and vulnerability result in large loss of livelihood assets and/or extreme food consumption deficits.	Effects of hazards and vulnerability result in near complete collapse of livelihood assets and/or near complete food consumption deficits.

**Notes:**

- i. **Adequate dietary energy intake** relates to the condition of regularly consuming, over a significant period of time, an amount of food that provides the dietary energy needed to cover the requirements for an active and healthy life. Dietary energy intake is used as a convention and convenience to assess the average energy requirements for a population group. Characteristics that affect requirements include gender, age, body size, body composition and physical activity level as well as unknown factors that produce variations among individuals, as defined by the World Health Organization (WHO, 1985). The energy cut-offs included in the IPC Acute Food Insecurity Reference Table are not intended to be used for empirical assessment of percentage of the population consuming adequate/inadequate amounts of food, but rather, the indicator acts as a reference for food consumption, and the cut-off of 2,100 kcal/day is associated with the Household Economy Analysis (HEA) survival deficit cut-off and borderline FCS. The selected dietary energy requirements are based on average requirements for an average individual (BMI of 21–22), engaged in normally active life (physical activity level, or physical activity level = 1.75) for Phase 1, with an average of 2,350 Kcal/day, and in a sedentary lifestyle (physical activity level=1.55) for Phase 2 (FAO, WHO and United Nations University, 2004) with an average of 2,100 Kcal/day.
- ii. The **Household Dietary Diversity Score (HDDS)** is an indicator developed by Food and Nutrition Technical Assistance (FANTA) and promoted by FAO. It aims to reflect the economic ability of a household to access a variety of foods and is based on households' self-reporting of the number of food groups consumed in the previous 24 hours. IPC cut-offs have been prepared for HDDS with 12 food groups, based on the FANTA/FEWS NET Household Food Consumption Indicator Study (2015).
- iii. The **Food Consumption Score (FCS)** is a WFP corporate indicator collected in all assessments and monitoring activities. The FCS is a composite score based on self-reported information on nine consumed food groups and food frequency (number of days food groups were consumed during the past seven days), weighted by the ascribed relative nutritional importance of different food groups. Based on standard thresholds, households are classified into one of three food consumption groups: poor, borderline, or acceptable, with scores of ≤21, 28 and 35, respectively, except in situations of high oil and sugar consumption, for which the cut-offs used for the same groups are ≤28, 35 and 42, respectively. These same groupings are used as cut-offs for different phases in the IPC Acute Food Insecurity Reference Table.
- iv. The **Household Hunger Scale (HHS)** is an indicator developed by FANTA. It assesses whether households have experienced problems of food access in the preceding 30 days, as reported by the households themselves. The HHS assesses the food consumption strategies adopted by households facing a lack of access to food. The cut-offs for the HHS are based on the FANTA (2015) Household Food Consumption Indicator Study report, and the alignment with the Acute Food Insecurity Reference Table phase descriptions.
- v. The **reduced Coping Strategies Index (rCSI)** developed by CARE International is an experience-based indicator collecting information on household use and the frequency of five different food-based coping strategies over the past 7 days. It is thought to be most useful in early onset crises when households change their food consumption patterns to respond to shocks, but not in protracted emergencies when households are likely to have already exhausted some coping mechanisms. The rCSI cut-offs are based on FANTA (2015) and the validation conducted by WFP.
- vi. The **Household Economy Analysis (HEA)** is a livelihoods-based framework founded on the analysis of people in different social and economic circumstances. In particular, the HEA examines the self-reporting of information on: (i) how people access the food and cash they need; (ii) their assets, the opportunities available to them, and the constraints they face; and (iii) the options open to them in times of crisis. Two thresholds define basic needs in the HEA: the Survival Threshold and the Livelihoods Protection Threshold. The HEA Survival Threshold represents the most basic needs, including minimum food energy requirements (calorie requirements), the costs associated with food preparation and consumption if associated inputs are purchased (such as salt, firewood or kerosene), as well as expenditure on water for human consumption. All HEAs should consider the extent of reversible coping that is possible. HEA deficits are presented with cut-offs that reflect the expected situation in terms of livelihood stress and food gaps, as explained in IPC phase descriptions.
- vii. **FIES** cut-offs are common, normalized thresholds developed specifically for use with the FIES 30 day-recall in the IPC Acute Food Insecurity Reference Table. These thresholds do not correspond to those defined for use of FIES in the context of SDG monitoring and in the IPC Chronic Food Insecurity Reference Table, which are different and based on a 12 month recall period. The threshold that identifies "moderate" food insecurity in the context of SDG monitoring is less severe than the one that identifies IPC Acute Phase 3 or worse. While the standard FIES including 8 questions (i.e. 8 items) does not include cut-offs to differentiate between Phases 3, 4 and 5, an extended version of the FIES has been created and preliminary findings indicate that this extended version might be able to better differentiate between Phase 3, Phase 4 and Phase 5. Use of available FIES extended data for analyses, this should be carefully applied as indirect evidence and only with support from the IPC Global Support Unit.
- viii. **Livelihood Coping Strategies (LCS)** is an indicator developed by WFP and is derived from a series of questions regarding the household's experience with livelihood stress and asset depletion due to lack of food or lack of money to buy food during the 30 days prior to the survey. The module needs to be adapted based on local context, both in terms of the strategies selected for data collection and the severity assigned to each strategy during analysis. For IPC Acute Food Insecurity, this indicator needs to be carefully analysed together with evidence on acute events and their impact on the food security pillars (availability, access, utilization and stability). This indicator may have limited use in severe protracted crises, since households may have engaged in and exhausted specific activities prior to the recall period. Analysts should also consider that less vulnerable households may be more capable of changing livelihood strategies and asset levels, and thus may have a higher score, not because they are facing more severe food insecurity, but because they are more capable of responding to shocks (e.g. wealthier households are likely to have more savings, better access to loans, and more animals to sell than poorer households). For the purpose of IPC Acute Food Insecurity classification, analysts should identify the most severe level of coping used by households. IPC cut-offs are based on groupings of strategies, i.e. stress, crisis and emergency strategies, depending on the strategies' sustainability and potential negative impact on future livelihoods and food security of the household.



- ix. **Nutritional status and mortality** are used to support the classification of acute food insecurity due to the expected linkages between severity of food deprivation and acute malnutrition and mortality. Household food consumption deficits must be a likely explanatory factor of acute malnutrition and mortality in order for this evidence to be used to support a phase classification. For example, elevated malnutrition due to disease outbreak or lack of access to health care should not be used as evidence for an IPC Acute Food Insecurity Analysis if it is determined to not likely be related to food consumption deficits. Similarly, excessive mortality rates due to trauma-related deaths should not be used as evidence for Acute Food Insecurity Phase classification. A complementary IPC for Acute Malnutrition has been developed to inform decision-makers of the severity and likely drivers of acute malnutrition.
- x. **Global acute malnutrition based on weight-for-height Z-score (GAM based on WHZ)** is defined as the percentage of children under five who are below -2 standard deviations of the median of weight for height (<-2 WHZ) or in the presence of oedema. Cut-offs are derived from WHO guidance, as well as from the Review of Nutrition and Mortality Indicators for the IPC -study (2009).
- xi. **Global Acute Malnutrition based on mid-upper arm circumference (GAM based on MUAC)** is defined as the percentage of children under five who have readings below 125 mm or the presence of oedema. Although GAM based on MUAC is a common measure of acute malnutrition, especially in emergency settings when the IPC Acute Food Insecurity classification is most relevant, global thresholds have not been developed. Evidence on GAM based on MUAC is included in the IPC so that evidence use is maximized, especially in emergency settings. The IPC acknowledges that concordance between MUAC and WHZ varies depending on context and is usually around 40–50 percent. The MUAC thresholds endorsed by the IPC have been developed based on extensive research by the Centers for Disease Control and Prevention and the JRC on the specificity and applicability of MUAC for the detection of GAM prevalence at the population level. MUAC thresholds can only be used in conjunction with the other contextual information by taking into account the immediate causes of acute malnutrition and the locally understood relationship between MUAC and WHZ prevalence, and by using the convergence of evidence approach.
- xii. The **Body Mass Index (BMI)** measures central body mass and is an indicator of weight in relation to height. BMI is typically measured on non-pregnant women between 15 and 49 years of age. The IPC thresholds are based on the percentage of people with scores of <18.5. The thresholds use the WHO reference cut-offs that have been adopted by the IPC.
- xiii. The **crude death rate (CDR)** is an indicator that accounts for all the deaths that have occurred per day per 10,000 people over a given recall period (often 90 days) in an area or community. According to the IPC Acute Food Insecurity Analysis, the CDR should not include trauma-related deaths, but should include deaths due to unknown causes. IPC cut-offs are based on WHO guidance, as well as on the Review of Nutrition and Mortality Indicators for the IPC study (2009).
- xiv. The **under-five death rate (U5DR)** refers to all deaths of children under five (up to 59 months) per 10,000 children under five per day over a given recall period (often 90 days) in an area or community. The U5DR is typically around twice that of the CDR. The U5DR should not include trauma-related deaths. The under-5 mortality rate (i.e. the probability of dying between birth and the fifth birthday per 1,000 live births) can be used in order to understand the indicative U5DR, if the conditions between the collection of data for the under-5 mortality rate and the current situation have not changed.
- xv. **Access to safe water** of ≥15 litres per person per day and further severity cut-offs per day per person for other phases are based on Sphere guidance for emergency situations. However, exact information on water quantity is rarely available outside camp settings or other situations where access to water is monitored

Non-defining characteristic (NDC) is included for some indicators in the IPC Acute Food Insecurity Reference Table when no cut-offs were identified to differentiate between some Phases. For example, given that a "poor" FCS is indicative of Phases 4 and 5 (since it is an NDC to differentiate between Phases 4 and 5), the proportion of households with a "poor" score should be indicative of the proportion of households in Phases 4 and 5.



PROTOCOL 2.3: ADHERE TO THE PARAMETERS FOR ANALYSIS

Figure 28: Analytical parameters (Tool 4)

- a. Definition of acute food insecurity and an analytical focus
- b. Informing action with short-term strategic objectives
- c. Five severity phases
- d. Convergence of evidence
- e. The twenty percent rule for area classification
- f. Unit(s) of analysis
- g. Snapshot in time with validity period
- h. Incorporating humanitarian assistance
- i. Current classifications
- j. Projection classifications
- k. Identification of areas that have received or will receive significant humanitarian food assistance
- l. Identification of key drivers and most affected populations
- m. Population in need of urgent action

All IPC Acute Food Insecurity classifications need to adhere to the thirteen parameters identified in Figure 28 and detailed below

- a. Definition of acute food insecurity and an analytical focus:** According to the IPC, acute food insecurity refers to food deprivation that threatens lives or livelihoods, regardless of the causes, context or duration. The IPC Acute Food Insecurity classification focuses on identifying the needs for urgent action to decrease food gaps and protect and save lives and livelihoods.
- b. Informing action with short-term strategic objectives:** The Acute Food Insecurity classification primarily informs action that has measurable results immediately or within a one-year time period. Ideally, these should be linked to action with medium- and longer-term objectives. The IPC Chronic Food Insecurity classification focuses on identifying the need for these longer-term interventions.
- c. Five severity phases:** IPC classifies the severity of Acute Food Insecurity into five severity phases: (1) None/Minimal; (2) Stressed; (3) Crisis; (4) Emergency; and (5) Catastrophe/Famine.
- d. Convergence of evidence:** The IPC approach draws upon data and information from a wide range of sources to classify and distribute the population of households into the five phases of Acute Food Insecurity. The IPC approach relies on building consensus among a team of multisectoral experts who are brought together to evaluate and discuss evidence systematically. Convergence of evidence uses the IPC Analytical Framework with a livelihood-based lens supported by indicators directly measuring food security outcomes as well as contributing factors in order to estimate the proportion of households in each phase. Although convergence of evidence calls for all evidence to be assessed, only evidence that is relevant to acute food insecurity and of a minimum reliability should be used for classification. Evidence on malnutrition and mortality are only considered to the extent that they are driven by food gaps and livelihood changes due to limited access to food. Therefore, nutrition and mortality are considered to support food insecurity classification but not to drive the classification. Evidence that is less than somewhat reliable may only be used to contextualize and explain findings during the convergence of evidence.
- e. The twenty percent rule for area classification:** An area is classified according to a specific IPC phase when at least 20 percent of the population in the area are experiencing the conditions related to that phase or more severe phases. Ideally, the distribution of affected populations across Phases 1 to 5 should be provided, as each phase is linked to a different severity and calls for different action. Whenever it is not possible

to provide detailed population estimates, some form of aggregated numbers that respect IPC protocols should be provided.

f. Unit(s) of analysis: There are two key approaches to classification, which can be used independently or together in support of each other:

- **Area-based analysis:** Analysis is performed while considering the conditions experienced in a certain area, which are assessed through the convergence of evidence that contains estimates for the whole area being analysed. Populations are distributed among different phases based on the co-existence of conditions. As good practice, even when household groups are not individually classified, it is important to gather information on different subgroups residing in the area, such as information on the conditions of the poorest or the agriculturalists, as that is helpful in supporting area-based classification.
- **Household Analysis Group (HAG) analysis:** The HAG analysis is performed considering relatively homogeneous subgroup(s) of households with regard to food security outcomes, based on a wide range of factors such as wealth, social affiliations, livelihoods and exposure to shocks. For example, displaced populations, subsistence farmers and the poorest households in a certain area may be identified as a relevant HAG for analysis. Either all HAGs in an area can be classified or just a subset of them. HAG analysis may result in more precise and informative classification if the available evidence and analytical skills are adequate for this type of analysis. Detailed population tables, which show the distribution of households across the five phases, cannot be produced unless all household subgroups are analysed so that the total population classified is 100 percent of the population living in the area. This analysis should include, as a minimum, household group(s) that will allow area classification based on the 20 percent rule.

g. Snapshot in time with validity period: The severity classification is a snapshot of food insecurity that is either: (i) currently occurring (thereby referring to the current analysis period); or (ii) projected in the future within a specified timeframe (referring to analysis projections). Classification is a real-time statement and has a validity period during which the situation is not expected to change. The time validity of the classification can refer to short or long periods, depending on the stability of the situation and the needs of decision-makers, and thus it can range from a period of a few weeks up to a year. If the situation changes during the validity period of the analysis, an update or a new analysis may be required.

h. Incorporating Humanitarian Assistance. The current snapshot is based on actual conditions, without removing the effects of any humanitarian assistance. The future projection includes anticipated effects of humanitarian assistance which is regularly programmed/inter-annual, and any ad hoc assistance which is planned and likely to be funded and delivered in the projection period. Newly requested assistance is not included in the projected classification. Current population tables identify those currently found in different severity phases. A population in Phase 3+ does not necessarily mean that the full population is in need of urgent action to decrease food gaps and protect and save lives and livelihoods. This is because some households may be in Phase 2 or even 1 but only because of receipt of assistance, and as a result they may be in need of continued action. Decision-makers should be informed that estimations refer to numbers in need of action further to the action already taken.

i. Current classifications: These are based on the actual conditions prevalent at the time of analysis, regardless of causes, context and duration. Analysis should consider the following:

- Classification is based on actual food security contributing factors and outcomes as measured by taking into account all interactions among different contributing factors. Analysis of contributing factors must consider aggravating factors such as conflict, loss of food production and price



increases, as well as mitigating factors, such as good rainfall, access to wild foods and humanitarian assistance. This combined analysis not only informs the expected actual food insecurity status, but also provides analysts with the key drivers and mitigating factors of crises. These interactions manifest at the household and individual levels through food consumption, livelihood changes, nutrition and mortality, which are assessed through outcome indicators.

- Emphasis should be on contributing factors and first-level outcomes of food consumption and livelihood change. Analysis should include measurements of indicators included in the Reference Table, as well as any other relevant indicators and analysis of contributing factors. These should be supported by the second-level outcomes of nutrition and mortality. Given that food insecurity and malnutrition do not always concur due to their different causes, different aggravating factors and time lag, Acute Food Insecurity classification does not necessarily imply that acute malnutrition and mortality are at the same or similar level as food insecurity. However, differences between recorded levels of malnutrition and food insecurity should be critically analysed and explained.

j. Projection classifications: These are based on the most likely expected situation in the future and should consider the following:

- Projections should forecast the most likely conditions based on a sound understanding of the current situation, historical trends and assumptions on the evolution of the situation. Assumptions should be clearly documented, and as in current classification, projection classification should take into account the likely trends of both aggravating and mitigating factors, including any effects of humanitarian assistance that is planned and is likely to be funded and delivered. Assumptions must consider relevant trends as well as events that have already occurred and are expected to continue to have consequences, or events that are most likely to occur within the projected period.
- All mapping and population estimates are limited to most-likely scenarios only. Nevertheless, other supporting analyses may inform alternate 'worse or better' scenarios, which can be communicated in text form to decision-makers.
- Projections can be updated whenever there is a need, or when new information alters assumptions made during a previous analysis. Although less labour-intensive than projection analysis, projection updates still require that all protocols in the four Functions are completed. Projection updates differ from new current classifications since they review a previous analysis, with analysts assessing whether assumptions and forecasts developed as expected. Updates can be prepared without new direct evidence on outcomes but need to rely on new evidence on contributing factors. Updates can only cover the timespan up to the end of the latest projection validity period and cannot be the basis for successive further projections. Both area classification and population tables may be revised during updates. If evidence is available on outcomes, analysts can decide if an update or a new current classification should be completed.

k. The identification of areas that have received or will likely receive significant humanitarian food assistance: This should be carried out after phase classifications and consider the following:

- IPC protocols are not designed (nor should they be used) to assess or evaluate the impact of any humanitarian food assistance on food insecurity, or to monitor achievements towards programme-level goals.

- Humanitarian food assistance to be considered includes direct resource transfers in response to acute events that aim to reduce food gaps, and protect and save lives and livelihoods. Only transfers that have an immediate positive effect on access to food are to be considered. Humanitarian food assistance may include different modalities, such as transfers of food, cash, livestock and other productive tools if they immediately improve households' access to food during the analysis period. Inter-annual assistance in the form of safety nets, grants, insurances or another mode that is predictable and part of normal livelihoods should not be included. Nevertheless, ad-hoc increases in inter-annual assistance that are a response to an acute crisis must be considered.
- Identification of areas should follow two rules based on coverage and size of assistance as follows:
 - Areas where at least 25 percent of households meet between 25 and 50 percent of their caloric needs through humanitarian food assistance.
 - Areas where at least 25 percent of households meet over 50 percent of their caloric needs through humanitarian food assistance.
- For projections, only humanitarian food assistance that has been planned and is either already funded or likely to be funded and delivered should be considered. Analysts should review plans from implementing partners and assess whether there are constraints on delivery of assistance, such as lack of humanitarian access or conflict which could prevent delivery of planned assistance.
- Phase classification and population estimates should not change in areas identified as receiving substantial humanitarian food assistance (i.e. this analysis does not lead to a modification of the classification). See Figure 29 for a summary of the analysis of humanitarian food assistance and its relationship to area classification and population estimates.

I. Identification of key drivers and most affected populations. IPC Acute Food Insecurity analysis provides tools that can be used for a basic analysis of key drivers and limiting factors as per the IPC Food Insecurity Analytical Framework. Limiting factors of food insecurity are analysed by identifying which combination of factors relating to availability, access, utilization and stability prevents people from being food-secure. By identifying the key shocks and vulnerabilities affecting current conditions, analysts are also able to indicate the likely key drivers of acute food insecurity and, to the extent possible, the most affected populations.

m. Populations in need of urgent action: The identification of populations in Phase 3 or above refers to those with significant food deficits that are in need of urgent action. Populations in Phase 3 or above require urgent action to decrease food gaps and to protect and save lives and livelihoods, with severity of situation increasing in Phase 4 and subsequently in Phase 5. Following protocol 2.3.h, population estimates take into consideration any mitigating impacts of any regular or ad-hoc assistance and as a result, a population in Phase 3+ does not necessarily reflect the full population in need because some households may be in Phase 2 or 1 but only because of receipt of assistance, and may thus still be in need of continued action. The IPC Technical Manual Version 3.0 does not provide protocols to generate population estimates without the effects of humanitarian assistance which is necessary to estimate the total population in need of assistance. The IPC partnership acknowledges that this analysis is also important and is committed to exploring with the relevant stakeholders how this analysis can be conducted.



Figure 29: Humanitarian Assistance – A summary of considerations for classification (parameters H to L)



PROTOCOL 2.4: EVALUATE EVIDENCE RELIABILITY

The evidence to be used in the IPC consists of available data, and the final classification is obtained based on a comprehensive, integrated analysis of the whole body of available evidence. Hence, **all evidence needs to be evaluated for its reliability**, including evidence from quantitative methods, such as surveys, and from qualitative methods, such as focus group discussions. Evidence to be assessed includes all evidence on contributing factors (e.g. satellite images, price trends, food production, rainfall estimations and employment levels) and on outcomes, such as food consumption and livelihood change (Figure 30).

The **IPC Reliability Score Table** (Figure 31) presents the general criteria for assessing reliability scores as well as the more specific guidance for assessing the soundness of method and time relevance for all food security evidence as follows:

- **Part A** presents the combination of method (M) and time relevance (T) that underpins the different reliability scores. Evidence is only reliable if the method used is robust and evidence depicts current conditions. If evidence is yielded through a reasonable but less rigorous method, such as evidence with limited representativeness, or if evidence needs to be extrapolated to the current analysis period because it was collected in past seasons or years, the evidence can at most be R_1 . Evidence that has either limited soundness of M or T scores R_1+ , while evidence that has both types of limited parameters scores R_1- . Reasonable evidence that scores less than R_1 (such as field trip reports and local knowledge) can be referred to as R_0 and may still be used in the IPC to support the analysis. However, it should be carefully reviewed and cannot be counted towards achieving minimum



evidence requirements, except for areas with limited humanitarian access for collecting evidence if the data adhere to the specific parameters included later in the IPC Technical Manual Version 3.1. The IPC also draws on historical data and other evidence, such as contextual conditions, to support analysis of current or projected evidence. Both quantitative and qualitative methods can potentially be assigned as R₂.

► **Part B** presents the general working definition of 'good' and 'limited' for soundness of M and T as well as specific guidance for assessing the reliability of evidence on indicators included in the IPC Acute Food Insecurity Reference Table.

Figure 30: Assigning reliability scores – Examples

- Evidence on rainfall estimates from the National Remote Sensing Unit for the area being analysed presented in comparison with the 30 years' average (R₂);
- Evidence from participants who claim that the fields in the district that they visited two months ago on a holiday were completely dry, and that harvests are expected to be minimal (less than R₁);
- A report by an Oxfam programme officer claiming that the poor do not have as much to eat in the district as they normally do and will likely run out of food soon, based on a two-day field trip a few weeks prior to monitor the conditions in the field during which the staff member carried out informal discussions with various NGO field staff, local government officers, and some community members (R₁₊)
- Evidence on the HHS from a probabilistic cluster sample with over 25 clusters collected in the previous two months in the season of the current classification (R₂).



Figure 31: Reliability Score Table – For evidence to be used in IPC Acute Food Insecurity classifications (Tool 5)

Part A: Guidance for Evaluating the Reliability Score			
R_2 = Reliable R_1 = Somewhat reliable (+ or -)	Time Relevance (T)		
	Good (T_2)	Limited (T_1)	
Soundness of Method (M)	Good (M_2)	R_2	$R_1 +$
	Limited (M_1)	$R_1 +$	$R_1 -$
Part B: Definitions and Guidance for Evaluating Soundness of Method (M) and Time Relevance (T)			
Soundness of Method (M)	Good (M_2)	<p>Scientific quantitative and qualitative methods recognized internationally as good practices</p> <ul style="list-style-type: none"> • Specific parameters for selected methods include: <ul style="list-style-type: none"> • Surveys* <ul style="list-style-type: none"> • Simple/systematic surveys with at least 150 cases or probabilistic multi-stage surveys with at least 25 clusters • Computer assisted telephone interviewing with at least 150 cases with more than 75 percent of households owning at least one operating phone • Household Economy Approach <ul style="list-style-type: none"> • Outcome analysis based on full baseline with problem specification supported by at least four pieces of R_2 evidence on contributing factors 	
	Limited (M_1)	<p>Reasonable quantitative and qualitative methods that follow good practices but have limited representativeness</p> <ul style="list-style-type: none"> • Specific parameters for selected methods include: <ul style="list-style-type: none"> • Surveys* <ul style="list-style-type: none"> • Estimates from at least five clusters and at least 90 observations • Computer assisted telephone interviewing with at least 90 cases with more than 60 percent of households owning at least one operating phone • Estimates from an $R_1 +$ representative survey from similar nearby areas with comparable food security conditions • Household Economy Approach <ul style="list-style-type: none"> • Outcome analysis based on rapid baseline or detailed profiles with problem specifications supported by at least four pieces of $R_1 +$ evidence on contributing factors • Monitoring systems <ul style="list-style-type: none"> • Estimates from at least five sites with at least 200 randomly selected cases in total (at least five sites and at least 100 cases in total for pastoral areas) 	
Time Relevance (T)	Good (T_2)	<p>Evidence reflecting current conditions</p> <ul style="list-style-type: none"> • Specific parameters for selected methods include: <ul style="list-style-type: none"> • Surveys and monitoring systems <ul style="list-style-type: none"> • Evidence collected during the season of analysis • Household Economy Approach <ul style="list-style-type: none"> • Baseline or profiles up to ten years where there have not been significant changes in livelihoods (up to 5 years in unstable situations) 	
	Limited (T_1)	<p>Evidence inferred to reflect current condition</p> <ul style="list-style-type: none"> • Specific parameters for selected methods include: <ul style="list-style-type: none"> • Surveys and monitoring systems <ul style="list-style-type: none"> • Inferred estimates of evidence collected within last six months not necessarily from the same food security season (12 months for unimodal areas) • Historical evidence with M₁ collected during the season of analysis from at least one similar year in the last five years; only to be used in the absence of significant unusual shocks • Household Economy Approach <ul style="list-style-type: none"> • Baseline or profiles older than ten years where there have not been significant changes in livelihoods 	

*The recommended instructions on the soundness of methods and time relevance, including estimated sample sizes and clusters, have been calculated for IPC reliability purposes only. They do not intend to constitute a best practice for the design of any method, including surveys involving primary data collection in the areas of analysis. The IPC acknowledges that evidence that score less than R_2 may not provide accurate estimates of the conditions, and thus the IPC requires various pieces of evidence to be analysed and converged to provide an overall classification when R_1 evidence is being used. The IPC acknowledges that the soundness of methods, including surveys, is also driven by factors other than sample design, such as measurement error, selection bias, field practices and analytical skills. Although important, the IPC cannot identify globally comparable parameters for these, and analysts are urged to assess the soundness of all methods further to issues identified in this table.



Notes

- 1. General criteria** for assessment of evidence reliability are equally applicable to all evidence, including qualitative and quantitative data informing indicators in the IPC Reference Tables (i.e. direct evidence, such as the FCS and the HEA) and those informing other indicators not included in the IPC Reference Tables (i.e. indirect evidence, such as market prices, rainfall estimates and production figures). Although all evidence used for IPC classifications is to be assigned a reliability score, the IPC provides specific guidance only for indicators included in the IPC Reference Tables. Analysts are encouraged to use the general criteria to support evaluation of evidence on other indicators not included in the IPC Reference Tables.
- 2. Nutrition evidence** should be evaluated as per the criteria for assessing the reliability scores included in the IPC Acute Malnutrition protocols.
- 3. Surveys** refer to studies of a geographical area or household group to gather data on food security outcomes and/or contributing factors and are carried out by polling a random section of the population or through a universal census.
 - The sample size for surveys with a cluster sampling design will generally depend on the following parameters: P: expected prevalence; D: desired precision; d: design effect; Z: desired confidence level of estimations; and, only for populations smaller than 10,000, the population size. The sample formula: $n \geq d [Z^2(P)(1-P)/D^2]$ applies to simple random and cluster sampling. However, in simple random sampling, design effect (d) is 1, whereas the d of cluster sampling will vary between surveys, often ranging between 1.5 and 2.5. To support the evaluation of the validity of the surveys' method, the IPC refers to the Sphere and Standardized Monitoring and Assessment of Relief and Transitions Surveys guidance of 25 clusters as a "good" sample size. While 25 clusters can generally be applied globally since the large size allows for assessment of most conditions, an acceptable minimum sample size cannot be globally developed since it will depend on actual P (expected prevalence), d (design effect) and D (desired precision). Nevertheless, assuming general parameters of P:20 percent (following the IPC's 20 percent rule for area classification), D: 8.5 percent, d: 1.5 and Z:1.65 (90 percent desired confidence level of estimates), the IPC has identified the need for 5 clusters and 90 observations as the minimally acceptable sample size, labelled as "limited". Although analysts may use the minimum sample size of 5 clusters and 90 observations as the acceptable minimum sample size to support evidence reliability assessment, IPC analysts should revise the minimum sample size based on real parameters as much as possible. Any calculated sample size below 90 households cannot have a sampling/standard error of more than 8.5 percent nor a confidence interval of less than 90 percent. A smaller sample may be accepted if design effect is confirmed to be less than 1.5..
 - The validity of the surveys is also driven by factors other than sample design, such as measurement error, selection bias, field practices and analytical skills. Although important, the IPC cannot identify globally comparable parameters for these factors, and analysts are urged to assess the soundness of the survey methods.
 - Surveys with a good method can only come from a census or a probabilistic randomized assessment with selection that is based on an adequate sample frame. A good method needs to adhere to the optimal sample size (see bullet above), have low measurement error and selection bias, and be collected using adequate field practices and analytical skills.
 - Surveys with a limited method can be: (i) a probabilistic assessment; (ii) a non-probabilistic assessment for various purposes; or (iii) re-analysed survey data collected with a good method valid at a higher administrative unit. Surveys with limited representativeness should still meet minimum sample size requirements for an 8.5 percent precision, have a low measurement error and selection bias, and be carried out using adequate field practices and analytical skills. Given that estimates from surveys with a lower sample size are likely to generate large confidence intervals, field data collectors are urged to conduct surveys representative of the unit of analysis. The IPC also calls for care when disaggregated evidence is used, as the information generated can be misleading, especially if selection bias and heterogeneity are large. As far as possible and as a best practice, estimates should be provided with confidence intervals to support responsible use of this evidence.
- 4. Computer-Assisted Telephone Interviewing** (CATI) is conducted remotely by trained specialized operators who work from a call centre and interview randomly selected respondents. CATI can be used either as a



survey or as a monitoring system. In principle, the same sample size that would be applicable to face-to-face surveys and monitoring systems should be applied to computer-assisted telephone interviewing assessments. However, an increase of 1.5x should be applied if the selection bias needs to be corrected. In order to be accepted for IPC classification, computer-assisted telephone interviewing questionnaire modules also need to be tested and approved, considering the challenges imposed on operators by not being in the direct physical presence of the respondents. Optimally, especially in areas where there is bias associated with phone ownership, it is best to use both computer-assisted telephone interviewing and face-to-face interviews with a 10 percent sample overlap to check for mode biases between the two approaches and produce reliable estimates for variance. Unless computer-assisted telephone interviewing is used within a dual mode (computer-assisted telephone interviewing and face-to-face) survey, or the phone numbers come from a previous cluster-sample survey, computer-assisted telephone interviewing follows a simple stratified random sample design, and therefore does not require cluster selection or other requisites of cluster surveys.

5. Full Household Economy Analysis (HEA) refers to estimations of livelihood and survival deficits carried out by a trained professional using either the Livelihood Impact Analysis Spreadsheet or the Dashboard. The full analysis and assumptions need to be well documented and available for review by the IPC Technical Working Group and the potential IPC Quality Review. Full baselines are based on approximately 50 focus group and key informant interviews and should be relevant at the time of the analysis considering the stability of the situation: not older than ten years in stable situations, and not older than five years in unstable situations. Analysis needs to be supported by at least four pieces of R2 evidence on contributing factors. The HEA needs to adhere to the best practice checklist.

6. Rapid Household Economy Analysis (HEA) refers to estimations of outcomes carried out by a trained professional using a less complete analysis system, such as the Scenario-Building Tool or the Dashboard. Both rapid baselines and rapid profiles belong to this category, although there are differences between the two: rapid baselines are based on approximately 30 focus group and key informant interviews and use the Dashboard for detailed estimates, whereas rapid profiles are based on 8–10 focus group and key informant interviews, and use the Scenario Development tool for rough estimations of outcomes. Analysis and assumptions need to be well documented and made available for review by the IPC Technical Working Group and for the potential IPC Quality Review. Reference values can be obtained from rapid baselines or rapid profiles provided that they quantify sources of food and income for the subjects being classified. Rapid baselines and detailed profiles should be relevant at the time of the analysis considering the stability of the situation: optimally not older than ten years in stable situations, and not older than five years in unstable situations. Analysis needs to be supported by at least four pieces of R₂ evidence on contributing factors. The HEA needs to adhere to the best practice checklist. The “zone summaries” or equivalents, which are also based on the concepts of the HEA but which do not provide detailed information on food and income sources, score less than R₁.

7. Monitoring systems include estimates usually collected routinely in community-based sites purposively selected with prevalence statistics typically done through pooled analysis for surveillance and monitoring. Observations may be selected randomly or purposively for various reasons.

8. Evidence collected during the season of analysis refers to food security data collected during the period of time defined as the current analysis period, considering seasonal changes in food consumption and livelihood change outcomes within years. Season of analysis is often referred in relation to peaks in food production, usually because of harvests and animal production. In rural settings that are highly dependent on non-irrigated local food production, food consumption seasons are mostly likely linked to rainfall patterns. If an area of analysis does not have significant seasonal changes within years, the entire year can be treated as one “season”. Acute Food Insecurity and Acute Malnutrition seasons may or may not be aligned, depending on the interactions between the different drivers of acute malnutrition and food consumption.

9. Estimates from an R₁ representative survey from a similar area can only be used to support the classification if the area being classified is relatively small and when the evidence on the same indicator is not available for the area of interest through another method. An analysis of the similarity of food insecurity between areas, based on evidence on contributing factors and outcomes, needs to be presented to demonstrate comparability of areas. Evidence from similar nearby areas needs to be supported by at least two pieces of reliable evidence on contributing factors to food insecurity to allow analysts to confirm the likely outcomes for the area of analysis.



PROTOCOL 2.5: MEET MINIMUM EVIDENCE AND ANALYSIS REQUIREMENTS

IPC Evidence-level Criteria (Figure 32) identify the minimum requirements for three distinct levels. Requirements are based on the number of pieces of reliable (R_2) and somewhat reliable (R_1) evidence as per the parameters stipulated in Protocol 2.4. The evidence level is assessed in two steps with analysts first identifying the number and reliability of pieces of direct evidence on Food Consumption and Livelihood Change Outcomes (i.e. evidence on indicators included in the IPC Acute Food Insecurity Reference Table) and then the number and reliability of additional pieces of direct or indirect evidence on contributing factors and outcomes.

Figure 32: Evidence-level criteria for classification (Tool 6)

Evidence level	Criteria		
	Current	Projected	Projection Updates ¹
* Acceptable (Evidence Level 1) (only for Area Classification – no population tables can be produced)	<ul style="list-style-type: none"> 1. At least one piece of R_1 + direct evidence for either food consumption or livelihood change outcome + 2. Four other pieces of R_1 (+ or -) evidence, with at least two of those from the season of analysis 	<ul style="list-style-type: none"> 1. IPC Current adhering to Evidence Level 1 + 2. Evidence used for current classification at most 12 months old at the end of projection period² + 3. Four pieces of R_1 (+ or -) evidence presented with clear assumptions on forecasted trends 	<ul style="list-style-type: none"> 1. Still valid IPC Projection adhering to Evidence Level 1 + 2. Evidence used for current classification at most 12 months old at the end of projection period² + 3. Four new pieces of R_1 (+ or -) evidence on contributing factors from the season of update
** Medium (Evidence Level 2)	<ul style="list-style-type: none"> 1. At least two pieces of R_1 (+ or -) or one piece of R_2 direct evidence for either food consumption or livelihood change outcome + 2. Five other pieces of R_1 (+ or -) evidence, with at least two of those from the season of analysis 	<ul style="list-style-type: none"> 1. IPC Current adhering to Evidence Level 2 + 2. Evidence used for current classification can be at most 12 months old at the end of projection period² + 3. Five pieces of R_1 (+ or -) evidence presented with clear assumptions on forecasted trends 	<ul style="list-style-type: none"> 1. Still valid IPC Projection adhering to Evidence Level 2 + 2. Evidence used for current classification at most 12 months old at the end of projection period² + 3. Four new pieces of R_1 (+ or -) evidence on contributing factors from the season of update
*** High (Evidence Level 3)	<ul style="list-style-type: none"> 1. At least two pieces of R_2 direct evidence for either food consumption or livelihood change outcome + 2. Six other pieces of R_1 (+ or -) evidence, with at least two of those from the season of analysis 	<ul style="list-style-type: none"> 1. IPC Current adhering to Evidence Level 3 + 2. Evidence used for current classification can be at most 12 months old at the end of projection period² + 3. Six pieces of R_1 (+ or -) evidence presented with clear assumptions on forecasted trends 	<ul style="list-style-type: none"> 1. Still valid IPC Projection adhering to Evidence Level 3 + 2. Evidence used for current classification at most 12 months old at the end of projection period² + 3. Four new pieces of R_1 (+ or -) evidence on contributing factors from the season of update

Notes:

¹ If new evidence is available for outcomes, analysts can choose whether to conduct a projection update or a current analysis.

² If historical evidence is being used for a current classification, the guidance on the maximum age of evidence at the end of the projection period does not apply.



The minimum analysis requirements identify the core analytical products that IPC Acute Food Insecurity analysis should provide, presented in Figure 33 below.

Figure 33: Minimum analysis requirements (Tool 7)

A. Current classification
<ul style="list-style-type: none"> • Evidence analysis with references (source and dates of data collection) linking current conditions to IPC phases, context, historical trends and other relevant analysis. • Area classification based on the 20 percent rule. • Classification justification based on the convergence of contextualized evidence and including a critical review of supporting and contradictory evidence. • Population estimates - percentage (%) and number (#) of people in different phases (not applicable for classifications with an acceptable evidence level). • Key drivers and limiting factors to food security are identified.
B. Projected classification
<ul style="list-style-type: none"> • Evidence analysis with references (source and dates of data collection) describing expected trends. • Area classification based on the 20 percent rule. • Classification justification, including a critical review of assumptions and likely trends used to arrive at phase conclusions. • Population estimates - percentage (%) and number (#) of people in different phases (not applicable for classifications with an acceptable evidence level). • Risk factors to monitor are identified to trigger projection updates or a new current analysis.
C. Projection update
<ul style="list-style-type: none"> • Evidence analysis with references (source and dates of data collection) describing a review of assumptions. • Area classification based on the 20 percent rule. • Classification justification, including a critical review of the updated assumptions and key evidence used to arrive at updates of phase conclusions. • Updated estimates of distribution of the households in different phases (percentage and number of people).

PROTOCOL 2.6: SYSTEMATICALLY DOCUMENT EVIDENCE AND ANALYSIS, AND PROVIDE THEM UPON REQUEST

All evidence and analyses need to be clearly and systematically documented in order to provide analysts with the body of evidence needed to support their classification. The documented evidence should be made available if requested for quality review purposes.

The IPC Analysis Worksheet

The IPC Analysis Worksheet supports systematic, transparent and consistent evidence-based analysis by guiding the analysis through the IPC Food Security Analytical Framework and linking evidence to the IPC Acute Food Insecurity Reference Table. The use of the Worksheet is a major advantage for IPC analyses and is highly recommended.

The IPC Analysis Worksheet is organised into steps (Figure 34). While Steps 1, 2 and 12 are common for current and projected classifications, Steps 3 to 6 only apply for the classification of current conditions and are subsequently followed by Steps 7 to 11 for projection. If various projection periods are analysed, Steps 7 to 11 should be repeated. The procedures for completing the Analysis Worksheet are described below. It is highly advisable that parts of the Worksheet, especially Steps 1, 2, 3, 5 and 7, are prepared before the analysis workshops and reviewed during the analysis.

Figure 34: Analysis Worksheet Steps (Tool 8)

All	<p>Step 1: Identify context and analysis parameters.</p> <p>Step 2: Populate the evidence repository.</p>
Current	<p>Step 3: Analyse evidence</p> <p>Step 4: Determine phase classification and population estimates.</p> <p>Step 5: Identify areas that received significant humanitarian food assistance.</p> <p>Step 6: identify key drivers & limiting factors..</p>
Projection	<p>Step 7: Develop assumptions for future shocks and on-going conditions.</p> <p>Step 8: Analyse evidence.</p> <p>Step 9: Determine phase classification and population estimates.</p> <p>Step 10: Identify areas where a significant amount of humanitarian food assistance has been planned and is likely to be funded and delivered. .</p>
All	<p>Step 11: Identify risk factors to monitor.</p> <p>Step 12: Identify priority Response Objectives</p>

The Worksheet is best utilized in the web-based IPC ISS, but may also be completed in MS Word™, which can be found on the IPC website.

Steps 1 and 2: Common to current and projected classifications

Step 1: Identify context and analysis parameters (for all classifications)

Purpose: To introduce the characteristics of the area and the population of households within the area to allow for contextualization of evidence and livelihood-based analyses.

Approach overview:

- Decide on the spatial extent of the analysis area. A single phase classification will be determined for each area analysed. The determination of the analysis area can be informed by, but not limited to, units such as livelihood or agro-ecological zones, hazard zones, administrative boundaries, market catchment zones, camps of IDPs or refugees, among other things. The IPC is adaptable and applicable to any spatial size, and the spatial area of the classification can vary widely. IPC analysts must determine the spatial extent of the analysis area depending on the situation, availability of evidence and the needs of decision-makers as well as the feasibility of the number of areas being classified. In general, the analysis area should be as homogeneous as possible with regard to likely food security outcomes and causes.
- Decide on time periods for an analysis. The analysis is a snapshot of the current or projected food security situation. Each analysis has a validity period where conditions are likely to remain similar and is determined by the analysts. The validity period can be as short as a few weeks and as long as a few months up to a maximum of 12 months, depending on seasonality and stability contexts. However, the existing (current) or expected (projection) food security situation should not change significantly during the validity period of the analysis. If the food security situation unexpectedly changes during the validity period of the analysis, analysts can either conduct a new analysis or an update of the projection analysis, depending on how significant the change has been and what new evidence is available. Multiple projections can be prepared, each with its own validity period. In case of multiple projections Steps 7 to 11 of the Analysis Worksheet would need to be repeated for each new projection.



- Provide a brief description of the area, including the relevant information to be used in contextualizing evidence. Important aspects may include common livelihood strategies to acquire food and income, seasonal patterns, cultural habits and economic environment. Add population figures, specifying source and reference years. If applicable, use projected populations only if a significant population movement is expected.

Whenever possible, further information should be added as follows:

- Indicate the chronic food insecurity level for the area if IPC Chronic Food Insecurity Analysis results are available. If no IPC Chronic Food Insecurity Analysis has been conducted, use findings from another classification approach if available, or highlight the fact that a chronic food insecurity situation is not known for the area.
- Identify if the analysis area experienced IPC Phases 3, 4 and 5 in at least three years over the previous ten years. If IPC Acute Analyses have not been conducted in enough years to determine this, either use an equivalent classification system or highlight the fact that a recurrence of the crisis cannot be identified.
- Identify and describe groups living in the area. HAGs are groups of households that compared with each other are assumed to likely have different phase classifications pending evaluation and analysis of the evidence. Individual HAGs are relatively homogeneous groups of households with regard to their food security situation, including contributing factors and likely outcomes. These groups may be defined, for example, by variations in wealth, gender, ethnic affiliation, livelihood, religion, exposure to a hazard event, or any other factor or combination of factors that make these groups distinct. The number of HAGs identified will depend on the complexity of the situation. Also, specify the estimated number of people in each HAG and their percentage share of the total people in the area. It is important to ensure that some food security evidence is available for the different HAGs, in particular if an acute analysis is conducted on HAGs. Even when analysis follows the area-based approach, it would significantly benefit from a complementary analysis of specific household groups. For example, analysis taking into consideration the situation of refugees and IDPs, poorest households or female-headed households would help to estimate populations in different severity phases and understand the overall food insecurity in the area as well as provide a stronger basis for identifying the characteristics of those most affected.

Step 2: Populate the evidence repository (for all classifications)

Purpose: To help organize wide-ranging evidence from multiple sources for ease of access and reference.

Approach overview:

- Provide references for all the evidence to be reviewed in the analysis, including identification of source and dates of evidence collection.
- Provide a note on methods of data collection and time relevance to support the assessment of the reliability score whenever possible. Indicate the reliability score if possible.
- When possible, insert pieces of evidence, such as graphs, text and numbers and identify which food security element(s) it informs.



Step 3: Analyse evidence (current classification)

Purpose: To analyse evidence following the IPC Acute Food Insecurity Analytical Framework and Reference Table considering the local context and reliability scores, including reference to historical trends and socio-economic differences (Figure 35).

Figure 35: Evidence statements – Examples for current classification

Outcomes

- **Food Consumption Score (FCS):** 29% poor (equiv. to P4 or more severe), 53% borderline. Similar to 2015 (33% poor) but better than in 2016 (55% poor). (Crop and Food Supply Assessment Mission (CFSAM), July–August/2017, R₂)
- **Household Hunger Scale (HHS):** 26% scored 4 (equiv. to P4), and 18% scored 5–6, which is equiv. to P5. (CFSAM, Jul-Aug/2017, R₂)
- **Reduced Coping Strategies Index (rCSI):** 32% scored ≥43 (equiv. to P4 or more severe), 35% scored 19–42 (equiv. to P3). Similar average to 2015 (current 27, past 23) but better than in 2016 (avg. 37). (CFSAM, July–Aug/2017, R₂)
- **Food Insecurity Experience Scale (FIES):** 80% scored more than 0.36 what is equivalent of P3, 4 and 5. (FAO 2017, R₂)
- **Meals per day:** Although not direct evidence, the fact that 27% ate only one meal per day could support a Phase 4 classification. (CFSAM, Jul–Aug/2017, R₂)
- **Acute malnutrition:** GAM based on MUAC 6% (equiv. to P2-3), decreasing trend from 11% in Jan 2017. (UNICEF, April/2017, R₂)
- **Mortality:** U5DR 1.56 (equiv. to P3), CDR 1.68 (equiv. to P4). (UNICEF, Apr/2017, R₂)

Contributing factors

- **Food production:**
 - Maize production was 185 MT, significantly higher than the previous year's bottom-low production (81 MT). Albeit better than in 2017, production is still only one-fourth that of 2012 (777 MT). (CFSAM, Jul–Aug/2017, R₂)
 - Cassava production follows a similar trend where the 1 MT obtained in 2017 reflected a major reduction from the 29 MT yielded in 2012. (CFSAM, Jul–Aug/2017, R₂)
- **Food sources:** 66% rely mainly on purchases and 26% on own production; 87% of households practise agriculture. (FEWS NET Baseline 2016, R₂)
- **Income sources:** 85% of households have limited sources of income, relying mainly on sale of agricultural production. (Agriculture Census, 2016, R₂)
- **Shocks experienced:** Drought experienced by 12% of households, economic shocks by 12%, social events by 9%, illness or accidents by 2%, pests by 15%, other shocks by 8%. (DMMU, June/2017, R₁)
- **Precipitation:** Between September and November, the rainfall was/is forecast to be <80% of average levels, which is contributing to expected below-average rice production. (Meteorology Office, 2017, R₁)
- **Humanitarian aid programme:** This programme explains a somewhat better livelihood situation since it focused on agriculture and livelihood restoration and covered 50% of the population in the area. (United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2017, R₂)



Approach overview:

- Consider and analyse evidence by assessing the current levels of key indicators and by linking current outcomes and conditions to IPC phases, context, historical trends and other relevant analysis such as specific socio-economic groups and gender inequalities. Consider also the other four protocols for Function 2 (i.e. use of the IPC Analytical Framework, IPC Reference Table, reliability scores and IPC key parameters).
- Include source of information, linking it to the reference(s) specified in Step 2.
- Consider the reliability scores of all evidence – if this has not been done in Step 2 or needs to be modified for the area, do it at this point. Assess whether evidence that does not reach R1 should be included in the analysis for contextualization and explanation.
- Provide conclusions, considering supporting and contradictory evidence, contexts, and critical reasoning. As much as possible, conclude how the current condition compares with typical times and past trends. Two examples of conclusion statements are available in Figure 36 and examples of conclusions for specific elements are provided below.
 - *Hazards and vulnerability*: Assess the key hazards and ongoing conditions that are likely impacting current food security outcomes. Describe and consider usual and unusual shocks, both positive and negative, which are affecting current food security. Indicate the level of humanitarian/relief assistance that focuses on direct asset transfers, such as food, cash and other inputs, as well as policies and other long-term assistance that the area has received, such as road or dam construction.
 - *Food availability, access, household utilization and stability*: Consider the impact of shocks on the dimensions of food security, including, for example: food availability – levels of food production, functioning of markets and transportation networks, imports and food movements; food access – the ability of households to access food, as a function of physical, financial and social considerations; household food utilization – ability to maximize consumption, including, for example, access to safe water, food preparation, cooking, storage and care practices; and stability – assess how it affects each of the dimensions, considering seasonal patterns and atypical events.
 - *Food consumption and livelihood change*: Provide summary conclusions, with the aim of distributing the proportion of households among the five phases or classifying HAGs. Ensure that evidence is contextualized and that supporting and contradictory evidence is presented. Analysts should consider what the likely situation is after all factors (including mitigating factors such as humanitarian or social assistance) have impacted the conditions. Specific considerations include:
 - *Food consumption*: Review relevant evidence on indicators included in the Reference Table (i.e. direct evidence, including FCS, HHS, rCSI, HEA, HDDS and FIES), as well as other evidence relevant to the area being analysed, together with the inference of contributing factors. Focus especially on the caloric quantity of food consumed by households.
 - *Livelihood change*: For acute food insecurity, livelihood change is analysed as households' response to their inability to access food and income. This is difficult to quantify because livelihood changes can take a multitude of forms and vary depending on households' resilience, and the depth, duration and type of problem; as a result, universal thresholds do not exist. Thus, general descriptions are used in conjunction with a typology of coping strategies developed by WFP that identifies three main strategy types. Although WFP's livelihood coping strategies indicator is included in the IPC Acute Food Insecurity Reference Table as a globally comparable indicator, analysts need to adapt the indicator tool to local conditions, considering that certain strategies may be perceived as more severe than others in the local context.



- *Food consumption and livelihood change interactions:* Careful analysis of livelihood change is important, especially to ensure that food insecure households are not overlooked in the event that food consumption has been protected through the use of unsustainable coping strategies. Therefore, livelihood change information for a given population should be considered after food consumption has been assessed, rather than simultaneously. It should be noted that livelihood change assumes that households can respond to acute events or ongoing conditions; however, the most food insecure, especially households that have lost assets in previous, ongoing or protracted crises, often have little to no ability to change their livelihoods or asset levels. This may render the analysis of livelihood change challenging when using typical livelihood change indicators and requires the contextualization of the available information on livelihood change.
- Acute malnutrition and mortality: Consider IPC Acute Malnutrition Classification findings if available. If classification has not been completed, review the prevalence of acute malnutrition and death rates, and provide a critical reasoning of linkages with food insecurity.

Figure 36: Conclusion statements – Examples

The ongoing fighting and a siege on the city affected food availability in the local market in different ways, e.g. food movements, food prices and food stocking. Local production of cereal was reduced by more than 13 percent in 2016 compared with 2014. The conflict has badly affected the production and supply of all fishery and agricultural products. In Yemen, in general, as well as for Mati, in particular, 55 percent of food products consumed are imported, and 90 percent of wheat (the main staple) is imported. Due to the absence of the normal institutions and processes, it is very difficult to estimate the specific amount of commercial food commodities transported to local markets and the stock information for these commodities at the governorate level. The situation is worse in areas under severe conflict, such as the three districts of Mati city, the southern districts of Mati, and the coastal areas of Zata. In addition, the population in the mountain areas of Mati had many years of experience in stocking their food either from own production or purchased from the market during the harvest period, but the conflict disrupted these practices and the social support systems. The livestock and fishery products have been badly reduced for several reasons, including the continuous conflict in Mati city and the coastal areas. As a result of the disruption of livelihoods and the massive destruction of infrastructure and businesses, as well as loss of jobs and incomes due to the impact of the crisis, significant effects on the living conditions of the affected households will continue to be felt.

Around 69.6 percent or more of the population has inadequate (poor or borderline) food consumption, compared with 43.3 percent in 2014. The mean HDDS is 4.8 food group compared with 5.1 in 2014. Almost 42.8 percent of households have either low or extremely low food diversity. In addition, the survey shows an exceptionally high ranking in the rCSI. Most vulnerable groups include agricultural labourers, fishers, livestock owners, the landless, marginalized groups, as well as construction workers and small business labourers, since many have lost their income due to the difficult situation in the governorates and surrounding districts. The lack of salary payment, as well as the suspension of the safety net programme have affected the lives and livelihoods of the communities as a whole. Only 30.3 percent of the households in Mati have acceptable food consumption and as many as 80% of households had experienced food insecurity (based on FIES) equivalent to Phase 3 or worse.. With the worsening situation, this group might move to the borderline or poor consumption category.



Step 4: Determine phase classification and population estimates (current classification)

Purpose: To assign a phase classification and to estimate the population (number and percentage of people) in different phases.

Approach overview:

- Use convergence of evidence to conclude on a phase classification for the current period based on relevant supporting and contradictory evidence. Area classification should be carried out based on the acute food insecurity conditions of the worst-off 20 percent of the population. The classification is carried out through convergence of evidence, where analysts consider the whole body of evidence, including evidence on outcomes, contributing factors and context. Only evidence that is relevant to acute food insecurity should be used for classification. Evidence on malnutrition and mortality are only considered to the extent that they are driven by food gaps and livelihood changes due to limited

Figure 37: Convergence of evidence – Key considerations

The whole body of evidence should be brought together for classification, including relevant direct and indirect evidence scoring at least R₁ (or those scoring less but to be used mainly to contextualize and validate findings). For example, analysts need to consider an ongoing conflict, disruption of markets, destruction of crops and assets, low dietary intake, and increasing reliance on unsustainable livelihoods when deciding on a classification.

- **Evidence does not always converge.** Correlation among food consumption indicators is usually low. For example, the FANTA and the FEWS NET Household Food Consumption Indicator Study found a generally moderate correlation between different indicators. In addition, while the FCS and the HDDS focus on dietary consumption, livelihood coping focuses on non-consumption-related strategic responses to difficulties in accessing food. Indeed, a defining characteristic of Phases 3 and 4 is that food consumption might reflect a lower phase, but only because households are using negative crisis or emergency coping. If households are protecting their food consumption at the expense of their livelihoods, this should be considered in the classification.
- **Accuracy of indicators is different:** While there is no global agreement on a single ‘best indicator’, some indicators provide better correlation with actual household dietary consumption. For example, income and expenditure surveys that aim to measure both food items and quantities consumed by households typically provide more accurate information on food consumption than assessments focusing on interviewing households on the food groups consumed in the previous week.
- **Context matters:** Although globally comparable cut-offs are provided, the IPC highlights that they are guiding values and that analysis should be contextualized. It is acknowledged that indicators may work differently in different contexts, and appropriate cut-offs may vary from one region to another. For example, indicators focusing on coping may not be informative in protracted emergency contexts where households have already eroded their ability to cope. A trend analysis that shows the difference from the baseline and from other indicators, together with local knowledge, should be considered.
- **Quality of evidence may be different:** Analysts may choose to consider the evidence of an FCS that scores R₂ more than an HHS value from a different survey that scores R₁.



access to food. Therefore, nutrition and mortality are considered to support or examine food insecurity classification but not to override it. For a discussion on key considerations for convergence of evidence and population estimations, see Figure 37.

- Provide a conclusion for the final classification by adding a critical rationale for area classification, summarizing key supporting and contradictory evidence in a short paragraph. The final conclusion needs to provide an overall view of the evidence used to support the classification. The paragraph should be guided by the IPC Food Security Analytical Framework. The rationale for discarding contradictory evidence should also be provided as relevant. As much as possible, the conclusion should also mention which household groups are the most affected. Simply put, the summary conclusion needs to describe the storyline behind the classification and reflect the group discussion and rationale for the conclusion. When carrying out a HAG analysis, provide an indicative classification for each HAG.
- Distribute the population of households in each phase, converging the body of evidence. This should be carried out only if evidence and analysis so allow. Population estimates in IPC phases should be made by taking into account both contributing factors and outcomes, and considering direct and indirect evidence, including inferences from contributing factors and locally specific indicators. Analysis of direct evidence, considering the context, is usually the most useful type of evidence for population estimates, since the prevalence of households in each category allows for the distribution of households across the five severity phases. For example, knowing that 35 percent of households have a poor FCS and that 25 percent have an HHS of over 4 enables the analysts to better estimate the population in Phase 4 than knowing that food production was only 80 percent of normal, food prices were 60 percent higher than last year and that employment opportunities decreased. However, evidence on indirect indicators and contributing factors is useful when used for inference and to contextualize the estimates and to ascertain or contradict the results from direct evidence. It is also recommended that a rationale for the population estimates be provided when feasible. See Figure 38 for an example of how evidence is converged.
- Assign evidence levels of analysis (*, **, ***) by counting the number of pieces of direct evidence available for food consumption and livelihood change outcomes, and other supporting indirect evidence on contributing factors or outcomes. See Figure 32 for the criteria for evidence levels.

**Figure 38: Population estimates – Example**

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Trends, contextualization and other issues
Food Consumption		19%	53%	29%		Similar to 2015 (when 33% had a poor score) and worse than in 2016 (20% poor)
Household Hunger Scale	38%	9%	26%	8%	18%	Very high Phase 5 linked to high severity but unlikely to be Catastrophe/Famine based on analysis of other indicators and contributing factors
Reduced Coping Strategies Index	14%	19%		67%		Very high rCSI; higher than in 2016, but mainly linked to less severe strategies
Household Dietary Diversity Score		28%	32%	40%		High levels of low HDDS, indicating low dietary diversity of households
Food Insecurity Experience Scale	20%	25%		55%		More than half of the households are in Phase 3 or above (55%)
Livelihood coping	15%	1%	77%	13%	0%	Low use of emergency-level livelihood coping strategies probably due to context issues and long-term crisis
Meals per day		73%		27%		It has been assumed that 1 or less meals are indicative of Phase 4 or worse
Inference from contributing factors		50%		50%		Low production (only 30-50% of normal) and high dependency of poor households on own production with increased food prices indicate that at least 50% of households are likely in Phase 3 or more severe
Acute malnutrition			X			Low disease incidence and protective child care mitigate the negative impact on child nutrition
Total	20%	25%	30%	20%	5%	

Rationale for the population estimate:

Food consumption indicators, supported by analysis of contributing factors, converge around Phase 4. As a result, more than 20 percent of the total population would be expected to be in Phase 4 based on food consumption outcome. Although the livelihood coping outcome does not support this conclusion, it is thought that low emergency-level livelihood coping is likely due to an inability to further exhaust livelihoods assets and strategies. The crisis levels of acute malnutrition (GAM based on MUAC around 10 percent) are explained by relatively low disease prevalence and the typical cultural habit of protecting children's food consumption. Findings from FIES show that about 55% of households would be expected to be in Phase 3 or worse. Based on a trend analysis of contributing factors (not included in the table of direct evidence), the food security situation in the area has been in crisis for about three years, therefore becoming a protracted crisis and has accentuated the impacts of current conditions. As the conflict intensifies, the Xshoko ethnic group is the most affected. Statements made by relief workers on displaced Xshokos found that they suffer from an extreme lack of food and other basic needs, and their livelihood has collapsed. Given that they account for 5–10 percent of the population and indicators showing that Phase 5 Catastrophe severity is noted (i.e. 18 percent of households have an HHS of 5–6 and 40 percent of households have an HDDS of 0–2 indicating Phases 4 and 5). Thus, it is expected that at least about 5 percent of the population is in Phase 5.

Figure 39: Key drivers of food insecurity – Examples

- Drought, high dependency on rainfed agriculture and below-normal production;
- Higher food prices;
- Conflict, destruction of assets and displacement, which made people lose their subsistence and assets;
- Change in immigration policies from a neighbouring country and loss of remittances;
- Tsunami, destruction of property and land;
- Agriculture and livelihood assistance and other mitigating factors.

Step 5: Identify areas that received significant humanitarian food assistance (current classification)

Purpose: To enable decision-makers to identify areas that received significant humanitarian food assistance as this was incorporated in the analysis as a mitigating factor. Step 5 should not be considered an impact assessment of assistance or a monitoring and evaluation product to assess the impact of response and the achievements towards developmental goals.

Approach overview:

- Identify areas that received significant humanitarian food assistance.
- Flag areas that received significant humanitarian food assistance as per the two categories relating to coverage and size of transfer. While coverage is assessed over the total population of households, the size of transfer is estimated in reference to households' caloric needs. If the assistance provided includes modalities different from in kind food transfer (such as cash and livelihood inputs) analysts should assess whether resource transfers would be enough to meet the reference caloric needs:
 - At least 25 percent of the households meet between 25 and 50 percent of their caloric needs through humanitarian food assistance;
 - At least 25 percent of the households meet over 50 percent of their caloric needs through humanitarian food assistance.
- The reference period for an analysis of humanitarian food assistance should be the period that best reflects current assistance delivery. In cases where *assistance* is regularly delivered each month, a one-month reference period may be appropriate. However, depending on the pattern of food assistance delivery in the area of analysis, this reference period may be extended to a maximum of three months. For example, if emergency rations are provided every other month, it may make sense to define "current humanitarian food assistance" as the average for the last two months.

Step 6: Identify key drivers and the main factors limiting food security (current classification)

Purpose: To enable decision-makers to identify the key drivers triggering the current food security situation and the factors limiting food security so that action can be more strategically planned.

Approach overview:

- Identify key drivers of acute food insecurity, including reference to possible acute shocks such as drought and conflict, as well as



to ongoing conditions and vulnerability to shocks, such as lack of diversified income, high reliance on rain-fed agriculture, and inadequate or harmful policies. See Figure 39 for examples.

- Identify the main factors that limit food security, including reference to evidence on food availability, access, utilization and stability.

Step 7: Develop assumptions for future shocks and ongoing conditions (projection classification)

Purpose: To provide analysts with an expected outlook for the key factors to be considered when projecting the severity and magnitude of future acute food insecurity.

Approach overview:

- Describe the key assumptions on impacts of shocks and ongoing conditions that are likely to affect food availability, access, utilization and stability during the projected period. Consider the likely occurrence of both seasonal and usual events as well as any unusual shocks likely to occur. Consider the most likely evolution of all the factors that are expected to impact food security, including aggravating and mitigating factors. Consider impacts of events that have already occurred or will occur.
- The assumptions on likely impacts of shocks and ongoing conditions will be used in Steps 8 and 9 as the basis for the projection of food availability, access, utilization and stability, as well as for the consequent projection of outcomes.

Step 8: Analyse evidence (projection classification)

Purpose: To organize, evaluate and analyse evidence for the forecast of the most likely future conditions of food security elements, taking into account their current levels, historical trends, previous and most likely future impacts of shocks as guided by the IPC Food Security Analytical Framework and the IPC Acute Food Insecurity Reference Table.

Approach overview:

Conclude on the expected projected trends by relating current conditions to context, historical trends and assumptions on the evolution of the current situation (examples provided in Figure 40). Provide other analyses such as information on specific socio-economic groups and gender inequalities as relevant..

- Include the source of information, linking all evidence statements to the references specified in Step 2.
- Assess reliability scores of all evidence and assess whether evidence that does not reach R_i- should be included in the analysis.
- Provide conclusions, for example:
 - *Hazards and vulnerability elements:* Consider typical livelihood strategies and assets that are important for the projected period, including typical sources of food and income, and adaptive capacity. Consider also the typical hazards that are likely to occur over the projection period. Consider the likely impact (if any) that humanitarian assistance will have on the evolution of factors affecting food insecurity (e.g. indirect impacts of assistance on potential displacement).



Figure 40: Evidence Statements – Examples for projection analysis

Outcomes

- rCSI: The situation in terms of coping has worsened over time, and in the current period, 32 percent of households had rCSI of at least 19. This share is expected to increase even more in the upcoming lean season.

Contributing Factors

- Normally, agricultural labour and firewood and bush product sales contribute 20 percent of households' annual income. Agricultural labour income, however will likely be limited due to expected below-average October–November Deyr rains and subsequent low cultivation.
- Normally, own production (maize) provides about 55 percent of total annual food needs of a poor household. The October–December Deyr production and harvest that will occur is forecast to be below-average due to below-average rainfall. No harvest takes place during February–May 2017.
- Food security among poor households is expected to further deteriorate during this time, since households will have depleted household food stocks and will rely on markets to access food.
- According to the International Research Institute for Climate and Society/Climate Prediction Center (IRI/CPC) forecast, a strong negative Indian Ocean Dipole and negative Pacific Ocean Sea Surface Temperatures are forecast during the Deyr season. According to forecasts by the National Oceanic and Atmospheric Administration (NOAA) and the U.S. Geological Survey (USGS), this will result in below-average Deyr rainfall; rainfall is forecast to be below average in October and November. Average rainfall is forecast for December. Total seasonal rainfall is forecast to be below average. The Climate Outlook of the Intergovernmental Authority on Development Climate Outlook Forum (IGAD/COF) also suggests below-average October–December Deyr rains.
- There is a likelihood that rainfall levels will be below normal, especially in the first months of the projection period, which would impact cultivation in the coming months and prolong the lean season, expected to last until March.

- *Food availability, access, household utilization and stability:* Review any relevant evidence referring to current conditions as well as assumptions on the most likely impact of shocks, supported by other relevant evidence. Conclude on the food security projection, including how the situation is likely to evolve.
- *Food consumption and livelihood change:* Consider the whole body of evidence, including likely trends of food availability, access, utilization and stability based on impacts of shocks on livelihood strategies (sources of food and income) and livelihood assets, as well as the likely evolution of outcomes based on current levels, and conclude on the most likely evolution of food consumption and livelihood change.
- *Acute malnutrition and mortality:* Consider IPC Acute Malnutrition Classification findings if available. If classification has not been completed, make assumptions on how acute malnutrition and mortality are likely to evolve in the projected period due to the most likely expected conditions of food consumption and livelihood change. Once again, although useful, analysts should recall that evidence on nutrition and mortality is considered to support or examine food insecurity classification but not to override it.



Step 9: Determine phase classification and population estimates (projection classification)

Purpose: To project the most likely phase classification and estimate the number and percentage of people in different phases, based on a critical review of the supporting and contradictory evidence available.

Approach overview:

- Conclude on the phase classification for the projected period using all supporting and contradictory evidence, based on the severity of the worst-off 20 percent of the population, similar to Step 4. If conducting a HAG-based analysis, provide an indicative classification of each HAG. Note that projections should consider the most likely situation, incorporating the likely effects that the planned, funded or likely to be funded and delivered humanitarian food assistance will have on the evolution of the situation.
- Distribute the proportion of households in each phase by converging the body of evidence (only if evidence and analysis allow), similar to Step 4.
- Add the critical rationale for summarizing key supporting and contradictory evidence, both in support of and disputing area classification, similar to Step 4.
- Identify the evidence levels of analysis by determining the number of pieces of direct evidence available for food consumption and livelihood change outcomes and other supporting indirect evidence on contributing factors or outcomes (see Figure 32 on criteria for evidence levels).

Step 10: Identify areas where a significant amount of humanitarian food assistance has been planned and is likely to be funded and delivered

Purpose: To allow decision-makers to identify areas where the likely delivery of humanitarian food assistance will be significant, as this was incorporated in the analysis. Step 10 should not be considered an impact assessment of humanitarian food assistance or a monitoring and evaluation system to assess the impact of action and achievements towards developmental goals.

Approach overview:

- Identify areas that will likely receive significant humanitarian assistance that has been planned and will likely be funded (or has already been funded) and delivered.
- *Flagging areas* that will likely receive significant humanitarian food assistance as per the two categories relating to coverage and size of transfer. While coverage is assessed over the total population of households, the size of transfer is estimated in reference to households' caloric needs. If assistance provided includes modalities different from in-kind food transfer (such as cash and livelihood inputs) analysts should assess whether resource transfers would be enough to meet the reference caloric needs. The categories are as follows:
 - At least 25 percent of the households will likely meet between 25 and 50 percent of their caloric needs through humanitarian food assistance;
 - At least 25 percent of the households will likely meet over 50 percent of their caloric needs through humanitarian food assistance;

Figure 41: Risk factors to monitor – Examples

- Resurgence of conflict;
- Flash floods;
- Hurricanes.

- Planned humanitarian food assistance should meet the above thresholds over the selected reference period. Plans for transfers should inform the validity period of the projected analysis.
- Analysts should also consider factors that might prevent planned assistance from being delivered such as lack of access, corruption, conflict and so on.

Step 11: Identify the risk factors to monitor

Purpose: To identify triggers for analysis updates and validity of projections.

Approach overview:

- Identify risk factors to monitor. Consider risk factors that could increase or decrease food insecurity over the short or medium term, and thus need to be monitored against the assumed evolution included in Step 7. Examples of risk factors to monitor include conflict, rainfall, price and inflation, flash floods and hurricanes (Figure 41).

Step 12: Identify priority strategic response objectives

Purpose: To highlight to decision-makers and partners the key strategic response objectives that should be assessed during posterior response analysis.

Approach overview:

- Based on an analysis of drivers, limiting factors and severity of outcomes, identify the key response objectives that should be prioritized. For example, if the dietary intake of displaced households is extremely poor (e.g. 5 percent of households have acceptable consumption), this calls for responses that aim at decreasing inadequate dietary intake.
- Present strategic objectives as starting points for response analysis and do not define the modalities for response. For example, if agricultural inputs are needed due to losses highlight the need to increase access to seeds and agricultural inputs rather than mentioning how they should be delivered.



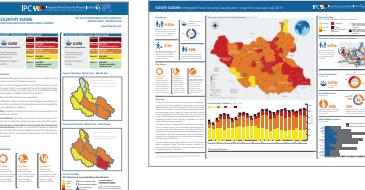
FUNCTION 3: COMMUNICATE FOR ACTION

The aim of Function 3 is to communicate the core aspects of the situation in a consistent, accessible and timely manner to inform strategic decision-making. Communication is considered an integral part of the food security analysis process.

Protocols For Completing Function 3

Function 3 consists of three protocols: the first two focus on the production of reports and maps, and the third focuses on product dissemination, as presented in Figure 42 and explained in the paragraphs that follow.

Figure 42: Protocols for Function 3

Protocols	Procedures	Tools
3.1 Produce the IPC Analysis Report	Prepare a consistent and effective IPC Analysis Report, including the minimum key information, preferably by completing the IPC Analysis Modular Communication Template.	Tool 9: Minimum information requirements 
3.2 Adhere to mapping standards	Develop IPC maps following the basic guidelines.	Tool 10: Modular Communication Template 
3.3 Strategically share communication products in a timely manner	Plan and implement a minimum set of activities for sharing the final IPC results with key actors.	Tool 11: Mapping protocols  Tool 12: Minimum set of dissemination activities 

Although not a protocol, it is strongly recommended that for all IPC analysis exercises, the development of a **communication plan** is initiated from the earliest planning stages, including:

- carrying out public information activities (e.g. briefings, dissemination sessions) and producing communication products prior to, during and after IPC analysis;
- advising the relevant stakeholders when IPC Analysis Reports are expected to be available and how IPC results can be used for response planning;
- involving communication experts in the analysis to support the development of the communication plan and the drafting and dissemination of IPC Analysis Reports and other communication products;
- planning and conducting press conferences targeting local and international media whenever suitable;
- integrating the communication plan in the overall IPC implementation plan and updating it every 6 to 12 months considering any lessons learned and any forthcoming IPC activities.

PROTOCOL 3.1: PRODUCE THE IPC ANALYSIS REPORT

At the conclusion of the analysis process, the analysis team should draft the key messages to be included in the report. The IPC Analysis Report outlined below should be finalised and released preferably within 15 days of completing the analysis. Any IPC analysis reporting should contain the minimum information as per Figure 43.

Figure 43: Minimum information requirements (Tool 9)

Topic Areas	Contents
1. Key messages	<ul style="list-style-type: none"> • Summarise key findings, including key outcomes of food insecurity, especially for the most severely affected areas.
2. Maps	<ul style="list-style-type: none"> • Provide current and projected Classification Maps adhering to the mapping protocols provided in IPC Protocol 3.2.
3. Population table	<ul style="list-style-type: none"> • Provide the estimated number and percentage of people in IPC phases (current and projected).
4. Situation overview, key drivers, limiting factors, trends and assumptions	<ul style="list-style-type: none"> • Provide conclusions on current and projected situation. • Identify major factors driving acute food insecurity, focusing on shocks and vulnerabilities. • Identify key limiting factors, focusing on food availability, access, utilization and stability. • Identify trends by comparing with previous IPC analysis findings or other classifications. • Identify key assumptions for projections.
5. Recommendations for action	<ul style="list-style-type: none"> • Recommend strategic objectives of responses aligned to those included in the IPC Acute Food Insecurity Reference Table. • Provide recommendations for monitoring the situation as needed. • Recommend improvements for data collection and information systems as needed.
6. Process, methodology and data sources	<ul style="list-style-type: none"> • Describe the analysis process. • Indicate the main sources of evidence used. • Explain key challenges. • Plan for the next analysis.
7. Minimum visual identity/accountability requirements of the IPC Analysis Reports	<ul style="list-style-type: none"> • IPC Logo • National analysis partners' logos • Resource partner's logo • E-mail addresses for any queries and information requirements • Reference to the IPC website www.ipcinfo.org



If IPC Acute Food Insecurity and Acute Malnutrition analyses are conducted simultaneously, it is highly recommended that one report be produced combining the analyses results.

The IPC Modular Communication Template

The IPC Modular Communication Template (Tool 10) provides a standard format and content guide for developing IPC Analysis Reports. The Template has been developed to meet the different interests and needs of a variety of IPC stakeholders while ensuring that the minimum requirements for communicating IPC results are met. By using the Template, IPC Analysis Reports effectively communicate key findings in a clear, concise, accessible and consistent format.

The Modular Communication Template for Acute Food Insecurity consists of nine modules: (1) Key facts and messages; (2) Classification maps and the Summary Population Table; (3) Situation overview, key drivers and limiting factors (Figure 45); (4) Recommendations for action; (5) Detailed Population Table(s); (6) Process, methodology and data sources; (7) Snapshot; (8) Profiles of the most affected areas/groups; and (9) Comparative analysis.

General guidelines for completing the IPC Acute Food Insecurity Modular Communications Template include the following:

- All modules of the template should be completed. The full IPC Analysis Report should include at least Modules 1 to 6; Modules 7 to 9 are optional, though highly recommended.
- Modules can be selected and combined to develop specific products that meet the needs of different stakeholders. See Figure 44 for examples of selection of modules for different audiences.
- Modules are designed to ensure consistent IPC branding as well as ownership. Key information should be provided, for example the name of the country, contacts, institution housing IPC, resource partners and the logos of the analysis partners.
- The IPC Integrated Food Security and Nutrition Modular Communication Template is available and should be used to produce a report combining acute food insecurity and acute malnutrition results.
- The IPC Modular Communication Template can be developed in the ISS or offline.
- The use of the IPC Modular Communication Template does not prevent countries from producing further documents or incorporating IPC results into other documents.

Figure 44: IPC analysis reports for different audiences – Examples

- Reports targeting global-level stakeholders, which may include only the Key Findings (Module 1);
- Reports targeting national senior stakeholders, which may include three modules, such as the one-page key findings overview, maps and the population table (Modules 1, 2 and 3);
- Reports targeting national and subnational stakeholders, which include most or all modules, including an overview of the most affected areas (Modules 1 to 9).



Figure 45: Situation overview – Example

In March 2018, seven IDP camps in Central Africa Republic (CAR) were classified in emergency (IPC Phase 4) and ten prefectures and two IDP camps were classified in crisis (IPC Phase 3). During the lean season, from April to August 2018, without humanitarian food assistance, it was estimated that there would be five prefectures and eight IDP camps in emergency (IPC Phase 4), and eight prefectures and one IDP camp in crisis (IPC Phase 3). Only the Bangui area would maintain IPC Phase 2 (stress). In March 2018, even with the current humanitarian food assistance, around 1.6 million people were in need of immediate assistance, and during the lean period (April to August 2018) the number was estimated to rise to 2 million, one-third of whom were located in sub-prefectures with a high concentration of displaced persons.

The most vulnerable populations were found where the population was highly concentrated, i.e. in the main cities of the prefectures affected by the conflict (Alindao, Obo, Bria, Rafai/ Bangassou, Kaga-bandoro, Bambari, Batangafo and Paoua). These concentrations represented large proportions of displaced populations, with one-third in host sites and two-thirds in host families. In February 2018, in the country, there were around 700,000 IDPs out of a total population of 4.5 million, which represents an increase of 47 percent compared with the situation analysed at the beginning of 2017 (IPC figures from December 2016). The largest groups of displaced persons were located in the sub-prefecture of Paoua in Ouham Pende (65,000 displaced persons), in Bambari in Ouaka prefecture (91,450 displaced persons) and in Bria in the Haute Kotto prefecture (63,415 displaced persons), who represented between 50 percent and 70 percent respectively of the population of these areas.

Insecurity persists across the country and remains the leading cause affecting household access to food and livelihoods, especially for displaced persons, host families and returnees. Insecurity makes it difficult to fully exploit means of production because of the security risks associated with the movements needed to conduct agricultural and livestock activities. This has generated a drop in production levels, which, together with the deterioration of the main supply routes, affects the functioning of markets, and in turn severely impacts the availability and access of households to food.

Source: Central Africa Republic, IPC Acute Food Insecurity Analysis Report, March 2018.



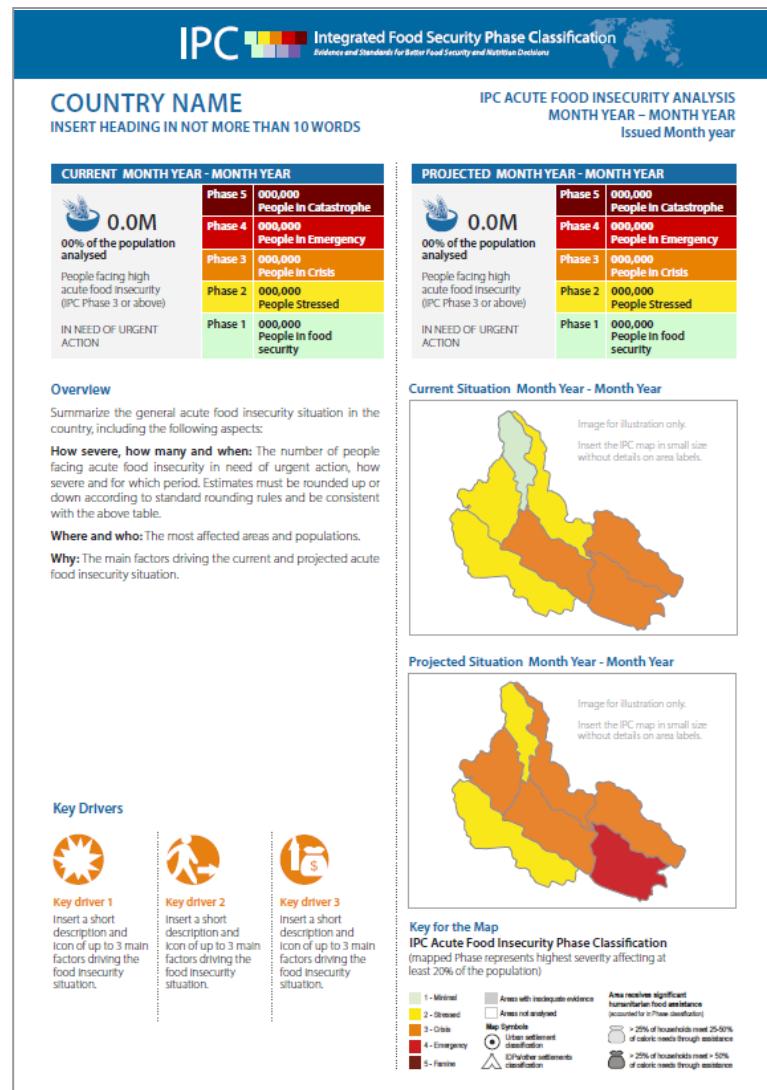
MODULE 1: KEY FACTS AND MESSAGES

Purpose: To provide concise responses to the six key questions: how severe, how many, when, where, who and why (Figure 46).

Key information:

- Aggregated population tables:** Provide the aggregate number of people in different phases (if available) for both the current and projected periods. The number of people in need of urgent action further to received action (i.e. Phase 3 or above) is highlighted.
- How severe, how many and when?** Refer to the number of people facing acute food insecurity in need of urgent further action, and for which period.
- Where and who?** Identify the most affected areas and, if available, the characteristics of the most affected populations.
- Why?** Highlight the main factors driving the current and projected food insecurity situation.
- Current and projected situation maps:** Include small IPC maps without details on area labels and limit extra symbology as appropriate.

Figure 46: IPC Communication Template Module 1



Note that, in this module, population estimates in the table and in the narrative (how many) should be rounded up or down according to the standard rounding rules, for example, analysts may choose to round to the nearest one thousand ('000) people. It is important to maintain consistency in the way numbers are rounded throughout the report.

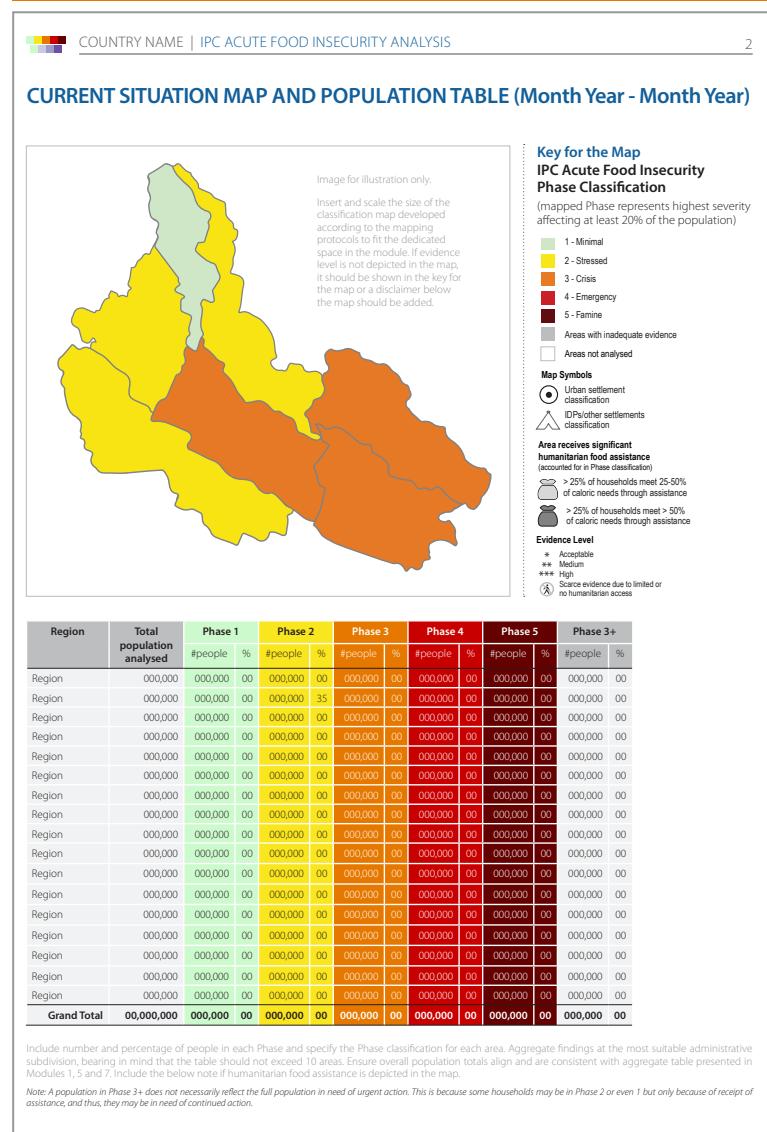
MODULE 2: CLASSIFICATION MAPS AND SUMMARY POPULATION TABLES

Purpose: To provide larger-scale, more detailed classification maps (for both current and projected) and summary tables of population estimates (Figure 47).

Key information:

- **Classification maps:** Include and scale the size of the classification maps to fit the dedicated space in the module. Use this module specifically for current and projected maps.
 - **Summary population tables:** Use the template or develop summary population tables for the current and projected classifications to be added below the respective maps. Include the number and percentage of people in each phase and specify the phase classification for each area if findings have not been aggregated. If more than ten areas are classified, include aggregate findings at the most suitable administrative sub-division unit level, bearing in mind that the table should not exceed ten to fifteen areas (consider aggregating by regions if necessary). Ensure that overall population totals align and are consistent with the aggregate table presented in Modules 1, 5 and 7 (if developed). If aggregation is not possible, population tables should be presented in easily digestible graphics showing values as well as percentages. Full population tables should then be shown in Module 5.

Figure 47: IPC Communication Template Module 2





MODULE 3: SITUATION OVERVIEW, KEY DRIVERS AND LIMITING FACTORS

Purpose: To provide more detailed analysis of current and projected classification considering the six key questions of how severe, how many, where, when, why, and who, already summarized in Module 1 (Figure 48).

Key information:

Current situation overview, considering:

- **context**, including relevant historical information and trends;
- **summary of classification results** in terms of where, how many and how severe, focusing on the worst-affected areas and population figures; and current acute food insecurity conditions, including reference to food security outcomes (e.g. percentage of households having poor consumption, engaging in emergency strategies) and relating to malnutrition and mortality as relevant;
- **why?** focusing on the key drivers triggering the conditions and limiting dimensions, including identification of the key shocks and vulnerabilities contributing to the situation and the most limiting dimensions (food availability, access, utilization or stability);

Figure 48: IPC Communication Template Module 3

<p> COUNTRY NAME IPC ACUTE FOOD INSECURITY ANALYSIS</p> <p>CURRENT SITUATION OVERVIEW (Month Year - Month Year)</p> <p>Context, including relevant historical information and trends;</p> <p>Summary of classification results in terms of where, how many and how severe, focusing on the worst-affected areas and population figures; and current acute food insecurity conditions, including reference to food security outcomes (e.g. percentage of households having poor consumption, engaging in emergency strategies) and relating to malnutrition and mortality as relevant;</p> <p>Why, focusing on key drivers triggering the conditions and limiting dimensions, including identification of key shocks and vulnerabilities contributing to the situation and the most limiting dimensions (food availability, access, utilization or stability);</p> <p>Who, providing general socio-economic characteristics of the most food insecure;</p> <p>How different, providing a comparison with the previous IPC analyses to show any change over time and with other areas;</p> <p>Identification of areas that received significant humanitarian food assistance. Provide an overview of assistance delivered and identify areas where assistance provided met between 25% and 50% or over 50% of caloric needs of at least 25% of households.</p>	3
<p> COUNTRY NAME IPC ACUTE FOOD INSECURITY ANALYSIS</p> <p>PROJECTED SITUATION OVERVIEW (Month Year - Month Year)</p> <p>Context, including seasonally and expected usual impact of shocks during the projected period;</p> <p>Key Conclusions for the projected period, including: <ul style="list-style-type: none"> • An assessment of shocks that are most likely going to impact future food security, including past and forecasted shocks; • Likely impact of shocks on future food security dimensions (food availability, access, utilization and stability); • Critical reasoning for conclusion on likely change of outcomes (food consumption, livelihood change, nutrition and mortality). </p> <p>Identification of areas which would likely receive significant humanitarian food assistance in the projected period. Provide an overview of the planned, funded or likely to be funded and delivered assistance, and identify areas where assistance to be provided will likely meet between 25% and 50% or over 50% of caloric needs of at least 25% of households.</p>	5
Key Assumptions for the projected period Include the assumptions related to the most likely scenario set for developing the projection period scenario, in particular regarding expected shocks, food availability, food access, food utilization and the stability of these elements.	

- **who?** providing the general socio-economic characteristics of the most food insecure populations;
- **how different?** providing a comparison with the previous IPC analyses to show any change over time and with other areas;
- Identification of areas that received significant humanitarian food assistance and provide a brief overview of assistance delivered.

The projected situation overview, considering:

- **context**, including seasonality aspects and the expected usual impact of shocks during the projected period;
- **key assumptions and conclusions** for the projected period, including:
 - an assessment of shocks that will most likely impact future food security, including previous and forecasted shocks and their likely positive or negative impact on future food security dimensions (food availability, access, utilization and stability);
 - critical reasoning for conclusions on likely changes in outcomes (food consumption, livelihood change, nutrition and mortality).
- **Identification of areas** that will likely receive significant humanitarian food assistance based on reviewed existing plans that have either been funded or will likely be funded, with planned assistance likely to be delivered. Provide an overview of the key characteristics of the plans.



MODULE 4: RECOMMENDATIONS FOR ACTION

Purpose: To provide general recommendations for: (i) response priorities; (ii) situation monitoring and plans for analysis updates; and (iii) data collection and information system (Figure 49).

Key information:

Response priorities:

- Identify populations in need of different strategic actions. Refer to the priority response objectives of different IPC phases as detailed in the IPC Acute Food Insecurity Reference Table. Defining specific modalities of response is not required and usually not possible at this stage of situation analysis.

Situation monitoring and analysis updates:

- Identify IPC and other plans to monitor the situation. Indicate timing of future IPC analysis.
- Identify key risk factors to monitor that would trigger the need to update an analysis. Particular attention should be paid to factors such as conflict and rainfall, which inform the key assumptions underpinning the phase classification.
- Identify recommendations for data collection and information systems, i.e. timing, coverage and indicators that are relevant to fill data quality gaps and inadequacies that may emerge during the analysis.

Figure 49: IPC Communication Template Module 4

COUNTRY NAME IPC ACUTE FOOD INSECURITY ANALYSIS	6
RECOMMENDATIONS FOR ACTION	
Response Priorities <ul style="list-style-type: none"> Identify populations in need of different strategic actions. Refer to the Priority Response Objectives of different IPC phases as detailed in the Reference Table. Defining specific modalities of response is not required and usually not possible at this stage of situation analysis. 	
Situation Monitoring and Update <ul style="list-style-type: none"> Identify food security and IPC Analysis plans to monitor the situation. Indicate timing of future IPC analysis. Identify recommendations for data collection and information systems, i.e. timing, coverage and indicators as relevant to fill the data quality gaps and inadequacy faced during the analysis. 	
Risk Factors to Monitor <ul style="list-style-type: none"> Identify key risk factors to monitor what would trigger the need to update the analysis. Particular attention should be paid to factors such as conflict and rainfall, which inform key assumptions underpinning the phase classification. 	

MODULE 5: DETAILED POPULATION TABLE(S)

Purpose: To develop and share the population estimates for different phases for current and projected periods (Figure 50).

Key information:

Overview of methods for population estimates:

- A brief methodological note on how the populations were estimated. Focus should be on the evidence-based consensus-building nature of the method where direct and indirect evidence is used to estimate the distribution of people among the five severity phases.
 - Highlight the fact that population estimates for the current and projected periods refer to those in need of action in addition to any action already provided or planned to be provided (Refer to p. 32–33 for detailed guidance.)

Population Table:

- Develop the detailed Population Tables for both current and projected periods, detailing findings of all analysed areas, disaggregated at the relevant administrative level or other unit used in the analysis.
 - Include total population, number and percentage of people in different phases, and the aggregate number and percentage of people in Phase 3 or more severe for each area.
 - The percentage in each phase should be calculated in relation to the population analysed (e.g. if only rural populations were classified, total population should refer to rural population).
 - Specify the area phase classification for each area analysed.
 - Add the following note below the table: Population in Phase 3+ does not necessarily reflect the full population in need of urgent action. This is because some households may be in Phase 2 or even 1 but only because of receipt of assistance, and as a result they may be in need of continued action.
 - When ISS is used, the population table will be generated automatically.
 - If the population tables are longer than one page, they should be moved to the end of the report.

District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00
District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00
District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00
District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00
Total	000,000	000,000	00												
Grand Total	000,000,000	000,000	00												

Note: A population in Phase 3+ does not necessarily reflect the full population in need of urgent action. This is because some households may be in Phase 2 or even 1 but only because of receipt of assistance, and thus, they may be in need of continued action.

Figure 50: IPC Communication Template Module 5

COUNTRY NAME | IPC ACUTE FOOD INSECURITY ANALYSIS

7

Detailed population table

- A brief methodological note on how the populations provided were estimated. Focus should be on the evidence-based consensus-building nature of the method, where prevalence of direct (and indirect) evidence is used to estimate the distribution of people among the five severity phases.
- Highlight that population estimates for the current period refer to those in need of action in excess of any assistance already provided; and estimation for the projected period refers to those in need of action.

Name of relevant administrative unit/level	Name of relevant administrative unit/level	Total population analysed	Phase 1		Phase 2		Phase 3		Phase 4		Phase 5		Area Phase	Phase 3+ #people %
			#people	%										
Province	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	Total	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00		000,000 00
Province	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	Total	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
This is for illustration only.														
<ul style="list-style-type: none"> Develop the detailed population estimates table for both current and projected periods, merging findings of all areas analysed, and disaggregated at relevant administrative level or other unit used in the analysis. Include total population, number and percentage of people in different phases, and the aggregate number and percentage of people in Phase 3 or worse for each area. The population estimates in each phase should be done in relation to population analysed (e.g. if only rural populations were classified, total population should refer to rural population). Specify the area phase classification for each area analysed. If using ISS, the population table will be done automatically. 														
Province	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
	District	000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00	\$	000,000 00
Grand Total		000,000	000,000	00	000,000	00	000,000	00	000,000	00	000,000	00		000,000 00

Note: A population in Phase 3+ does not necessarily reflect the full population in need of urgent action. This is because some households may be in Phase 2 or even 1 but only because of receipt of assistance, and thus, they may be in need of continued action.

Note: A population in Phase 3+ does not necessarily reflect the full population in need of urgent action. This is because some households may be in Phase 2 or even 1 but only because of receipt of



MODULE 6: PROCESS AND METHODOLOGY

Purpose: To describe the IPC approach, the analysis process, main data sources and key limitations (Figure 51).

Key information:

Process and methodology

- Detail the analysis process, including reference to the National Technical Working Group, identification of institutional arrangements, training, and activities undertaken before, during and after analysis.
- Include a list of the main data sources used.

Limitations of the analysis:

- Technical and process challenges, such as evidence gaps, institutional arrangements and participation.

Figure 51: IPC Communication Template Module 6

COUNTRY NAME IPC ACUTE FOOD INSECURITY ANALYSIS					8										
PROCESS AND METHODOLOGY															
<p>Detail the analysis process, including reference to the national TWG, institutional arrangements, training, and activities undertaken before, during and after analysis.</p>															
<p>Sources Include a list of main data sources used.</p>															
<p>Limitations of the analysis Identify limitations of the analysis, including technical and process challenges, such as evidence gaps, institutional arrangements and participation.</p>															
<p>What is the IPC and IPC Acute Food Insecurity? The IPC is a set of tools and procedures to classify the severity and characteristics of acute food and nutrition crises as well as chronic food insecurity based on international standards. The IPC consists of four mutually reinforcing functions, each with a set of specific protocols (tools and procedure). The core IPC parameters include consensus building, convergence of evidence, accountability, transparency and comparability. The IPC analysis aims at informing emergency response as well as medium and long-term food security policy and programming.</p>															
<p>For the IPC, Acute Food Insecurity is defined as any manifestation of food insecurity found in a specified area at a specific point in time of a severity that threatens lives or livelihoods, or both, regardless of the causes, context or duration. It is highly susceptible to change and can occur and manifest in a population within a short amount of time, as a result of sudden changes or shocks that negatively impact on the determinants of food insecurity.</p>															
<p>Contact for further Information Surname, Name IPC function email@email.com IPC Global Support Unit www.ipcinfo.org</p>															
<p>This analysis has been conducted under the patronage of the(e.g. Ministry of Agriculture). It has benefited from the technical and financial support of(e.g. European Commission, UK Government).</p>															
<p>Classification of food insecurity and malnutrition was conducted using the IPC protocols, which are developed and implemented worldwide by the IPC Global Partnership - Action Against Hunger, CARE, CILSS, EC-JRC, FAO, FEWSNET, Global Food Security Cluster, Global Nutrition Cluster, IGAD, Oxfam, PROGRESAN-SICA, SADC, Save the Children, UNICEF and WFP.</p>															
<p>Acute Food Insecurity Phase name and description</p> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th>Phase 1 None/Minimal</th> <th>Phase 2 Stressed</th> <th>Phase 3 Crisis</th> <th>Phase 4 Emergency</th> <th>Phase 5 Catastrophe/ Famine</th> </tr> </thead> <tbody> <tr> <td>Households are able to meet essential food and non-food needs without engaging in atypical and unsustainable strategies to access food and income.</td> <td>Households have minimally adequate food and non-food gaps that are reflected by high or above-usual acute malnutrition; or are marginally able to meet minimum food needs but only by depleting essential livelihood assets through crisis-coping strategies.</td> <td>Households either: • have large food consumption gaps that are reflected by high acute malnutrition and excess mortality; or are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation</td> <td>Households have an extreme lack of food and/or other basic needs even after full deployment of coping strategies. Starvation, death, destitution and emergency medical acute malnutrition levels are evident.</td> <td>(For famine classification, area needs to have extreme critical levels of acute malnutrition and mortality.)</td> </tr> </tbody> </table>						Phase 1 None/Minimal	Phase 2 Stressed	Phase 3 Crisis	Phase 4 Emergency	Phase 5 Catastrophe/ Famine	Households are able to meet essential food and non-food needs without engaging in atypical and unsustainable strategies to access food and income.	Households have minimally adequate food and non-food gaps that are reflected by high or above-usual acute malnutrition; or are marginally able to meet minimum food needs but only by depleting essential livelihood assets through crisis-coping strategies.	Households either: • have large food consumption gaps that are reflected by high acute malnutrition and excess mortality; or are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation	Households have an extreme lack of food and/or other basic needs even after full deployment of coping strategies. Starvation, death, destitution and emergency medical acute malnutrition levels are evident.	(For famine classification, area needs to have extreme critical levels of acute malnutrition and mortality.)
Phase 1 None/Minimal	Phase 2 Stressed	Phase 3 Crisis	Phase 4 Emergency	Phase 5 Catastrophe/ Famine											
Households are able to meet essential food and non-food needs without engaging in atypical and unsustainable strategies to access food and income.	Households have minimally adequate food and non-food gaps that are reflected by high or above-usual acute malnutrition; or are marginally able to meet minimum food needs but only by depleting essential livelihood assets through crisis-coping strategies.	Households either: • have large food consumption gaps that are reflected by high acute malnutrition and excess mortality; or are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation	Households have an extreme lack of food and/or other basic needs even after full deployment of coping strategies. Starvation, death, destitution and emergency medical acute malnutrition levels are evident.	(For famine classification, area needs to have extreme critical levels of acute malnutrition and mortality.)											
<p>IPC Analysis Partners:</p> <hr/>															

MODULE 7: SNAPSHOT

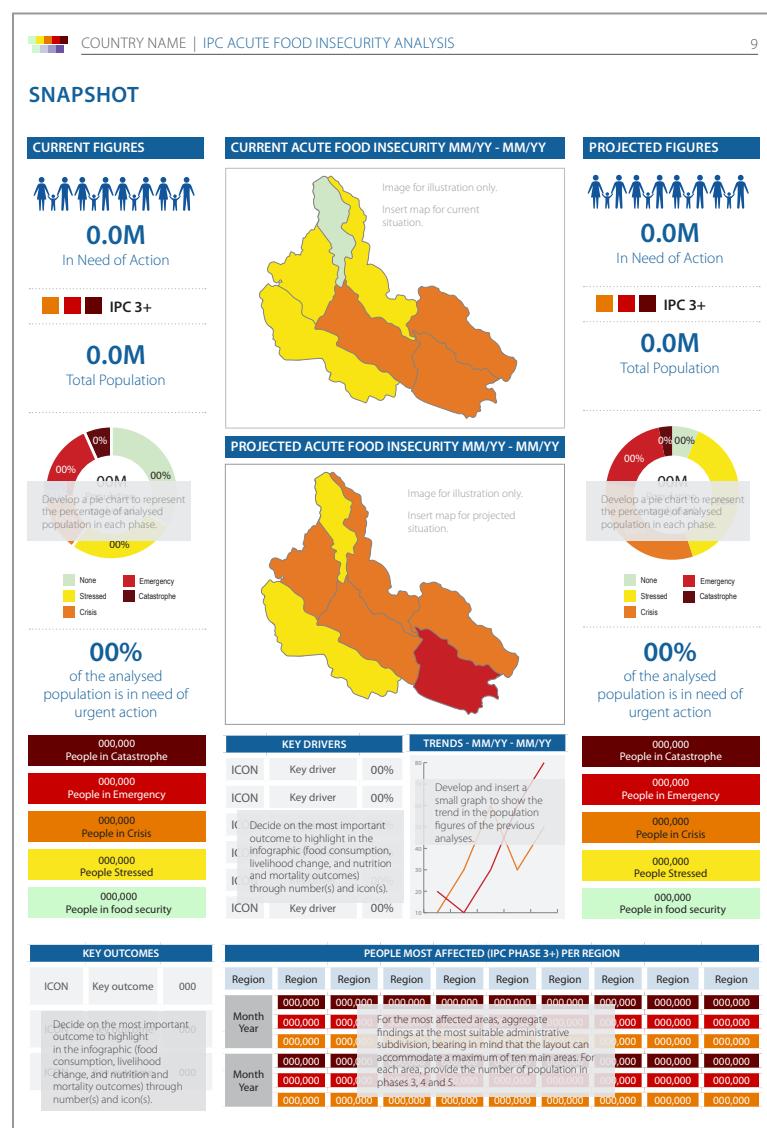
Purpose: To present key results in an easily accessible infographics (Figure 52).

Key information:

Graphic visual representation of the most important results/information in the IPC analysis for the current and projected period (if available), specifically:

- **IPC map(s).**
- **Population figures:** Insert the total number of people in Phase 3 or above (i.e. Phase 3+) rounded as in Module 1. Insert the total number of people analysed and develop a pie chart to represent the percentage of analysed population in each phase.
- **Contextualizing text:** Include a brief overview of the situation contextualizing the figures and maps being represented in the infographic.
- **Key drivers:** Identify two to three key drivers to highlight in the infographic through appropriate icons and a brief description as well as any numbers/figures if available.
- **Trends:** If possible, develop and insert a small graph to show the trend in the population figures of the previous analyses.
- **Key outcomes:** Decide on the most important outcome to highlight in the infographic (food consumption, livelihood change, nutrition or mortality outcome) through number(s) and icon(s).
- Although this module is not mandatory, it is **highly recommended** that a snapshot of the situation is developed, in order to be able to reach audiences other than technical ones, especially in the case of high concern countries.

Figure 52: IPC Communication Template Module 7





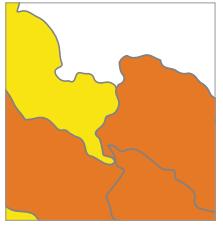
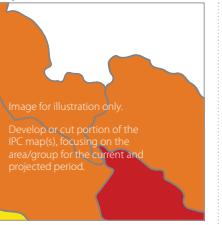
MODULE 8: PROFILES OF THE MOST AFFECTED AREAS/GROUPS

Purpose: To present key findings for each area or group of major concern (Figure 53).

Key information:

- Provide an overview of the current and projected conditions, including reference to evidence aiming to answer the six key questions (how severe, how many, why, who, when, where). Provide recommendations for action as relevant.
- Develop or cut a portion of the IPC map(s), focusing on the area/group for the current and projected period.
- Fill in the table with population estimates in different IPC phases for that area/group in the current and projected period.
- Insert icons representing two to four key driving factors for that area/group.
- Although this module is not mandatory, it is **highly recommended** that an in-depth analysis of each region is presented in this module, especially for areas in Phase 4 or worse and for high concern countries. This should be based on the concluding statements on the evidence for each region in ISS.

Figure 53: IPC Communication Template Module 8

COUNTRY NAME IPC ACUTE FOOD INSECURITY ANALYSIS		10																								
PROFILE OF THE MOST AFFECTED AREAS																										
Name of the Affected Area/Group <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">  <p>Current</p> </div> <div style="text-align: center;">  <p>Projected</p> </div> </div> <div style="margin-top: 10px;"> <p>Image for illustration only. Develop or cut portion of the IPC map(s), focusing on the area/group for the current and projected period.</p> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #0070C0; color: white;">IPC AFI Phase</th> <th style="background-color: #0070C0; color: white;">Current</th> <th style="background-color: #0070C0; color: white;">Projected</th> <th style="background-color: #0070C0; color: white;">KEY DRIVERS</th> </tr> </thead> <tbody> <tr> <td>None</td> <td>000,000</td> <td>000,000</td> <td></td> </tr> <tr> <td>Stressed</td> <td>000,000</td> <td>000,000</td> <td></td> </tr> <tr> <td>Crisis</td> <td>000,000</td> <td>000,000</td> <td></td> </tr> <tr> <td>Emergency</td> <td>000,000</td> <td>000,000</td> <td></td> </tr> <tr> <td>Catastrophe</td> <td>000,000</td> <td>000,000</td> <td></td> </tr> </tbody> </table> </div> <div style="width: 45%;"> <p>Provide an overview of the current and projected conditions, including reference to evidence and attempting to answer the six key questions</p> <p>How Severe? How Many? Why? Who? When? Where?</p> </div> </div>			IPC AFI Phase	Current	Projected	KEY DRIVERS	None	000,000	000,000		Stressed	000,000	000,000		Crisis	000,000	000,000		Emergency	000,000	000,000		Catastrophe	000,000	000,000	
IPC AFI Phase	Current	Projected	KEY DRIVERS																							
None	000,000	000,000																								
Stressed	000,000	000,000																								
Crisis	000,000	000,000																								
Emergency	000,000	000,000																								
Catastrophe	000,000	000,000																								

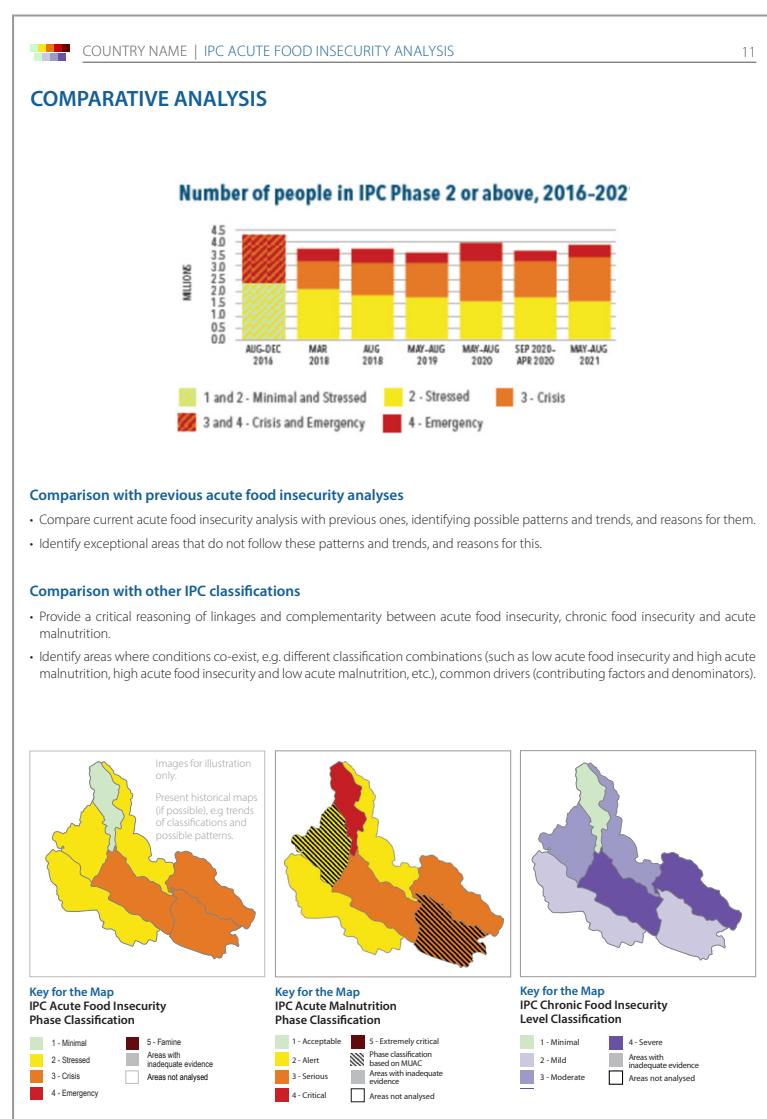
MODULE 9: COMPARATIVE ANALYSIS

Purpose: To contextualize the current classification in relation to relevant IPC Acute Malnutrition and/or Chronic Food Insecurity classifications, presenting the linkages and complementarity between them, if possible. If previous IPC Acute Food Insecurity classifications have been completed, trends over time should also be provided (Figure 54).

Key information:

- Provide a critical reasoning for linkages and complementarity between acute food insecurity, chronic food insecurity and acute malnutrition.
- Identify areas where conditions and common drivers (contributing factors and denominators) co-exist.
- Present historical maps (if possible), for example, trends of classifications and possible patterns, especially those of acute food insecurity and acute malnutrition in juxtaposition, and possible patterns.
- Although this module is not mandatory, it is highly recommended that a comparative analysis with previous analyses is made, especially in the case of high concern countries.

Figure 54: IPC Communication Template Module 9





PROTOCOL 3.2: ADHERE TO MAPPING STANDARDS

Figure 55: Mapping standards (Tool 11)

Key for the Map IPC Acute Food Insecurity Phase Classification

(mapped Phase represents highest severity affecting at least 20% of the population)

- 1 - Minimal
- 2 - Stressed
- 3 - Crisis
- 4 - Emergency
- 5 - Famine
- Areas with inadequate evidence
- Areas not analysed

Map Symbols

- Urban settlement classification
- IDPs/other settlements classification

Area receives significant humanitarian food assistance (accounted for in Phase classification)

- > 25% of households meet 25-50% of caloric needs through assistance
- > 25% of households meet > 50% of caloric needs through assistance

Evidence Level

- * Acceptable
- ** Medium
- *** High
- Scarce evidence due to limited or no humanitarian access

Area-specific call-out box (ISS map digital version)

Area Name
IPC Acute Food Insecurity Phase #,###+##% Aggregated # and % of population in Phase 3 or above
 % of people in each phase

The following mapping parameters need to be adhered to on all maps of IPC Acute Food Insecurity Classifications:

- Areas should be mapped according to the standardized red-green-blue (RGB) colour scheme: Phase 1 (205,250,205); Phase 2 (250,230,030); Phase 3 (230,120,000); Phase 4 (200,000,000); and Phase 5 (100,000,000).
- Areas are only classified and mapped if they meet the minimum evidence requirements. If requirements are not met, they should be mapped using a grey colour (RGB 166, 166, 166), indicating "inadequate evidence".
- Areas that are not included in the analysis should be coloured white (RGB 255, 255, 255), indicating "area not analysed".
- The evidence level of the analysis should be added in the map through the use of *Acceptable, **Medium, and ***High. If not possible, evidence level of analysis should be added in the map key or in a note under the map.
- In the case of classifications of **urban areas, IDPs and other settlements**, specific symbols should be used as illustrated in Figure 55. The colour of the symbol should be chosen according to the phase classified.
- If the classification is made with less than adequate evidence in areas with **limited or no humanitarian access**, a specific symbol should be placed on the concerned area as per Figure 55.
- Add symbols for areas identified as having received or that will likely receive significant assistance depending on the coverage and size of the transfer as follows:
 - at least 25% of households meet 25-50% of their caloric requirements through humanitarian food assistance
 - at least 25% of households meet over 50% of their caloric requirements through humanitarian food assistance
- Digital maps may have further information included, which may include the total population in Phase 3 or a more severe phase, IPC Chronic Food Insecurity and IPC Acute Malnutrition classifications, the recurrence of crisis, and the population distribution per phase.

PROTOCOL 3.3: STRATEGICALLY SHARE COMMUNICATION PRODUCTS IN A TIMELY MANNER

IPC communication products, including the analysis report and maps, should be shared with the relevant stakeholders as soon as they are finalized, preferably within 15 days of analysis completion. Given the humanitarian imperative, the Technical Working Group should aim, upon consensus, to release analysis results that include final classifications, population estimates and key messages, in the shortest time possible.

Should the Technical Working Group require more time to organize the release of the analysis, the preliminary results should be shared with national stakeholders and published on the IPC website, preferably within 21 days of completing the analysis process, using the following disclaimer "*Preliminary findings pending official release at country level*". Once an official release has taken place, the disclaimer will be removed.

Three key activities should be implemented to accomplish the protocol and are defined in Figure 56.

Figure 56: Communication activities required for effective dissemination (Tool 12)

- Presentation of results to national and regional stakeholders: At least one presentation of the key findings needs to be given to the relevant stakeholders and decision-makers. This dissemination can be amplified by communications officers in key participating organizations.
- Sharing of key IPC products (maps, population tables and reports) with the IPC Global Support Unit: The Technical Working Group shares key classification products with the IPC Global Support Unit for posting on the IPC website, and for further dissemination at the global level as applicable.
- Dissemination of key IPC products such as the IPC report with maps and tables and the snapshot, to key IPC audiences (donors, organizations, the media, the technical community, academia and governments) through appropriate channels such as mailing lists, social media and the IPC website.

FUNCTION 4: QUALITY ASSURANCE

Function 4 ensures the technical rigour and neutrality of analysis as well as learning for future improvements. These are achieved through self-assessments and, if necessary, external quality reviews. By completing Function 4, analysts assess to what extent they have followed all the IPC protocols included in Functions 1, 2 and 3, and identify areas for future improvements. If all 13 protocols have been followed, the resulting product can be labelled IPC. Therefore, by inserting the IPC logo into a report, the Technical Working Group recognizes its accountability, confirming that classification was based on consensual and unbiased analysis developed according to IPC protocols. Lack of adherence to IPC protocols may result in the IPC Global Steering Committee requiring that the Technical Working Group remove the IPC logo.

Further to Function 4, the IPC initiative aims to support countries to produce analyses that meet high-quality standards. To this end, the IPC Quality and Support Strategy has been developed around three additional components: (i) Capacity Development; (ii) Country Technical, Implementation and Strategic Support; and (iii) Technical Standards and Guidelines. The IPC Global Support Unit is responsible for overseeing Quality Assurance and has a variety of ex ante and ex post mechanisms at its disposal to ensure the technical rigour and neutrality of the analysis and to identify learning for future improvements. Among these, the IPC Global Support Unit provides systematic technical support and facilitation during analyses for all countries that are in their first two years of IPC implementation. The same modality applies to a range of other contexts, such as contexts where adherence to IPC protocols has been questioned



in previous analyses, contexts where partner(s) disagreement on classification is frequent, and contexts where conflict and/or insecurity is identified as a key driver of food insecurity and therefore further assurance on the neutrality of the IPC analysis may be required. Given the predominant role of IPC in informing decisions about humanitarian food assistance potentially required in these latter contexts, this mechanism aims at ensuring optimal quality for the analysis. Following the completion of IPC analyses, the IPC Global Support Unit works to support Function 4 by reviewing self-assessments and, if necessary, by conducting external quality reviews together with IPC Global Partners.

Figure 57: Protocols for Function 4

Protocol	Procedure	Tool
4.1 Conduct a self-assessment of analysis.	Complete the self-assessment tool through a participatory process.	Tool 13: Self-Assessment Tool 
4.2 Request and engage in an external quality review if necessary.	Contact IPC Global Support Unit with concerns.	Quality. Assurance@ ipcinfo.org

Protocols For Completing Function 4

There are two protocols for Function 4: the first focuses on self-assessment and the second entails requesting and engaging in an external quality review if deemed necessary (Figure 57).

PROTOCOL 4.1: CONDUCT A SELF-ASSESSMENT OF THE ANALYSIS

A self-assessment needs to be conducted at the end of all analyses to critically reflect on the extent to which the IPC protocols for Functions 1, 2 and 3 were followed and to identify areas for future improvements.

To this end, the analysis team needs to complete the Self-Assessment Tool (Figure 58). The tool should be completed based on a collective discussion involving all analysis team members. To facilitate the discussion and completion of the tool, guiding questions are provided in Figure 59. As an optional step, the tool can also be completed by individual analysis team members or facilitators to provide feedback to the National Technical Working Group and/or Global Support Unit on the process and suggestions on how to improve future IPC analyses, tools, procedures, specific guidance and/or implementation processes.

The Self-Assessment Tool serves two purposes:

- To identify how well protocols have been followed. In the event that they have not been followed, the analysis team should revise the analysis to ensure adherence to all protocols and the quality of the IPC products. If for some reason the protocols cannot be entirely adhered to, the analysis team should provide a reasonable explanation. Should the outcomes of the self-assessment raise serious concerns, an external quality review may be initiated.
- When planning a new IPC analysis, the IPC Technical Working Group should reflect on the content of previous self-assessments to ensure that the lessons learned in preceding analyses are applied.

Once completed by the analysis team, the Self-Assessment Tool should be submitted to the IPC Global Support Unit either via the ISS (when the ISS is used for the analysis) or via e-mail ([Quality.Assurance@
ipcinfo.org](mailto:Quality.Assurance@ipcinfo.org)).

**Figure 58: The Self-Assessment Tool (Tool 13)**

Country: _____ Date: _____				
Organizations Participating in the Self-Assessment:				
IPC Protocols	Specify if the protocol was completed 1. Yes 2. Partially 3. No	If partially or not completed, explain why	Provide recommendations for future analysis improvements	
Function 1: Build Technical Consensus	1.1 Compose the analysis team with relevant sectors and organizations.			
	1.2 Conduct the analysis on a consensual basis.			
Function 2: Classify Severity and Identify Key Drivers	2.1 Use the IPC Analytical Framework to guide the convergence of evidence.			
	2.2 Compare evidence against the IPC Acute Food Insecurity Reference Table.			
	2.3 Adhere to the parameters for analysis.			
	2.4 Evaluate evidence reliability.			
	2.5 Meet minimum evidence and analysis requirements.			
	2.6 Methodically document evidence and analyses and provide them upon request.			
Function 3: Communicate for Action	3.1 Produce the IPC Analysis Report.			
	3.2 Adhere to mapping standards.			
	3.3 Strategically share communication products in a timely manner.			
Function 4: Quality Assurance	4.1 Conduct a self-assessment of the analysis.			
	4.2 Request and engage in an external quality review if necessary.			



Figure 59: The Self-Assessment Tool – Guiding questions

IPC Protocols	Guiding Questions
Function 1: Build Technical Consensus	<p>1.1 Compose the analysis team with relevant sectors and organizations.</p> <p>Was the Analysis Team composed of relevant sectors and organizations? Were different relevant stakeholder organizations (e.g. government, United Nations agencies, international and national NGOs and technical agencies) and sectors (e.g. food security, agriculture, markets, nutrition and communication) represented? Areas for improvement/learning: Is there any organization and/or sector whose participation should be further promoted?</p>
	<p>1.2 Conduct the analysis on a consensual basis.</p> <p>Was the analysis conducted on a consensual basis? Did IPC analysts review, discuss and debate the preliminary IPC classifications and population estimates, reach a consensus and agree on the final results? If different views were expressed by any analysis team member(s) on the results, were they addressed? Areas for improvement/learning: Are changes in the process needed to facilitate consensus-building?</p>
Function 2: Classify Severity and Identify Key Drivers	<p>2.1 Use the Analytical Framework to guide convergence of evidence.</p> <p>Were the analysis and population estimates based on convergence of evidence? Was all the available evidence used in the analysis? Was there contradictory, or at least somewhat reliable evidence, and if so, how was this addressed in the analysis? Areas for improvement/learning: Were vulnerabilities and shocks documented and analysed? Were the four dimensions of food security documented and analysed? Were the food security outcomes documented and used to conclude on area classification?</p>
	<p>2.2 Compare evidence against the IPC Acute Food Insecurity Reference Table.</p> <p>Has direct evidence been compared against the Reference Table by taking into account the globally comparable cut-offs for key food insecurity outcome indicators? Was direct evidence analysed and made available to allow comparison against Reference Table cut-offs? Areas for improvement/learning: Have the indicative phases of various outcome indicators been assessed against the IPC Acute Food Insecurity Reference Table?</p>
	<p>2.3 Adhere to the parameters for analysis.</p> <p>Were all IPC analytical parameters respected? For example: Was the 20 percent rule used for classification? Were the areas that received significant humanitarian food assistance identified according to the guidance provided? Areas for improvement/learning: In particular, can adherence to the following parameters be improved: convergence of evidence, 20 percent rule for area classification, unit of analysis, validity period, identification of areas where significant humanitarian food assistance is delivered, and identification of key drivers and the most affected populations?</p>
	<p>2.4 Evaluate evidence reliability.</p> <p>Was all evidence assessed against methodological and time validity? Were the evidence reliability criteria correctly used? Were reliability scores allocated to all pieces of evidence? Areas for improvement/learning: Have methodological notes on the sources of evidence been made available to analysts? Could the soundness of method and time relevance of the evidence be improved through better planning? If so, how?</p>
	<p>2.5 Meet minimum evidence and analysis requirements.</p> <p>Were the minimum evidence and analysis requirements met? Was there sufficient evidence for all classified areas to meet minimum evidence requirements? Areas for improvement/learning: What were the key issues related to data? Was any key evidence missing, outdated or not representative for the areas analysed? Which evidence was available but not very recent or not from the same season?</p>
	<p>2.6 Methodically document evidence and analysis, and provide them upon request.</p> <p>Was the evidence and analysis methodically documented and made available? Was the convergence of evidence and conclusions documented? Was all evidence coded and made available to all analysts? Were these pieces of evidence accessible? Areas of improvement/learning: Was the reasoning behind the convergence of evidence documented and, for the projected analysis, linked to the most likely scenario?</p>



Function 3: Communicate for Action	3.1 Produce the IPC Analysis Report.	Is the minimum information on the seven topics provided in the IPC Analysis Report? Has the guidance for the content of each topic been followed? Areas for improvement/learning: Did the analysis team ensure that the IPC population estimates provided in the IPC Population Table contain no calculation errors/inconsistencies and that they sum up the total population analysed? Were the key messages discussed and agreed in plenary during the analysis? Was the IPC Modular Communication Template used?
	3.2 Adhere to mapping standards.	Do the map and legend follow standard requirements? Mapping standards: (i) standardized Red-Green-Blue colours should be used; (ii) areas that do not meet minimum evidence requirements should be mapped in grey; (iii) areas that are not analysed should be mapped in white; (iv) the evidence level of analysis should be indicated in the map for each area using the standard mapping symbols; (v) urban areas, IDP and other settlements, as well as areas with limited or no humanitarian access must be indicated using the standard mapping symbols; and (vi) where relevant, the symbols for identifying areas that receive significant humanitarian food assistance were correctly used. Areas for improvement/learning: Do the mapped areas correspond to the units of analysis?
	3.3 Strategically share communication products in a timely manner.	Will IPC communication products be shared strategically and in a timely manner? Is there a plan in place for sharing the analysis products with relevant stakeholders? Is this expected to occur within 15 days after completion of the analysis? Areas for improvement/learning: Was a communication plan (including dissemination) developed and discussed with Technical Working Group members prior to the IPC analysis? Will the results of the analysis be presented to key stakeholders/decision-makers prior to public release?
Function 4: Quality Assurance	4.1 Conduct a self-assessment of the analysis.	Was the self-assessment tool completed based on a collective discussion?
	4.2 Request and engage in an external quality review if necessary.	If quality review criteria were met, was a quality review requested? If so, were the quality review recommendations followed?
Add any relevant notes on country implementation issues, including for the different stages of the analysis cycle:		
Planning	Has the analysis been planned and timed taking into account data availability, context (seasonality or sudden shocks) and decision-makers' information needs (e.g. the process for the development of the Humanitarian Response Plan)?	
Preparation	Did the analysis planning and preparation allow for the optimal participation of all stakeholders, including timely communication on the dates of training (if any) and analysis events, access to data for analysts, and so on?	
Learning	Have key challenges and gaps (including resource, capacity and evidence gaps) been identified to inform future improvements?	



PROTOCOL 4.2: REQUEST AND ENGAGE IN AN EXTERNAL QUALITY REVIEW IF NECESSARY

Figure 60: External Quality Reviews – Objective, modality and focus

Objective: To ensure the overall quality, technical rigour and neutrality of analyses and related products.

Modality: External quality reviews are implemented within a short timeframe (3–5 days) prior to the finalization and release of the final IPC product. They are conducted remotely by a team of officers from the IPC Global Support Unit and, whenever possible, from IPC Global Partners, who are not involved in the analysis. External quality reviews consist in a review of documented analysis (optimally using the IPC Analysis Worksheets), including all evidence used. The Technical Working Group is consulted and provides inputs throughout the process, as needed.

Focus: External quality reviews focus on assessing adherence to all protocols.

Technical Working Groups, analysis team members or facilitators are provided with the opportunity to communicate directly with the Global Support Unit regarding major concerns related to the IPC analysis. The communication must include a short explanation of the concern as well as basic information on the analysis, and must be submitted to the relevant regional Global Support Unit officer. Should there not be one available, it must be submitted to the Global Support Unit at Quality.Assurance@ipcinfo.org.

External quality reviews are carried out to ensure the overall quality, technical rigour and neutrality of the analysis under the following specific circumstances:

- i. (i) When there is a breakdown in the technical consensus regarding the actual or potential classification of areas in Phase 4 or 5.
- ii. When the classification is performed with scarce evidence in areas with no or limited humanitarian access that did not receive support from the Global Support Unit during the analysis.
- iii. Based on the review of the completed Self-Assessment Tool by the Global Support Unit or a communication to the Global Support Unit from the analysis team members or facilitator(s) expressing concerns regarding a lack of adherence to protocols, especially for the actual or potential classification of areas in Phase 4.

Figure 60 provides an overview of the objectives and implementation modalities of external quality reviews. While external quality reviews are a valuable mechanism to support analysis teams in resolving technical disagreements and overcoming major analytical challenges, they are a last-resort action. Other steps should therefore be taken upstream, such as requesting real-time technical support for the preparation and implementation of the analysis.

IPC FAMINE CLASSIFICATION – SPECIAL ADDITIONAL PROTOCOLS

IPC promotes accountable famine classification, and thus **specific protocols have been adapted to ensure the technical rigour, neutrality and quality of analysis**. While IPC Famine classifications follow all regular IPC protocols, special protocols also need to be observed in all four Functions, as detailed below.

As a best practice, a national IPC Technical Working Group that foresees the possibility that its upcoming or ongoing IPC analysis might result in a classification of Famine or Famine Likely is strongly encouraged to consult the IPC Global Support Unit to clarify the way forward in terms of support and the review process.

While this section provides an overview of the special protocols for Famine and Famine Likely classifications, more detailed guidance is included in IPC Resources.

Function 1: Build a Technical Consensus

- When a Famine classification is being considered, it is imperative that the analysis team include food security experts, nutritionists, experts with advanced knowledge in analysis of mortality data and, optimally, communication experts. Additionally, given the high profile of the classification, it is strongly advised that global and regional experts be invited to support the analysis.

Function 2: Classify Severity and Identify Key Drivers

- Evidence requirements for Famine are different from those of other phase classifications. The amount and reliability of evidence will determine if a Famine or Famine Likely classification is allowed, with less strict requirements for areas with limited or no humanitarian access. The criteria are described in Figure 61 and detailed below.

Figure 61: Evidence-level criteria (Special Tool 1 for Famine Classification)

Evidence level for Famine	Criteria	
	Current	Projected
Famine	<ol style="list-style-type: none"> The three outcomes with R₂ direct evidence + Four other pieces of R₁ (+ or -) evidence, with at least two of those from the season of analysis 	<ol style="list-style-type: none"> 1. IPC Current adhering to Evidence Level for Famine classification + 2. Evidence used for current classification at most 12 months old at the end of projection period + 3. Four pieces of R₁ (+ or -) evidence presented with clear assumptions on forecasted trends
Famine Likely	<ol style="list-style-type: none"> At least two outcomes with R₁ (+ or -) direct evidence or other evidence allowed for Famine Likely classifications (Figure 62) + Four other pieces of R₁ (+ or -) evidence, with at least two of those from the season of analysis 	<ol style="list-style-type: none"> 1. IPC Current adhering to Evidence Level for Famine Likely classification + 2. Evidence used for current classification can be at most 12 months old at the end of projection period + 3. Four pieces of R₁ (+ or -) evidence presented with clear assumptions on forecasted trends

Notes:

¹ The three outcomes refer to: (i) food consumption and livelihood change; (ii) acute malnutrition; and (iii) mortality.

² Direct evidence for Food Consumption and Livelihood Change includes the Dietary Energy Intake, the Household Dietary Diversity Score (HDDS), the Food Consumption Score, the Household Hunger Scale (HHS), the reduced Coping Strategy Index (rCSI), the Household Economy Analysis, the Food Insecurity Experience Scale (FIES) and the Livelihood Coping Strategies -indicator. Direct evidence should ideally be available for indicators that have thresholds assigned for IPC Phase 5 in the IPC Acute Food Insecurity Reference Table, such as the HHS. If direct evidence is available for mortality and acute malnutrition, a Famine classification can still be performed without relying on direct evidence for food consumption and livelihood change, provided that analysts document the analytical process of inference for food consumption or livelihood change from at least four pieces of R1 direct or indirect evidence on outcomes and/or contributing factors.



³ Direct evidence for Acute Malnutrition includes GAM based on WHZ. The Famine threshold for GAM based on WHZ is 30 percent and above. In the absence of data on WHZ, for Famine Likely classifications, data on MUAC can be used together with an understanding of the relationship between WHZ and MUAC in the area of analysis supported by at least two indicators with R₁ evidence on the immediate causes of malnutrition to confirm MUAC findings. Note that in both indicators the presence of oedema is included.

⁴ Direct evidence for Mortality includes the CDR and the U5DR. The CDR should be calculated for non-trauma deaths only. The famine thresholds for the CDR are more than two deaths per 10,000 people per day. If the CDR is below 2 deaths per 10,000 people per day but the U5DR is greater than four deaths per 10,000 children-under-five per day, this evidence can be used to classify Famine if the 95 percent confidence interval of CDR includes 2.

⁵ The Evidence Reliability Assessment should follow Protocol 2.4, with indicators on food consumption and livelihood change adhering to the protocol detailed under the IPC Acute Food Insecurity classification, and indicators on acute malnutrition adhering to the protocol for the IPC Acute Malnutrition classification.

⁶ Other evidence allowed for Famine Likely classifications includes inferred outcomes of food consumption and livelihood change, GAM based on MUAC from a method of limited soundness (M₁) or limited time relevance (T₁), and the CDR or U5DR from a method of limited soundness (M₁) or limited time relevance (T₁).

⁷ If available evidence does not meet the minimum criteria for the evidence requirement and the Technical Working Group is concerned about the existence of Famine, the Technical Working Group should contact the Global Support Unit for further guidance on how to proceed.

⁸ In extreme circumstances, a Famine Likely classification can be made using substantial indirect or lower reliability evidence in consultation with the Famine Review Committee (see page 85 for details).

⁹ Famine and Famine Likely can be projected even if no Phase 5 classification is reached for the current analysis period. In these cases, the amount and reliability of evidence used to classify the current situation need to correspond to the criteria included in Evidence Levels of Famine and Famine Likely.

- **Famine classification** requires R₂ direct evidence on all three outcomes (food consumption and livelihood change, nutritional status and mortality), with the following notes and exceptions:

- **Evidence for Food Consumption and Livelihood Change** should optimally include the Household Hunger Scale (HHS), since this is typically the only collected indicator with a cut-off for Phase 5. However, other pieces of evidence on the other indicators included in the IPC Acute Food Insecurity Reference Table can be counted towards meeting the minimum evidence requirements for Famine classification. In cases where direct reliable evidence is available for mortality or acute malnutrition, a classification can still be performed without relying on direct evidence on food consumption and livelihood change, provided that analysts document the analytical process of inference for food consumption or livelihood change, which needs to be based on at least four pieces of evidence on outcomes and/or contributing factors and rely on at least two of the three recognized inference approaches, i.e. calibration, extrapolation or causal pathways. The inference should indicate the proportion of households expected to be in Phase 5 Catastrophe, and in order to support Famine classification, at least 20 percent of households should be in IPC Phase 5 Catastrophe.

- **Evidence for Nutritional Status** only includes reliable data on GAM based on WHZ or oedema.

- **Evidence for Mortality** includes the CDR and the U5DR from representative surveys of good method. If the CDR is below the Famine threshold but the U5DR is higher, the latter can be used to classify the Famine if the 95 percent confidence interval of CDR includes the Famine threshold (i.e. 2/10,000/day). The recall period for the CDR should optimally be around 90 days during the recent past; however, in the event that recall periods are longer, evidence can be still used but analysts should assess trends in deaths and provide an explanation on how death rates reflect recent conditions. Death rates should reflect deaths in the areas being classified. Death rates need to be directly attributable to outright starvation or to the interaction of food consumption deficits and disease; all deaths due to trauma should therefore be discounted from death rates.

- **Famine Likely classifications** can be performed when evidence requirements for a Famine classification are not met but there is at least R₁ (+ or -) direct evidence on outcomes, or other evidence as described in Figure 62 and detailed below:

- **Evidence for Food Consumption or Livelihood Change** optimally includes direct evidence, but in the absence of direct evidence, indirect evidence including inference of outcomes can be used. For

inference to meet the requirements, it must be based on at least four pieces of evidence on outcomes and/or contributing factors and should indicate the proportion of households expected to be in Phase 5 Catastrophe. At least two of the three recognized inference approaches, i.e. calibration, extrapolation or causal pathways need to be used to conduct the analysis. In order to support Famine Likely classification, at least 20 percent of households should be in IPC Phase 5 Catastrophe.

- **Evidence for Nutritional Status** includes GAM based on WHZ or MUAC, including oedema. The cut-off for GAM based on WHZ for Famine Likely classification is 30 percent, whereas for GAM based on MUAC the cut-off is 15 percent as per the IPC Acute Food Insecurity and Acute Malnutrition Reference Tables.
- **Evidence for Mortality** includes the CDR and the U5DR, following the same cut-offs and guidance as for Famine classification. In addition to accepting mortality data from reliable household surveys, Famine Likely classifications can also use R1 mortality data collected through monitoring systems such as hospital records, community-based surveillance systems and vital registration records.

**Figure 62: Other evidence allowed for Famine Likely classifications
(Special Tool 2 for Famine Classification)**

Outcome 1: Food consumption & livelihood change	Outcome 2: Nutritional status	Outcome 3: Mortality
<p>Inference of outcomes: Any relevant evidence on outcomes or contributing factors:</p> <ul style="list-style-type: none"> • A combined analytical approach using calibration of local evidence which do not have global cut-offs included in the reference table; extrapolation across time and space and causal pathways of contributing factors (at least two out of three methods). • Include reference to at least four pieces of somewhat reliable (R1) indirect evidence collected during the same season of analysis, or during a period of six months prior to the analysis. • Methodical and well documented analysis demonstrating the use of the methods for inference. 	<p>GAM based on MUAC from representative surveys of good method: Disaggregated surveys representative at the level of a higher administrative unit</p> <ul style="list-style-type: none"> • Evidence must be collected from at least 5 sites with 100 observations in total from the same season of analysis. <p>Surveys of similar areas</p> <ul style="list-style-type: none"> • Evidence must come from the same season of analysis. <p>Recent surveys</p> <ul style="list-style-type: none"> • Inferred estimates of evidence collected within the last 6 months but not from the same season of analysis (12 months for areas with no seasonality). <p>Historical evidence</p> <ul style="list-style-type: none"> • Evidence must have been collected during the same season of analysis from at least 2 similar years in the last 5 years. 	<p>CDR or U5DR from representative surveys of good method: Surveys of similar areas</p> <ul style="list-style-type: none"> • Evidence must come from the same season of analysis. <p>Recent surveys</p> <ul style="list-style-type: none"> • Inferred estimates of evidence collected within the last 6 months but not from the same season of analysis (12 months for areas with no seasonality). <p>Historical evidence</p> <ul style="list-style-type: none"> • Evidence must have been collected during the same season of analysis from at least 2 similar years in the last 5 years. <p>CDR or U5DR from functioning monitoring systems including:</p> <ul style="list-style-type: none"> • Hospital records, community-based surveillance systems and vital registration records.

- **Classifications of areas with limited or no humanitarian access** can rely on evidence with a reliability score of R₀ even for Famine classification, provided that the data adhere to general IPC guidance for collecting evidence on these areas as per special protocols for areas with limited or no humanitarian access.
- **For projections**, in addition to the requirements specified above, evidence should not be older than 12 months at the end of the projection period, and at least four supporting pieces of evidence should be inferred for the projection period. Historical evidence used to classify Famine Likely conditions is exempted from the 12-month rule.
- **Households can be in Phase 5 Catastrophe** even if areas are not classified as Phase 5 Famine. This indicates that households in Phase 5 Catastrophe experience the same severity of conditions even if the area is not (yet) classified as Famine. This can occur due to the time-lag between food insecurity, malnutrition and mortality, or in the case of a localized situation.



- All current, projected or inferred evidence needs to be at or above Famine thresholds for Famine or Famine Likely classifications (i.e. at least 20 percent of households with extreme food gaps, at least 30 percent of children acutely malnourished identified through GAM based on WHZ, and in the absence of GAM based on WHZ, at least 15 percent of children acutely malnourished identified through GAM based on MUAC for Famine Likely classifications; and a CDR of at least two deaths per 10,000 per day, or a U5DR of at least four deaths per 10,000 per day). For a projection of famine, the current situation can still be below famine thresholds, but through a critical analysis, it is concluded that the condition will pass the famine cut-offs in the projection period.
- There may be situations when circumstances suggest that a Famine may be occurring or will occur but the evidence available is insufficient to meet the minimum requirements described in Figure 62. In such cases, in the presence of substantial evidence, which can include both indirect and lower reliability evidence, an in-depth consultation process between the Famine Review Committee and the Technical Working Group can be put in place. This process can result in a Famine Likely classification based on the whole body of evidence and on expert judgment.
- Any unit of analysis can be classified as Famine, including household groups or any geographical area, provided that they add up to at least 10,000 people.

Figure 63: IPC Phase 5 Famine vs. Catastrophe – Considerations for communication

The existence of households in IPC Phase 5 Catastrophe should be highlighted, especially when areas have not been classified as IPC Phase 5. Famine, since immediate response is crucial. Communication should underscore that these households have an extreme lack of food and/or other basic needs even after full employment of coping strategies.

Furthermore, areas classified in IPC Phase 4 Emergency should also be emphasized as areas with a critical need for humanitarian action to save lives and livelihoods.

Function 3: Communicate for Action

- Develop the IPC Famine Alert as a summarized version of the IPC Standard Communication Brief to provide a clear and concise explanation of the situation.
- Adhere to the following procedures:
 - Communicate the classification clearly, using the guidance in Figure 64, stating the name of the classification (Famine or Famine Likely), the key message (including severity, number of people and evidence level), and linking the classification to decision-making (calling for urgent action to prevent widespread deaths and reduce malnutrition and starvation and to strengthen data collection as relevant).
 - Specify areas/groups classified in the Famine/Famine Likely and the time frame (Figure 63).
 - Provide a critical reasoning for classification, including reference to actual supporting evidence and source(s).
 - Include separate map(s)/zoom-in(s) for the areas classified in the Famine/Famine Likely as relevant.
 - Include the definition of famine: "According to the IPC, 'Famine' exists in areas where at least one in five households suffers from an extreme deprivation of food. Starvation, extreme critical levels of acute malnutrition (at least 30 percent of children malnourished) and significant mortality, directly attributable to outright starvation or to the interaction of malnutrition and disease (at least 1 person for every 5,000 dies each day) are occurring."
 - State the Famine review process followed.

Figure 64: Communication, implications for decision-making and mapping protocols

Classification	Key message	Key implications for decision-making	Mapping protocols
Current	Famine is Occurring <ul style="list-style-type: none">An area is classified in Famine, which is affecting ['000] people.	IMMEDIATE ACTION REQUIRED Immediate large-scale action needed to halt widespread deaths, acute malnutrition and starvation.	Phase 5 Famine
	Famine is Likely Occurring but limited evidence does not allow confirmation <ul style="list-style-type: none">Famine is likely occurring and while available evidence indicates a Famine, the evidence is not enough to confirm or deny the condition. ['000] people are likely to be facing catastrophic conditions.	IMMEDIATE ACTION REQUIRED Immediate large-scale action needs to be initiated to halt the likelihood of widespread deaths, acute malnutrition and starvation. Additional evidence should be collected to confirm the classification urgently.	Phase 5 Famine Likely
Projected	Famine is Projected to Occur <ul style="list-style-type: none">There are concrete indications that Famine will occur from [date] if conditions evolve as expected and humanitarian assistance is insufficient to prevent it. ['000] people are likely to face catastrophic conditions.	IMMEDIATE ACTION REQUIRED Immediate large-scale action needs to be initiated to prevent the likelihood of widespread deaths, acute malnutrition and starvation.	Phase 5 Famine Projected
	Famine will Likely Occur but limited evidence does not allow confirmation <ul style="list-style-type: none">There are concrete indications that Famine will occur from [date] if conditions evolve as expected and humanitarian assistance is insufficient to prevent it. Although evidence is not adequate to confirm the projection of Famine, the limited available evidence indicates that a Famine will likely occur. ['000] people are likely to face catastrophic conditions.	IMMEDIATE ACTION REQUIRED Immediate large-scale action needs to be initiated to prevent the likelihood of widespread deaths, acute malnutrition and starvation. Additional evidence should be collected to urgently confirm the classification urgently.	Phase 5 Famine Likely

Function 4: Quality Assurance

A Famine Review is mandatory for any Famine classification (Famine or Famine Likely). The Review focuses on **assessing the plausibility of Famine classification** so that the classification can be validated or disproved, and includes two main activities:

- 1. The Famine Review preparation**, which is led by the Global Support Unit with direct inputs from experts from IPC Global Partners who have not been involved in the IPC analysis. This review consists of a preliminary screening of the Famine classification in order to verify adherence to IPC protocols and provide the Famine Review Committee with recommendations.
- 2. The Famine Review by the Famine Review Committee** is led by a four- to six-member team of independent international food security and nutrition experts who are objective concerning the IPC outcome and who have the relevant technical knowledge and experience in the specific crisis context. The Famine Review by the Committee aims at validating (or disproving) the Famine classification, including when the body of evidence available does not meet the minimum requirements for Famine Likely classification.

Famine Reviews are mandatory for both IPC products and IPC compatible products and are to be conducted before the release of findings. These Reviews are activated by the Global Support Unit based on a request from the Technical Working Group or, in case of a breakdown in the technical consensus relating to a (potential) Famine classification, by IPC partner(s) or by the Global Support Unit, based on the evidence available. The Famine Review conclusions and recommendations are communicated by the Global Support Unit to the country Technical Working Group members and shared with the IPC Global Steering Committee. The Famine Review Committee report is made publicly available on the IPC website together with the IPC country report.



IPC CLASSIFICATION IN AREAS WITH LIMITED OR NO HUMANITARIAN ACCESS – SPECIAL ADDITIONAL PROTOCOLS

IPC analysis is also needed in situations where **limited access prevents humanitarian organizations from collecting suitable evidence**. For classification of areas with limited or no humanitarian access, where IPC standard data requirements cannot be met, classification can still be completed provided that the additional specific protocols are followed for each Function.

Limited or no humanitarian access refers to the areas to which access for collecting evidence is either non-existent or very restricted, usually due to conflict or a major natural disaster.

Function 1: Build a Technical Consensus

- When analyses are conducted in areas with limited or no humanitarian access, it is imperative that the analysis team also include people who have an in-depth understanding of the context. Key analysts should participate in data collection exercises as much as possible and bring their expert assessment into the analysis.
- If Famine is being assessed, the analysis team should, in addition to food security experts, also include nutritionists, analysts with advanced knowledge of analysis of mortality data and, optimally, communication experts. Given the high profile of the classification, it is strongly advised that regional or global experts be invited to support the analysis.

Function 2: Classify Severity and Identify Key Drivers

- R_0 evidence can be used to support the IPC analysis, provided they follow the parameters stipulated in Figure 65.
- A combination of sources of evidence should be used to the extent possible (e.g. use of rapid helicopter missions, assessment of new arrivals by area of residence and travel time, evidence from similar nearby areas, historical trend analysis, and evidence from distribution points).
- The minimum evidence level includes at least two outcomes with R_0 evidence, as detailed in Figure 66.
- Population tables should not be produced. If the evidence allows, analysts may be able to provide general working numbers to support the response analysis.
- The time validity of the analysis should be short, and projection updates are not allowed.



Figure 65: Reliability Score R_0 – Guidance for data collection

Validity of rapid ad hoc methods

- Estimates should reflect the overall food insecurity, malnutrition and mortality situation, given the limited window of opportunity (usually hours) to collect data and make observations.
- These methods may include rapid and non-representative assessments carried out in small geographical areas such as villages and camps. The results of rapid assessments are only applicable to the assessment area or to similar areas (e.g. estimates from an IDP camp may be used to infer the situation in other similar camps, provided that expert knowledge and other evidence indicate a similarity between camps).
- The results from several of these small geographical units may be used to express the situation in a larger geographical area to be analysed, such as a district or county, if at least three sites are surveyed in the analysis area.
- The type of malnutrition that is of concern in these types of conditions is acute malnutrition and it is assessed through MUAC screening. If possible, oedema should also be checked for.
- For acute food insecurity, the focus should be on assessing the occurrence of extreme experiences such as spending the whole day without eating. Thus, the HHS is the most important indicator. If time and resources allow, the FCS should also be collected.
- In general, data collection should involve collecting information from as many individuals as possible and using many different simultaneous approaches.
- The sample should optimally be selected either exhaustively or randomly. If possible, the assessment should include interviews/measurements at a central place and in residences. Estimates taken at intervention points (e.g. food distribution points, and health care admission screening points) should be contextualized according to a known selection bias and used together with evidence from community screening.
- If data are collected from both household and central point screening, merging the data may not be valid; each sample should be described separately, and then the best estimate is produced by understanding the selection biases of both samples. This may require advanced analytical skills and a clear understanding of what was carried out on the ground and how.
- As regards mortality assessments, the type of mortality that is of interest is the CDR. A mix of quantitative and qualitative methods should be used, such as interviews with key informants, counting graves, and a review of hospital or health centre records.
- The approach to sample design and selection can be ad hoc since it uses the opportunities on the ground to quickly access subjects (such as distribution campaigns, health clinic services, and available key informants), and may include measuring anthropometric indicators in non-conventional target groups, such as adults rather than children. When using these types of approaches to sampling, the limitations, potential biases or restricted conclusions should be clear.
- Anthropometric measurements of new arrivals to neighbouring areas can provide evidence on the likely conditions of their place of origin if information on length of journey is considered to ensure that the condition of those newly arrived can inform the conditions expected in the inaccessible areas.
- The IPC Guidelines only provide basic guidance, and the methods may need to be adapted to the situation on the ground. It is absolutely critical to thoroughly document the methods and procedures used for data collection in this situation to clearly understand the possible limitations and selection biases of the sampling methods used. It is also critical to thoroughly document all activities carried out in the community (e.g. distributions, vaccination, health clinic activities and access), as well as to exhaustively describe what was carried out during the assessment, including why and how the assessment was done.
- An external IPC Quality Review needs to be conducted for all classifications in areas with limited humanitarian access that did not receive external support during the analysis. A Famine Review will be conducted if analysts suspect Famine in these areas.

Time relevance:

- Given the high volatility of areas with limited or no humanitarian access, current classifications should be based on data collected within the previous three to five months of classification, not necessarily from the season of analysis.
- Evidence collected during times when estimates are expected to likely be different from the current time (either because of seasonality or negative shocks) should be extrapolated to their potential current values.



Figure 66: Evidence level for areas with limited or no humanitarian access

Evidence level of areas with limited humanitarian access	Criteria	
	Current	Projected
 Reduced evidence due to limited or no humanitarian access	<ol style="list-style-type: none"> 1. At least two of the three outcomes with R_0 direct evidence (three of the three outcomes with R_0 direct evidence are needed for Famine Classification)¹ + 2. Two other pieces of R_1 evidence from the season of analysis 	<ol style="list-style-type: none"> 1. IPC Current adhering to evidence level with limited humanitarian access + 2. Evidence used for current classification at most 12 months old at the end of projection period + 3. Four pieces of R_1 evidence presented with clear assumptions on forecasted trends

¹ Direct evidence for food consumption and livelihood change should ideally be available for indicators that have thresholds assigned for IPC Phase 5 in the IPC Acute Food Insecurity Household Reference Table. If direct evidence is not available for food consumption or livelihood change outcomes but is available for mortality or acute malnutrition, a classification can still be conducted provided that analysts document the analytical process of inference for food consumption or livelihood change from at least four pieces of evidence on outcomes and/or contributing factors indicating what proportions of households are expected to be in the most severe phases..

Function 3: Communicate for Action

- Communication should clearly highlight the fact that the area was classified with reduced evidence due to limited or no humanitarian access using the specific mapping protocols.
- If Famine is being classified, special communication protocols should equally apply.

Function 4: Quality Assurance

- An External Quality Review needs to be conducted when evidence is reduced due to limited or no Humanitarian access and the analysis team did not receive support from the Global Support Unit. See Function 4 under Acute Food Insecurity Protocols for details on External Quality Reviews.



PART 2B

CHRONIC FOOD INSECURITY CLASSIFICATION





Functions

1**Build Technical Consensus****2****Classify Severity and Identify Key Drivers****3****Communicate for Action****4****Quality Assurance**

The purpose of this module is to provide analysts with succinct and clear guidance for completing the Protocols for Integrated Phase Classification of Chronic Food Insecurity and for conducting the IPC Chronic Analysis. These protocols include tools and procedures and are presented according to the four Functions of the IPC: (i) Build a Technical Consensus; (ii) Classify Severity and Identify Key Drivers; (iii) Communicate for Action; and (iv) Quality Assurance.

All the protocols should be completed in the country-owned and -managed (ISS) to mainstream and facilitate the analysis, especially those for Function 2.

Important note for using Part 2B:

1. This Part is an integral part of the IPC Technical Manual Version 3.1, which also includes an Overview of the IPC (Part 1), Protocols for Acute Food Insecurity Classification (Part 2A) and Protocols for Acute Malnutrition Classification (Part 2C).
2. This module focuses on providing succinct and clear guidance to complete the Protocols required to develop IPC Chronic Food Insecurity products. It includes the 13 tools that are required for chronic food insecurity classification as well as a brief overview of the procedures for completing them. Additional guidance, reasoning for technical decisions and other relevant issues are included as IPC Resources on the IPC website.



FUNCTION 1: BUILD TECHNICAL CONSENSUS

Function 1 promotes a neutral and participatory process to build a technical consensus by ensuring that classifications are carried out through multi-agency and multi-sectoral analysis teams and by providing general guidelines to achieve a consensus.

Protocols For Completing Function 1

There are two protocols for completing Function 1 that, when correctly followed, will ensure that the analysis includes the necessary variety of experts from relevant institutions and organizations, and that it is conducted following a consensus-based, unbiased approach. Figure 67 provides an overview of these protocols; specific tools and procedures are provided below for each protocol.

Figure 67: Protocols for Function 1

Protocol	Procedure	Tools
1.1 Create the analysis team with relevant sectors and organizations.	Complete the IPC Analysis Team Matrix and ensure representation of relevant stakeholders.	Tool 1: IPC Analysis Team Matrix
1.2 Conduct the analysis on a consensual basis.	Follow good practices for consensus-building, such as strong facilitation, adequate analytical capacity of analysts, vetting of results and preliminary presentation to decision-makers.	Refers to good practices (no specific tools)

PROTOCOL 1.1: COMPOSE THE ANALYSIS TEAM WITH RELEVANT SECTORS AND ORGANIZATIONS

The **analysis team** should include representatives from different institutions/organizations and sectors so as to create the inclusive environment needed for unbiased consensus-building analysis (Figure 68).

When planning the analysis and forming the analysis team, the following should be considered:

- There is a need to raise awareness on and interest in IPC Chronic Food Insecurity classification among country-level stakeholders prior to initiating the analysis process.
- There is a need to inform partners at the country level in advance of forthcoming analysis activities.
- The analysis team should include members of the national IPC Technical Working Group, which has the overall task of coordinating and implementing IPC in-country and other experts whose knowledge or skills are relevant for the specific analysis, including knowledge of local conditions and context.



Figure 68: The IPC Analysis Team – Examples of members

Examples of members of the IPC analysis team include:

- members of the National IPC Technical Working Group;
- food security analysts and nutritionists who are not part of the Technical Working Group but can contribute to the analysis;
- officers who can support the contextualization and interpretation of evidence;
- sectoral experts as needed;
- communication officers to support the development of communication products.

- The Technical Working Group should ensure that most analysis team members have adequate IPC Chronic Food Insecurity training and have passed the IPC test prior to the analysis.

The **IPC Analysis Team Composition Matrix** needs to be completed for each analysis (Figure 69). If correctly used, it makes it possible to clearly visualize the diversity achieved. The matrix should identify:

- the Technical Working Group chairperson and hosting organization;
- analysis facilitators;
- all analysis participants, including their name, title, organization, area(s) of expertise and IPC training/certification status. Analysts can have advanced knowledge of different sectors, and thus the same person may appear more than once in the matrix.

Figure 69: Composition matrix for the analysis team (Tool 1)

Chairperson: Hosting organization: IPC analysis facilitators:	Stakeholder Organization Representation (Indicate the name, title, organization and IPC training/certification status of each analyst in the relevant cells)				
	National government (at all relevant levels)	National NGOs/civil society/the private sector	Technical agencies/ academic institutions	International NGOs	United Nations agencies
Area of Expertise (include as relevant to the analysis)	Food Security/ livelihoods				
	Nutrition				
	Markets				
	Agriculture				
	Livestock				
	Fisheries				
	Climate				
	Human health				
	Water/sanitation				
	Gender				
	Statistics				
	Conflict analysis				
	Economic development				
	Social development				
	Rural development				
	Other				



PROTOCOL 1.2: CONDUCT THE ANALYSIS ON A CONSENSUAL BASIS

The analysis team members must commit to conducting evidence-based and unbiased analysis, with the objective of classifying and describing food insecurity conditions as accurately as possible through a mutual agreement.

Formulating a mutual understanding and agreement is one of the central tasks of the IPC Technical Working Group leadership and IPC facilitators, and a range of strategies may be applied to this end.

Consensus does not necessarily imply unanimity, since some disagreement or dissent is common. Nevertheless, consensus should leave all parties in a better position than when they started, thus adding to the trust and credibility among themselves and in the public's eye. Common ground between the analysts can be sought through joint analysis and critical review of the data available, and by a good understanding of the context of the area analysed. However, since arriving at a consensus is complex, it requires the support of a qualified facilitator. One of the initial tasks of the IPC Technical Working Group leadership and IPC analysis facilitators is to define the ground rules for building consensus with the participating analysts (see examples in Figure 70).

Consensus-building is dependent on the ability of analysts to critically analyse and discuss evidence. Hence, it is imperative that members have a strong understanding of their sector(s), food security and IPC protocols. Furthermore, in order to ensure that adequate time is spent to critically review evidence and achieve consensus on classification, it is imperative that evidence be well prepared and organized for and prior to the analysis.

Consensus is not always achieved. Disagreements may relate to a particular area or analysis overall. In these situations, the best approach is to address the disagreements within the analysis team through neutral facilitation and seek an agreement at the country level to avoid delays. If this is not possible, the dissenting organization(s) can decide to disagree with the analysis results, in which case the minority view may be documented and communicated to decision-makers. However, if the disagreement relates to classification in IPC Level 4, an external quality review of the alternative analysis (reflecting the minority view) may be requested either by the Technical Working Group or partner(s) supporting the minority view.

Vetting of classification and population estimations is also a good practice for IPC consensus-building. Although the IPC does not define the process for reaching consensus, it strongly recommends that some form of vetting be carried out. Vetting usually takes place after preliminary classification and population estimates have been performed, and it typically consists of sessions during which IPC analysts who participated in the analysis review, discuss and debate the preliminary IPC classifications and population estimates resulting from the exercise, reach consensus, and agree on the final results.

Presentation of IPC results to key decision-makers before public release is another recommended activity. This process achieves two objectives: (i) it is a double-check on the results, allowing for open discussion as necessary, which may in some instances lead the Technical Working Group to revisit the analysis if supported by evidence; and (ii) it promotes ownership of the findings by key stakeholders before the results are presented to the public.

Figure 70: Consensus-building – Examples of ground rules

- Identify the modalities of the analytical process (e.g. subgroups conduct preliminary analyses and present their findings to the larger group for vetting);
- Agree on how decisions will be made (e.g. based on a full consensus or majority view) and how minority views will be documented and communicated.

FUNCTION 2: CLASSIFY SEVERITY AND IDENTIFY KEY DRIVERS

Figure 71: Protocols for Function 2

Protocol	Procedure	Tool
2.1 Use Analytical Framework to guide convergence of evidence.	Analyse evidence following the IPC Food Security Analytical Framework.	Tool 2: IPC Food Security Analytical Framework
2.2 Compare evidence against the Reference Table.	Use the IPC Chronic Food Insecurity Reference Table for characteristics of levels and thresholds of selected international indicators.	Tool 3: Reference Table
2.3 Adhere to parameters for analysis.	Respect the key parameters as the rules for classification.	Tool 4: Analytical Parameters
2.4 Evaluate evidence Reliability.	Assess the soundness of methods and time relevance of all evidence following stipulated parameters.	Tool 5: Evidence Reliability Scores
2.5 Meet minimum evidence and analysis requirements.	Present evidence and analysis that adhere to minimum requirements.	Tool 6: Evidence-level Criteria
		Tool 7: Minimum Analysis Requirements
2.6 Methodically document evidence and analysis and provide them upon request.	Use the Analysis Worksheet preferably in the Information Support System (ISS).	Tool 8: Analysis Worksheet

Function 2 promotes systematic analysis of complex information to classify populations and areas into meaningful categories to guide decision-making. Classification of Chronic Food Insecurity focuses on identifying areas with severe food insecurity that requires urgent interventions to improve the quality and quantity of food consumption, and to lower the prevalence of chronic malnutrition. This is usually reached through interventions focusing on structural dimensions.

By completing Function 2, IPC classification should be able to answer the following questions:

- **How severe** is the situation?
- **Where** are the most chronically food-insecure people located?
- **How many people** are chronically food-insecure?
- **Why** are people chronically food-insecure?
- **Who** are the chronically food-insecure?

Protocols For Completing Function 2

In order to complete Function 2 in IPC Chronic Food Insecurity Analysis, analysts need to follow six protocols, as briefly introduced in Figure 71 and further explained below.

While this section focuses only on the technical protocols that must be followed during the actual IPC Chronic Food Insecurity Analysis, the completion of the entire analysis cycle, including the preliminary activities related to adequate planning and preparation for analysis workshops, is of uttermost importance for a high quality and wide use of IPC products. Especially important to successful analysis is the preparation of evidence, including identification, gathering and conducting re-analysis as needed to better align indicators to the Reference Table and unit of analysis.



PROTOCOL 2.1: USE THE ANALYTICAL FRAMEWORK TO GUIDE CONVERGENCE OF EVIDENCE

Figure 72: The IPC Food Security Analytical Framework – Elements for analysis

- Contributing factors

Causal factors

- Vulnerabilities
- Hazards (acute events or ongoing conditions)

Food security dimensions

- Availability
- Access
- Household utilization
- Stability

- Outcome elements

First-level outcomes

- Food consumption
- Livelihood change

Second-level outcomes

- Nutritional status
- Mortality

The purpose of the IPC Food Security Analytical Framework (Figure 76) is to guide convergence of evidence through a logical outline of food insecurity. The framework is divided into ‘contributing factors’ and ‘outcomes’ (Figure 72). While contributing factors include causal factors and dimensions of food insecurity, outcomes include the expected manifestation of food insecurity at the household and individual levels. These are related to inadequate food consumption in terms of food quality and quantity, and chronic malnutrition.

Causal factors: vulnerabilities and acute events or ongoing conditions

According to the IPC, the interaction between recurrent shocks/ongoing conditions and vulnerabilities drives food insecurity. Thus, analysis of these interactions identifies the key drivers of food insecurity. Vulnerability is defined as the household’s exposure, susceptibility and resilience to specific recurrent hazards. According to the IPC, vulnerability analysis is mainly driven by an understanding of: the livelihood strategies of households (how they obtain food and income; how sustainable the food and income sources are; and expenditure patterns); the livelihood assets that the households can rely on including financial, physical, human, social and natural assets; and how policies, institutions and processes, gender, and mitigating factors positively or negatively affect, or could affect, their ability to achieve food security and to cope with the different recurrent acute events or ongoing conditions. Recurrent acute events or ongoing conditions can be natural or human-made, including recurrent droughts or floods or other natural phenomena, price volatility, energy or food shortages, civil unrest, diseases, generalized poverty, and other conditions that can impact food security.

The concept of resilience is explicitly included in the IPC Food Security Analytical Framework, since it is acknowledged as a factor that, together with exposure and susceptibility, determines the vulnerability of households to specific recurrent acute events and ongoing conditions. Consideration of resilience is ensured through an examination of livelihood strategies, assets and policies, institutions and processes. IPC analyses can contribute to and benefit from more comprehensive analyses of resilience.

Food security dimensions: availability, access, household utilization and stability

The four food security dimensions (food availability, access, utilization and stability) are directly impacted by the results of the interactions between the recurrent acute events/ongoing

Figure 73: Limiting dimensions to food security – Examples

- Semi-arid or arid climate may affect food production levels and thus limit food availability.
- Household access to food is limited by low or irregular income, e.g. from casual labour, resulting in low purchasing power and the inability to cover all basic food and non-food needs.
- Inadequate feeding practices of children, taboos limiting consumption of certain nourishing food items, poor food storage practices, and inadequate access to cooking fuel and potable water negatively affect food utilization.

conditions and the vulnerabilities. Analysis of how each of the dimensions limits food security is important to confirm and contextualize outcome indicators (Figure 73). This information enables a better design of interventions, which may differ depending on what is limiting food security (i.e. food availability, access, utilization or stability). These dimensions interact in a sequential manner as follows:

- Food availability addresses whether food is actually or potentially physically present for purchase or consumption, including aspects of production, food reserves, imports, markets and transportation, and wild foods.
- Once analysis on the presence of food has been conducted, the next question is how households access it through different sources (e.g. own production, purchases, gifts, aid, gathering) and whether this will be sufficient. The ability to access enough food will depend on **physical access** (e.g. crop/livestock production, gathering, fishing, and distance to markets), **financial access** (e.g. purchasing power, access to credit) and **social access** (e.g. social networks, gifts, and family support).
- If food is available and households have adequate access to it, the next question is whether households are able to consume the accessible food and whether that provides adequate quantities of nutrients and energy, usually a factor of food preferences, preparation, storage, and access to adequate quantity and quality of water.
- Once the dimensions of availability, access and utilization are understood, the next question is whether the whole system is stable, thus ensuring that the households are food-secure at all times. Stability problems can refer to short-term instability, which can lead to recurrent acute food insecurity, or medium-/long-term instability, which can lead to chronic food insecurity. Climatic, economic, social and political factors can all be a source of instability.

Figure 74: First-level outcomes – Examples

- Proportion of households unable to consume adequate diets, such as those with a poor FCS;
- Proportion of households highly reliant on staple foods, or proportion of children within households with low dietary diversity.

First-level outcomes: Food consumption and livelihood change

If food availability, access, utilization and stability are inadequate, the household's consumption is likely to also be inadequate. The severity of the inadequacy of food consumption is dependent on how inadequate one or more elements are, and how well households are able to adapt to the situation. In the IPC Chronic Food Insecurity analysis the adequacy of both the micronutrient and energy intake is assessed, whereas in the IPC Acute Food Insecurity analysis, the focus is on the adequacy of energy intake (Figure 74).



If households have difficulties in securing enough food, they may engage in unsustainable strategies, such as selling assets, decreasing expenditure on education and health, and consuming seeds. In situations of chronic food insecurity, however, the presence of severe livelihood coping behaviour such as selling homes or land because of food insecurity is very rare, and even other negative livelihood coping behaviours are not common over a long period of time. As a result, livelihood change outcome is not analysed in the IPC's Chronic Food Insecurity Analysis; rather, the sustainability and strength of household livelihoods are analysed, by focusing on assessing the share of households that employ low-value livelihood strategies, i.e. strategies that yield either little or unstable income that is insufficient to cover the basic needs of a household in terms of food consumption, education and health expenses.

Second-level outcomes: Nutritional status and mortality

The focus of the analysis of nutritional status is on chronic malnutrition, which is measured by the height-for-age Z-score (HAZ) and is estimated at the area level by the prevalence of children 6–59 months with a HAZ of less than -2 standard deviations, referred to as prevalence of stunting (Figure 75). It is generally agreed that stunting is caused by poor diets (quantity and quality of consumption) and morbidity, which in turn are a product of inadequate caring and feeding practices, and inadequate health services and environmental health, together with food security factors. Given that many of the root causes of chronic food insecurity and chronic malnutrition are the same, it is expected that a prevalence of chronic malnutrition informs the analysis of the chronic food insecurity situation to a certain extent.

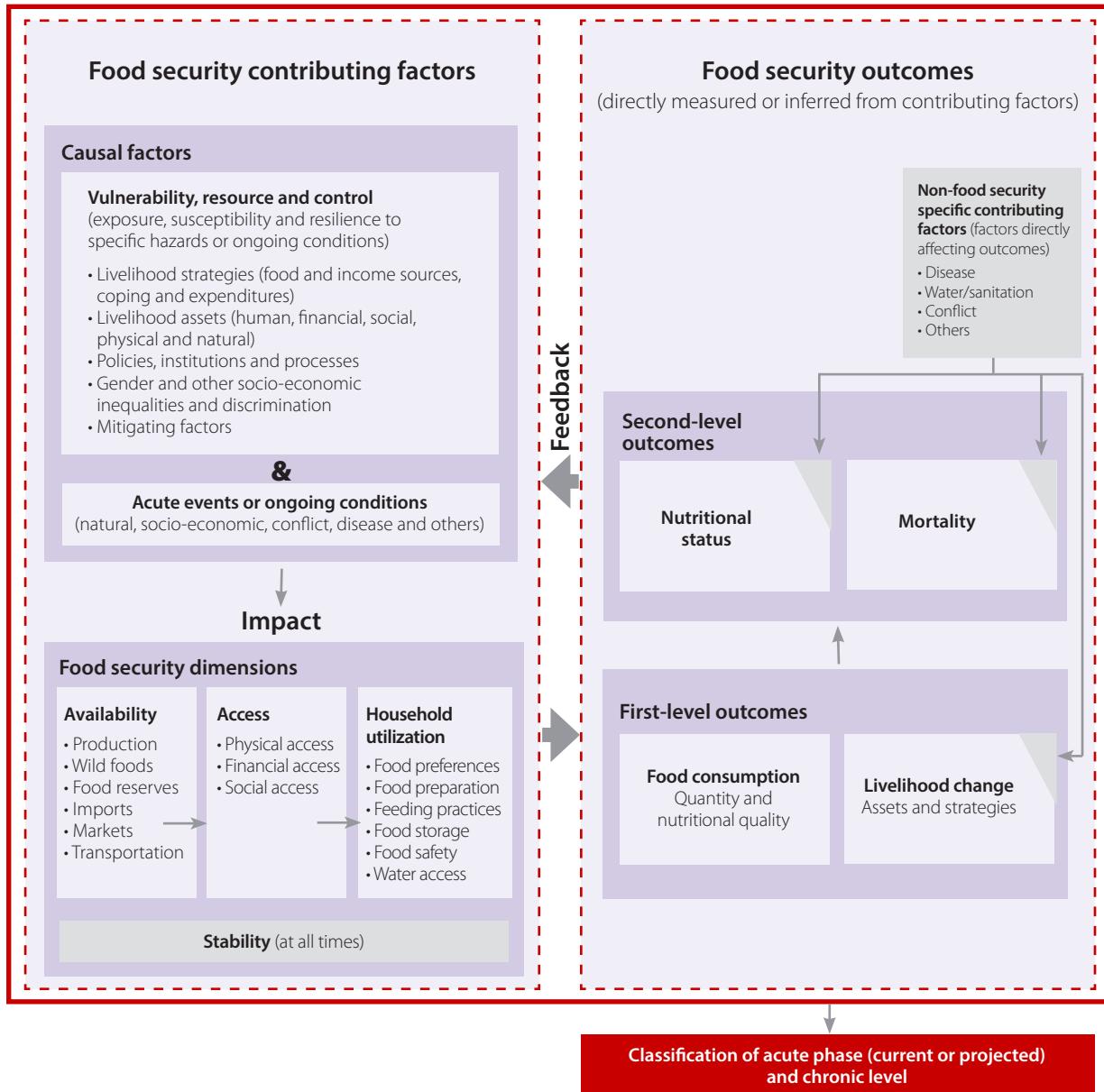
Mortality as an outcome is not analysed in the IPC's Chronic Food Insecurity Analysis. While it is known that malnutrition contributes to around half (45 percent) of the deaths of children under 5 globally,¹⁴ the use of death rates to support the classification of chronic food insecurity is not included for two main reasons. First, death rates are expected to remain at a stable and relatively low level (typically a CDR at or below 0.5 per 10,000 daily and a U5DR at or below 1 per 10,000 daily) in chronic situations, making it less useful for differentiating severity. In addition, since the mortality indicators are expressed as rates rather than as a prevalence, unlike the other indicators included in the Reference Table, their usefulness is further decreased since they do not inform the distribution of populations among the four levels.

Figure 75: Second-level outcomes – Examples

- In situations with a high chronic food insecurity level, it is also common to find high stunting rates for children. If the chronic food insecurity level in a given area is 4 (severe), it is expected that there is also a sizeable share of children who are severely stunted, with a height-for-age Z-score (HAZ) less than -3 standard deviations.
- If the chronic food insecurity level is 3 (moderate), it is expected that a sizeable share of children in the area are at least moderately stunted, with a HAZ between -3 and -2 standard deviations.

¹⁴ WHO, Children: reducing mortality. Fact sheet, updated in October 2017. <https://www.who.int/en/news-room/fact-sheets/detail/children-reducing-mortality>

Figure 76: The IPC Food Security Analytical Framework (Tool 2)





PROTOCOL 2.2: COMPARE EVIDENCE AGAINST THE IPC CHRONIC FOOD INSECURITY REFERENCE TABLE

The purpose of the IPC Chronic Food Insecurity Reference Table is to guide comparisons of available evidence against generally accepted international standards and thresholds (Figure 81).

The IPC Chronic Food Insecurity Reference Table is organized according to the IPC Analytical Framework – i.e. outcomes of food consumption (organized into quality and quantity of dietary intake) and nutrition; and contributing factors of vulnerabilities and hazards, and the four food security dimensions. The Table guides the critical evaluation and contextualization of evidence in relation to different severities of chronic food insecurity.

The IPC Chronic Food Insecurity Reference Table is organized into four severity levels: Level 1: No or Minimal; Level 2: Mild; Level 3: Moderate; and Level 4: Severe (Figure 77). The Table describes the typical characteristics for each level and assumes that the populations of households under each level are likely to share the same general characteristics (Figure 78).

Each level is linked to priority response objectives. While the Chronic Food Insecurity Reference Table links response objectives with each level, it is necessary to conduct a response analysis subsequent to the completed analysis to effectively determine which particular interventions and activities are best suited to mitigating chronic food insecurity.

Figure 77: The IPC Reference Table – Example of contents for Level 4

Each IPC Level has a description, priority response objective, and a set of common characteristics expected among households. Below is an example of how this is presented for IPC Chronic Food Insecurity Level 4.

- **Level 4 Description:** In a common year, households have seasonal deficits in quantity of food for more than four months of the year and consistently do not consume a diet of adequate quality. Household livelihoods are very marginal and not resilient. Households are likely to have severely stunted children.
- **Priority Response Objectives for Level 4:**
 - Households experiencing Level 4 should be targeted with safety net programmes to improve quality and quantity of food consumption.
 - Complementary programmes should also be implemented to address underlying factors to substantially decrease chronic food insecurity and chronic malnutrition.
- **Key characteristics of Level 4:** Populations of households experiencing gaps in quality and quantity of food consumption needs are also more likely to have very limited livelihood strategies and a low income that does not allow them to cover their basic food and non-food needs. These households are expected to have no or very little resilience to shocks. It is also likely that households have children who are severely chronically undernourished.

Figure 78: Some common characteristics expected among households within Levels

Populations of households experiencing gaps in food consumption quality and quantity (Level 4) are also more likely to have very limited livelihood strategies and a low income that does not allow them to cover their basic food and non-food needs. These households are expected to have no or very little resilience to shocks. It is also likely that households have children who are severely chronically undernourished.

Figure 80: Using the Reference Table with analytical reasoning – Context and critical thinking is key

Evidence should be analysed against the IPC Reference Table in context and using critical reasoning. Below is an actual example from Burundi, IPC 2016.

'The IPC Chronic Food Insecurity Analysis showed that despite most food consumption quality indicators (such as children having minimum dietary diversity) showing a relatively severe situation, the percentage of cash spent on food provided contradictory evidence across the country.'

'It was noted that in the rural context of Burundi, households do not typically purchase food, but consume their own production, which explained the generally low expenditure on food items.'

'Yet, the proportion of consumption of starchy foods remained high, with around half of households in most areas eating more than 70 percent of their total caloric intake from starchy food items. After discussions and clarifications, it was decided not to emphasize the evidence on the proportion of cash expenditure on food in the analysis or classification.'

The IPC Chronic Food Insecurity Reference Table identifies **globally comparable cut-offs for key food security outcome indicators** so that the population of households can be distributed across the four levels. Evidence for these indicators is recognized by the IPC as **direct evidence**. Although the IPC identifies "generally globally comparable" indicator cut-offs, it acknowledges that, inevitably, indicator cut-offs do not always align due to issues relating to context and to indicator characteristics. Thus, while the IPC Chronic Food Insecurity Reference Table provides general guidance for evidence alignment, it is the convergence of evidence based on critical contextualization and an understanding of indicator use and limitations that will allow analysts to conclude on a classification (Figure 80). Analysts will be required to explain their reasoning for classification, including reference to supporting and contradictory evidence. Figure 79 summarises the key expected characteristics of indicators for each level, organized by food security elements.

Figure 79: The IPC Reference Table – General profile for each Level

According to IPC, the severity of chronic food insecurity among the population of households is classified as a function of the size and duration of food consumption gaps in terms of quality and quantity of food consumption. Populations of households experiencing larger and longer gaps in food consumption are also more likely to have lower sustainability of livelihoods and less resilience to commonly recurring shocks. Given the persistence of gaps in quality and quantity of food as well as insufficient livelihood strategies and assets, these households are also more likely to have chronically undernourished members. Although the relationship between these food security elements is not "one-to-one", IPC assumes that populations of households experiencing certain conditions are also more likely to experience other conditions of similar severity. Convergence of evidence on the food security elements is required to reach the ultimate conclusions and classification.

	Level 1 No/Minimal	Level 2 Mild	Level 3 Moderate	Level 4 Severe
Classification of population of households by food consumption for an active and healthy life at all times.				
First-level outcome	Food consumption - Quality of diet	Adequate	Moderately inadequate	Inadequate
	Food consumption - Quantity of diet	Adequate	Adequate	Mildly inadequate
Populations of households with differing food consumption levels are also more likely to have the following conditions..				
Second-level outcome	Nutritional status - Presence of chronically malnourished member	No/Minimal	Not likely	Likely members moderately malnourished
Contributing factors	Household's livelihoods (strategies and assets)	Sustainable	Borderline sustainable	Marginally sustainable
	Household's resilience to common shocks	Adequate	Limited	Very limited

Note: Descriptions of condition definitions, including adequacy levels, are included in the Reference Table.



Although the IPC Chronic Food Insecurity Reference Table only identifies selected indicators as direct evidence, it does not preclude the use of **information from other indicators not included in the Table** during the analysis. In fact, the IPC encourages the inclusion of other relevant indicators in the analysis. The Reference Table is not for review at the country or regional levels; however, it may be updated by the global IPC partnership through the Technical Advisory Group, considering users' feedback and the latest technical developments.

Indirect evidence includes all relevant evidence not listed in the IPC Chronic Food Insecurity Reference Table, including locally specific indicators on outcomes and most indicators on contributing factors. Indirect evidence is usually available at the subnational levels with greater frequency, since it is often collected through national monitoring systems. Furthermore, some of these locally specific indicators may have been calibrated for local conditions. Since the Reference Table does not identify globally applicable cut-offs for indirect evidence, such evidence needs to be interpreted and analysed within their context.

If, however, locally applicable cut-offs have been developed, analysts may refer to them. In the absence of locally applicable cut-offs, it is the task of the analysts to understand and infer the meaning of the evidence and to relate the evidence to the level descriptions and other indicators and their cut-offs.

Figure 81: The IPC Chronic Food Insecurity Reference Table (Tool 3)

Purpose: To guide convergence of evidence by using generally accepted international standards and cut-offs. The classification aims to guide decision-making aiming at medium-term improvements in food security.

Chronic food insecurity level name and description	Level 1 No/Minimal Chronic Food Insecurity	Level 2 Mild Chronic Food Insecurity	Level 3 Moderate Chronic Food Insecurity	Level 4 Severe Chronic Food Insecurity				
Key Implications for response planning ¹	Monitor the food security situation, invest in disaster risk reduction, and reinforce livelihoods as needed.	Monitor the food security situation, invest in disaster risk reduction, and protect and strengthen livelihoods as needed. Address underlying factors to increase the quality of food consumption.	Urgent Action Required to: → Address underlying factors to increase the quality and quantity of food consumption and decrease chronic malnutrition. Consider safety net programmes as needed.	Implement safety net programmes to improve the quality and quantity of food consumption. Implement complementary programmes to address underlying factors to substantially decrease food insecurity and chronic malnutrition.				
Household Outcomes: Food Consumption ¹²	Quality: Adequate nutrient intake Share of energy from macronutrients: Carbohydrate 55–75%, Fat 15–30%, Protein 10–15% ⁶ Children with minimum dietary diversity⁶ Minimum Dietary Diversity of Women⁷ ≥5 Starchy Staple Ratio⁸ <50% of kcal consumption Starchy Staples Expenditure Ratio⁹: <30% of food consumption-expenditure	Quality: Moderately inadequate nutrient intake during at least some months of the year Share of energy from macronutrients: Borderline inadequate Children not eating minimum dietary diversity: non-defining characteristic (NDC) ¹⁰ to differentiate L2, L3 & L4 Minimum Dietary Diversity of Women: <5 - NDC to differentiate L2, L3 & L4 Starchy Staple Ratio: 50–70% of kcal consumption Starchy Staples Expenditure Ratio: 30–50% of food consumption-expenditure	Quality: Inadequate nutrient intake during most of the year Share of energy from macronutrients: Inadequate Children not eating minimum dietary diversity: NDC ¹ Minimum Dietary Diversity of Women: NDC ¹ Starchy Staple Ratio: >70% of kcal consumption Starchy Staples Expenditure Ratio: >50% of food consumption - expenditure	Quantity: Inadequate ongoing moderate deficits and/or seasonal severe energy deficits Dietary Energy Intake¹²: Insufficient Prevalence of Undernourishment¹³: not undernourished				
Area outcomes Nutritional Status ^{21/22}	Stunting among children²³: height-for-age Z-score (HAZ) ≥ -2 standard deviations		Stunting: Moderately stunted (HAZ < -2 standard deviations but ≥ -3 standard deviations)	Stunting: Severely stunted (HAZ < -3 standard deviations)				
Contributing Factors	Hazards and vulnerabilities²⁴ Availability, access, utilization, stability	Livelihood strategies, assets and policies, institutions and processes²⁵: Sustainable Reliance on low-value livelihood strategies²⁶: Not present National Poverty Line (NPL)²⁷: Above poverty line % of total cash expenditure spent on food²⁸: <40% Total income as a % of survival needs²⁹: >150% Household resilience³⁰: Resilient Iodized salt³¹: Is present in the household	Livelihood strategies, assets and policies, institutions and processes: Borderline sustainable Reliance on low-value livelihood strategies: Not present National Poverty Line: Above poverty line % of total cash expenditure spent on food: 40–50% Total income as a % of survival needs: >125–150% Household resilience: Limited resilience Iodized salt: Is present in the household	Livelihoods strategies, assets and policies, institutions and processes: Marginal Reliance on low-value livelihood strategies: Present National Poverty Line: Below poverty line but above extreme poverty line % of total cash expenditure spent on food: 50–70% Total income as a % of survival needs: 110–125% Household resilience: Very limited resilience Iodized salt: Is not present in the household	Livelihoods strategies, assets and policies, institutions and processes: Very marginal Reliance on low-value livelihood strategies: Present National Poverty Line: Below extreme poverty line % of total cash expenditure spent on food: >70% Total income as a % of survival needs: <110% Household resilience: Not resilient Iodized salt: Is not present in the household	Inadequate to meet food consumption requirements for a diet of acceptable quantity and quality Water Source³²: Improved and Water Access³³: ≥15 litres per person per day	Inadequate to meet food consumption requirements for a diet of acceptable quantity and quality Water Source: Non-improved or Water Access: <15 litres per person per day	Very inadequate to meet food consumption requirements for a diet of acceptable quantity and quality Water Source: Non-improved and Water Access: <15 litres per person per day

For contributing factors, most indicators and cut-offs for inferring the IPC level of Chronic Food Insecurity need to be determined and analysed according to the livelihood context of the area.



Explanatory Notes for the IPC Chronic Food Insecurity Reference Table

1. **Response planning** should include monitoring and disaster risk reduction activities across all IPC levels of chronic food insecurity, including IPC Level 1. For the most chronically food-insecure households (IPC Levels 3 and 4), responses focusing on disaster risk reduction, protection and strengthening of livelihoods, and monitoring activities are assumed necessary to decrease chronic vulnerability and to increase resilience to recurrent shocks. Response planning should also consider complementary and mutually reinforcing interventions among households at different levels of food insecurity.
2. **Food consumption indicators** that are included in the IPC Chronic Food Insecurity Reference Table have been identified by the IPC Global Partners who participate in the IPC Food Security Working Group. Most of these indicators capture overall food consumption and experiences; the IPC Global Support Unit and Food Security Working Group have interpreted some of them as being more closely correlated with either the quality or the quantity of food consumption. This grouping is illustrative and only aims to facilitate understanding and analyses of how aspects of quality and quantity are characterized in the area under analysis. The indicators included in the IPC chronic food insecurity Reference Table are not direct measures of each food consumption component; rather, the convergence of evidence on these different aspects from available information makes it possible to characterize the severity of chronic food insecurity for the area, based in part on the relationships between the quality and quantity of food consumption.
3. The IPC Food Security Working Group recognizes that indicators based on the analysis of **households' responses to and experiences of food insecurity**, such as the Household Hunger Scale (HHS), the Reduced Coping Strategies Index (rCSI), the Food Insecurity Experience Scale (FIES), the Household Food Insecurity Access Scale, and the Latin American and Caribbean Food Security Scale, may be useful as part of the convergence of evidence process for classifying the severity of Chronic Food Insecurity in a given area. With the exception of the HHS and the FIES, these indicators and their respective cut-offs are not included in this version of the IPC Chronic Food Insecurity Reference Table. National IPC Technical Working Groups, in close collaboration with the IPC Global Support Unit and Food Security Working Group, are asked to carefully include all existing coping and experience-based indicators in their Chronic Food Insecurity analyses as indirect evidence of household responses to food insecurity, and to provide feedback to the Global Support Unit and Food Security Working Group to inform decisions on the possible inclusion of these other indicators in future versions of the IPC Chronic Food Insecurity Reference Table.
4. Adequate dietary nutrient intake relates to the condition of regularly consuming, over a specified period of time, an amount of food that provides the dietary energy needed to cover the requirements and recommendations of nutrients for an active and healthy life. Although the IPC Chronic Food Insecurity Reference Table does not weigh indicators, a **tier rating of indicators** is provided to guide analysts in considering how strongly each of the indicators included in the food consumption quality portion of the IPC Chronic Food Insecurity Reference Table relates to the quality of food consumption. Indicators with stronger relationships to food consumption quality are given a tier rating of 1, while indicators with a weaker relationship are given a tier rating of 3 (Figure 82).
5. The macronutrient cut-offs presented for Level 1 are drawn from the Joint WHO/FAO Expert Consultation guidelines for a balanced diet.¹⁵ It is hoped that in future collaborative efforts through partnerships and applied analyses, it will be possible to identify specific cut-offs for the **share of energy from macronutrients** for IPC Levels 2, 3 and 4 of the IPC Chronic Food Insecurity Reference Table. In addition, national IPC Technical Working Groups are urged to use this and any other similar indicators in close collaboration with the IPC Global Support Unit and the Food Security Working Group for convergence toward classification in IPC Levels 2, 3 and 4, and to seek assistance for analyses of data on the share of energy from macronutrient intake with the IPC Global Support Unit for use in IPC Chronic Food Insecurity analysis.
6. **Minimum dietary diversity among children** aged 6–23 months is a WHO standard indicator on infant and young child feeding practices and is collected from the self-reporting of mothers in Standardized Monitoring and Assessment of Relief and Transitions surveys, Demographic and Health Surveys and Multiple Indicator Cluster Surveys. It has been noted that information on the diversity of dietary intake at the individual level relates more strongly to dietary quality than to dietary quantity (FAO, 2010¹⁶).
7. Indicators of **women's dietary diversity**, developed by FANTA and FAO, are used to indicate the overall quality of an individual's diet during the previous day. These indicators are based on women's self-reporting and include either nine or ten food groups, depending on whether the evidence comes from the Individual Dietary Diversity Score, which is composed of nine food groups, or from the Minimum Dietary Diversity for Women (MDD-W), which is composed of ten food groups. Independently of the source of evidence, a cut-off of five or more food groups for an acceptable diet has been validated for both the Individual Dietary Diversity Score and MDD-W.¹⁷ Since 2014, however, the MDD-W has emerged as the main indicator used to measure women's dietary diversity and as a result, it has been included in the IPC Chronic Food Insecurity Reference Table rather than Individual Dietary Diversity Score. For the Individual Dietary Diversity Score and the MDD-W indicators, women are defined as females aged 15 to 49. It has been agreed that information on the diversity of dietary intake at the individual level relates more strongly to dietary quality than to dietary quantity (FAO, 2010).

Figure 82: IPC Chronic Food Insecurity Reference Table food quality indicators

Food quality indicators	Tier rating
Share of Energy from Macronutrients	1
Children Eating Minimum Dietary Diversity	2
Minimum Dietary Diversity of Women (MDD-W)	2
Starchy Staple Ratio (SSR)	2
Starchy Staple Expenditure Ratio (SSEXRR)	3

¹⁵ World Health Organization. 2003. Diet, Nutrition and the Prevention of Chronic Diseases. Report of a Joint WHO/FAO Expert Consultation. WHO, Technical Report Series No. 916. Geneva: World Health Organization.

¹⁶ FAO. 2010. Guidelines for measuring household and individual dietary diversity. www.fao.org/docrep/014/i1983e/i1983e00.pdf

¹⁷ FAO and FANTA. July 2014. Consensus Meeting on a Global Indicator to Measure Women's Dietary Diversity.

www.fantaproject.org/news-and-events/2014-consensus-meeting-on-mddw

8. The **Starchy Staple Ratio** (SSR) indicates the proportion of energy from starchy foods, such as maize, rice, potatoes and cassava, based on the self-reporting of foods consumed. This indicator is used as one piece of evidence to indicate the adequacy of the share of energy from macronutrients. Although there is a direct relationship between the SSR and the share of energy from carbohydrates, it is expected that the SSR will be lower than the percentage of total energy coming from carbohydrates, since non-starchy foods such as sugar and vegetables are also considerable sources of carbohydrates. The cut-offs for the SSR identified in the IPC Chronic Food Insecurity Reference Table are based on unpublished applied research conducted by the World Bank. Further research is recommended to assess the appropriateness of these SSR cut-offs.
9. The **Starchy Staple Expenditure Ratio** (SSEXER) indicates the share of self-reported food expenditure on starchy staples, which are typically among the cheapest sources of calories. The cut-offs for the SSEXER identified in the IPC Chronic Food Insecurity Reference Table (as for the SSR described above) are based on unpublished applied research conducted by the World Bank. Further research is recommended to assess the appropriateness of these SSEXER cut-offs.
10. **Non-defining characteristics** (NDCs) relate to the inability of the IPC Global Support Unit and Food Security Working Group to identify the cut-offs needed to assist in estimating the proportion of households in specific levels of Chronic Food Insecurity. This often occurs either because an indicator is binary (yes/no), or because the IPC Global Support Unit and Food Security Working Group have not found sufficient evidence to inform specific cut-offs by the time of the release of this IPC Chronic Food Insecurity Reference Table.
11. **Adequate dietary energy intake** relates to the condition of regularly consuming, over a relevant period of time, an amount of food that provides the dietary energy needed to cover the requirements for an active and healthy life. Although the IPC Chronic Food Insecurity Reference Table does not weigh indicators, a **tier rating of indicators** is provided to guide analysts in assessing to what degree each of the indicators included in the food consumption quantity section of the IPC Chronic Food Insecurity Reference Table is correlated with the quantity of food consumption. Indicators with stronger relationships are given a tier rating of 1, while indicators with a weaker relationship are given a tier rating of 3 (Figure 83).
12. The IPC Global Support Unit and Food Security Working Group acknowledge that an assessment of the probability of insufficient **dietary energy intake** in a population or group of individuals is best obtained from data collected through individual dietary intake survey. Although highly preferred, data from such surveys are seldom available at the needed disaggregation level.
13. The **prevalence of undernourishment** (PoU) is a corporate FAO indicator and refers to the percentage of the population with any gap in their habitual dietary energy consumption. It can be calculated from individual dietary intake assessments or household food consumption data. When no data from individual dietary intake assessments are available, the PoU is computed based on food consumption data from household surveys, for example from Income and Expenditure Surveys. For IPC Chronic Food Insecurity analyses, the PoU is first used to estimate the percentage of the population in Levels 3+4. In a second step, a differentiation between Levels 3 and 4 is conducted based on the size of the mean dietary energy consumption gap in the undernourished population. The percentage of the population that is undernourished is divided into two groups: those that have an estimated average gap lower than 10 percent of the minimum dietary energy requirements, and those that have a gap equal to or greater than 10 percent of the minimum dietary energy requirements. The two shares are assigned, respectively, to Levels 3 and 4. Testing conducted by the Global Support Unit, FAO and SICA with two PoU datasets have confirmed the appropriateness of the selected cut-offs. It should, however, be noted that food consumption data collected in household surveys are often imprecise. While using a statistical model for the PoU helps in reducing the risk of bias, the estimates can still be unreliable, especially when based on small samples or when appropriate sampling weights are not available. The Global Support Unit and the Food Security Working Group acknowledge the difficulties in analysing this indicator, and the FAO Statistics Division is committed to assisting countries' National Statistical Offices in carrying out estimations of the PoU at the national and sub-national levels in the context of the support given for the monitoring of the 2030 Agenda for Sustainable Development.
14. The **Food Consumption Score** (FCS) is an indicator collected in all WFP assessments and monitoring activities. The FCS is a composite score based on self-reported information on dietary diversity, food frequency (number of days food groups were consumed during the past 7 days), weighted by the ascribed relative nutritional importance of different food groups. Based on standard thresholds, households are classified into one of three Food Consumption Groups: poor, borderline, or acceptable.
- 15A. The **Food Insecurity Experience Scale** (FIES) is an FAO indicator and a global metric for the severity of household or individual food insecurity (defined as the inability to access food during the last 12 months). The metric is based on information provided by data on self-reported experiences and conditions typically associated with food insecurity, analysed through Item Response Theory methods. Data collected with the FIES Survey Module or with other existing experience-based food security scales (e.g. the Household Food Security Survey Module, the Latin American and Caribbean Food Security Scale, the Mexican Food Security Scale, or the Brazilian Food Insecurity Scale) can be used to estimate the distribution of households or individuals by level of severity. The levels of severity are expressed on the FIES global reference scale defined by FAO,¹⁸ thus improving the cross-country comparability of the classifications. Pending further validation to be conducted as more FIES datasets become available, the threshold currently defined by FAO as indicative of moderate or severe and used for global monitoring of Sustainable Development Goal Target 2.1 will be used to support the convergence of evidence to estimate the percentage of households in IPC Chronic Food Insecurity Levels 3+4 for the IPC Chronic Food Insecurity Reference Table.

Figure 83: IPC Chronic Food Insecurity Reference Table food quantity indicators

Food quantity indicators	Tier rating
Individual adequacy of caloric intake	1
Prevalence of undernourishment (PoU)	1
Food Consumption Score (FCS)	2
Food Insecurity Experience Scale (FIES)	2
Household Dietary Diversity Score (HDDS)	2
Household Hunger Score (HHS)	2
Presence of Household Economy Approach (HEA) Survival Deficit	2
Minimum Meal Frequency (MMF) among children (PoU)	3
Months of Adequate Household Food Provisioning (MAHFP)	3

¹⁸ Ballard, T.J., Kepple, A.W. & Cafiero, C. 2013. The food-insecurity experience scale: development of a global standard for monitoring hunger worldwide. Technical Paper. Rome: FAO. www.fao.org/economic/ess/ess-fs/voices/en



16. The **Household Dietary Diversity Score** (HDDS) developed by FANTA and FAO aims to reflect the economic ability of a household to access a variety of foods and is based on household self-reporting of the number of food groups (out of a total of 12) consumed in the previous 24 hours. Studies have shown that an increase in dietary diversity is associated with higher socio-economic status and household energy availability.^{19/20} Cut-offs presented in the IPC Chronic Food Insecurity Reference Table are based on case studies and the FANTA-FEWS NET Household Food Consumption Indicator Study report (2015).
17. The **Household Hunger Scale** (HHS) developed by FANTA assesses whether households have experienced problems of food access in the preceding 30 days, as self-reported by the households to classify the severity of food insecurity. The household hunger scale assesses food consumption strategies adopted by households facing a lack of access to food. The household hunger scale is composed of three questions, which were found to be valid across cultures: (i) In the past four weeks or 30 days, was there ever no food to eat of any kind in your house due to a lack of resources to obtain food? (ii) In the past four weeks or 30 days, did you or any household member go to sleep at night hungry because there was not enough food? and (iii) In the past four weeks or 30 days, did you or any household member go a whole day and night without eating anything at all because there was not enough food?
18. The **Household Economy Analysis** (HEA) is a livelihoods-based framework created by Save the Children UK and is currently used by various organizations, including Save the Children, the Food Economy Group, FEWS NET and Oxfam. The HEA is founded on the analysis of people in different social and economic circumstances. In particular, the HEA analysis examines the self-reporting of information on: (i) how people access the food and cash needed; (ii) their assets, the opportunities available to them, and the constraints they face; and (iii) the options open to them in times of crisis. Two thresholds define basic needs in the HEA, i.e. the survival threshold and the livelihoods protection threshold, although only the survival threshold is used as direct evidence in IPC Chronic Food Insecurity Analyses. The HEA survival threshold represents the most basic of needs, including minimum food energy requirements (calorie requirements), the costs associated with food preparation and consumption if associated inputs are purchased (e.g. salt, firewood or kerosene [paraffin]), as well as expenditure on water for human consumption. The HEA survival deficit should reflect the whole baseline/normal year, which should not include any exceptional circumstances.
19. **Minimum meal frequency among children** aged 6–23 months is a standard infant and young child feeding-indicator and collected among mothers/caretakers in the Demographic and Health Surveys, Multiple Indicator Cluster Surveys and Standardized Monitoring and Assessment of Relief and Transition surveys. The indicator assesses whether a child has been fed a predetermined number of times in the previous 24 hours, as per age-specific requirements.
20. **Months of Adequate Household Food Provisioning** (MAHFP) indicates in how many months of the past year a household self-reports that it was able to access enough food. MAHFP was designed by Africare to classify the magnitude of food insecurity in project-targeted areas, facilitating the targeting of vulnerable households, as well as the design and implementation of intervention strategies. MAHFP focuses on household access to food, taking into consideration own production, stocks, purchases, gathering, and food transfers from relatives, members of the community, the government or donors.
21. Although evidence suggests that chronic food insecurity may increase the risk of mortality, no thresholds for mortality are provided in the IPC Chronic Food Insecurity Reference Table, in part because mortality indicators are typically presented as a rate, rather than as a prevalence, making it difficult to use these indicators to classify households into IPC Chronic Food Insecurity levels.
22. For **nutrition area outcomes**, chronic malnutrition should be related to household food consumption deficits. A dose-response relationship between chronic food insecurity and stunting is assumed based on the available research, for example, a study by Saaka and Osman (2013) showing a correlation between Height-for-Age Z-score (HAZ) and FCS/HDDS.
23. **Chronic malnutrition** is classified by stunting levels in terms of the standardized HAZ score among children (height or length Z-score for specific sex and age). Stunting is the measure of growth retardation due to the persistent inability to meet minimum micro- and macronutrient absorption requirements, the frequent recurrence of acute malnutrition episodes, or a combination of these.
24. **Hazards** are any phenomena that have the potential to cause disruption or damage to food security in a household or area. Vulnerability is defined as exposure and sensitivity to hazards.
25. **Livelihood strategies** are the activities people employ to earn food and income. The IPC's Chronic Food Insecurity Analysis focuses on understanding and estimating the extent to which a population's livelihood strategies allow people to satisfy their food and essential non-food needs from day to day in a sustainable manner. The livelihood assets that people own or have access to (e.g. education, housing conditions, and productive assets) and the existing policies, institutions and processes (e.g. access to health care, vaccination campaigns and agricultural policies) influence their ability to generate sustainable livelihoods. The IPC Chronic Food Insecurity Analysis focuses on the analysis of livelihood strategies, assets and policies, institutions and processes that exist under non-exceptional circumstances while also looking at long-term trends.
26. The categorization of **low-value livelihood strategies** should be contextually constructed and may include, *inter alia*: a high dependency on firewood, grass and/or charcoal sales, and a high dependency on the consumption or sale of wild foods. The categories of low-value livelihood strategies presented in the IPC Chronic Food Insecurity Reference Table are based on the importance of these sources of income within the three main income sources of the populations under analysis.

¹⁹ Hoddinott, J. & Yohannes, Y. 2002. Dietary diversity as a food security indicator. Washington D.C.: FANTA. https://www.researchgate.net/publication/5056359_Dietary_Diversity_as_a_Food_Security_Indicator

²⁰ Hatloy, A., Hallund, J., Diarra, M.M. & Oshaug, A. 2000. Food variety, socio-economic status and nutritional status in urban and rural areas in Koutiala (Mali). Public Health Nutrition, 3: 57–65.

27. The **National Poverty Line** (NPL) is used to assess national poverty rates (i.e. the percentages of the population living below the extreme and moderate national poverty lines). The NPL is based on the cost of basic food and non-food needs, and whether households can afford: (i) the basic food basket (extreme poverty line); and (ii) other essential expenses, such as health and education, in addition to the basic food basket (moderate poverty line).
28. **Household expenditure surveys** can be used to estimate the percentage of households' total expenditure that is spent on food. Experts typically agree that the food share of total expenditure is inversely related to wealth (i.e. as households become wealthier, the percentage of their total expenditure on food will decline). This transition is typically also accompanied by a change in the composition of food demand among wealthier families, including reduced consumption of unprocessed and lower-value commodities (such as starchy foods) and increased consumption of higher-value commodities (such as meat, fruits and dairy products). Conversely, as a food security indicator, a higher percentage of total expenditure on food has been related to food deprivation at the household level (FAO, 2003).²¹
29. The **total income as a percentage of survival needs** from the HEA provides information on the strength of livelihoods with respect to the cost of minimum needs and can be used as an indicator of food insecurity.
30. Due to ongoing global efforts to define and measure **resilience** and to relate it to food security measures, and given the current lack of accepted globally comparable resilience indicators, the IPC Chronic Food Insecurity Reference Table does not include specific indicators for resilience. Nevertheless, the IPC recognizes that various resilience initiatives have been adopted around the world. IPC analysts are encouraged to use available resilience data to complement the vulnerability analysis section of the Chronic Food Insecurity analysis and to provide feedback on their experiences to the IPC Global Support Unit.
31. Although **iodized** salt is a useful contextual indicator, it should not be considered as much as other contributing factor indicators. Other country-specific indicators of micro-nutrient fortification should also be taken into account. In all cases, consideration of micronutrient fortification information should include coverage, fortification adequacy and actual consumption.
32. **Water** is an important aspect of food security and especially pertinent for analysis of utilization. The WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation has defined a number of standard drinking water and sanitation categories. According to the Programme, the category of 'improved' drinking water source includes sources that, by nature of their construction and if properly used, are adequately protected from outside contamination (specifically from faecal matter). Improved water sources include piped water at the household level located inside the user's dwelling, plot or yard. Other examples of improved drinking water sources are public taps or standpipes, tube wells or boreholes, protected dug wells, protected springs and rainwater collection. The cut-off of 15 litres per person per day is derived from Sphere guidance, according to which 15 litres per person per day is an acceptable quantity, covering basic needs.
33. In 2010, the United Nations General Assembly and the United Nations Human Rights Council recognized adequate access to safe drinking water as a human right. Specifically, it is recognized that 'everyone has the right to a water and sanitation service that is physically accessible within or in the immediate vicinity of the household, educational institution, workplace, or health institution'. According to WHO, the water source must be within 1,000 m of the home, and collection time should not exceed 30 minutes. The water requirements identified in the Sphere Handbook for total combined survival needs are between 7.5 and 15 litres per person per day, depending on a number of local factors, including climate, individual physiology and social/cultural norms

²¹ FAO. 2003. Keynote Paper: FAO methodology for estimating the prevalence of undernourishment. Presented by L. Naiken, in the International Scientific Symposium on Measurement and Assessment of Food Deprivation and Undernutrition. Rome, 26–28 June 2002.



PROTOCOL 2.3: ADHERE TO THE PARAMETERS FOR ANALYSIS

Figure 84: Analytical parameters (Tool 4)

- a. Definition of chronic food insecurity and an analytical focus
- b. Informing action with medium- and long-term strategic objectives
- c. Four severity levels
- d. Convergence of evidence
- e. Twenty percent rule for area classification
- f. Unit(s) of classification
- g. Analysis referring to periods with non-exceptional circumstances during previous ten years
- h. Classification based on actual conditions as seen in non-exceptional circumstances
- i. Validity period and analysis frequency
- j. Humanitarian assistance and development programmes
- k. Identification of key drivers and most-affected populations
- l. Population in need of urgent action

All IPC chronic food insecurity classifications need to adhere to the twelve parameters identified in Figure 84 and detailed below.

- a. Definition of chronic food insecurity and an analytical focus:** The IPC considers as chronic food insecurity any persistent or seasonal inability to consume adequate diets for a healthy and active life mainly due to structural causes. The analytical focus is to identify areas with a large proportion of households with a long-term inability to meet minimum food requirements both in terms of quality and quantity. Seasonal and cyclical food insecurity, i.e. food insecurity that is found within years following a predictable pattern, is also defined as chronic food insecurity.
- b. Informing action with medium- and long-term strategic objectives:** The IPC Chronic Food Insecurity Classification primarily informs programming with medium- and long-term strategic objectives, which are usually measurable within 5–10 years.
- c. Four severity levels:** IPC classifies severity of Chronic Food Insecurity into four severity levels: No/Minimal (Level 1); Mild (Level 2); Moderate (Level 3); and Severe (Level 4). Each level has different implications for response planning.
- d. Convergence of evidence:** The IPC approach draws upon data and information from a wide range of sources to classify and distribute the population of households into the four levels of Chronic Food Insecurity. The IPC approach relies on building a consensus among a team of multisectoral experts who are brought together to evaluate and debate evidence systematically. Convergence of evidence uses the IPC Analytical Framework with a livelihood-based lens supported by indicators directly measuring food security outcomes, as well as contributing factors, to estimate the proportion of households in each level. Although convergence of evidence calls for all evidence to be assessed, only evidence that is relevant to chronic food insecurity and of a minimum reliability should be used for classification. Evidence that is less than somewhat reliable may only be used to contextualize and explain findings during the convergence of evidence.
- e. Twenty percent rule for area classification:** An area is classified according to a specific IPC level when at least 20 percent of the population in the area are experiencing the conditions relating to that level or more severe levels. Ideally, the distribution of affected populations across Levels 1 to 4 should be provided, as each level is linked to different severity and calls for different action.

f. Unit(s) of classification: Classification is performed at the area level. Analysis benefits from an assessment of the conditions of specific household groups.

- **Area-based classification:** IPC analysis is carried out considering the conditions experienced in a certain area, which are assessed through a convergence of evidence that contains estimates for the whole area being analysed. Populations are distributed among different levels based on the co-existence of conditions. As good practice, even when household groups are not individually classified, information on different subgroups residing in the area, such as information on the conditions of the poorest or the agriculturalists, is helpful in supporting an area-based classification.
- **Household Analysis Group (HAG) analysis:** The HAG analysis is performed considering relatively homogeneous subgroup(s) of households with regard to food security outcomes, based on a wide range of factors such as wealth, social affiliations, livelihoods and exposure to shocks. Household groups may include those considered most at risk of chronic food insecurity, such as certain livelihood or socio-economic groups (e.g. households engaging in casual labour and households headed by the elderly, women or children). Either all HAGs in an area can be provided with an indicative classification, or just a subset of them. HAG analysis may result in a more precise and informative classification, especially to characterize those who are most food-insecure, which is invaluable for response analysis. These analyses can, however, only be completed if the available evidence and analytical skills are adequate for this type of analysis. As a best practice, information on analysing chronic food insecurity among different livelihoods and socio-economic household groups within areas is useful to support convergence of evidence and area classification. Information on the chronic food insecurity conditions of specific household groups is also valuable to help identify the general characteristics of those most affected, which in turn is important to support strategic targeting.

g. Analysis referring to periods with non-exceptional circumstances during the previous ten years: Classification is conducted by analysing historical and current evidence that reflects non-exceptional circumstances. These are times during which food security in the area is not affected by significant impacts of unusual shocks. In order to conduct an analysis, it is therefore necessary to identify periods that were non-exceptional so that evidence collected during these periods can inform the chronic food insecurity levels. Evidence collected during the ten years prior to the analysis can be used in a context of relative stability. If a country has undergone significant structural change within the previous ten years, only evidence collected after the change should be used in the analysis.

h. Classification based on actual conditions as seen during non-exceptional circumstances: Classification is based on conditions noted during non-exceptional circumstances. Hence, it is guided by actual outcomes (food consumption quality and quantity and nutritional status) and evidence on contributing factors as measured.

i. Validity period and analysis frequency: Since chronic food insecurity is characteristically persistent, and a chronic food insecurity situation is only expected to change slowly and gradually, the validity period for an analysis is relatively long, typically from three to five years in the absence of structural changes. If, however, new good-quality data sources become available or there are other valid reasons to review the analysis before the end of the validity period, analysts can update the existing analysis, or prepare a new analysis.



- j. Humanitarian assistance and development programmes:** Persistent food insecurity is classified based on conditions occurring in non-exceptional circumstances, irrespective of the provision of humanitarian or development assistance. Thus, analysts do not diminish the impact of any interventions, but rather classify what they observe through the use of indicators. The existence of relief interventions, such as cash transfers, safety nets and food distributions, even during times of non-exceptional circumstances, are included in analyses of policies, institutions and processes and how they affect the pillars of food availability, access, utilization and stability. Areas with significant humanitarian or development programmes are not identified.
- k. Identification of key drivers and most-affected populations:** IPC Chronic Food Insecurity classification provides tools that can be used for a basic analysis of key drivers and limiting factors as per the IPC Food Security Analytical Framework. Limiting factors of food insecurity are analysed by identifying which combination of factors relating to availability, access, utilization and stability prevents people from being food-secure in the medium and long term. Key drivers are derived from the analysis of vulnerabilities (i.e. livelihood strategies and assets, policies, institutions and processes), as well as acute events or ongoing conditions that drive persistent food insecurity. In this context, analysts are also encouraged to look at trends and assess the impact that gender or other socio-cultural inequalities may have on these factors and, to the extent possible, identify who are likely the most-affected populations.
- l. Population in need of urgent action:** The identification of a population in Level 3 or more severe refers to those in need of urgent action to decrease gaps in quality and quantity of food consumption, and to address chronic malnutrition. Population estimates take into consideration the potentially mitigating impacts of any development assistance, including safety nets, delivered during the period of analysis, especially in areas where large development programmes are being implemented. As a result, the number of people in more severe levels is likely less than what would be observed without these development programmes. Decision-makers should be informed that estimations refer to numbers in need of action beyond the action being given, but no specific analysis of assistance programmes is conducted during the IPC Chronic Food Insecurity Analysis. No alternative numbers can be calculated using IPC protocols.

PROTOCOL 2.4: EVALUATE EVIDENCE RELIABILITY

Figure 85: Assigning reliability scores – Examples

- Evidence on rainfall patterns over the past ten years, compared with a 30-year average (R_2);
- Evidence from participants who claim that the area suffers from a lack of basic services, access to markets and credit and that most areas are rather isolated and agricultural practices are very rudimentary and not efficient (Less than R_1 -).
- Evidence on Minimum Dietary Diversity of Women (MDD-W coming from a probabilistic cluster sample with over 25 clusters collected in non-exceptional circumstances within the previous three years (R_2).

The evidence to be used in the IPC consists of available data, and the final classification is obtained based on a comprehensive, integrated analysis of the whole body of available evidence. Hence, **all evidence needs to be evaluated for its reliability**, including evidence coming from quantitative methods, such as surveys, as well as from qualitative methods, such as focus group discussions. Evidence to be assessed includes all evidence on contributing factors, for example, satellite images, price trends, food production, rainfall estimates and employment levels, as well as evidence on outcomes, such as food consumption quality and quantity (Figure 85).

Evidence used in the IPC can have a **Reliability Score** of R_2 = reliable; or R_1 = somewhat reliable. R_1 is further divided into two scores: (i) R_1+ refers to evidence that has either limited soundness of method or time relevance; and (ii) R_1- refers to evidence that has both limited soundness of method and time relevance. The assessment of reliability is not based on a statistically rigorous process, but rather on a general assessment of the soundness of methods of data collection and analysis (**M**) and the time relevance of the evidence (**T**).

The IPC Reliability Score Table (Figure 86) presents the general criteria for assessing reliability scores as well as more specific guidance for assessing the soundness of method and time relevance for all food security evidence as follows:

► **Part A** presents the combination of method (**M**) and time relevance (**T**) that underpins the different reliability scores. Evidence is only reliable when the method used is robust and evidence depicts ongoing conditions. If evidence is yielded through a reasonable but less rigorous method, such as evidence with limited representativeness, the evidence can be at most R_1 . Evidence that has limited soundness of **M** or **T** scores R_1+ , while evidence that has both types of limited parameters scores R_1- . Reasonable evidence that scores less than R_1 (such as field trip reports and local knowledge) can be referred to as R_0 and may still be used in the IPC to support the analysis. However, it should be carefully reviewed and cannot be counted towards achieving minimum evidence requirements. Both quantitative and qualitative methods can potentially be assigned as R_2 .

► **Part B** presents the general working definition of 'good' and 'limited' soundness of **M** and **T** as well as specific guidance for assessing the reliability of evidence on indicators included in the IPC Chronic Food Insecurity Reference Table.



Figure 86: Reliability Score Table – For evidence to be used in Chronic Food Insecurity classifications (Tool 5)

Part A: Guidance for Evaluating the Reliability Score			
		Time relevance (T)	
		Good (T ₂)	Limited (T ₁)
Soundness of method (M)	Good (M ₂)	R ₂	R ₁ +
	Limited (M ₁)	R ₁ +	R ₁ -

Part B: Definitions and Guidance for Evaluating Soundness of Method (M) and Time Relevance (T)			
Soundness of method (M)	Good (M ₂)	Scientific quantitative and qualitative methods internationally recognized as good practices.	
		<ul style="list-style-type: none"> • Specific parameters for selected methods include: <ul style="list-style-type: none"> • Surveys <ul style="list-style-type: none"> • Simple/systematic surveys with at least 150 cases or cluster surveys with at least 25 clusters; • Computer-assisted telephone interviewing with at least 150 cases with more than 75 percent of households owning at least one operating phone. • Household Economy Analysis <ul style="list-style-type: none"> • Outcome estimations based on a full baseline with a problem specification supported by at least four pieces of R₂ evidence on contributing factors. 	
Time relevance (T)	Limited (M ₁)	Reasonable quantitative and qualitative methods that follow good practices but have limited representativeness.	
		<ul style="list-style-type: none"> • Specific parameters for selected methods include: <ul style="list-style-type: none"> • Surveys <ul style="list-style-type: none"> • Estimates from at least five clusters and at least 90 observations; • Computer-assisted telephone interviewing with at least 90 cases with more than 60 percent of households owning at least one operating phone; • Estimates from an R₁ representative survey from similar nearby areas with comparable food security conditions • Household Economy Analysis <ul style="list-style-type: none"> • Outcome estimations based on rapid baseline or detailed profiles supported by at least four pieces of R₁ evidence on contributing factors. • Monitoring Systems <ul style="list-style-type: none"> • Estimates from at least five sites with at least 200 randomly selected cases in total (at least five sites and at least 100 cases in total for pastoral areas). 	
	Good (T ₂)	Evidence reflecting current conditions	
		<ul style="list-style-type: none"> • Specific parameters for selected methods include: <ul style="list-style-type: none"> • Evidence collected during periods with non-exceptional circumstances within the previous ten years preceding the analysis; • Evidence on quick-changing indicators collected during the lean season; • Baseline or profiles up to ten years old where there have not been significant changes in livelihoods. 	
	Limited (T ₁)	Evidence inferred to reflect current condition	
		<ul style="list-style-type: none"> • Specific parameters for selected methods include: <ul style="list-style-type: none"> • Inferred estimates of evidence on quick-changing indicators collected during the non-lean season in non-exceptional circumstances; • Baseline or profiles older than ten years where there have not been significant changes in livelihoods. 	

*The recommended instructions on the soundness of methods and time relevance, including estimated sample sizes and clusters, have been calculated for IPC reliability purposes only. They do not intend to constitute a best practice for the design of any methods, including surveys involving primary data collection in the areas of analysis. The IPC acknowledges that evidence scoring less than R2 may not provide accurate estimates of the conditions and thus the IPC requires various pieces of evidence to be analysed and converged to provide an overall classification when R1 evidence is being used. The IPC acknowledges that the soundness of methods, including surveys, is also driven by factors other than sample design, such as measurement error, selection bias, field practices and analytical skills. Although important, the IPC cannot identify globally comparable parameters for these factors, and analysts are urged to assess the soundness of all methods further to issues identified in this table.

**Notes:**

- 1. The general criteria** for assessing evidence reliability are equally applicable to all evidence, including qualitative and quantitative data on indicators in the IPC Reference Tables (i.e. direct evidence) and on other indicators not included in the IPC Reference Tables (i.e. indirect evidence, such as market prices, rainfall estimates and production figures). Although all evidence used for IPC Classifications can be assigned a reliability score, the IPC only provides specific guidance for indicators included in the IPC Reference Tables. Analysts are encouraged to use the general criteria to support evaluation of evidence on other indicators not included in the IPC Reference Table.
- 2. Nutrition evidence** should be evaluated as per the Criteria for Reliability Scores assessment included in the IPC Acute Malnutrition protocols.
- 3. Surveys** refer to studies of a geographical area or household group to gather data on food security outcomes and/or contributing factors and are carried out by polling a random section of the population or through a universal census.
 - The sample size for surveys with a cluster sampling design will generally depend on the following parameters: P: expected prevalence, D: desired precision, d: design effect, Z: desired confidence level of estimations, and, only for populations of less than 10,000, the population size. The sample formula: $n \geq d [Z^2 (P) (1-P) / D^2]$ applies to simple random and cluster sampling. However, in simple random sampling, design effect (d) is 1, whereas the d of cluster sampling will vary between surveys, often ranging between 1.5 and 2.5. To support the evaluation of the method validity of surveys, the IPC refers to the Sphere and Standardized Monitoring and Assessment of Relief and Transition Survey guidance of 25 clusters as a "good" sample size. While 25 clusters can generally be applied globally since the large sample size allows for assessing most conditions, an acceptable minimum sample size cannot be globally developed since it will depend on actual P (expected prevalence), d (design effect) and D (desired precision). Nevertheless, assuming general parameters of P:20 percent (following the IPC's 20 percent rule for area classification), D: 8.5 percent, d: 1.5 and Z:1.65 (90 percent desired confidence level of estimates), the IPC has identified the need for five clusters and 90 observations as the minimally acceptable sample size, which is labelled as "limited". Although analysts may use the minimum sample size of five clusters and 90 observations as an acceptable minimum sample size, IPC analysts should revise the minimum sample size based on real parameters as much as possible. Any calculated sample size below 90 households cannot have a sampling/standard error of more than 8.5 percent or a confidence interval of less than 90 percent. A smaller sample may be accepted if the design effect is confirmed as less than 1.5.
 - The validity of surveys is also driven by factors other than sample design, such as measurement error, selection bias, field practices and analytical skills. Although important, the IPC cannot identify globally comparable parameters for these factors, and analysts are urged to assess the soundness of the survey methods.
 - Surveys with a good method can only come from a census or a probabilistic randomized assessment with a selection that is based on an adequate sample frame. A good method also needs to adhere to the optimal sample size (see bullet above), have low measurement error and selection bias, and be collected with adequate field practices and analytical skills.
 - Surveys with a limited method can be: (i) a probabilistic assessment; (ii) a non-probabilistic assessment for various purposes; or (iii) re-analysed survey data collected with a good method valid at a higher administrative unit. Surveys with limited representativeness should still meet minimum sample size requirements for an 8.5 percent precision and have a low measurement error and selection bias and be administered with adequate field practices and analytical skills. Given that estimates from surveys with a lower sample size are likely to generate large confidence intervals, field data collectors are urged to conduct surveys representative of the unit of analysis. The IPC also calls for care when disaggregated evidence is used, as the information generated can be misleading, especially if selection bias and heterogeneity are high. As much as possible and as a best practice, estimates should be provided with confidence intervals to support responsible use of this evidence.
- 4. Computer-Assisted Telephone Interviewing** -based surveys are conducted remotely by trained specialized operators who work from a call centre and interview randomly selected respondents. Computer-assisted telephone interviewing can be used either as a survey or as a monitoring system. In principle, the same sample size that would be applicable to face-to-face surveys and monitoring systems should be applied to computer-assisted telephone interviewing assessments. However, an increase of 1.5x should be applied if the sample needs to be corrected for the increased design effect. In order to be accepted for IPC Classification, computer-assisted telephone interviewing questionnaire modules also need to be tested and approved, considering the challenges imposed on operators by not being in the direct physical presence of the respondents. Optimally, especially in areas where there is bias associated with phone-ownership, it is best to use both computer-assisted telephone interviewing and face-to-face interviews with a 10 percent sample overlap to check for mode-biases between the two approaches and produce reliable estimates for variance. Unless the computer-assisted telephone interviewing is used within a dual mode (computer-assisted telephone interviewing and face-to-face) survey or the phone numbers come from a previous cluster-sample survey, computer-assisted telephone interviewing follows a simple stratified random sample design, and therefore does not require cluster selection and the other requisites of cluster surveys.
- 5. Full Household Economy Analysis** (HEA) refers to estimations of livelihood and survival deficits carried out by a trained professional using either the Livelihoods Impact Analysis Spreadsheet or the Dashboard. The full analysis and assumptions need to be well documented and available for review by the IPC Technical Working Group and a possible IPC Quality Review. Full baselines are based on approximately 50 focus group and key informant interviews and should be relevant at the time of the analysis, considering the stability of the situation: no older than ten years in stable situations, and no older than five years in unstable situations. Analysis needs to be supported by at least four pieces of R₂ evidence on contributing factors. The HEA needs to adhere to the best practice checklist.



6. **Rapid Household Economy Analysis (HEA)** refers to estimations of outcomes carried out by a trained professional using a less complete analysis system, such as the Scenario Building Tool or the Dashboard. Both rapid baselines and rapid profiles belong to this category, although there are differences between the two: rapid baselines are based on approximately 30 focus group and key informant interviews and use the Dashboard for the provision of detailed estimates, whereas rapid profiles are based on eight to ten focus group and key informant interviews, and use the Scenario Development tool for rough estimations of outcomes. Analysis and assumptions need to be well documented and made available for review by the IPC Technical Working Group and possible IPC Quality Reviews. Reference values can be obtained from rapid baselines or rapid profiles provided that they quantify the sources of food and income for the subjects being classified. Rapid baselines and detailed profiles should be relevant at the time of the analysis, considering the stability of the situation: no older than ten years in stable situations, and no older than five years in unstable situations. Analysis needs to be supported by at least four pieces of R_2 evidence on contributing factors. The HEA needs to adhere to the best practice checklist. The 'zone summaries' or equivalents, which are also based on the concepts of the HEA but which do not provide detailed information on food and income sources score less than R1.
7. **Monitoring systems** include estimates collected routinely in community-based sites purposively selected with prevalence statistics, usually carried out through a pooled analysis for surveillance and monitoring. Observations may be selected randomly or purposively for various reasons.
8. **Evidence collected during non-exceptional circumstances** refers to food security data collected during the period of time defined as the non-exceptional period, considering usual and unusual shocks. If a usual or typical shock takes place during the data collection period, the evidence can still be rated as having "good" time validity, since the time period of data collection reflects non-exceptional conditions. If, however, an unusual shock (e.g. severe drought or flooding) occurred during the data collection period, the evidence does not reflect typical underlying conditions. In these situations, it is preferable not to use the evidence in the IPC Chronic Food Insecurity Analysis. If, however, available evidence from non-exceptional circumstances is scarce and the evidence collected during exceptional circumstances can be reasonably inferred to non-exceptional circumstances, the evidence can be used to support the analysis but cannot be rated even as R_1 .
9. **Evidence on quick-changing indicators** is evidence on indicators that tend to change fast, for example, seasonally, and that typically have a short recall period. For example, most food consumption indicators belong to quick-changing indicators. The cut-offs of the quick-changing indicators included in the IPC Chronic Food Insecurity Reference Table have been calibrated for the lean season, and as a result, evidence collected over the lean season is considered to have good time relevance (T_1). If, however, evidence has been collected over a non-lean season, evidence on quick-changing indicators can receive maximum T_1 for time relevance.
10. **Estimates from an R_1 representative survey from a similar nearby area** can only be used to support the classification when the evidence on the same indicator is not available for the area of interest through another method. An analysis of the similarity of food insecurity between areas, based on evidence on contributing factors and outcomes, needs to be presented to demonstrate the comparability of areas. Evidence from similar nearby areas needs to be supported by at least two pieces of reliable evidence on contributing factors to food insecurity to allow analysts to confirm the likely outcomes for the area of analysis.

PROTOCOL 2.5: MEET MINIMUM EVIDENCE AND ANALYSIS REQUIREMENTS

The IPC Evidence-level Criteria (Figure 87) identify the minimum requirements for three distinct levels. The requirements are based on the number of pieces of reliable (R_2) and somewhat reliable (R_1) evidence as per the parameters stipulated in Protocol 2.4. The evidence level is assessed in two steps, with analysts first identifying the number and reliability of pieces of direct evidence (i.e. evidence on indicators included in the Chronic Food Insecurity Reference Table), and then the number and reliability of additional pieces of direct or indirect evidence on contributing factors and outcomes.

Figure 87: Evidence-level criteria for classification (Tool 6)

Evidence Level	Minimum Criteria
* Acceptable (Evidence Level 1)	<p>Two indicators from different outcomes¹ with direct R_1 evidence with</p> <p>1. One of which is available for two or more years + Three other indicators with R_1 evidence²</p>
** Medium (Evidence Level 2)	<p>Three indicators one from each outcome¹ with direct R_1 evidence with</p> <p>One of which is a Tier 1 indicator and One of which is available for two or more years + Four other indicators with R_1 evidence²</p>
*** High (Evidence Level 3)	<p>Four indicators from food consumption outcome¹ with direct evidence with</p> <p>Two of which are R_1 and two R_2 + 3. One indicator for nutritional outcome with R_2 evidence with</p> <p>Two of which are Tier 1 indicators and One of which is available for 2 or more years + Five other indicators with R_1 evidence²</p>

Notes:

¹ Outcomes include: food consumption quality, food consumption quantity, and chronic malnutrition.

² These indicators may come from any contributing factors or outcomes.



The Minimum Analysis Requirements (Figure 88) identify the core analytical products that the IPC Chronic Food Insecurity Analysis should provide.

Figure 88: Minimum analysis requirements (Tool 7)

Minimum Analysis Requirements

- **Evidence analysis** – with references (sources and dates of data collection), linking current conditions to IPC levels, context, historical trends and other relevant analysis
- **Area classification** – based on 20 percent rule
- **Classification justification** – based on convergence of contextualized evidence and including a critical review of supporting and contradictory evidence
- **Population estimates** – percentage (%) and number (#) of people in each level
- **Key drivers of chronic food insecurity** – identified as much as possible
- **Key limiting factors of food security** – identified as much as possible

PROTOCOL 2.6: SYSTEMATICALLY DOCUMENT EVIDENCE AND ANALYSIS, AND PROVIDE THEM UPON REQUEST

Figure 89: Analysis Worksheet Steps (Tool 8)

- Step 1:** Identify context and analysis parameters.
- Step 2:** Populate the evidence repository.
- Step 3:** Identify periods with non-exceptional circumstances.
- Step 4:** Analyse evidence.
- Step 5:** Determine area classification and population estimates.
- Step 6:** Identify key drivers.
- Step 7:** Identify limiting factors.

All evidence and analysis need to be clearly and systematically documented so that analysts have a body of evidence to support their classification. The documented evidence should be made available if requested for quality review purposes..

The IPC Analysis Worksheet

The IPC Analysis Worksheet supports systematic, transparent and consistent evidence-based analysis by guiding the analysis through the IPC Food Security Analytical Framework and linking evidence to the IPC Reference Table. The use of the Analysis Worksheet, is a major advantage for IPC analysis and is highly recommended.

The Analysis Worksheet is organized into seven steps (see figure 89) that, if completed, will meet all the analysis requirements, as detailed in protocol 2.5. The procedures for completing the Analysis Worksheet are briefly described below. It is highly advisable that some parts of the Worksheet, especially Steps 1, 2 and 3, are completed by analysts before the analysis workshop and reviewed during the analysis. The order of the steps is not pre-determined, and analysts may complete them in any order as well as edit previous steps during the analysis.

The Worksheet is best utilized in the web-based IPC Information Support System, but may also be completed in MS Word™, which can be found on the IPC website.

Step 1: Identify context and analysis parameters

Purpose: To support the contextualization of evidence and livelihood-based analyses of food security by providing information on livelihood strategies and assets, including a review of the seasonal calendar and the key characteristics of the population living in the area.

Approach overview:

In order to characterize each area to be analysed, analysts will utilize Step 1 of the Chronic Food Insecurity Analysis Worksheet. In addition, they should carry out the following:

- Decide on the spatial extent of the analysis area. A single level classification will be determined for each area analysed. Generally, administrative areas are used for analysis, but other units such as livelihood zones can also be applied. Analysts must determine the spatial extent of the analysis area, depending on the needs of decision-makers as well as the availability of evidence and the feasibility of classifying the desired number of areas. In general, the analysis area should be as homogeneous as possible with regard to likely food security outcomes and causes.
- Provide a brief description of the area, including relevant information to be used in contextualizing evidence. Important aspects may include common livelihood strategies for acquiring food and income, seasonal patterns, cultural habits and the economic environment. Optimally, a summary of the food security seasonal calendar should also be included in the description.
- Provide the number of people living in the area. Indicate population numbers and the source of evidence and specify the reference year (usually the current year) if the population has been projected, e.g. based on an earlier census.
- Identify and describe household groups living in the area, as relevant. Household Analysis Groups (HAGs) may be identified and described to better support analysis, especially if evidence is available for them. HAGs should have a relatively homogeneous food security situation, including contributing factors and likely outcomes. These groups may be defined, for example, by variations in wealth, gender, ethnic affiliation, livelihood, religion, or any other factor or combination of factors that make the groups distinct. The number of groups identified can vary. For each group, preferably specify the estimated number of people and their percentage share of the total number of people in the area.
- Provide a brief description of the recurrent shocks that affect the area and their usual frequency.
- Identify whether the analysis area has experienced Acute Food Insecurity Phase 3 Crisis or more severe in at least three different years over the last ten years. If IPC Acute Food Insecurity Analyses have not been conducted in enough years to determine this, either use an equivalent classification system or highlight that a recurrence of crisis cannot be identified.



Step 2: Populate the evidence repository

Purpose: To help organize wide-ranging evidence from multiple sources for ease of access and reference.

Approach overview:

- Provide references for all the evidence to be reviewed in analysis, including identification of sources and dates of evidence collection and season of data collection (e.g. lean or non-lean).
- Provide a note on data collection methods to support assessment of Reliability Score whenever possible.
- When possible, include the actual evidence (e.g. graphs, text, and figures) in the evidence repository and identify what food security elements it informs (i.e. it can inform more than one).

Step 3: Identify periods with non-exceptional circumstances

Purpose: To identify periods within the previous ten years during which the area did not suffer or benefit from the impacts of unusual and significant shocks. Identifying periods of non-exceptional circumstances is key to correctly using quick-changing indicators against the Chronic Food Insecurity Reference Table cut-offs, which are set for the lean season of periods with non-exceptional circumstances. If evidence on quick-changing indicators was collected in a lean season with non-exceptional circumstances, the cut-offs in the Reference Table can be directly applied. However, if evidence was collected during exceptional circumstances, the evidence has to be inferred against the Reference Table and may not be granted even R1- but can still be used to support the analysis, especially if evidence collected over non-exceptional circumstances is scarce. Figure 90 details the concepts and approach for identifying non-exceptional circumstances.

Approach overview:

- Assess whether the area has suffered or benefited from the impacts of unusual shocks in the last ten years.
- Identify the occurrence of shocks that might have positively or negatively affected the area.
- Assess whether the shocks resulted in exceptional food insecurity conditions, and if so, for how long the effects were felt.
- Identify whether any structural changes have affected the area.

Step 4: Analyse evidence

Purpose: To analyse evidence by following the IPC Food Security Analytical Framework and Reference Table considering the local context and evidence reliability scores, including reference to historical trends and socio-economic differences.

Approach overview:

- Review evidence by assessing the levels of key indicators and linking outcomes and conditions to IPC levels, context, historical trends and other relevant analysis such as specific socio-economic groups and gender inequalities. Consider also the other four protocols for Function 2 (i.e. use of the IPC Analytical Framework, Reference Table, reliability scores and key parameters).

Figure 90: Non-exceptional circumstances – Importance and definitions

Importance

- **Persistent food insecurity** is determined based on an analysis of conditions in non-exceptional circumstances.
- **The Chronic Food Insecurity Reference Table** lists global cut-offs for indicators as they would present themselves during non-exceptional circumstances. Thus, any evidence collected during non-exceptional circumstances can be directly compared against the Reference Table.
- **Evidence collected during exceptional circumstances** can also be used, especially if other evidence is scarce and if it is interpreted in relation to conditions expected during non-exceptional circumstances, but with limited reliability.

Definitions of Terms

- **Non-exceptional circumstances** are times without significant adverse impacts of unusual positive or negative shocks.
- **Hazards** are any phenomena that have the potential to cause disruption or damage to food security.
- **Shocks** are events that result in an impact on food security. Shocks may have positive or negative impacts. Shocks may originate within or outside the area of analysis..
- **Impact of a shock** is the shock's effect on households' ability to acquire and/or retain food and income sources and assets. The impact (effect) of a shock can and usually does outlast its occurrence and can spread outside the place of occurrence.
- **Unusual shocks** are shock events that are severe, widespread and rare.¹
- **Structural change** is understood in the IPC as the result of sudden or short-lived events that have significantly changed the structures of the society, and consequently the food security situation in an area, to such a degree that the changed situation is expected to continue in the future. For this reason, the evidence to be used in analysis can only include evidence collected after a structural change, if it was observed. Progressive and gradual structural change, characterized as a relatively continuous, usually slow phenomenon, is not used to support the identification of non-exceptional circumstances, but its occurrence can and should be captured during time-trend analysis as much as possible.
- **Periods with non-exceptional circumstances** are any time period (usually quarters/three-month periods and full years). All time periods in the ten years prior to the analysis are to be identified as having either exceptional or non-exceptional circumstances. Identifying times with non-exceptional circumstances is crucial to guide the use of evidence against the cut-offs set for non-exceptional circumstances in the Reference Table.

¹ The definitions of severe, widespread and rare have deliberately not been given due to the lack of agreement in the disaster literature. National working groups are urged to use expert knowledge and assess whether a situation can be considered mild, moderate or severe; common, occasional or rare; and localized or widespread. Efforts will be made to find more specific tools to support the identification of unusual shocks.



- Include source of information, linking all statements to the references specified in Step 2.
- Assess the reliability scores of all evidence and assess whether evidence that does not reach R1 should be included in the analysis for contextualization and explanation purposes.
- Provide conclusions, considering supporting and contradictory evidence, context, trend analysis and critical reasoning, for example:
 - Food security contributing factors:
 - *Hazards and vulnerability:* Assess the usual and unusual key hazards and vulnerabilities that likely limit consistent food security. Include the available evidence on vulnerability, such as livelihood strategies, livelihood assets (financial, physical, human, social and natural) and policies, institutions and processes. Also include evidence and analysis on usual and unusual shocks that impact the analysis area. Identify the key drivers of chronic food insecurity, and the extent to which each underlying factor is estimated to contribute to chronic food insecurity.
 - *Food availability, access, household utilization and stability:* Include evidence and analysis statements on typical food availability (e.g. levels of food production, functioning of markets and transportation networks, imports and food movements); food access (e.g. ability of households to obtain food, as a function of physical, financial and social access); household food utilization (e.g. access to safe water, food preparation, cooking, storage, and care practices); and stability (e.g. considering typical and seasonal stability and how stability affects each food security dimension). Conclude to what extent each of the dimensions limits food security in the area.
 - Food security outcomes:
 - *Food consumption quality:* Include relevant evidence on the indicators included in the Reference Table (i.e. Starchy Staple Ratio (SSR), Starchy Staples Expenditure Ratio (SSEXR), and share of children who meet the requirements for minimum dietary diversity). Also include indirect evidence (e.g. on the typical food groups consumed by households, seasonality aspects, and any inference of food consumption quality through evidence on contributing factors based on the data available). Conclude on the indicative level, based on the evidence and analysis conducted, and distribute the total population across the four severity levels based on the analysis conducted on food consumption quality.
 - *Food consumption quantity:* Present relevant evidence on indicators included in the Reference Table (e.g. FCS, HHS, HDDS and FIES) as well as other evidence relevant to the area being analysed and seasonality aspects together with the inference of contributing factors (including, for example, the number of meals or expected number of households with food gaps). Provide summary conclusions for quantity of food consumption and distribute the total population across the four severity levels based on the analysis conducted on food consumption quantity.
 - *Nutrition:* Include relevant evidence on stunting of children and any other evidence on nutritional status (e.g. recurrent low weight for height/wasting of children, BMI of women, or evidence on micronutrient deficiencies). Also include any inference based on contributing factors. Prepare an indicative level classification for nutrition outcome, as well as the population distribution across the different levels.

Step 5: Determine area classification and population estimates

Purpose: To assign a level classification and to estimate the population in different levels.



Figure 91: Convergence of evidence – Key considerations

- The IPC approach relies on building a **consensus** among a team of multisectoral experts who are brought together to systematically evaluate and debate evidence. Although the evidence used in the IPC is based on previously collected primary data and analyses, they are converged through a process similar to the Delphi Technique rather than to econometrics or statistical models. The IPC approach is thus a consultative, evidence-based, consensus-building process in which experts discuss and analyse evidence in a structured form, using the Analysis Worksheet and referencing evidence against the common global indicators detailed in the IPC Chronic Food Insecurity Reference Table, accompanied by a National Matrix of Indirect Evidence when relevant. Analyses are guided by the IPC Analytical Framework, and the process is conducted through the four Functions of the IPC (Build Technical Consensus, Classify Severity and Identify Key Drivers, Communicate for Action and Quality Assurance).
- The **whole body of evidence**, including relevant direct and indirect evidence scoring at least R1 (or those scoring less but to be used mainly to contextualize and validate findings), should be brought together for classification. For example, analysts need to consider high poverty levels, low diversification of income, high dependency on rainfed agriculture and low resilience to drought, low dietary intake, and high levels of stunting when arriving at a classification.
- **Evidence does not always converge.** Correlation among food consumption indicators is usually low. For example, the Food and Nutrition Technical Assistance (FANTA)/Famine Early Warning Systems Network (FEWS NET) Household Food Consumption Indicator Study (2015) found a generally moderate correlation between the FCS, HDDS, rCSI and HHS. Analysts need to assess all contradictory evidence and provide an explanation on the likely reasons for discrepancy. Analysis should consider that discrepancies may be due to the following:
 - *Indicators measure different things:* For example, some indicators may reflect more the quality of diet, others the quantity, and still others may reflect a combination of both.
 - *The accuracy of indicators is different:* While there is no global agreement on a single ‘best indicator’, some indicators provide better correlation with actual household dietary consumption. For example, income and expenditure surveys that aim to measure both food items and quantities consumed by households typically provide more accurate information on food consumption than assessments focusing on interviewing households on the food groups consumed in the previous week.
 - *Context matters:* Although ‘globally comparable’ cut-offs are provided, the IPC highlights that they are guiding values and that analysis should be contextualized. For example, it is acknowledged that indicators may work differently in different contexts, and appropriate cut-offs may vary from one region to another.
 - *The quality of evidence may be different:* Analysts may choose to give greater consideration to the evidence of an FCS that scores R₂ than an HHS from a different survey that scores R₁.

Note on limitations: A lack of classification at the household level limits the accuracy of the estimates of populations in each level as analysts cannot assess if the household that met one condition also met the other one. For example, it is not known if the household classified as having poor food consumption is the same household that is below the extreme poverty level and if it is the same household that has severely stunted children. However, through livelihood-based analysis and the convergence of evidence, the IPC approach allows for an estimate of the “big picture” – albeit with limited precision – of the expected population distribution of households in each severity level. In addition, it is more likely that households with one severity condition, such as poverty, also face other severity conditions, for example poor livelihoods and gaps in food consumption quantity and/or quality.



Figure 92: Classification justification – Example

Cox's Bazar is classified as Level 3, with 27 percent of the population experiencing moderate chronic food Insecurity. The population in this area suffers from gaps in food consumption quality; nearly 70 percent of the children are not eating a minimum diet and over 60 percent of the women consume fewer than five food groups. Food consumption quantity, however, is not a major problem. Despite diversified income opportunities, 23 percent of the households depend on low-value livelihoods such as unskilled labour as their main source of income. Approximately 30 percent live below the poverty line and 15 percent are extremely poor. Food utilization is a major limiting factor, with low literacy rates, poor female education, the majority of the houses (also floors) having low-quality materials, and the majority of the households not having access to improved sanitation. The area also has a high refugee influx from Myanmar.

Source: Based on an IPC Chronic Food Insecurity Analysis of Cox's Bazar, Bangladesh 2015.

Approach overview:

- Use the convergence of evidence to conclude on level classification based on all relevant supporting and contradictory evidence. Area classification should be carried out based on the chronic food insecurity conditions of the worst-off (at least) 20 percent of the population. The classification is carried out through convergence of evidence, where analysts consider the whole body of evidence, including evidence on outcomes, contributing factors and context. Only evidence that is relevant to chronic food insecurity should be used for classification. Evidence on chronic malnutrition is considered to support the distribution of households among the four severity levels due to likely common key underlying drivers. For a discussion on the key considerations for convergence of evidence and population estimates, see Figure 91.
- Conclude on the final classification by adding a critical rationale for area classification, summarizing the key supporting and contradictory evidence in a short paragraph. The final conclusion needs to provide an overall view of the evidence used to support the classification. The paragraph should be guided by the IPC Food Security Analytical Framework, encompassing the food security elements and how they contribute to the final decision taken on the classification. The rationale for discarding contradictory evidence should also be provided as relevant. As much as possible, the conclusion should also mention which household groups are the most affected. In simple terms, the summary conclusion needs to describe the storyline behind the classification and reflect the group discussion and rationale for the conclusion. If carrying out a supplementary HAG-based analysis, also provide an indicative classification of each HAG. See Figure 92 for an example of a conclusion statement.
- Distribute the population of households in each level by converging the body of evidence. The population should be estimated for IPC levels by taking into account both contributing factors and outcomes, and considering direct and indirect evidence, including inferences from contributing factors for outcomes and locally specific indicators (Figure 93). Analysis of direct evidence, considering the context, is usually the most useful type of evidence for population estimates, as the prevalence of households in each category as per the Reference Table allows households to be distributed across the four severity levels. For example, when estimating the population in Level 4, it is more helpful to analysts to know that 40 percent of women have a MDD-W of fewer than five food groups, and 5 percent have an HDDS of four, and 10 percent have an HDDS of five to six rather than to know that the poorest households depend on rainfed agriculture, that a crisis recurs on

Figure 93: Convergence of evidence for population estimation – Examples of best practice

- Estimate indicative household distribution for food security elements: contributing factors, water, quality of food consumption, quantity of food consumption, and chronic malnutrition. Estimates should be made based on direct and indirect evidence, including inferences from contributing factors for outcomes and locally specific indicators. Analysts may need to use ranges (e.g. 10 to 15 percent) if they cannot estimate an absolute number with confidence. When using ranges, the mid-points of the ranges will need to add up to 100 percent to account for the total population analysed. Below is one overly simplistic example (i.e. indirect evidence and inference from contributing factors are not considered) where analysts are estimating the indicative distribution of households for food consumption quality:
 - 40 percent of women had an MDD-W <5 (cut-off of Levels 2, 3 and 4).
 - 20 percent of households had a borderline and 15 percent had poor FCS (cut-off for Levels 3 and 4, respectively).
 - 25 percent of households had HDDS 5–6 and 15 percent had HDDS ≤4 (cut-off for Levels 3 and 4, respectively)
 - 30 percent of households were below the moderate but above the extreme poverty line and 20 percent were below the extreme poverty line (cut-off for Levels 3 and 4, respectively).
 - The likely conclusion is that indicative percentage of households in different levels of food consumption quality is 20–30 percent in Level 3 and 15–20 percent in Level 4.
- Conclude on the household distribution for overall chronic food insecurity: Based on the indicative distribution of households in each food security element, analysts converge all evidence for an overall conclusion. Analysts are encouraged to use point estimates for the final conclusion of populations in different severity levels, even if ranges can be used to distribute populations indicatively over different levels when estimating food security outcomes and contributing factors. The use of point estimates for final conclusion is favoured for reasons of clarity and for easier communication. This illustrative example is shown in Figure 94.
- The indicative classification of each food security element should not be used on its own to provide a separate classification, because the IPC process has been designed to converge evidence from different food security elements to classify overall chronic food insecurity, rather than to classify each outcome of food insecurity separately.

Figure 94: Population Estimates – Example

	Level 1 No Chronic Food Insecurity	Level 2 Mild Chronic Food Insecurity	Level 3 Moderate Chronic Food Insecurity	Level 4 Severe Chronic Food Insecurity
Contributing factors – underlying factors	20 – 30%	20 – 30%	20 – 30%	10 – 20%
Contributing factors – water		10% - 20%	40% - 50%	40% - 50%
Food consumption quality conclusion	10%	40%		50%
Food consumption quantity conclusion		55 – 60%	30 – 40%	5 – 10%
Nutrition status conclusion		50%	20%	30%
Specify % of households in each level	40%	20%	20%	20%



Figure 95: Key drivers of food insecurity – Examples

- Low purchasing power and heavy reliance on rainfed agriculture;
- Political tensions and fear of conflict resurgence, limiting investments;
- Low education levels;
- Restricted access to forests and other natural resources.

average every four years, and that access to markets is restricted. Nevertheless, evidence on indirect indicators and contributing factors is helpful when used for inference to contextualize the estimates and to ascertain or contradict the results from direct evidence. It is also recommended that a rationale be provided for the population estimates when feasible.

- Assign evidence levels to an analysis (*, **, ***) by counting the number of pieces of direct evidence used for food consumption quality and quantity, and nutrition outcomes and other supporting indirect evidence on contributing factors or outcomes (see Figure 87 for the criteria for evidence levels).

Step 6: Identify key drivers

Purpose: To enable decision-makers to identify the key factors driving existing levels of chronic food insecurity so that action can be more strategically planned.

Approach overview:

- Identify the key drivers of chronic food insecurity, including reference to a possible recurrence of acute shocks, such as drought or conflict, as well as ongoing conditions and high vulnerability to shocks, such as poverty levels, lack of diversified income, heavy reliance on rainfed agriculture and inadequate or harmful policies.
- Identify individual drivers by looking at the entity of evidence on livelihood assets (human, social, natural, financial and physical capital) and on policies, institutions and processes, and assessing which factors belonging to different types of capital and policies, institutions and processes are likely to be the key drivers of chronic food insecurity in the area. See Figure 95 for examples on key drivers.

Step 7: Identify limiting factors

Purpose: To enable decision-makers to identify the factors limiting food security so that the response can target appropriate areas of interventions (availability, access, utilization and stability).

Approach overview:

- For each dimension, identify to what extent the dimension limits food security, including reference to evidence on food availability, access, utilization and stability. Refer to the key evidence used in Step 4.

FUNCTION 3: COMMUNICATE FOR ACTION

Figure 96: Protocols for Function 3

Protocols	Procedures	Tools
3.1 Produce the IPC Analysis Report	Prepare a consistent and effective IPC Analysis Report, including the minimum key information, preferably by completing the IPC Analysis Report Modular Template.	Tool 9: Minimum information requirements
3.2 Adhere to mapping standards	Develop IPC maps following the basic guidelines.	Tool 10: Modular Communication Template
3.3 Strategically share communication products in a timely manner	Plan and implement a minimum set of activities for sharing the final IPC results with key actors.	Tool 11: Mapping protocols
		Tool 12: Minimum set of dissemination activities

The aim of Function 3 is to communicate the core aspects of a situation in a consistent, accessible and timely manner to inform strategic decision-making. Communication is considered an integral part of the food security analysis process.

Protocols for Completing Function 3

Function 3 consists of three protocols: the first two focus on the production of reports and maps, and the third focuses on product dissemination, as presented in Figure 96 and explained in the paragraphs that follow.

Although not a protocol, it is strongly recommended that for all IPC analyses, the development of a **communication plan** is initiated from the earliest planning stages, including:

- carrying out public information activities (e.g. briefings, dissemination sessions) and producing communication products prior to, during and after IPC analysis;
- advising the relevant stakeholders when IPC Analysis Reports are expected to be available and how IPC results can be used for response planning;
- involving communication experts in the analysis to support the development of the communication plan and the drafting and dissemination of IPC Analysis Reports and other communication products;
- planning and conducting press conferences targeting local and international media whenever appropriate;
- integrating the communication plan in the overall IPC implementation plan and updating it every 6 to 12 months taking into considering lessons learned and any other forthcoming IPC activities.



PROTOCOL 3.1: PRODUCE THE IPC ANALYSIS REPORT

At the conclusion of the analysis process, the analysis team should draft the key messages to be included in the report. The Analysis Report outlined below should be finalized and shared as soon as possible, e.g. preferably within one or two months of the completion of the analysis. The completed Report, as well as any reports on the findings of IPC analysis, should contain the minimum information, as per Figure 97.

Figure 97: Analysis report information requirements (Tool 9)

Topic areas	Contents
1. Key messages	<ul style="list-style-type: none"> Summarize key findings, including the key outcomes of chronic food insecurity (quality and quantity of food consumption and chronic malnutrition), especially for the most severely affected areas.
2. Maps	<ul style="list-style-type: none"> Produce a classification map adhering to the mapping protocols for chronic food insecurity provided in IPC Protocol 3.2.
3. Population table	<ul style="list-style-type: none"> Provide the estimated number and percentage of people as per IPC levels.
4. Situation overview, key drivers and limiting factors	<ul style="list-style-type: none"> Provide conclusions on chronic food insecurity situation. Identify the main factors driving chronic food insecurity, focusing on structural causes. Identify the key limiting factors, focusing on food availability, access, utilization and stability.
5. Recommendations for action	<ul style="list-style-type: none"> Recommend strategic objectives of response aligned to those included in the IPC Chronic Food Insecurity Reference Table. Provide recommendations for monitoring the situation as needed. Recommend improvements for data collection and information systems as needed.
6. Process, methodology and data sources	<ul style="list-style-type: none"> Describe the analysis process. Identify the main sources of evidence used. Identify the key challenges. Plan for the next analysis.
7. Minimum visual identity/accountability requirements of the IPC Analysis Reports	<ul style="list-style-type: none"> The IPC Logo National analysis partners' logos Resource partners' logos Email addresses for any queries and information requirements Reference to the IPC website www.ipcinfo.org

Figure 98: IPC analysis reports for different audiences – Examples

- Reports targeting global-level stakeholders, which may include only the Key Findings (Module 1).
- Reports targeting national senior stakeholders, which may include three modules, such as the one-page key findings overview, maps and the population table (Modules 1, 2 and 3).
- Reports targeting national and subnational stakeholders, which include most or all modules, including an overview of the most affected areas (Modules 1 to 9).

IPC Modular Communication Template

The IPC Modular Communication Template (Tool 10) provides a standard format and content guide for producing IPC Analysis Reports. The Template has been developed to meet the different interests and needs of a variety of IPC stakeholders while ensuring that the minimum requirements for communicating IPC results are met. By using the modular template, IPC Analysis Reports effectively communicate key findings in a clear, concise, accessible and consistent format.

The Modular Communication Template for Chronic Food Insecurity consists of nine modules: (1) Key facts and messages; (2) Classification maps and the Summary Population Table; (3) Situation overview, key drivers and limiting factors; (4) Recommendations for action; (5) Detailed Population Table(s); (6) Process, methodology and data sources; (7) Results in figures; (8) Limiting factors and key drivers matrix; and (9) Profiles of the most affected areas/groups.

The general guidelines for completing the IPC Chronic Food Insecurity Communication Template include the following:

- All the template modules should be completed. At the very least, the full IPC Analysis Report should include Modules 1 to 6; Modules 7 to 9 are optional, but highly recommended.
- Modules can be selected and combined to develop specific products that meet the needs of different stakeholders. See Figure 98 for examples of selection of modules for different audiences.
- Modules are designed to ensure consistent IPC branding as well as ownership. Key information should be provided, for example the name of the country, contacts, the institution hosting the IPC, resource partners and the logos of the analysis partners.
- The IPC Modular Communication Template can be developed in the ISS or offline.
- The use of the IPC Modular Communication Template does not prevent countries from producing further documents or incorporating IPC results in other documents.



MODULE 1: KEY FACTS AND MESSAGES

Purpose: To provide concise responses to the five key questions: how severe, how many, where, who and why (Figure 99).

Key information to be included:

- Aggregated population estimates:** Provide the aggregate number of people in need of action (Level 3+) and the total number of people at different IPC levels).
- How many and how severe:** Refer to the number of people facing moderate or severe chronic food insecurity in need of urgent action.
- Where and who:** Identify the most affected areas and, if available, the characteristics of the most affected populations.
- Why:** Highlight the main factors driving the chronic food insecurity situation.
- Situation map:** Include a small IPC map without details on area labels.

Figure 99: IPC Communication Template Module 1

COUNTRY NAME INSERT HEADING IN NOT MORE THAN 10 WORDS		IPC CHRONIC FOOD INSECURITY ANALYSIS MONTH YEAR – MONTH YEAR Issued Month year												
MONTH YEAR 000,000 00% of the population <small>People facing Moderate and Severe chronic food insecurity (IPC Level 3+)</small>	Key Drivers Key driver 1 <small>Insert a short description and icon of up to 3 main factors driving the food insecurity situation.</small> Key driver 2 <small>Insert a short description and icon of up to 3 main factors driving the food insecurity situation.</small> Key driver 3 <small>Insert a short description and icon of up to 3 main factors driving the food insecurity situation.</small>	<small>The results of this IPC Chronic Food Insecurity Analysis will remain valid for the next 3.5 years, in absence of unusual shocks.</small>												
Overview <small>Sum up the overall chronic food insecurity situation of the country, including the following aspects:</small> How Severe, How Many and When: the number of people facing moderate or severe chronic food insecurity in need of urgent action. Estimates should be rounded up or down according to the standard rounding rules and consistent with the above table. Where and Who: the most affected areas and, if available, the characteristics of the most affected populations. Why: the main factors driving the chronic food insecurity situation.	Chronic Food Insecurity Month Year <small>Image for illustration only. Insert the IPC map in small size without details on area labels.</small>													
Key for the Map IPC Chronic Food Insecurity Level Classification <small>(mapped Level represents highest severity affecting at least 20% of the population)</small> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10px; height: 10px; background-color: #e6f2ff;"></td> <td>1 - Minimal</td> </tr> <tr> <td style="width: 10px; height: 10px; background-color: #d9e1f2;"></td> <td>2 - Mild</td> </tr> <tr> <td style="width: 10px; height: 10px; background-color: #b2c6e2;"></td> <td>3 - Moderate</td> </tr> <tr> <td style="width: 10px; height: 10px; background-color: #8094c4;"></td> <td>4 - Severe</td> </tr> <tr> <td style="width: 10px; height: 10px; background-color: #a9a9a9;"></td> <td>Areas with inadequate evidence</td> </tr> <tr> <td style="width: 10px; height: 10px; background-color: #f0f0f0;"></td> <td>Areas not analysed</td> </tr> </table> <div style="display: flex; justify-content: space-between; width: 100%;"> Map Symbols Evidence level: </div> <div style="display: flex; justify-content: space-between; width: 100%;"> Urban settlement classification * Acceptable </div> <div style="display: flex; justify-content: space-between; width: 100%;"> Recurrence of crisis - area classified as Crisis or worse during the last three years in the previous 10 years. ** Medium </div> <div style="display: flex; justify-content: space-between; width: 100%;"> Areas not analysed *** High </div>				1 - Minimal		2 - Mild		3 - Moderate		4 - Severe		Areas with inadequate evidence		Areas not analysed
	1 - Minimal													
	2 - Mild													
	3 - Moderate													
	4 - Severe													
	Areas with inadequate evidence													
	Areas not analysed													

Note that, in this module, the population estimates in the table and in the narrative (how many) should be rounded up or down according to the standard rounding rules; for example, analysts may choose to round to the nearest 5 percent and/or to the nearest one thousand ('000) people. It is important to maintain consistency in the way numbers are rounded throughout the report.

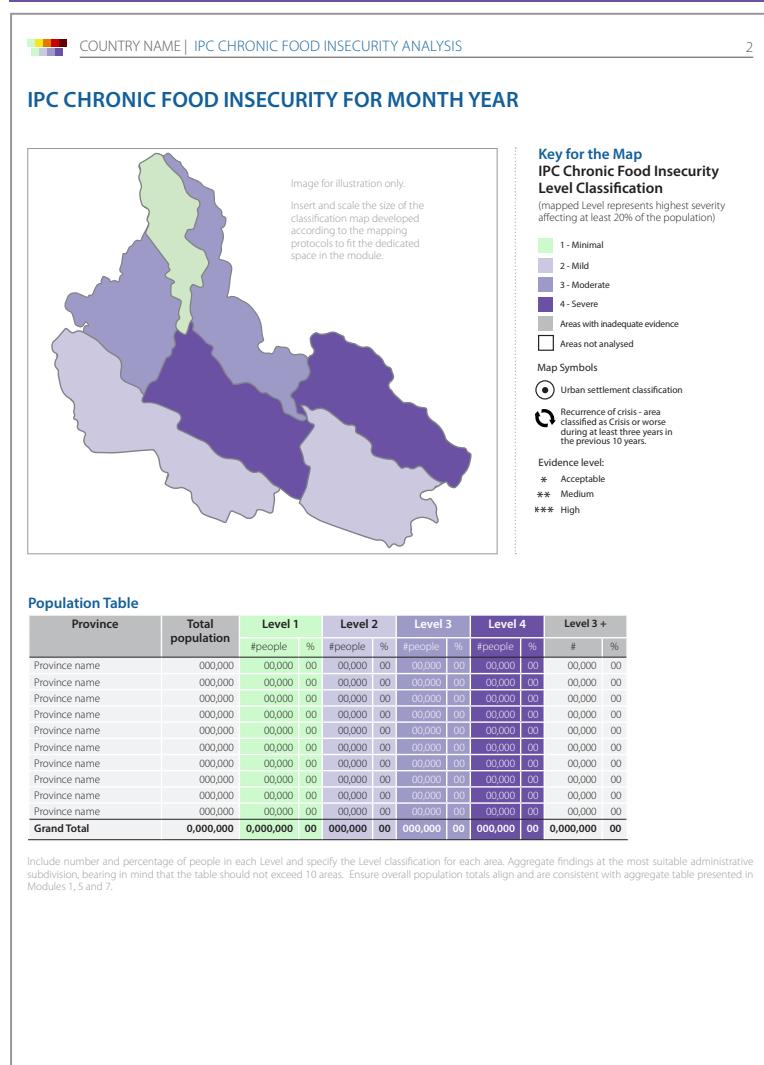
MODULE 2: CLASSIFICATIONS MAPS AND SUMMARY POPULATION TABLES

Purpose: To provide larger-scale, more detailed classification map and summary table of the population estimates (Figure 100).

Key information to be included:

- **Classification map:** Include and scale the size of the classification map to fit the dedicated space in the module.
- **Summary population tables:** Use the template or develop a summary population table to be added below the map. Include the number and percentage of people in each level and specify the level classification for each area. Aggregate findings at the most suitable administrative subdivision level, bearing in mind that the table should not exceed ten to fifteen areas (consider aggregating by regions if needed). Ensure that overall population totals align and are consistent with the aggregate table presented in Modules 1, 5 and 7 (if developed). If aggregation is not possible, population tables should be presented in easily digestible graphs showing values as well as percentages. Full population tables should then be shown in Module 5.

Figure 100: IPC Communication Template Module 2





MODULE 3: SITUATION OVERVIEW, KEY DRIVERS AND LIMITING FACTORS

Purpose: To provide a more detailed analysis of classification to answer the five key questions of how severe, how many, where, why, and who, already summarized in Module 1 (Figure 101).

Key information:

Classification results, considering:

- **context**, including relevant historical information and trends;
- **where, how many and how severe**, focusing on the most severely affected areas and on population figures;
- **current conditions**, with references to food security outcomes (food consumption quality and quantity and nutritional status);
- **who**, providing the general socio-economic characteristics of the most food-insecure, including gender disparities if possible.

Key drivers and limiting factors underpinning chronic food insecurity:

Provide a description of the main drivers of chronic food insecurity:

- *Identify the vulnerabilities* contributing to the situation and the most limiting dimensions (food availability, access, utilization or stability).
- *Highlight the direct or proximate factors* driving food insecurity and emphasize where and why they are prevalent.
- *Break down major factors* – Explain the actual problems and related main indicators/aspects, for example, relating to the quality and quantity of diet, livelihood strategies and resilience to shocks.

Outcomes of chronic food insecurity: Provide a description of the main outcomes, including levels of food consumption quality, quantity and chronic malnutrition. (See Figure 102 for an example of a situation overview.)

Figure 101: IPC Communication Template Module 3

COUNTRY NAME IPC CHRONIC FOOD INSECURITY ANALYSIS		3
SITUATION OVERVIEW AND KEY DRIVERS		
Classification results • Context, including relevant historical information and trends; • Where, how many and how severe, focusing on worst affected areas and population figures; • Current conditions, with references to food security outcomes (food consumption quality and quantity and nutritional status); • Who, providing general socio-economic characteristics of the most food-insecure, including gender disparities if possible.		
Limiting and underlying factors driving Chronic Food Insecurity Provide a description of the following issues: • Identify vulnerabilities contributing to the situation and the most limiting dimensions (food availability, access, utilization or stability); • Highlight the direct or proximate factors driving food insecurity, trying also to emphasize where and why these are prevalent; • Break down major factors – explain the actual problems and related major indicators/aspects, e.g. relating to quality and quantity of diet, livelihood strategies, and resilience to shocks.		
Outcomes of Chronic Food Insecurity Provide a description of the main outcomes, including food consumption and nutrition levels.		

Figure 102: Situation overview – Example

Around 64 per cent of the Filipino population nationwide, or 54.9 million people, are chronically food-insecure (IPC Level 2 and above). Specifically, this represents a 39 percent mildly, 17 percent moderately, and 8 percent severely chronically food-insecure population. Of the 71 provinces analysed, four provinces – Lanao del Sur, Northern Samar, Occidental Mindoro and Sulu – have been classified in IPC Level 4 (Severe Chronic Food Insecurity), accounting for 658,000 people; 48 provinces have been classified in IPC-Chronic Level 3 (Moderate Chronic Food Insecurity), while the remaining 19 provinces have been classified in IPC Level 2 (Mild Chronic Food Insecurity). Approximately 21.6 million Filipinos are facing higher-level chronic food insecurity (IPC Levels 3 and 4). The population classified in IPC Levels 3 and 4 are of major concern, with the highest prevalence in Lanao del Sur, Occidental Mindoro and Northern Samar (50 to 52 percent) followed by Sulu, Masbate, Samar, Zamboanga del Norte, Maguindanao, Sultan Kudarat, Southern Leyte, Zamboanga Sibugay, Bukidnon and Saranggani (40 to 49 percent).

Overall, food consumption quality and chronic undernutrition are the main drivers of chronic food insecurity. Severe chronic food insecurity (IPC Level 4) is driven by poor food consumption quality and quantity, and a high level of chronic undernutrition. In provinces at IPC Level 3, the quality of food consumption is worse than the quantity, and chronic undernutrition is also a major problem. The most chronically food-insecure people tend to be the landless poor households, indigenous people, population such as farmers, unskilled labourers, forestry workers and fishers who are engaged in unsustainable livelihood strategies that provide an inadequate and often unpredictable income. Thus, it is likely that these people are not able to satisfy their food and non-food needs in a sustainable manner. Households living in provinces highly susceptible to flooding, landslides and drought are likely to experience excessive stresses on their coping mechanisms.

Specifically, the main factors limiting food security are the poor utilization of food in 33 provinces and access to food in 23 provinces. Unsustainable livelihood strategies are the main drivers of food insecurity in 32 provinces followed by recurrent risks in 16 provinces and lack of financial capital in 17 provinces. In the provinces at IPC Levels 3 and 4, the majority of the population is engaged in unsustainable livelihood strategies and is vulnerable to seasonal unemployment and inadequate income. Low-value livelihood strategies and high underemployment rates result in a high poverty incidence, particularly in Sulu, Lanao del Sur, Maguindanao, Sarangani, Bukidnon, Zamboanga del Norte (Mindanao), Northern Samar, Samar (Visayas) and Masbate, and Occidental Mindoro (Luzon). These economic constraints combined with the increase in retail prices of major commodities led to a decline in purchasing power. Food utilization is also poor in the majority of the provinces as evidenced by low rates of exclusive breastfeeding and limited access to improved sources of water, toilets and cooking fuel, which mostly limit food consumption quality and caring practices.

Source: Philippines, IPC Chronic Food Insecurity Analysis, Consolidated Report, 2017.



MODULE 4: RECOMMENDATIONS FOR ACTION

Purpose: To provide general recommendations for: (i) response priorities; (ii) situation monitoring activities; and (iii) the data collection and information system (Figure 103).

Key information to be included:

Response priorities:

- Identify the populations in need of different strategic action. Refer to the priority response objectives of the relevant IPC levels as detailed in the Chronic Food Insecurity Reference Table. Defining specific modalities of response is not required and usually not possible at this stage of the situation analysis.

Situation monitoring and updates:

- Identify plans for food security monitoring and any upcoming IPC analyses.
- Identify recommendations for data collection and information systems, i.e. timing, coverage and indicators as relevant to fill the data quality and quantity gaps found during the analysis.

Figure 103: IPC Communication Template Module 4

	COUNTRY NAME IPC CHRONIC FOOD INSECURITY ANALYSIS	4
RECOMMENDATIONS FOR ACTION		
Response Priorities		
Identify population in need of different strategic actions. Refer to the Priority Response Objectives of the relevant Levels as detailed in the Reference Table. Defining specific modalities of response is not required and usually not possible at this stage of situation analysis.		
Situation Monitoring and Update		
<ul style="list-style-type: none">Identify IPC Analysis and other plans to monitor the situation.Identify recommendations for data collection and Information systems, i.e. timing, coverage and Indicators as relevant to fill the data quality and quantity gaps faced during the analysis.		

MODULE 5: DETAILED POPULATION TABLE

Purpose: To develop and share the population estimates for different IPC levels (Figure 104).

Key information to be included:

Overview of methods for population estimates:

- A brief methodological note on how the populations were estimated. Focus should be on the evidence-based consensus-building nature of the method where direct and indirect evidence is used to estimate the distribution of people among the four severity levels.

Population Table:

- Develop a detailed Population Table for all areas analysed, disaggregated at the relevant administrative level or other unit used in the analysis.
- Include total population, number and percentage of people in different levels and the aggregate number and percentage of people in Levels 3 and 4 for each area.
- The percentage in each level should be calculated in relation to the population analysed (e.g. if only rural populations are classified, then the total population should refer to the rural population).
- Specify the classification level for each area analysed.
- When using ISS, the population table will be generated automatically.
- If the population tables are longer than one page, they should be moved to the end of the report.

Figure 104: IPC Communication Template Module 5

COUNTRY NAME IPC CHRONIC FOOD INSECURITY ANALYSIS												5
DETAILED POPULATION TABLE												
Insert a brief methodological note on how the populations were estimated. Focus should be on the evidence-based consensus-building nature of the method, where prevalence of direct (and indirect) evidence is used to estimate the likely distribution of people between the four severity levels.												
Province	District	Total population	#people	%	#people	%	#people	%	#people	%	District level	Level 3 +
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	Total	0,000,000	000,000	00	000,000	00	000,000	00	000,000	00		000,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	District name	000,000	00,000	00	00,000	00	00,000	00	00,000	00	#	00,000 00
	Total	000,000	000,000	00	000,000	00	000,000	00	000,000	00		000,000 00
	Grand Total	0,000,000	0,000,000	00	0,000,000	00	0,000,000	00	0,000,000	00		0,000,000 00
Image for illustration only.												
Develop a detailed population table merging findings of all areas analysed and disaggregated at relevant administrative level or other unit used in the analysis.												
Include total population, number and percentage of people in different Levels and the aggregate number and percentage of people in Levels 3 and 4 for each area. The calculation of percentage in each Level should be done in relation to population analysed.												
Specify the area Level classification for each area analysed.												



MODULE 6: PROCESS AND METHODOLOGY

Purpose: To describe the IPC approach, analysis process, main data sources and key limitations (Figure 105).

Key information to be included:

Process and methodology

- Detail the analysis process, including reference to the National Technical Working Group, identification of institutional arrangements, training, and activities undertaken before, during and after analysis.
- Include a list of the main data sources used and a statement on evidence reliability.

Identify the limitations of the analysis:

- Technical and process challenges, such as evidence gaps, institutional arrangements and participation.

Figure 105: IPC Communication Template Module 6

COUNTRY NAME IPC CHRONIC FOOD INSECURITY ANALYSIS		6								
PROCESS AND METHODOLOGY										
Process and Methodology <ul style="list-style-type: none"> Detail the analysis process, including reference to the National TWG, identification of institutional arrangements, training, and activities undertaken before, during and after analysis. 										
Sources <ul style="list-style-type: none"> Include a list of main data sources used and a statement on evidence reliability. 										
Limitations of the analysis <ul style="list-style-type: none"> Identify limitations of the analysis, including technical and process challenges, such as evidence gaps, institutional arrangements, and participation. 										
Chronic Food Insecurity Level name and description <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; background-color: #f2f2f2;">Level 1 – No/Minimal Chronic Food Insecurity</th> <th style="text-align: center; background-color: #f2f2f2;">Level 2 – Mild Chronic Food Insecurity</th> <th style="text-align: center; background-color: #f2f2f2;">Level 3 – Moderate Chronic Food Insecurity</th> <th style="text-align: center; background-color: #f2f2f2;">Level 4 – Severe Chronic Food Insecurity</th> </tr> </thead> <tbody> <tr> <td>In a common year, households are consistently able to access and consume a diet of acceptable quantity and quality for an active and healthy life. Household livelihoods are sustainable and resilient to shocks. Households are not likely to have stunted children.</td> <td>In a common year, households are able to access a diet of adequate quantity and quality for an active and healthy life. Household livelihoods are sustainable and resilient to shocks. Households are not likely to have stunted children.</td> <td>In a common year, households have ongoing mild deficits in food quantity or quality. Household livelihoods are sustainable and resilient to shocks. Is limited. Households are not likely to have stunted children.</td> <td>In a common year, households have seasonal food quantity deficits for 2 to 4 months of the year, and consistently do not consume a diet of adequate quality. Household livelihoods are marginally sustainable, and resilience to shocks is very limited. Households are likely to have moderately stunted children.</td> </tr> </tbody> </table>			Level 1 – No/Minimal Chronic Food Insecurity	Level 2 – Mild Chronic Food Insecurity	Level 3 – Moderate Chronic Food Insecurity	Level 4 – Severe Chronic Food Insecurity	In a common year, households are consistently able to access and consume a diet of acceptable quantity and quality for an active and healthy life. Household livelihoods are sustainable and resilient to shocks. Households are not likely to have stunted children.	In a common year, households are able to access a diet of adequate quantity and quality for an active and healthy life. Household livelihoods are sustainable and resilient to shocks. Households are not likely to have stunted children.	In a common year, households have ongoing mild deficits in food quantity or quality. Household livelihoods are sustainable and resilient to shocks. Is limited. Households are not likely to have stunted children.	In a common year, households have seasonal food quantity deficits for 2 to 4 months of the year, and consistently do not consume a diet of adequate quality. Household livelihoods are marginally sustainable, and resilience to shocks is very limited. Households are likely to have moderately stunted children.
Level 1 – No/Minimal Chronic Food Insecurity	Level 2 – Mild Chronic Food Insecurity	Level 3 – Moderate Chronic Food Insecurity	Level 4 – Severe Chronic Food Insecurity							
In a common year, households are consistently able to access and consume a diet of acceptable quantity and quality for an active and healthy life. Household livelihoods are sustainable and resilient to shocks. Households are not likely to have stunted children.	In a common year, households are able to access a diet of adequate quantity and quality for an active and healthy life. Household livelihoods are sustainable and resilient to shocks. Households are not likely to have stunted children.	In a common year, households have ongoing mild deficits in food quantity or quality. Household livelihoods are sustainable and resilient to shocks. Is limited. Households are not likely to have stunted children.	In a common year, households have seasonal food quantity deficits for 2 to 4 months of the year, and consistently do not consume a diet of adequate quality. Household livelihoods are marginally sustainable, and resilience to shocks is very limited. Households are likely to have moderately stunted children.							
Contact for further Information Surname, Name IPC function email@email.com										
IPC Global Support Unit www.ipcinfo.org										
This analysis has been conducted under the patronage of the(e.g. Ministry of Agriculture). It has benefited from the technical and financial support of(e.g. European Commission, UK Government).										
Classification of food insecurity and malnutrition was conducted using the IPC protocols, which are developed and implemented worldwide by the IPC Global Partnership - Action Against Hunger, CARE, CILSS, EC-IRC, FAO, FEWSNET, Global Food Security Cluster, Global Nutrition Cluster, IGAD, Oxfam, PROGRESA-SICA, SADC, Save the Children, UNICEF and WFP.										
IPC Analysis Partners: <hr/>										

MODULE 7: SNAPSHOT

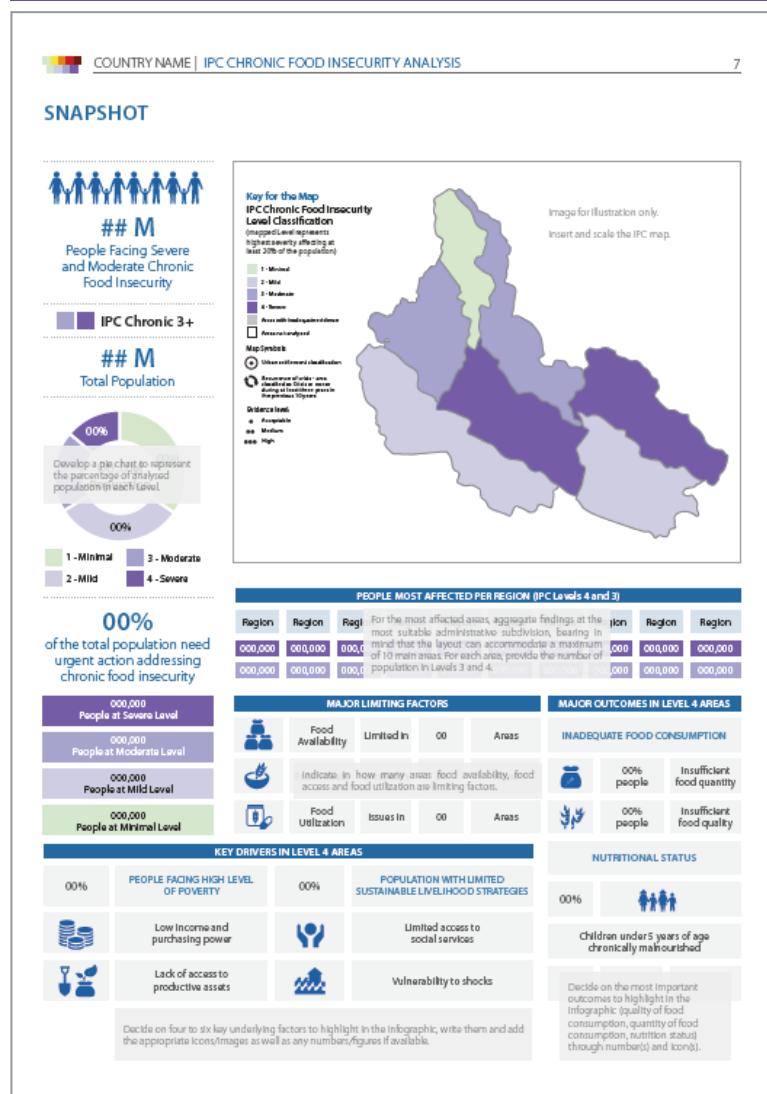
Purpose: To present key results in easily accessible infographics (Figure 106).

Key information to be included:

A graphic visual representation of the most important results/information of the IPC analysis, specifically:

- The IPC map and legend.
- **Population figures:** Insert the total number of people in Levels 3 and 4 rounded as in Module 1; insert the total number of people analysed and develop a pie chart to represent the percentage of analysed population in each level. Provide a break-down of the population figures of the different levels rounded as in Module 1.
- **Most affected areas and respective population estimates in the most severe level:** For the most affected areas, aggregate findings at the most suitable administrative subdivision level, bearing in mind that the layout can accommodate a maximum of ten main areas. For each area, provide the number of people in Levels 2, 3 and 4, if available.
- **Major limiting factors:** Indicate in how many areas food availability, food access and food utilization are limiting factors.
- **Major drivers:** Decide on four to six key drivers to highlight in the infographic, write them down and add the appropriate icons/images as well as any numbers/figures if available.
- **Key outcomes:** Decide on the most important outcomes to highlight in the infographic (quality of food consumption, quantity of food consumption, nutritional status) through number(s) and icon(s).

Figure 106: IPC Communication Template Module 7



MODULE 8: THE LIMITING FACTORS AND KEY DRIVERS MATRIX

Purpose: To provide an overview of the key drivers and limiting factors triggering existing levels of chronic food insecurity (Figure 107).

Key information to be included:

- Use the table provided in the module to indicate the major, minor and no limiting factors and key drivers as well as a lack of data availability per area.
 - Use ISS to complete the table.

Figure 107: IPC Communication Template Module 8

COUNTRY NAME | IPC CHRONIC FOOD INSECURITY ANALYSIS

8

MAJOR LIMITING FACTORS AND KEY DRIVERS MATRIX

OVERVIEW OF THE MAJOR LIMITING FACTORS AND KEY DRIVERS BY ANALYSIS UNIT											
ANALYSIS UNIT	LIMITING FACTORS OF FOOD INSECURITY					KEY DRIVERS OF FOOD INSECURITY					
	Food Availability	Food Access	Food Utilization	Livelihood Strategies	Human Capitals	Physical Capitals	Financial Capitals	Natural Capitals	Social Capitals	Policy/ Institutional Processes	Recurrent Risks
Name											
Name											
Name											
Name											
Name											
Name											
Name											
Name											
Name											
Name											
Legend		Major Factor		Minor Factor		Not a Factor		No Data			

Use the table provided in the module to indicate the major limiting factors, key drivers as well as no data availability per area. Use ISS to complete the table.

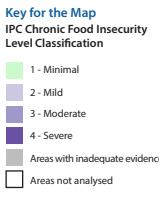
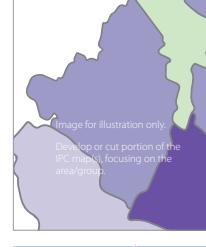
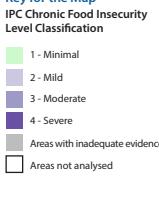
MODULE 9: PROFILES OF THE MOST AFFECTED AREAS/GROUPS

Purpose: To present the key findings for the most affected areas/groups, especially those in IPC Levels 3 and 4 (Figure 108).

Key information to be included:

- Overview of the situation in the area/group including reference to evidence and answers to the five key questions (how severe, how many, why, who, where) and recurrence of crisis. Provide recommendations for action as relevant:
- Develop or cut a portion of the IPC map(s), focusing on the affected area/group.
- Fill out the table with population estimates in the different IPC levels for that area/group.
- Insert icons representing two to four key limiting factors and key drivers for that area/group.
- Although this module is not mandatory, it is highly recommended that an in-depth analysis of each region is presented in this module, especially in the case of high concern countries. This should be based on the concluding statements on the evidence for each region in ISS.

Figure 108: IPC Communication Template Module 9

COUNTRY NAME IPC CHRONIC FOOD INSECURITY ANALYSIS				
PROFILE OF THE MOST AFFECTED AREAS				
Name of the Affected Area/Group  Image for illustration only. Develop or cut portion of the IPC map(s), focusing on the area/group.				
Key for the Map IPC Chronic Food Insecurity Level Classification  <ul style="list-style-type: none"> 1 - Minimal 2 - Mild 3 - Moderate 4 - Severe Areas with inadequate evidence Areas not analysed 				
Provide an overview of situation in the area/group including reference to evidence and attempting to answer the five key questions (how severe, how many, why, who and where), and recurrence of crisis. Provide recommendations for action as relevant.				
How Severe? How Many? Why? Who? Where?				
IPC CFI LEVEL % ('000s) MAJOR LIMITING FACTORS KEY DRIVERS				
Minimal	00	000,000	Fill out the table with population estimates in the different IPC Levels for that area/group and insert icons representing two to four key limiting factors and drivers for that area/group.	
Mild	00	000,000		
Moderate	00	000,000		
Severe	00	000,000		
Name of the Affected Area/Group  Image for illustration only. Develop or cut portion of the IPC map(s), focusing on the area/group.				
Key for the Map IPC Chronic Food Insecurity Level Classification  <ul style="list-style-type: none"> 1 - Minimal 2 - Mild 3 - Moderate 4 - Severe Areas with inadequate evidence Areas not analysed 				
Provide an overview of situation in the area/group including reference to evidence and attempting to answer the five key questions (how severe, how many, why, who and where), and recurrence of crisis. Provide recommendations for action as relevant.				
How Severe? How Many? Why? Who? Where?				
IPC CFI LEVEL % ('000s) MAJOR LIMITING FACTORS KEY DRIVERS				
Minimal	00	000,000	Fill out the table with population estimates in the different IPC Levels for that area/group and insert icons representing two to four key limiting factors and drivers for that area/group.	
Mild	00	000,000		
Moderate	00	000,000		
Severe	00	000,000		



PROTOCOL 3.2: ADHERE TO MAPPING STANDARDS

Figure 109: Mapping standards (Tool 11)

Key for the Map
IPC Chronic Food Insecurity Level Classification
 (mapped Level represents highest severity affecting at least 20% of the population)

- 1 - Minimal
- 2 - Mild
- 3 - Moderate
- 4 - Severe
- Areas with inadequate evidence
- Areas not analysed

Map Symbols

- Urban settlement classification
- Recurrence of crisis - area classified as Crisis or worse during at least three years in previous 10 years.

Evidence level:

- * Acceptable
- ** Medium
- *** High

Area-specific call-out box (ISS map digital version)

Area Name
 IPC Chronic Food Insecurity Phase
 ##### (#%) Aggregated # and % of population in Levels 3 and 4

 % of people in each level
 0% 100%

The following parameters need to be adhered to on all maps of IPC Chronic Food Insecurity Classifications (Figure 109):

- Areas should be mapped using the following red-green-blue (RGB) colour scheme: Level 1 (205, 250, 205); Level 2 (203, 201, 226); Level 3 (158, 154, 200); and Level 4 (106, 81, 163).
- Areas are only classified and mapped if they meet the minimum evidence requirements. If the requirements are not met, these areas should be mapped using a grey colour (RGB 166, 166, 166), indicating "inadequate evidence".
- Areas that are not included in the analysis should be coloured white (RGB 255, 255, 255), indicating "area not analysed".
- In case of classifications of urban areas, specific symbols should be used as illustrated in the legend. The colour of the symbol should be chosen according to the level classified.
- The evidence level of analysis should be added to the map through the use of *Acceptable, **Medium and ***High. If not possible, the evidence level of analysis should be added to the map key or to a note under the map. For areas experiencing a recurrence of Crisis (Phase 3 or worse during at least three years over the previous ten years), use the indicated symbol.
- Digital maps may have further information included in call-out boxes. This further information may include the total population in Level 3 or more severe, and the population distribution per level. Figure 108 includes extra information that can be added to digital maps.

PROTOCOL 3.3: STRATEGICALLY SHARE COMMUNICATION PRODUCTS IN A TIMELY MANNER

IPC communication products, including the analysis report and maps, should be shared with the relevant stakeholders as soon as they are finalized, preferably within one or two months of the completion of analysis. Three key activities should be implemented to accomplish the protocol, as described in Figure 110.

Figure 110: Communication activities required for effective dissemination (Tool 12)

- Presentation of results to national and regional stakeholders: At least one presentation of the key findings needs to be given to relevant stakeholders and decision-makers. This dissemination can be amplified by communications officers in key participating organizations.
- Sharing of key IPC products (maps, population tables and reports) with the IPC Global Support Unit: The Technical Working Group shares key communication products with the IPC Global Support Unit for posting on the IPC website and for further dissemination at the global level as applicable.
- Dissemination of key communication products (IPC report with maps and the snapshot) to key IPC audiences (donors, organizations, the media, the technical community, academia and governments) through appropriate channels such as mailing lists, social media and the IPC website.

FUNCTION 4: QUALITY ASSURANCE

Function 4 ensures the technical rigour and neutrality of an analysis as well as learning for future improvements. These are achieved through self-assessments and, if necessary, external quality reviews. By completing Function 4, analysts assess to what extent they have followed all the IPC protocols included in Functions 1, 2 and 3, and identify areas for future improvements. If all 13 protocols are followed, the resulting product can be labelled as IPC. Therefore, by putting the IPC logo onto a report, the Technical Working Group recognizes its accountability, confirming that classification was based on consensual and unbiased analysis developed according to IPC protocols.

Further to Function 4, the IPC initiative aims to support countries in producing analyses that meet high-quality standards. To this end, the IPC Quality and Support Strategy has been developed around three additional components: (i) Capacity Development; (ii) Country Technical, Implementation and Strategic Support; and (iii) Technical Standards and Guidelines.

Protocols For Completing Function 4

There are two protocols for Function 4: the first focuses on self-assessment and the second entails requesting and engaging in an external quality review if deemed necessary (Figure 111).

Figure 111: Protocols for Function 4

Protocol	Procedure	Tool
4.1 Conduct a self-assessment of the analysis.	Complete the self-assessment tool through a participatory process.	Tool 13: Self-Assessment Tool 
4.2 Request and engage in an external quality review if necessary.	Contact the IPC Global Support Unit with any concerns.	Quality.Assurance@ipcinfo.org

PROTOCOL 4.1: CONDUCT A SELF-ASSESSMENT OF THE ANALYSIS

A self-assessment needs to be conducted at the end of all analyses to reflect critically on the extent to which the IPC protocols for Functions 1, 2 and 3 were followed and to identify areas for future improvements. To achieve this, the analysis team needs to complete the Self-Assessment Tool (Figure 112). The Tool should be completed based on a collective discussion involving all analysis team members. To facilitate the discussion and completion of the tool, guiding questions are provided in Figure 113. As an optional step, the tool can also be completed by individual analysis team members or facilitators so as to provide feedback to the National Technical Working Group and/or Global Support Unit on the process and suggestions on how to improve future IPC analyses, tools, procedures, specific guidance and/or implementation processes.

The Self-Assessment Tool serves two purposes:

- To identify how well protocols have been followed. In the event that they have not been followed, the analysis team should revise the analysis to ensure adherence to all protocols and the quality of the IPC products. If for some reason the protocols cannot be entirely adhered to, the analysis team should provide a reasonable explanation. Should the outcomes of the self-assessment raise serious concerns, an external quality review may be initiated.
- When planning a new IPC analysis, the IPC Technical Working Group should reflect on the content of previous self-assessments to ensure that the lessons learned in preceding analyses are applied.

Once completed by the analysis team, the Self-Assessment Tool should be submitted to the Global Support Unit either via the ISS (when it is used for the analysis) or via email (Quality.Assurance@ipcinfo.org).



Figure 112: The Self-Assessment Tool (Tool 13)

Country: _____ Date: _____		Organizations Participating in the Self-Assessment: _____		
IPC Protocols		Specify if the protocol was completed 1. Yes 2. Partially 3. No	If partially or not completed, explain why	Provide recommendations for future analysis improvements
Function 1: Build a Technical Consensus	1.1 Compose the analysis team with relevant sectors and organizations.			
	1.2 Conduct the analysis on a consensual basis.			
Function 2: Classify Severity and Identify Key Drivers	2.1 Use the IPC Analytical Framework to guide the convergence of evidence.			
	2.2 Compare evidence against the IPC Chronic Food Insecurity Reference Table.			
	2.3 Adhere to parameters for analysis.			
	2.4 Evaluate evidence reliability.			
	2.5 Meet minimum evidence and analysis requirements.			
	2.6 Methodically document evidence and analyses, and provide them upon request.			
Function 3: Communicate for Action	3.1 Produce the IPC Analysis Report.			
	3.2 Adhere to mapping standards.			
	3.3 Strategically share communication products in a timely manner.			
Function 4: Quality Assurance	4.1 Conduct a self-assessment of the analysis.			
	4.2 Request and engage in an external quality review if necessary.			

**Figure 113: The Self-Assessment Tool – Guiding questions**

IPC Protocols	Guiding Questions
Function 1: Build a Technical Consensus	1.1 Compose the analysis team with relevant sectors and organizations. Was the analysis team composed of relevant sectors and organizations? Were different relevant stakeholder organizations (e.g. government, United Nations agencies, international and national NGOs, and technical agencies) and sectors (e.g. food security, agriculture, markets, nutrition, rural/social/economic development, health, education and communications) represented? Areas for improvement/learning: Any organizations and/or sector whose participation should be further promoted?
	1.2 Conduct the analysis on a consensual basis. Was the analysis conducted on a consensual basis? Did IPC analysts review, discuss and debate the preliminary IPC classifications and population estimates, reach a consensus and agree on the final results? If different views were expressed by any analysis team member(s) on the results, were they addressed? Areas for improvement/learning: Are changes in the process needed to facilitate consensus building?
Function 2: Classify Severity and Identify Key Drivers	2.1 Use the analytical framework to guide convergence of evidence. Were the analysis and population estimates based on convergence of evidence? Was all the available evidence used in the analysis? Was there contradictory or at least somewhat reliable evidence, and, if so, how was this addressed in the analysis? Areas for improvement/learning: Were hazards and vulnerabilities documented and analysed? Were the four dimensions of food security documented and analysed? Were the food security outcomes documented and used to conclude on area classification?
	2.2 Compare evidence against the IPC Chronic Food Insecurity Reference Table. Has direct evidence been compared against the Reference Table by taking into account the globally comparable cut-offs for key outcome indicators? Was direct evidence analysed and made available to allow comparison against Reference Table cut-offs? Areas for improvement/learning: Have the indicative levels of various outcome indicators been assessed against the Reference Table?
	2.3 Adhere to parameters for analysis. Were all IPC analytical parameters respected? For example, was the 20 percent rule used for classification? Were non-exceptional circumstances identified for all analysed areas? Areas for improvement/learning: Can adherence to the following parameters be improved: convergence of evidence, the 20 percent rule for area classification, unit of analysis, classification based on actual conditions as observed in non-exceptional circumstances?
	2.4 Evaluate evidence reliability. Was all the evidence assessed against methodological and time validity? Were the reliability criteria of the IPC Technical Manual Version 3.1 used to assess evidence reliability? Were reliability scores allocated to all pieces of evidence? Areas for improvement/learning: Have methodological notes on the sources of the evidence been made available to analysts? Could the soundness of method and time relevance of the evidence be improved through better planning? If so, how?
	2.5 Meet minimum evidence and analysis requirements. Were the minimum evidence and analyses requirements met? Was there sufficient evidence for all the classified areas to meet the minimum evidence requirements? Areas for improvement/learning: What were the key issues relating to data? Was any key evidence missing/outdated/not representative of the areas of analysis?
	2.6 Methodically document evidence and analysis, and provide them upon request. Were the evidence and analyses methodically documented and made available? Were convergence of evidence and conclusions documented? Was all evidence coded and provided to all analysts? Were these pieces of evidence accessible? Areas for improvement/learning: Was the reasoning behind the convergence of evidence documented?



Function 3: Communicate for Action	3.1 Produce the IPC Analysis Report.	Is the minimum information on the seven topics provided in the IPC Analysis Report? Has the guidance for the content of each topic been followed? Areas for improvement/learning: Did the analysis team ensure that the IPC population estimates provided in the IPC Population Table contain no calculation errors/inconsistencies and that they add up to the total population analysed? Were the key messages discussed and agreed in plenary during the analysis? Was the IPC Modular Communication Template used?
	3.2 Adhere to mapping standards.	Do the map and legend follow standard requirements? Mapping standards include: (i) standardized Red-Green-Blue colours should be used; (ii) areas that do not meet minimum evidence requirements should be mapped in grey; (iii) areas that are not analysed should be mapped in white; (iv) urban areas should be indicated using the standard mapping symbols; and (v) the evidence level of analysis should be indicated in the map for each area using the standard mapping symbols. Areas for improvement/learning: Do the mapped areas correspond to the unit of analysis?
	3.3 Strategically share communication products in a timely manner.	Will IPC communication products be shared strategically and in a timely manner? Is there a plan in place for sharing the analysis products with relevant stakeholders? Is this expected to occur within a month or two after completion of the analysis? Areas for improvement/learning: Was a communication plan (including dissemination) developed and discussed with Technical Working Group members prior to the IPC analysis? Will the analysis results be presented to key stakeholders/decision-makers prior to public release?

Add any relevant notes on country implementation issues, including for different stages of the analysis cycle

Planning	Has the analysis been planned and timed taking into account data availability, context and decision-makers' information needs?
Preparation	Did the analysis planning and preparation allow for the optimal participation of all stakeholders, including timely communication on the dates of training and analysis events, access to data for analysts, and so on?
Learning	Have key challenges and gaps (including resource, capacity and evidence gaps) been identified to inform future improvements?



PROTOCOL 4.2: REQUEST AND ENGAGE IN AN EXTERNAL QUALITY REVIEW IF NECESSARY

Figure 114: External Quality Reviews – Objective, modality and focus

Objective: To ensure the overall quality, technical rigour and neutrality of analyses and related products.

Modality: External quality reviews are implemented within a short timeframe prior to the finalization and release of the final IPC product. They are conducted remotely by a team of officers from the IPC Global Support Unit and, whenever possible, from IPC Global Partners who are not involved in the analysis. These Reviews consist of a review of documented analysis (optimally using the IPC Analysis Worksheets), including all evidence used. The Technical Working Group is consulted and provides inputs throughout the process, as needed.

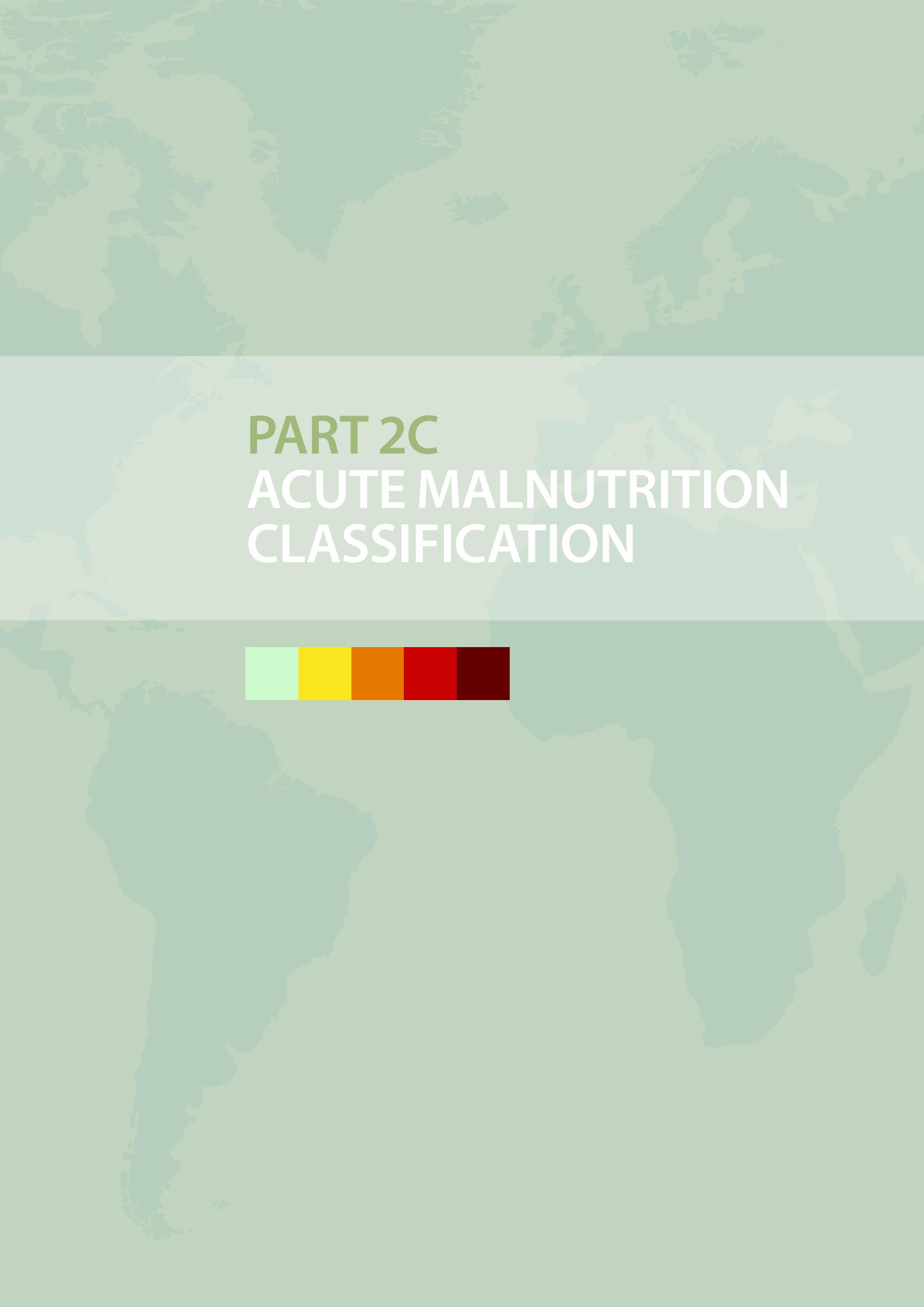
Focus: External quality reviews focus on assessing adherence to all protocols.

Technical Working Groups, analysis teams or facilitators are provided with the opportunity to communicate directly with the Global Support Unit regarding major concerns relating to the IPC analysis. The communication must include a short explanation of the concern as well as basic information on the analysis and must be submitted to the relevant regional Global Support Unit officer. Should there not be one available, it must be submitted to the Global Support Unit at Quality.Assurance@ipcinfo.org.

External quality reviews are carried out to ensure the overall quality, technical rigour and neutrality of analysis under the following specific circumstances:

- When there is a breakdown in the technical consensus regarding the (potential) classification of areas in Level 4; or
- Based on the review of the completed Self-Assessment Tool by the Global Support Unit or communication to the Global Support Unit from the analysis team or facilitator(s) expressing concerns about lack of adherence to protocols especially for the actual or potential classification of areas in Level 4.

Figure 114 provides an overview of the objectives and implementation modalities of external quality reviews. While they are a valuable mechanism for supporting analysis teams in resolving technical disagreements and overcoming major analytical challenges, they are a last-resort action. Other steps should thus be taken upstream, such as requesting real-time technical support for the preparation and implementation of the analysis.



PART 2C

ACUTE MALNUTRITION CLASSIFICATION





Functions

1

Build Technical Consensus

2

Classify Severity and Identify Key Drivers

3

Communicate for Action

4

Quality Assurance

This module describes the Protocols for the Integrated Phase Classification of Acute Malnutrition. These protocols are organized and presented according to the four Functions of the IPC: (i) Build Technical Consensus; (ii) Classify Severity and Identify Key Drivers; (iii) Communicate for Action; and (iv) Quality Assurance.

Additional and supporting protocols have been developed for **areas with limited access** and included in this module.

All protocols should optimally be completed in the country-owned and -managed ISS to mainstream analysis and facilitate recurring analysis.

Important note for using Part 2C

1. This Part is an **integral part of the IPC Technical Manual Version 3.1**, which also includes an Overview of the IPC (Part 1), Protocols for Acute Food Insecurity Classification (Part 2A), and Protocols for Chronic Food Insecurity Classification (Part 2B).
2. This module focuses on providing succinct and clear guidance to completing the Protocols required to develop IPC Acute Malnutrition products. It includes the 13 protocols that are required for acute malnutrition classification as well as a brief overview of the procedures for completing them. Additional guidance, the reasoning for technical decisions and other relevant issues are included as **IPC Resources** on the IPC website.



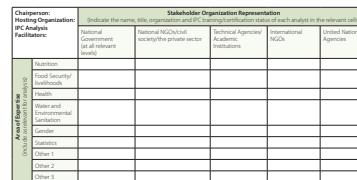
FUNCTION 1: BUILD TECHNICAL CONSENSUS

Function 1 promotes a neutral and participatory process to build technical consensus by ensuring that classifications are carried out through multi-agency and multi-sectoral analysis teams, and by providing general guidelines to achieve consensus.

Protocols For Completing Function 1

There are two protocols for completing Function 1 that, when correctly followed, will ensure that the analysis includes the needed variety of experts from relevant institutions and organizations, and that it is conducted following a consensus-based and unbiased approach. Figure 115 provides an overview of these protocols; specific tools and procedures are provided below for each protocol.

Figure 115: Protocols for Function 1

Protocol	Procedure	Tool
1.1 Compose the analysis team with relevant sectors and organizations	Complete the IPC analysis team Matrix and ensure the representation of relevant stakeholders.	Tool 1: IPC Composition Matrix for the analysis team 
1.2 Conduct the analysis on a consensual basis	Follow good practices for consensus-building, such as strong facilitation, adequate analytical capacity of analysts, vetting of results, and preliminary presentation to decision-makers.	Reference to good practices (no specific tools)

PROTOCOL 1.1: COMPOSE THE ANALYSIS TEAM WITH RELEVANT SECTORS AND ORGANIZATIONS

The **analysis team** should include representatives from different institutions/organizations and sectors so as to create the inclusive environment needed for unbiased consensus-building analysis (Figure 116).

The composition of the IPC analysis team may vary from one analysis event to the next, since different expertise may be needed for specific analyses. When planning the analysis and forming the analysis team, the following should be considered:

- There is a need to raise awareness on and interest in IPC Acute Malnutrition classification among country-level stakeholders prior to the actual analysis.
- There is a need to inform partners at the country level in advance of forthcoming analysis activities.
- The analysis team should include members of the national IPC Technical Working Group, which has the overall task of coordinating and implementing the IPC in the country, and other experts whose knowledge or skills are relevant for the specific IPC analysis, including knowledge of local conditions and context.

Figure 116: The IPC Analysis Team – Examples of members

Members of the IPC analysis team include:

- members of the national IPC Technical Working Group;
- nutritionists and food security analysts who are not part of the Technical Working Group but can contribute to the analysis;
- officers who can support the contextualization and interpretation of evidence;
- sectoral experts, such as conflict analysts when this is a key driver of acute malnutrition;
- communication officers to support the development of communication products.

- The Technical Working Group should ensure that most analysis team members have adequate IPC Acute Malnutrition training and have passed the IPC Acute Malnutrition Level 1 test prior to the analysis.

The **Analysis Team Composition Matrix** needs to be completed for each analysis (Figure 117). If correctly used, it provides a clear visualization of diversity achieved. The Matrix should identify:

- The Technical Working Group chairperson and hosting organization;
- analysis facilitators;
- all analysis participants, including their name, title, organization, area(s) of expertise and IPC training/certification status. Analysts may have advanced knowledge of different sectors, and thus the same person may appear more than once in the Matrix.

When **Acute Malnutrition and Acute Food Insecurity Classifications** are carried out simultaneously, either one common or two individual matrices can be filled in, depending on the approach used during the analysis.

Figure 117: Composition matrix for the Analysis Team (Tool 1)

Chairperson: Hosting Organization: IPC Analysis Facilitators:		Stakeholder Organization Representation (Indicate the name, title, organization and IPC training/certification status of each analyst in the relevant cells)				
		National Government (at all relevant levels)	National NGOs/civil society/the private sector	Technical Agencies/Academic Institutions	International NGOs	United Nations Agencies
Area of Expertise (include as relevant for analysis)	Nutrition					
	Food Security/livelihoods					
	Health					
	Water and Environmental Sanitation					
	Gender					
	Statistics					
	Other 1					
	Other 2					
	Other 3					



PROTOCOL 1.2: CONDUCT THE ANALYSIS ON A CONSENSUAL BASIS

The analysis team members must commit to conducting evidence-based and unbiased analysis, with the objective of classifying and describing acute malnutrition conditions and key drivers as accurately as possible through mutual agreement.

Formulation of a mutual understanding and agreement is one of the central tasks of the IPC Technical Working Group leadership and the IPC analysis facilitators, and a range of strategies may be applied to this end.

Consensus does not necessarily imply unanimity, since some disagreement or dissent is common. Nevertheless, a consensus should leave all stakeholders in a better position than when they started, thus adding to trust and credibility among themselves and in the public eye. Common ground between the analysts can be sought through joint analysis and a critical review of the data available, and through a good understanding of the context of the area analysed. However, since arriving at a consensus is complex, it requires the support of a qualified facilitator. One of the initial tasks for the IPC Technical Working Group leadership and the IPC analysis facilitators is to define the ground rules for building consensus, with the participating analysts (see examples in Figure 118).

Consensus-building is dependent on the ability of analysts to critically analyse and discuss evidence. Hence, it is imperative that members have a strong understanding of their sector(s), nutrition and IPC protocols. Furthermore, in order to ensure that adequate time is spent on critically reviewing evidence and achieving a consensus on classification, it is imperative that evidence be well organized for and prior to the analysis.

Consensus is not always achieved. Disagreements may relate to a particular area, or to the analysis overall. In these situations, the best approach is to address the disagreements within the analysis team through neutral facilitation and seek an agreement at the country level to avoid delays. If this is not possible, the dissenting organization(s) can decide to disagree with the analysis results, in which case the minority view may be documented and communicated to decision-makers. However, if the disagreement relates to classification in IPC Phase 4 or 5, an external quality review of the alternative analysis (reflecting the minority view) may be requested either by the Technical Working Group or the partner(s) supporting the minority view.

Vetting of classification and population estimations is also a good practice for IPC consensus-building. Although the IPC does not define the process for reaching a consensus, it recommends that some form of vetting be carried out. Vetting usually takes place after preliminary classification has been performed and typically consists of sessions during which IPC analysts who participated in the analysis review, discuss and debate the preliminary IPC classifications and identification of key drivers resulting from the exercise, reach a consensus, and agree on the final results.

Presenting the IPC results to key decision-makers before public release is another recommended activity. This achieves two objectives: (i) it is a double-check on the results, allowing for open discussion as necessary, which may in some instances lead the Technical Working Group to revisit the analysis if supported by evidence; and (ii) it promotes ownership of the findings by key stakeholders before the results are presented to the public.

Figure 118: Consensus-building – Examples of ground rules

- Identify the modalities of the analytical process (e.g. subgroups conduct preliminary analyses and present their findings to the larger group for vetting).
- Agree on how decisions will be made (e.g. based on a full consensus or majority view) and how minority views will be documented and communicated.

FUNCTION 2: CLASSIFY SEVERITY AND IDENTIFY KEY DRIVERS

Figure 119: Protocols for Function 2

Protocols	Procedures	Tools
2.1 Use Analytical Framework to guide convergence of evidence.	Analyse evidence following the IPC Acute Malnutrition Analytical Framework.	Tool 2: IPC Acute Malnutrition Analytical Framework
2.2 Compare evidence against the Reference Table.	Use the IPC Acute Malnutrition Reference Table for characteristics of phases, and thresholds of international standards.	Tool 3: Reference Table
2.3 Adhere to parameters for analysis.	Respect the key parameters as the rules for classification.	Tool 4: Analytical Parameters
2.4 Evaluate evidence reliability.	Assess soundness of methods and time relevance of all the evidence following stipulated parameters.	Tool 5: Evidence Reliability Scores
2.5 Meet minimum evidence and analysis requirements.	Present evidence and analyses that adhere to the minimum requirements.	Tool 6: Evidence-level Criteria
		Tool 7: Minimum Analysis Requirements
2.6 Methodically document evidence and analyses and provide them upon request.	Use an Analysis Worksheets preferably in the Information Support System (ISS).	Tool 8: Analysis Worksheets

Function 2 promotes a methodical analysis of complex information to classify areas into meaningful categories to guide decision-making. The classification of acute malnutrition focuses on identifying areas with a high proportion of acutely malnourished children that require urgent action.

By completing Function 2, for the classification of acute malnutrition, analysts should provide information on:

- **How** severe is the situation?
- **Where** are the worst affected areas?
- **How** many children are affected?
- **When** will children be affected?
- **Why** are children affected?

Protocols For Completing Function 2

In order to complete Function 2, analysts need to follow six protocols, as introduced in Figure 119 and explained further below.

While this section focuses only on the technical protocols followed during the actual analysis, the completion of the whole analysis cycle, including the preliminary planning and preparation activities, is of the utmost importance. Especially important is the preparation of evidence, including identifying and gathering evidence and ensuring that it aligns with the IPC Acute Malnutrition Reference Table and unit of analysis before the actual analysis stage.



PROTOCOL 2.1: USE ANALYTICAL FRAMEWORK TO GUIDE CONVERGENCE OF EVIDENCE

Figure 120: The IPC Acute Malnutrition Analytical Framework – Elements for analysis

Outcomes

1. Acute malnutrition
2. Mortality

Contributing factors

1. Basic causes
2. Immediate causes
3. Underlying causes

Figure 121: Basic causes of Acute Malnutrition – Examples

- Conflict, displacement and destruction of shelters or health facilities;
- Natural disasters such as drought and tsunami;
- Gender dynamics and women's education levels and social status;
- Institutional policies such as universal free health care for children and free primary education, and so on.
- Availability of, access to, and coverage of health and nutrition programme interventions

Figure 122: Underlying causes of Acute Malnutrition – Examples

- Infant and Young Child Feeding practices;
- Coverage of health services and immunization;
- Water, Sanitation and Hygiene (WASH) coverage and practices;
- Food insecurity.

The purpose of the IPC Acute Malnutrition Analytical Framework (Figure 125) is to guide the analysis through a logical outline of the drivers of acute malnutrition. By following the Framework, analysts are able to converge evidence for the classification of severity and identification of key drivers. The Framework is divided into contributing factors and outcomes (Figure 120). The contributing factors include the basic, immediate and underlying causes of acute malnutrition, and the outcomes are acute malnutrition and mortality. It should be noted that mortality is a higher outcome than acute malnutrition – i.e. being acutely malnourished is a risk factor for mortality. In the IPC Acute Malnutrition analysis, however, the outcome of interest is acute malnutrition.

The IPC Acute Malnutrition Analytical Framework is an adapted version of the UNICEF Conceptual Framework on Malnutrition.

Contributing factors

A. Basic causes

- a. **Vulnerability, Resources and Control:** This is the first component of the basic causes. The five livelihood assets (financial, physical, human, social and natural), policies, institutions and processes, gender, and mitigating factors are analysed in relation to their potential impact on acute malnutrition.
- **Livelihood assets** – This term relates to an analysis of the five assets and their impact on acute malnutrition.
- **Policies, institutions and processes** – These involve an analysis of key policies, institutional actors and socio-economic and political issues related to acute malnutrition.
- **Gender** – This causal factor takes into account gender roles at the societal, community and household levels, with a focus on aspects of livelihoods pertaining to food access, utilization and nutrition (including access to water, education and health services), and their relationship to acute malnutrition.
- **Mitigating factors** – These include factors that may have mitigating effects on acute malnutrition.
- b. **Acute Events or Ongoing Conditions:** This second component of the basic causal factors can include natural disasters (e.g. droughts, floods, and tsunamis), socio-economic instability (e.g. volatility in staple food prices, and energy or food shortages), conflict (e.g. war and civil unrest), and other events/conditions that can have an impact on acute malnutrition. See Figure 121 for examples of basic causes.

Figure 123: Immediate causes of Acute Malnutrition – Examples

- Prevalence and trends of common childhood illnesses;
- Quality and quantity of food consumed by children

Figure 124: Acute Malnutrition outcomes – Examples

- Global acute malnutrition (GAM) among children 6–59 months measured by Weight for Height Z-score (WHZ) < -2 or oedema;
- GAM among children 6–59 months measured by Mid-Upper Arm Circumference (MUAC) <125 mm or oedema.

B. Underlying causes

- **Caring and feeding practices:** Recognizing the importance of the care environment for mothers and children, and taking into consideration women's status in the family and the community, and protection issues, the IPC Acute Malnutrition Analysis considers issues that affect infant and young child feeding practices, intra-household allocation of resources, and cultural beliefs and practices (including food restrictions, care habits and taboos).
- **Health services and environmental health:** This refers to health and environmental factors affecting households and individuals. The analysis of health services and environmental health focuses on vaccination coverage (both routine as well as campaign), water, sanitation and hygiene (WASH), health-seeking behaviour, and the coverage of acute malnutrition treatment programmes.
- **Food security dimensions:** This refers to the four dimensions that form the basis of the food security conceptual framework: availability, access, utilization, and stability. Within these four broad categories, a general description of the food security context at the national, sub-national, community and household levels can be generated as applicable to the analytical framework. These dimensions determine the extent to which food is available in the area of analysis, if/how it can be accessed, how it is then utilized, and the overall consistency of these factors over time (stability). See Figure 122 for examples of underlying causes.

C. Immediate causes

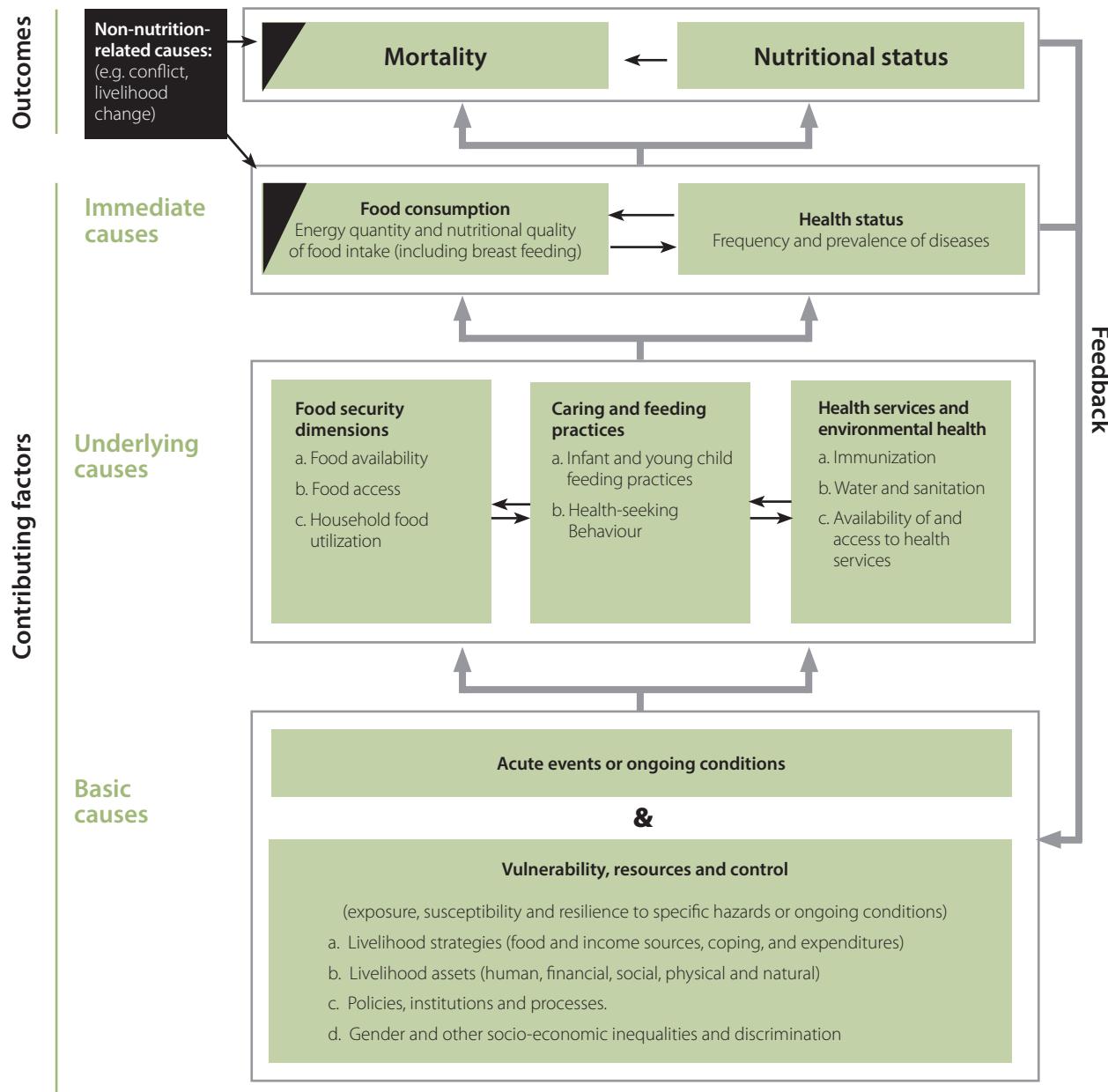
- **Health status:** The analysis of health status considers the main childhood illnesses according to the Integrated Management of Childhood Illnesses, such as malaria, diarrhoea, pneumonia, measles, and HIV/AIDS, because they directly contribute to acute malnutrition (Figure 123). Other context-specific diseases (e.g. dengue) that affect acute malnutrition as well as disease outbreaks are also taken into account in the analysis.
- **Food consumption:** Both the quality and quantity of food consumed by children are considered under food consumption. It is recognized that having adequate food security at the household level may not always guarantee adequate food consumption by children – i.e. behavioural and cultural norms and taboos all come into play with regard to child feeding.

Outcome

The result of the interaction of dietary intake and health status will directly affect the nutritional status of a child; if there is inadequate consumption and/or health status, the child is likely to become acutely malnourished (Figure 124). Furthermore, it is recognized that acute malnutrition may also lead to mortality, which is a higher-level outcome.



Figure 125: The IPC Acute Malnutrition Analytical Framework (Tool 2)



PROTOCOL 2.2: COMPARE EVIDENCE AGAINST THE REFERENCE TABLE

Figure 126: The IPC Reference Table – Overview of contents

Each IPC Phase has a description, priority response objective, and a set of common characteristics expected among households. Below is an example of how this is presented for Phase 4 (critical).

Phase description: 15–29.9 percent of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised.

Figure 127: Priority response objective – Example for Phase 4

Phase 4 (critical): Significant scale-up and intensification of treatment and protection activities to reach additional population affected.

The purpose of the IPC Acute Malnutrition Reference Table is to guide classification and convergence of evidence by using generally accepted international standards and thresholds.

The IPC Acute Malnutrition Reference Table is organized according to the IPC Acute Malnutrition Analytical Framework. Acute malnutrition is considered the outcome (since it is the outcome of interest in the IPC Acute Malnutrition classification (Figure 128). The immediate, underlying and basic causes of acute malnutrition are collectively referred to as contributing factors, so that evidence can be critically evaluated, contextualized and analysed in relation to different severities of acute malnutrition (Figure 129).

The IPC Acute Malnutrition Reference Table is organized into five severity phases (Phase 1: Acceptable; Phase 2: Alert; Phase 3: Serious; Phase 4: Critical; and Phase 5: Extremely Critical). Each phase is characterized by a certain level of acute malnutrition (Figure 126). Additionally, as the phase increases from 1 to 5, an increased incidence of diseases, a reduction in food consumption, and/or an elevated risk of mortality are generally expected.

Each IPC Acute Malnutrition phase is linked to priority response objectives (Figure 127). While the IPC Acute Malnutrition Reference Table links response objectives with each phase, it is necessary to conduct a response analysis, following the IPC Acute Malnutrition analysis, to determine the specific interventions and activities that are best suited to address acute malnutrition in each area of analysis.

Although acute malnutrition outcomes can take on different forms, the most common ones that are globally recognized and currently used as programme intervention criteria at present are: low WHZ; low MUAC; or the presence of bilateral pitting oedema. In population assessments, children with oedema or low WHZ (i.e. WHZ<-2 standard deviation from the reference) are reported as GAM. Similarly, children with oedema or low MUAC (i.e. MUAC <125mm) are also referred to as GAM. In the IPC, GAM derived from prevalence of low WHZ or the presence of oedema is referenced as GAM based on WHZ, while GAM derived from a prevalence of low MUAC or the presence of oedema is referenced as GAM based on MUAC.

The IPC recognizes and advocates for the treatment for all forms of acute malnutrition. All children with low MUAC should receive treatment for acute malnutrition together with those who have low WHZ or oedema, since it is the current practice of various partner agencies and governments in different parts of the world. The IPC also acknowledges the efforts of some countries to calculate the number of children who are acutely malnourished by combining GAM based on WHZ, and GAM based on MUAC so as to provide a more inclusive overview of the acute malnutrition situation.



However, global thresholds for GAM based on MUAC are unavailable at present and reporting on combined prevalence estimates of GAM based on MUAC and GAM based on WHZ is currently not a standard practice. The IPC urges the nutrition community to work towards developing global standards for a more inclusive approach when determining the magnitude of the acute malnutrition problem by including all forms of acute malnutrition.

Working with this vision, but also with the technical limitations, the IPC Acute Malnutrition Reference Table includes **globally accepted thresholds for GAM based on WHZ** (including oedema) as well as some **preliminary thresholds for GAM based on MUAC** (including oedema). Because the preliminary thresholds have been developed by the IPC Global Partnership, and authoritative thresholds are still missing, GAM based on MUAC can only be used in the absence of GAM based on WHZ. In exceptional cases when GAM based on MUAC portrays a significantly more severe situation (i.e. GAM based on MUAC is two or more phases higher than GAM based on WHZ), MUAC-based prevalence should be taken into account with a critical review of contributing factors.

The IPC Acute Malnutrition Reference Table is not for review at the country or regional level; however, it may be updated by the IPC Global Partnership, taking into consideration users' feedback, lessons learned, and the latest technical developments, including evidence-based research.

Figure 128: IPC Acute Malnutrition Reference Table (Tool 3)

Purpose: To identify areas in different phases based on the prevalence of acute malnutrition at the population level. The classification is aimed to guide decision-making in terms of priority areas and interventions to reduce acute malnutrition.

Phase name and description	Phase 1 Acceptable	Phase 2 Alert	Phase 3 Serious	Phase 4 Critical	Phase 5 Extremely Critical
	Less than 5% of children are acutely malnourished.	5-9.9% of children are acutely malnourished.	10-14.9% of children are acutely malnourished.	15-29.9% of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised.	30% or more children are acutely malnourished. Widespread morbidity and/or very large individual food consumption gaps are likely evident.
	The situation is progressively deteriorating, with increasing levels of acute malnutrition. Morbidity levels and/or individual food consumption gaps are likely to increase with increasing levels of acute malnutrition.				
Priority response objective to decrease acute malnutrition and to prevent related mortality. ²	Maintain the low prevalence of acute malnutrition.	Strengthen existing response capacity and resilience. Address contributing factors to acute malnutrition. Monitor conditions and plan response as required.	Urgently reduce acute malnutrition levels through →		
Global Acute Malnutrition (GAM) based on weight for height Z-score (WHZ)	<5%	5.0 to 9.9%	10.0 to 14.9%	15.0 to 29.9%	≥30%
Global Acute Malnutrition (GAM) based on mid-upper arm circumference (MUAC)	<5%	5-9.9%	10-14.9%	≥15%	
<small>*GAM based on MUAC must only be used in the absence of GAM based on WHZ; the final IPC Acute Malnutrition phase with GAM based on MUAC should be supported by an analysis of the relationship between WHZ and MUAC in the area of analysis and also by using convergence of evidence with contributing factors. In exceptional conditions where GAM based on MUAC is significantly higher than GAM based on WHZ (i.e. two or more phases), both GAM based on WHZ, and GAM based on MUAC should be considered, and the final phase should be determined with convergence of evidence.</small>					

Notes:

1. The mortality mentioned above refers to the increased risk of mortality with the increased levels of acute malnutrition.
2. Priority response objectives recommended by the IPC Acute Malnutrition Reference Table focus on decreasing acute malnutrition levels; specific actions should be informed through a response analysis based on the information provided by analyses of contributing factors to acute malnutrition as well as delivery-related issues, such as government and agencies' capacity, funding, insecurity in the area, and so on.
3. GAM based on WHZ is defined as WHZ<-2 or the presence of oedema; GAM based on MUAC is defined as MUAC<125mm or the presence of oedema.

Figure 129: Indicators for analysing contributing factors and other issues

<p>Purpose: To help identify and facilitate analyses of major contributing factors to acute malnutrition in the area of analysis; and to help identify other key issues related to malnutrition, such as anaemia, that may be of concern in the area of analysis. For definitions and sources of these indicators, refer to the IPC Resources in the IPC website.</p>	
Immediate causes	Minimum dietary diversity (MDD) Minimum meal frequency (MMF) Minimum acceptable diet (MAD) Minimum dietary diversity – women (MDD-W) ¹ Diarrhoea Dysentery Malaria/fever Acute respiratory infection (ARI) HIV/AIDS prevalence Cholera or acute watery diarrhoea (AWD) Measles
Underlying causes	The outcome of the IPC Acute Food Insecurity Analysis should be used in the analysis of food security as a contributing factor to acute malnutrition. Exclusive breastfeeding under 6 months Continued breastfeeding at 1 year Continued breastfeeding at 2 years Introduction of solid, semi-solid or soft foods by 6 months of age Routine measles vaccination coverage Routine polio vaccination coverage Routine vitamin A supplementation coverage Campaign measles vaccination coverage Campaign polio vaccination coverage Campaign vitamin A supplementation Measles vaccination campaign coverage Polio vaccination coverage from survey data or reports Vitamin A supplementation coverage from survey data or reports Coverage of all basic vaccinations from survey data or reports Skilled attendant at delivery Health-seeking behaviour Coverage of outreach programmes – community management of acute malnutrition (CMAM) programme coverage (SAM, MAM, or both) ² Access to a sufficient quantity of water ³ Access to improved sanitation facilities Access to an improved source of drinking water
Basic causes	Human capital Physical capital Financial capital Natural capital Social capital Policies, Institutions and Processes (PIPs) Usual/normal shocks Unusual shocks
Other issues	Anaemia among children 6-59 months ⁴ Anaemia among pregnant women ⁵ Anaemia among non-pregnant women ⁶ Vitamin A deficiency among pre-school children (6-71 months) ⁷ Vitamin A deficiency among non-pregnant women (15-49 years) ⁸ Low birth weight Fertility rate Crude Death Rate (CDR) ⁹ Under Five Death Rate (U5DR) ¹⁰ Maternal Malnutrition Stunting

Notes:

1. Women consuming foods from ≥5 food groups out of a standardized list of 10 food groups have a greater likelihood of meeting their micronutrient needs than women consuming foods from fewer food groups. Indicator developed by FAO [Women's Dietary Diversity Follow-up Project (WDDP-II)]
2. Rural areas: >50% | urban areas: >70% | camp situation: >90%. Sphere standard
3. Phase 1: usually adequate (> 15 litres per person per day), stable | Phase 2: borderline adequate (15 litres ppp day); unstable |Phase 3: 7.5-15 litres per person per day, accessed via asset stripping |Phase 4: < 7.5 litres per person per day (human usage only) |Phase 5: l. < 4 litres per person per day (human usage only). IPC Acute Food Insecurity Reference Table
4. Normal: ≤ 4.9% | Mild: 5 – 19.9% | Moderate: 20 – 39.9% | Severe: ≥ 40%
5. Normal: ≤ 4.9% | Mild: 5 – 19.9% | Moderate: 20 – 39.9% | Severe: ≥ 40%
6. Normal: ≤ 4.9% | Mild: 5 – 19.9% | Moderate: 20 – 39.9% | Severe: ≥ 40%
7. Mild: ≥2 – 10% | Moderate: ≥10 – <20% | Severe: ≥20%
8. Mild: ≥2 – 10% | Moderate: ≥10 – <20% | Severe: ≥20%
9. Minimal/Stressed: <0.5; Crisis: 0.5 to <1; Emergency: 1 to <2; Famine: >2. CDR>2 (excluding trauma and conflict related deaths) must be highlighted on the map. The IPC Acute Food Insecurity.
- 10 Minimal/Stressed: <1; Crisis: 1 to <2; Emergency: 2 to <4; Famine: >4. The IPC Acute Food Insecurity.



PROTOCOL 2.3: ADHERE TO PARAMETERS FOR ANALYSIS

Figure 130: Analytical parameters for IPC Acute Malnutrition classification (Tool 4)

- a. Preference of Global Acute Malnutrition (GAM) based on Weight-for-Height Z score (WHZ)
- b. Mid-Upper Arm Circumference (MUAC)-based classification based on convergence of evidence
- c. Total number of children acutely malnourished and in need of treatment
- d. A snapshot in time with validity period
- e. Frequency
- f. Current classification
- g. Projection classification

All analysis should adhere to the following key parameters (Figure 130):

- a. Preference of GAM based on WHZ:** GAM based on MUAC may only be used in the absence of GAM based on WHZ. In exceptional cases where GAM based on MUAC portrays a much more severe situation than GAM based on WHZ (i.e. two or more phases higher), GAM based on MUAC should also be taken into account along with a critical analysis of the contributing factors before a final phase is determined.
- b. MUAC-based classification is conducted through an analysis of the relationship between WHZ and MUAC in the analysis area and convergence of evidence:** GAM based on MUAC must only be used in the absence of GAM based on WHZ, and *convergence of evidence with contributing factors* must always be used to arrive at the final phase. In exceptional conditions where GAM based on MUAC portrays a much more severe situation than GAM based on WHZ (i.e. two or more phases), GAM based on MUAC should also be taken into account in the phase classification. MUAC-based classifications should be supported by the relationship between WHZ and MUAC in the area of analysis. Convergence of evidence should focus on assessing the status of contributing factors (e.g. disease outbreak, food security crisis) as well as historical trends.
- c. Total number of children acutely malnourished and in need of treatment:** Technical Working Groups should employ the standard method²² used at the country level by the Country Nutrition Clusters/Sectors when calculating the total number of children in need of treatment to report in the IPC. However, where data are available, country Technical Working Groups should work with the Country Nutrition Clusters/Sectors to assess the added value of presenting the total number of children in need of treatment by taking into account all forms of acute malnutrition – i.e. low WHZ ($WHZ < -2$), the presence of oedema, as well as low MUAC (<125 mm).
- d. A snapshot in time with a validity period:** The classification provides an overview of the acute malnutrition situation at a specific time period that is either currently occurring or projected within a specified timeframe. Classification is a real-time statement and has a validity period during which the situation is not expected to change. The time validity of the classification can refer to short or long periods depending on the stability of the situation and the needs of decision-makers; it may cover a period of a few weeks or up to a year. If the situation changes during the validity period of the analysis, an update or a new analysis may be required.

²² <http://nutritioncluster.net/resources/caseload-targets-supplies-calculator>

e. Frequency: Classification can be conducted whenever there is a need to verify the acute malnutrition situation and should be updated frequently in rapidly changing situations.

f. Current classification: Classification is based on actual conditions, regardless of causes, duration and mitigating factors. Hence, classification is guided by the actual outcome as measured.

g. Projection classification:

- Classification is based on assumptions about factors most likely to influence the evolution of acute malnutrition. Hence, projections should start from a good understanding of current and historical conditions and be forecasted based on a set of clear assumptions on the evolution of the condition, which may be impacted by past and future shocks.
- Projections are based on the most likely scenario in the absence of large-scale response activities.

PROTOCOL 2.4: EVALUATE EVIDENCE RELIABILITY

The IPC does not involve any form of primary data collection, but rather uses available evidence in its analysis and undertakes a comprehensive assessment of all the available evidence based on established criteria for assigning reliability scores (R). Evidence on both outcome indicators (such as GAM based on WHZ, and GAM based on MUAC) as well as contributing factors (e.g. evidence on diseases, feeding practices, water and sanitation, and so on.) should be evaluated, and an R should be assigned for each piece of evidence.

Evidence used in the IPC can have a reliability score of R_2 = reliable or R_1 = somewhat reliable. R_1 is further divided into two scores: R_{1+} and R_{1-} . R_{1+} refers to evidence that has good time relevance but is limited in terms of the soundness of the method or indicator used; R_{1-} refers to evidence that has limited time relevance but is considered good in terms of the method and indicator used. Outcome evidence that is limited both in terms of soundness of method and time relevance cannot be used in the IPC Acute Malnutrition classification. The assessment of reliability is not based on a statistically rigorous assessment, but rather on a general assessment of the soundness of methods of data collection and indicators used (M) and the time relevance of the evidence to current or projected analysis (T).

The Reliability Score Table for Acute Malnutrition Evidence (shown in Figure 131) presents the general criteria for assessing reliability scores and provides more specific guidance on the assessment of M and T for acute malnutrition evidence:

► **Part A** presents the combination of M and T that underpins the different reliability scores. Evidence is reliable when: it is based on a standardized indicator; the method used to collect the indicator is robust; and it depicts the current conditions. If the evidence is based on a non-standardized indicator (e.g. GAM based on MUAC), is yielded from a reasonable but less rigorous method (e.g. one with limited representativeness), or is based on inference (e.g. recent or historical evidence), it can be at most R1. Reasonable evidence that scores less than R_1 can only be used in IPC Acute Malnutrition classification under special conditions – e.g. R_0 evidence collected from areas with limited or no humanitarian access.

► **Part B** presents the general working definition of good and limited M and T as well as specific guidance for assessing the reliability of evidence on indicators included in the Reference Table.



Figure 131: Reliability Score Table – For evidence to be used in IPC Acute Malnutrition classifications (Tool 5)

Part A: General guidance for evaluating the reliability score			
R_2 = Reliable R_1 = Somewhat reliable		Time Relevance (T)	
		Good (T_2)	Limited (T_1)
Soundness of method (M)	Good (M_2)	R_2	R_1 -
	Limited (M_1)	R_1 +	X

Part B: General Guidance for Evaluation of M and T			
Soundness of method (M)	Good (M_2)	GAM based on WHZ²³ from surveys representative at the unit of analysis with adequate precision and validated by an authority in the country.	
		<ul style="list-style-type: none"> Cluster surveys with ≥ 25 clusters. Simple or systematic surveys with ≥ 150 observations. 	
Limited (M_1)	Limited (M_1)	GAM based on WHZ that partially meets representativeness and quality standards or GAM based on MUAC²⁴ from minimally acceptable methods.	
		<ul style="list-style-type: none"> Surveys representative at the unit of analysis. <ul style="list-style-type: none"> Estimates 'validated with caution' (for GAM based on WHZ only). Estimates of GAM based on MUAC from surveys rated good method. GAM based on WHZ from disaggregated surveys representative at a higher administrative unit. <ul style="list-style-type: none"> ≥ 5 clusters and ≥ 100 observations. GAM based on WHZ/MUAC from Sentinel sites. <ul style="list-style-type: none"> ≥ 5 sites per unit of analysis with ≥ 200 total observations (if the area is pastoral, ≥ 5 sites with 100 observations is acceptable). GAM based on MUAC from Screening. <ul style="list-style-type: none"> Exhaustive screening (door to door) carried out at the unit of analysis (>80% coverage) or Screening from ≥ 3 sites (selected either randomly or purposively, for variability reasons) from the unit of analysis totaling ≥ 600 observations (selected either randomly or with $\geq 80\%$ coverage). Surveys from similar areas. <ul style="list-style-type: none"> GAM based on WHZ from a survey with Good Method from a similar area. 	
Time relevance (T)	Good (T_2)	Evidence reflecting current conditions.	
	<ul style="list-style-type: none"> Evidence collected during the same season of analysis, when there is seasonality. Evidence collected anytime during the previous 12 months when there is no seasonality or significant shock to acute malnutrition contributing factors. 		
Limited (T_1)	Limited (T_1)	Evidence inferred to reflect current conditions.	
		<ul style="list-style-type: none"> Inferred estimates of evidence collected within the last 6 months but not from the same acute malnutrition season (12 months for areas with no seasonality). Historical evidence collected during the same acute malnutrition season from at least 2 similar years in the last 5 years – only to be used in the absence of any unusual shocks. 	

Note: The recommended instructions on soundness of methods and time relevance (including proposed sample sizes and number of clusters) included in this Manual are intended for IPC reliability purposes only. They are not intended as normative guidance on survey design or data analysis, especially for surveys involving primary data collection. For guidance on nutrition surveys, users are advised to consult the Standardized Monitoring and Assessment of Relief and Transitions methodology (www.smartmethodology.org). The IPC acknowledges that any evidence scoring less than R_2 may not provide accurate estimates of the conditions, and thus the IPC requires various pieces of evidence to be analysed and converged to provide an overall classification when R_1 level evidence is used. The IPC also acknowledges that the soundness of methods is also driven by factors other than sample design, such as measurement error, selection bias, field practices and analytical skills, which should also be considered when analysing evidence.

²³ GAM based on WHZ: Global acute malnutrition based on weight-for-height Z-score (WHZ) <-2 or the presence of oedema.

²⁴ GAM based on MUAC: Global acute malnutrition based on Mid-Upper Arm Circumference (MUAC) <125 mm or the presence of oedema.

Considerations:

1. **Surveys representative at the unit of analysis:** Surveys refer to collection of data from a specific population at a single point in time on nutrition outcomes and/or contributing factors. They are typically carried out on a subset of the population of interest (i.e. a sample), and the results from the sample are then applied to the survey population. Samples from the survey populations are typically selected using simple, systematic or cluster sampling methods. Surveys should be designed to be representative at the IPC unit of analysis. The size of the sample will vary from survey to survey and should be calculated separately for each survey based on a set of parameters such as expected prevalence, desired precision and design effect (for cluster surveys). Adequate sample sizes will ensure the precision of the survey estimates but not necessarily guarantee the validity (or accuracy) of the survey estimate. In order to assess the validity of anthropometric survey estimates, analysts must look at the Standardized Monitoring and Assessment of Relief and Transitions plausibility check results (see www.smartmethodology.org) for details. It should be noted that, in the case of Rapid Standardized Monitoring and Assessment of Relief and Transitions Surveys where samples are drawn from simple or systematic random sampling methods, a sample size of about 150 children would be adequate to get acceptable prevalence – e.g. about ± 6.5 percent precision for an expected GAM prevalence of 20 percent, about ± 3.5 percent precision for a GAM prevalence of 5 percent. Based on the minimum sample size of 150 children for simple random surveys, and an estimated design effect of 1.5 for cluster surveys, the minimum sample size for multi-cluster surveys with at least 25 clusters is 225 children. If the design effect is in fact something else, e.g. 1.2 or 1.3, the minimum sample size should be adjusted accordingly. For additional information, see <http://smartmethodology.org/survey-planning-tools/smart-methodology>
2. **Season** refers to “acute malnutrition season” and not food-security seasons such as pre-harvest, harvest or post-harvest. Different acute malnutrition seasons indicate the relative fluctuations in the levels of acute malnutrition – i.e. high/low levels of acute malnutrition. IPC Acute Malnutrition Analyses should establish the acute malnutrition season in the area of analysis prior to the analysis. Acute malnutrition seasons can be established based on the feeding centre admission data, nutrition survey data, surveillance data, and so on.
3. **Disaggregated survey data from a higher administrative level:** Surveys should ideally be representative at the unit of analysis. However, under some specific circumstances (see below), GAM based on WHZ data from surveys designed to be representative at a higher administrative level than the unit of analysis can be re-analysed to obtain estimates for lower administrative units and used in the IPC analysis. The main deciding factor in the case of disaggregated survey data is the design effect. If the design effect of the GAM based on WHZ from the higher administrative-level survey is <1.3 , this higher administrative-level estimate can be used for all lower administrative levels without disaggregating the data. If the design effect of the GAM based on WHZ obtained at the higher administrative level is between 1.3 and 1.7, the data should be disaggregated for lower administrative levels with ≥ 5 clusters and ≥ 100 observations, and the disaggregated estimates can be used based on the design effect:
 - If the design effect ≤ 1.7 , use the point estimate.
 - If the design effect >1.7 , use the lower bound of 95 percent confidence interval as the minimum phase (Note that minimum phase refers to the phase that an area would be classified in based on the lower bound of the confidence interval – i.e. the area would be at least in this phase). This is only an indicative phase. The final phase for the area should be decided by taking into account this indicative phase as well as the phases based on the point estimate and the upper CI and with convergence of evidence with the contributing factors.
 - It should be noted that if the design effect of the GAM based on WHZ obtained at the higher administrative level is >1.7 , these survey data should not be disaggregated for lower administrative levels.
4. **Sentinel sites** are usually purposively selected sites using predefined criteria. Sentinel sites can be community- or facility-based, but only data from community-based sentinel sites can be used in the IPC. Prevalence estimates from sentinel sites should be obtained by combining data from all sites.
5. **Screenings** are rapid population-based assessments, typically conducted to obtain a quick idea of the situation. Although GAM based on MUAC data are typically collected through screening, GAM based on WHZ can also be collected during screening. The same sample size and coverage requirements apply regardless of the indicator.
6. **Surveys from similar areas** can be used to classify a given unit of analysis when evidence is unavailable from that unit of analysis. Estimates from similar areas can only be used if they are good in terms of time relevance and soundness of method. Before surveys from a similar area are used to classify an area, the similarity between the two areas must be established through documented evidence. Two areas may be considered similar if they follow the same livelihood, seasonality and ecological patterns and if surveys from both areas (same season) in the past indicated comparable estimates, and so on. Additionally, there must be a documented analysis of contributing factors showing that there have been no significant changes in the context.
7. **Unusual events** refer to shocks that have an impact on acute malnutrition. There is a vast array of shocks, including but not limited to conflicts, disease outbreaks, displacement, droughts and floods. It should be noted that not all shocks would have an impact on acute malnutrition. For example, there has been no significant change in the acute malnutrition levels among Syrian refugees even after years of conflict and displacement. Prior to the IPC Acute Malnutrition Analysis, analysts need to review their contexts and determine the level of shocks and their likely impact on acute malnutrition levels.
8. **Historical evidence** can be used if it is good in terms of the soundness of method and is from the same season of analysis. Historical trend data must be converged with other contributing factors, and this analysis must be documented.



PROTOCOL 2.5: MEET MINIMUM EVIDENCE AND ANALYSIS REQUIREMENTS

The IPC evidence-level criteria (see Figure 132) provide the minimum requirements for three distinct levels. The requirements are based on the availability of reliable (R_2) and somewhat reliable (R_1) evidence on GAM based on WHZ and GAM based on MUAC, as well as a number of additional pieces of evidence on contributing factors. While the reliability of evidence (i.e. R_2/R_1) refers to individual pieces of evidence used in the IPC analyses, the Evidence Level is provided for the overall classification.

Figure 132: Evidence-level criteria for classification (Tool 6)

Evidence level	Criteria		
	Current	Projection	Projection updates ¹
* Acceptable (Evidence Level1)	1. R_1 - GAM based on WHZ + 2. Two pieces of evidence on contributing factors	1. IPC Current adhering to Evidence Level1 + 2. Evidence used for current classification at most 12 months old at the end of projection period ² + 3. Two pieces of R_1 evidence presented with clear assumptions on forecasted trends	1. Still valid IPC Projection adhering to Evidence Level1 + 2. Evidence used for current classification at most 12 months old at the end of projection period ² + 3. Two new pieces of R_1 evidence on contributing factors from the season of update
** Medium (Evidence Level2)	1. R_1 + GAM based on WHZ or R_1 + GAM based on MUAC + 2. Two pieces of evidence on contributing factors	1. IPC Current adhering to Evidence Level2 + 2. Evidence used for current classification can be at most 12 months old at the end of projection period ² + 3. Two pieces of R_1 evidence presented with clear assumptions on forecasted trends	1. Still valid IPC Projection adhering to Evidence Level2 + 2. Evidence used for current classification at most 12 months old at the end of projection period ² + 3. Two new pieces of R_1 evidence on contributing factors from the season of update
*** High (Evidence Level3)	1. R_2 GAM based on WHZ	1. IPC Current adhering to Evidence Level3 + 2. Evidence used for current classification can be at most 12 months old at the end of projection period ² + 3. Two pieces of R_1 evidence presented with clear assumptions on forecasted trends	1. Still valid IPC Projection adhering to Evidence Level3 + 2. Evidence used for current classification at most 12 months old at the end of projection period ² + 3. Two new pieces of R_1 evidence on contributing factors from the season of update

Notes:

- 1 Projection updates should only be conducted if no new evidence is available on outcomes. If new evidence is available for outcomes, analysts can choose whether to conduct a projection update or a current analysis.
- 2 If historical evidence is being used for current classification, guidance on the maximum age of evidence at the end of the projection period does not apply.



The minimum analysis requirements (Figure 133) identify the core analytical products that the IPC Acute Malnutrition should provide.

Figure 133: Minimum analysis requirements (Tool 7)

A. Current classifications
<ul style="list-style-type: none"> • Evidence Analysis with reference (sources and dates of data collection) linking current conditions to IPC Acute Malnutrition phases, context, historical trends and other relevant analysis. • Area Classification based on the prevalence of global acute malnutrition. • Number of children acutely malnourished and in need of treatment, ideally taking into account both GAM based on weight for height z-score WHZ, and GAM based on mid-upper arm circumference MUAC where available. • Classification justification, particularly when classification is performed with R_i evidence. • Key drivers of acute malnutrition.
B. Projected classification
<ul style="list-style-type: none"> • Evidence analysis with references (sources and dates of data collection) describing expected trends. • Area classification based on the expected most likely evolution of acute malnutrition. • Classification Justification, including a critical review of assumptions and likely trends used to arrive at phase conclusions. • Risk Factors to Monitor are identified to trigger projection updates or new analysis.
C. Projection update
<ul style="list-style-type: none"> • Evidence Analysis with references (sources and dates of data collection) describing a review of assumptions . • Area classification based on the expected most likely evolution of acute malnutrition • Classification justification, including a critical review of updated assumptions and key evidence used to update phase conclusions.

PROTOCOL 2.6: METHODICALLY DOCUMENT EVIDENCE AND ANALYSIS, AND PROVIDE THEM UPON REQUEST

All evidence and analyses need to be clearly and systematically documented so that the analysts have a body of evidence to support their classification. The documented evidence should be made available if requested for quality review purposes

The IPC Acute Malnutrition Analysis Worksheet supports methodical, transparent and consistent evidence-based analysis by taking the analysis through the IPC Acute Malnutrition Analytical Framework and linking evidence to the IPC Acute Malnutrition Reference Table. The Worksheet is a major advantage for analysis and, although not mandatory, is highly recommended.

The IPC Acute Malnutrition Analysis Worksheet consists in 10 steps (Figure 134). While Steps 1, 2 and 10 are applied to both current as well as Projection classifications, Steps 3 to 5 are only applicable for Current classifications, and Steps 6 to 9 are applicable only for Projections. If multiple projection classifications are carried out, Steps 6 to 9 should be repeated.



Figure 134: Analysis Worksheet Steps (Tool 8)

Step 1: Context and analysis parameters	
Step 2: References for evidence	
Current	Step 3: Analyse the evidence Step 3a: Analyse the evidence on outcomes Step 3b: Analyse the evidence on contributing factors and other issues Step 4: Determine Phase classification and population estimates Step 5: Identify key drivers and limiting factors
Projection	Step 6: Develop assumptions for future shocks and ongoing conditions Step 7: Analyse the evidence Step 8: Determine the phase classification Step 9: Identify risk factors to monitor
All	Step 10: Identify strategic priority response objectives

Procedures for completing the Worksheet are briefly described below. It is highly advisable that parts of the Worksheet, especially Steps 1 and 2 and optimally also Step 3 , are prepared before the analysis workshops.

Step 1: Identify the context and analysis parameters (common for both current and projection classifications)

Purpose: To introduce the characteristics of the area and population to allow for contextualization of evidence.

Approach overview:

- Decide on the spatial extent of the analysis area. A single phase classification will be determined for this area. The determination of the analysis area can be informed by, but not limited to, units such as administrative boundaries, livelihood zones, hazard zones, market catchment zones, and others. The IPC is adaptable and applicable to any spatial size, and the spatial area of the classification can vary widely. The IPC analysts must determine the spatial extent of the analysis area, depending on the situation and the needs of decision-makers, as well as the availability of evidence and feasibility of the number of areas being classified. In general, the analysis area should be as homogeneous as possible with regard to likely acute malnutrition outcomes and causes.
- Decide on time periods of analysis. The analysis is a snapshot of the current or projected acute malnutrition situation and each analysis has a validity period determined by the analysts. The validity period can be as short as a few weeks or as long as a few months or even up to a year. However, the existing (current) or expected (projection) acute malnutrition situation should not significantly change during the validity period of the analysis. If the acute malnutrition situation does change during the validity period of the analysis, analysts can either conduct a new analysis or update the projection analysis, depending on how significant the change has been and what new evidence is available. Decision-makers often require information on expected conditions many months in advance for planning purposes. Multiple projections can be prepared, each with its own validity period. In the case of multiple projections, Steps 7-9 of the IPC Acute Malnutrition Analysis Worksheets would need to be repeated for each new projection.
- Provide a brief description and the population characteristics of the area, including relevant information to be used in contextualizing evidence. Important aspects may include population subgroups such as crop and livestock farmers, common livelihood strategies employed by households in the area, seasonality patterns, cultural habits and the economic environment. Add population figures

(both total and under five population in the area), specifying sources and reference years. If applicable, use projected populations if a significant population movement is expected.

- Identify whether the analysis area has experienced IPC Acute Malnutrition Phase 3 “Serious” or more severe in at least three years over the previous ten years. If the IPC Acute Malnutrition Analysis has not been conducted in enough years to determine this, either use an equivalent classification system, or highlight that a recurrence of crisis cannot be identified.

Step 2: Populate the evidence repository (common for both current and projection classifications)

Purpose: To help organize wide-ranging data from multiple sources for ease of access and reference.

Approach overview:

- Provide references for all evidence to be reviewed in analysis, including identification of sources and dates of evidence collection. When possible, include the actual evidence (e.g. graph, text, figures).
- Optimally, provide a note on methods of data collection to support the assessment of the reliability score.

Step 3: Analyse the evidence

Step 3a: Analyse the evidence on outcomes (current classification)

Purpose: To analyse evidence following the IPC Acute Malnutrition Analytical Framework and Reference Table, considering the local context and reliability scores, including reference to historical trends.

Approach overview:

- Include information on all outcome indicators (i.e. GAM based on WHZ and GAM based on MUAC) that meet IPC Acute Malnutrition reliability criteria, identifying current levels and linking current conditions to IPC phases, contexts and historical trends.
- Include sources of information, linking all evidence to the reference specified in Step 2.
- Assign reliability scores for all evidence.

Step 3b: Analyse the evidence on contributing factors and other issues (current classification)

Purpose: To analyse evidence on contributing factors to acute malnutrition as well as other issues of concern so as to identify the major contributing factors to acute malnutrition and highlight other issues of concern in the analysis area.

Approach overview:

Provide evidence and critical reasoning for all contributing factors for which evidence is available and relevant to acute malnutrition, considering the following guidance:

- Preferably use current estimates for indicators affected by seasonality, such as diseases. If unavailable, analysts may rely on a critical analysis of conditions during the same season in the previous years and inferred estimates based on estimates seen recently, but not necessarily from the same season.



- For slow-changing indicators such as exclusive breastfeeding, information from the past three to five years can be used with contextualization and corroboration of evidence. The maximum age of the evidence will depend on how stable the condition is.
- Information on contributing factors from higher administrative levels can be extrapolated to lower administrative levels with documented justification. The historical trends of contributing factors should be considered, and any increasing trends should be carefully reviewed and their impact on acute malnutrition analysed. Information on contributing factors that is limited both in terms of method as well as time relevance may also be included in the analysis.
- Add additional indicators as relevant. The IPC Acute Malnutrition Analysis Worksheets provide a list of standard indicators to look at under the contributing factors, but analysts may need to consider other indicators depending on their context; for example, dengue may need to be considered under diseases in some contexts.

Other issues: Other important issues (e.g. mortality, anaemia, and vitamin A deficiency) that are not necessarily directly/strongly related to acute malnutrition but are important considerations should be taken into account and highlighted in the IPC Acute Malnutrition products as necessary.

Step 4: Determine phase classification and population estimates (current classification)

Purpose: To conclude on phase classification and provide the critical reasoning based on supporting and contradictory evidence used to arrive at phase conclusion (Figure 135).

Approach overview:

- Conclude on phase classification for the current period based on all supporting and contradictory evidence as relevant.
- If R_j level evidence is used to arrive at a final classification, convergence of evidence with contributing factors should be used to determine the final classification (see Figure 134).
- If GAM based on MUAC is used to determine the IPC Acute Malnutrition phase of an area, the historical relationship between WHZ and MUAC as well as the contributing factors should be taken into account when the phase is determined.
- Provide justification for the phase classification, particularly when convergence of evidence is used to arrive at the phase.
- Identify evidence levels of analysis, by identifying the type of indicator (GAM based on WHZ or GAM based on MUAC), source of information (e.g. surveys, sentinel sites, and historical data) and number of pieces of evidence (for contributing factors) used in the classification. (See Figure 132 for criteria on evidence level.)
- Calculate the total number of children acutely malnourished and in need of treatment. The calculation of the total number of children acutely malnourished and in need of treatment (B) should include the internationally agreed formula ($B=NPK$, where N = total number of children under 5 in the unit of analysis, P = estimated prevalence of GAM for the unit of analysis, and K = correction factor of 2.6, for one year). Where possible and where data are available, the IPC Technical Working Groups should work with Country Nutrition Clusters/Sectors to assess the added value of using the combined estimates of GAM for P (i.e. taking into account all forms of acute malnutrition).

Figure 135: Convergence of evidence – Key considerations

Convergence of evidence, taking into account contributing factors and historical data on acute malnutrition, is required when estimates of historical acute malnutrition based on WHZ, or GAM based on WHZ from similar areas, or evidence collected within the six months preceding the time of analysis (but not from the same season) are used to classify areas. Additionally, historical data on the relationship between GAM based on WHZ, and GAM based on MUAC in the area of analysis are required when classification is performed on GAM based on MUAC.

During the convergence of evidence, analysts first need to gather information on the following indicators:

- historical GAM prevalence (based on MUAC and WHZ) and their relationship;
- the relationship between MUAC and WHZ in the area of analysis (or at the regional level, livelihood zone level and so on, if data at the unit of analysis are unavailable);
- food intake indicators, e.g. minimum dietary diversity, minimum meal frequency and minimum acceptable diet;
- diseases (i.e. diarrhoea, malaria/fever and acute respiratory infection) and disease outbreaks;
- health system functioning (i.e. routine immunization coverage);
- health-seeking behaviour;
- coverage of the community management of acute malnutrition programme;
- outcome of the IPC Acute Food Insecurity analysis.

Both current and historical/trend data should be gathered; the historical data should come from the same season of analysis. At least two of the above indicators must be available to carry out the convergence of evidence, although more would strengthen the analysis. Ideally, information on these indicators should come from representative surveys. However, other sources such as the Health Management Information System (for diseases) can also be used. In terms of the community management of acute malnutrition coverage data, coverage surveys using acceptable methods should ideally be used. However, other methods of estimating coverage can also be used as proxy. Analysts would then look at the current as well as the historical/trend data on the contributing factors and determine whether these factors have been stable, deteriorating or improving.

Example 1: Consider an area with 11 percent GAM based on WHZ from re-analysed survey data (from a high administrative unit). According to the IPC Acute Malnutrition Reference Table, this level of prevalence indicates IPC Acute Malnutrition Phase 3. As per a health assessment, about 35 percent of children in the area are affected by diarrhoea during the current season of analysis. The historical data on diarrhoea for the same area show that diarrhoea prevalence has always been around 30 percent for the area in the past three years. The IPC Acute Food Insecurity Analysis has always placed the area in Phase 3 in the past two years, and the current IPC Acute Food Insecurity analysis indicates the same situation. There has been no major change in the health or the community management of acute malnutrition coverage for the area. In this case, it is reasonable to assume that all the main contributing factors remained stable during the current season of analysis.

Analysts would then look at the available historical data on acute malnutrition (i.e. GAM based on WHZ) for the area. Assume that according to the historical data, other than being in Phase 2 once two years ago, the area has always remained in Phase 3 in the same season in the past five years. Considering both current as well as historical data on both contributing factors and outcome indicators, in this case it is reasonable to classify the area as Phase 3.

Example 2: Consider that the same area has only GAM based on MUAC data from an exhaustive screening (8.3 percent) and assume that the contributing factors are described as above. In this case, analysts would look at the historical data on the relationship between GAM based on WHZ and GAM based on MUAC. Assume that the relationship shows the following:

WHZ	17.3	18.1	20.0	13.8	11.1
MUAC	13.2	11.5	11.9	12.4	7.1

It is evident from the above that the WHZ-based prevalence is always higher than the MUAC prevalence in this area; additionally, the upper bound of the phase (according to the GAM based on MUAC) has always corresponded with the GAM based on the WHZ phase - i.e. when the area was in Phase 4 based on WHZ, it corresponded with the upper Phase of MUAC; the same applied when the area was in Phase 3 based on WHZ. Therefore, given that there are no changes in the contributing factors, it is reasonable to assume that with the GAM prevalence of 8.3 percent, the area is likely to be in Phase 3.



Step 5: Identify the key drivers & limiting factors (current classification)

Purpose: To highlight the key drivers so that decision-makers are aware of the key factors triggering the crisis and action can be more strategically planned.

Approach overview:

List the key drivers of acute malnutrition, not only the immediate and underlying causes, but also include acute shocks, such as drought, conflict, and so on.

Step 6: Develop assumptions for future shocks and ongoing conditions (projection classification)

Purpose: To provide analysts with an expected outlook or the key factors to be considered when projecting the most likely evolution of acute malnutrition in the projection period.

Approach overview:

- Describe the key assumptions on the impacts of shocks and ongoing conditions that are likely to affect acute malnutrition during the projected period. Consider the likely occurrence of both seasonal and usual events as well as any unusual shocks that are likely to occur. Consider the most likely evolution of all the factors that are expected to impact acute malnutrition, including aggravating and mitigating factors. Consider the impacts of events that have already occurred or will occur.
- The assumptions on the likely impacts of shocks and ongoing conditions will be used in Steps 7 and 8 as the basis for the projection analysis.

Step 7: Analyse the evidence (projection classification)

Purpose: To determine the potential (most likely) changes in the contributing factors in order to identify the most likely future conditions of acute malnutrition considering current levels, historical trends, previous and most likely future impacts of shocks.

Approach overview:

In the projection analysis, the IPC Acute Malnutrition Analysis tries to determine the most likely evolution of global acute malnutrition. Since acute malnutrition is an outcome of various contributing factors, the potential changes in contributing factors are first looked at in this Step 7; that is, based on the historical trends and seasonality and so on, the most likely changes in each of the contributing factors to acute malnutrition are first determined. Based on the changes in the contributing factors, the changes in outcome (i.e. the global acute malnutrition) are then determined (in Step 8). In particular:

- Consider the most likely change. Indicate how the indicator is likely to change in the projection period – i.e. if it is likely to improve, deteriorate, or to stay the same.
- Provide explanation for the most likely change, taking into account historical trend data, key assumptions for the projection period, seasonality changes (where applicable), etc. Explain how the likely change was determined.

Step 8: Determine the phase classification (projection classification)

Purpose: To provide early warning information for decision-makers by highlighting the potential changes in the acute malnutrition situation.

Approach overview:

- Conclude on the phase classification for the projected period based on the review of all contributing factors and their potential changes in the projection period. (Note: acute malnutrition is an outcome of a range of contributing factors; the outcome indicators are determined by predicting the changes in the contributing factors.)
- Provide the rationale for the phase classification.

Step 9: Identify risk factors to monitor (projection classification)

Purpose: To identify triggers for analysis updates and validity of projections.

Approach overview:

Identify risk factors to monitor. Consider risk factors that could raise acute malnutrition during the projection period and thus need to be monitored against the assumed evolution included in Step 7 as well as the key assumptions identified in Step 6.

Step 10: Identify priority strategic response objectives (common for both current and projection classifications)

Purpose: To indicate to decision-makers and partners the key strategic response objectives that should be assessed during the posterior response analysis.

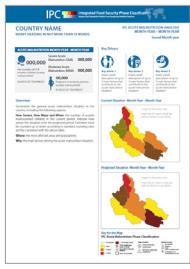
Approach overview:

- Based on an analysis of drivers, limiting factors and severity of outcomes, identify key response objectives that should be prioritized. For example, if the minimum dietary diversity is extremely poor (e.g. 9 percent) among children, this calls for responses that aim at decreasing inadequate dietary intake.
- Present strategic objectives as starting points for response analysis and do not define the modalities for response. For example, if an epidemic outbreak is a major driver of the situation, highlight the need to control disease epidemics rather than mentioning vaccinations, out-reach care or other modalities.



FUNCTION 3: COMMUNICATE FOR ACTION

Figure 136: Protocols for Function 3

Protocol	Procedure	Tool
3.1 Produce IPC Analysis Report.	Prepare a consistent and effective IPC Analysis Report, including the minimum key information, preferably by completing the IPC Analysis Modular Template Package.	Tool 9: Minimum information requirements  Tool 10: Modular Communication Template 
3.2 Adhere to mapping standards.	Develop IPC maps following the basic guidelines	Tool 11: Mapping protocols 
3.3 Strategically share communication products in a timely manner.	Plan and implement a minimum set of activities for sharing the IPC final results with key actors.	Tool 12: Minimum set of dissemination activities 

The aim of Function 3 is to communicate the core aspects of the situation in a consistent, accessible and timely manner to inform strategic decision-making. Communication is considered an integral part of the IPC Acute Malnutrition Analysis process.

Protocols For Completing Function 3

Function 3 consists of three protocols: the first two focus on the production of reports and maps, and the third focuses on product dissemination, as presented in Figure 136 and explained in the paragraphs that follow.

Although not a protocol, it is strongly recommended that, for all IPC analyses, development of a communication plan should be initiated from the earliest planning stages, including:

- carrying out public information activities (e.g. briefings and dissemination sessions) and communication products to be produced prior to, during and after IPC analysis;
- advising relevant stakeholders when IPC Analysis Reports are expected to be available and how IPC results can be used for response planning;
- involving communication experts in the analysis to support the development of the communication plan, and the drafting and dissemination of IPC Analysis Reports and other communication products;
- planning and conducting press conferences targeting local and international media whenever suitable;
- integrating the communication plan in the overall IPC implementation plan and updating it every 6 to 12 months considering lessons learned and any other forthcoming IPC activities.

PROTOCOL 3.1: PRODUCE THE IPC ANALYSIS REPORT

At the conclusion of the analysis process, the analysis team should draft the key messages to be included in the report. The IPC Analysis Report outlined below should be finalized and released preferably within 15 days of the completion of analysis. All IPC reporting should contain the minimum information, as per Figure 137.

Figure 137: Analysis report information requirements (Tool 9)

Topic Areas	Contents
1. Highlights	<ul style="list-style-type: none"> Summarize the key findings, including the most severely affected areas.
2. Maps	<ul style="list-style-type: none"> Provide current and projected classification maps adhering to mapping protocols provided in IPC Protocol 3.2.
3. Population tables	<ul style="list-style-type: none"> Provide the estimated number of children who are acutely malnourished and in need of treatment by area of analysis.
4. Situation overview, key drivers and limiting factors and assumptions	<ul style="list-style-type: none"> Provide an overview of the current and projected situation. Identify the major factors driving Acute Malnutrition, focusing on the immediate and underlying causes of acute malnutrition. Identify the key contributing factors to acute malnutrition. Identify the key assumptions for projections.
5. Recommendations for action	<ul style="list-style-type: none"> Recommend strategic objectives of response aligned to those included in the Reference Table. Provide recommendations for monitoring the situation as needed. Recommend improvements for data collection and information systems as needed.
6. Analysis process, limitations and next steps	<ul style="list-style-type: none"> Identify the main source and reliability of evidence used. Identify the key challenges. Plan for the next analysis. Describe the analysis process.
7. Minimum visual identity/accountability requirements of the IPC Analysis Reports	<ul style="list-style-type: none"> The IPC logo. Logos of national analysis partners Logos of resource partners. E-mail addresses for any queries and information requirements. Reference to the IPC website www.ipcinfo.org



Figure 138: IPC analysis reports for different audiences – Examples

- Reports targeting global-level stakeholders, which may include only the Key Findings and Recommendations for Actions (Modules 1 and 4).
- Reports targeting national senior stakeholders may include three modules, such as the one-page key findings overview, maps, and the number of acutely malnourished children estimates (Modules 1, 2 and 5).
- Reports targeting national and subnational stakeholders will include most or all modules, including an overview of the most affected areas (Modules 1 to 10).

If IPC Acute Food Insecurity and Acute Malnutrition analyses are conducted simultaneously, it is highly recommended that one report be produced combining the analyses' results.

The IPC Modular Communication Template

The IPC Modular Communication Template (Tool 10) provides a standard format and content guide for developing IPC Analysis Reports. The Template was developed to meet the different interests and needs of a variety of IPC stakeholders while ensuring that the minimum requirements for communicating IPC results are met. By using the Template, IPC Analysis Reports effectively communicate key findings in a clear, concise, accessible and consistent format.

The IPC Modular Communication Template for Acute Malnutrition consists of ten modules: (1) Key facts and messages; (2) Classification maps and estimated number of children acutely malnourished and in need of treatment; (3) Situation overview and key drivers; (4) Recommendations for action; (5) Detailed number of children who are acutely malnourished and in need of treatment; (6) Process, methodology and data sources; (7) Results in figures; (8) Summary of factors contributing to acute malnutrition; (9) Profiles of the most-affected areas; and (10) Comparative analysis.

General considerations for completing the IPC Modular Communication Template include the following:

- All modules of the template should be completed. As a minimum, the full IPC Analysis Report should include Module 1 to 6; Modules 7 to 10 are optional, though highly recommended.
- Modules can be selected and combined to develop specific products that meet the needs of different stakeholders. See Figure 138 for examples of a selection of modules for different audiences.
- Modules are designed to ensure consistent IPC branding as well as ownership. Key information should be provided, for example the name of the country, contacts, the institution hosting the IPC, the resource partners and logos of the analysis partners.
- An Integrated Food Security and Nutrition Modular Communication Template is available and should be used to produce a report combining IPC Acute Food Insecurity and Acute Malnutrition analysis results.
- The IPC Modular Communication Template can be developed in the ISS or offline in MS Word™.
- The use of the IPC Modular Template does not prevent countries from producing further documents or incorporating IPC results into other documents.

MODULE 1: KEY FACTS & MESSAGES

Purpose: To provide concise responses to the key five questions: how severe, how many, when, where and why (Figure 139).

Key information:

- Total number of children acutely malnourished and in need of treatment: In the table (Figure 138), provide: (i) the total number of children who are acutely malnourished and in need of treatment (GAM); (ii) the number of cases of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM); and, if available (iii) pregnant lactating women acutely malnourished and in need of treatment.
- How severe**, how many and when: Briefly describe the situation in terms of the number of children acutely malnourished for the current period and how severe the situation is for the projected period.
- Where:** Briefly describe the most affected areas.
- Why:** Briefly describe main factors driving the acute malnutrition.
- Current and projected situation maps:** Insert a small IPC classification map for current and projected periods.

Figure 139: Communication Template Module 1

COUNTRY NAME INSERT HEADING IN NOT MORE THAN 10 WORDS		IPC Integrated Food Security Phase Classification Evidence and Standards for Better Food Security and Nutrition Decisions	IPC ACUTE MALNUTRITION ANALYSIS MONTH YEAR – MONTH YEAR	Issued Month year																																								
KEY FIGURES 000,000 Severe Acute Malnutrition (SAM) 000,000 Moderate Acute Malnutrition (MAM) 000,000 IN NEED OF TREATMENT 00,000 cases of pregnant or lactating women acutely malnourished IN NEED OF TREATMENT	MONTH YEAR - MONTH YEAR	Key Drivers Key driver 1 Insert a brief description of up to 3 main factors that contribute to the acute malnutrition situation. Key driver 2 Insert a brief description of up to 3 main factors that contribute to the acute malnutrition situation. Key driver 3 Insert a brief description of up to 3 main factors that contribute to the acute malnutrition situation.	Overview Summarize the general acute malnutrition situation in the country, including the following aspects: How Severe, How Many and When: the number of acutely malnourished children in the current period. Indicate how severe the situation is for the projected period. Estimates must be rounded up or down according to standard rounding rules and be consistent with the above table. Where: the most affected areas and populations. Why: the main factors driving the acute malnutrition situation.																																									
Current Situation Month Year - Month Year Image for illustration only. Insert the IPC map in small size without details on area labels.																																												
Projected Situation Month Year - Month Year Image for illustration only. Insert the IPC map in small size without details on area labels.																																												
Key for the Map IPC Acute Malnutrition Phase Classification <table border="1"> <tr> <td>1 - Acceptable</td> <td>2 - Alert</td> <td>3 - Serious</td> <td>4 - Critical</td> <td>5 - Extremely critical</td> </tr> <tr> <td>■</td> <td>■</td> <td>■</td> <td>■</td> <td>■</td> </tr> <tr> <td>Phase classification</td> <td>Phase classification</td> <td>Phase classification</td> <td>Phase classification</td> <td>Phase classification</td> </tr> <tr> <td>Urban settlement</td> <td>Urban settlement</td> <td>Urban settlement</td> <td>Urban settlement</td> <td>Urban settlement</td> </tr> <tr> <td>Area with inadequate</td> </tr> <tr> <td>IPC/other settlements</td> <td>IPC/other settlements</td> <td>IPC/other settlements</td> <td>IPC/other settlements</td> <td>IPC/other settlements</td> </tr> <tr> <td>Classification</td> <td>Classification</td> <td>Classification</td> <td>Classification</td> <td>Classification</td> </tr> <tr> <td>Areas not analysed</td> </tr> </table> Map Symbols <ul style="list-style-type: none"> ○ Urban settlement △ Urban settlement △ Area with inadequate △ IPC/other settlements △ Classification Evidence Level <ul style="list-style-type: none"> * Acceptable ** Medium *** Scarce evidence due to limited or no humanitarian access 					1 - Acceptable	2 - Alert	3 - Serious	4 - Critical	5 - Extremely critical	■	■	■	■	■	Phase classification	Urban settlement	Area with inadequate	IPC/other settlements	Classification	Classification	Classification	Classification	Classification	Areas not analysed																				
1 - Acceptable	2 - Alert	3 - Serious	4 - Critical	5 - Extremely critical																																								
■	■	■	■	■																																								
Phase classification	Phase classification	Phase classification	Phase classification	Phase classification																																								
Urban settlement	Urban settlement	Urban settlement	Urban settlement	Urban settlement																																								
Area with inadequate	Area with inadequate	Area with inadequate	Area with inadequate	Area with inadequate																																								
IPC/other settlements	IPC/other settlements	IPC/other settlements	IPC/other settlements	IPC/other settlements																																								
Classification	Classification	Classification	Classification	Classification																																								
Areas not analysed	Areas not analysed	Areas not analysed	Areas not analysed	Areas not analysed																																								



MODULE 2: CLASSIFICATION MAPS AND ESTIMATED NUMBER OF ACUTELY MALNOURISHED CHILDREN IN NEED OF TREATMENT

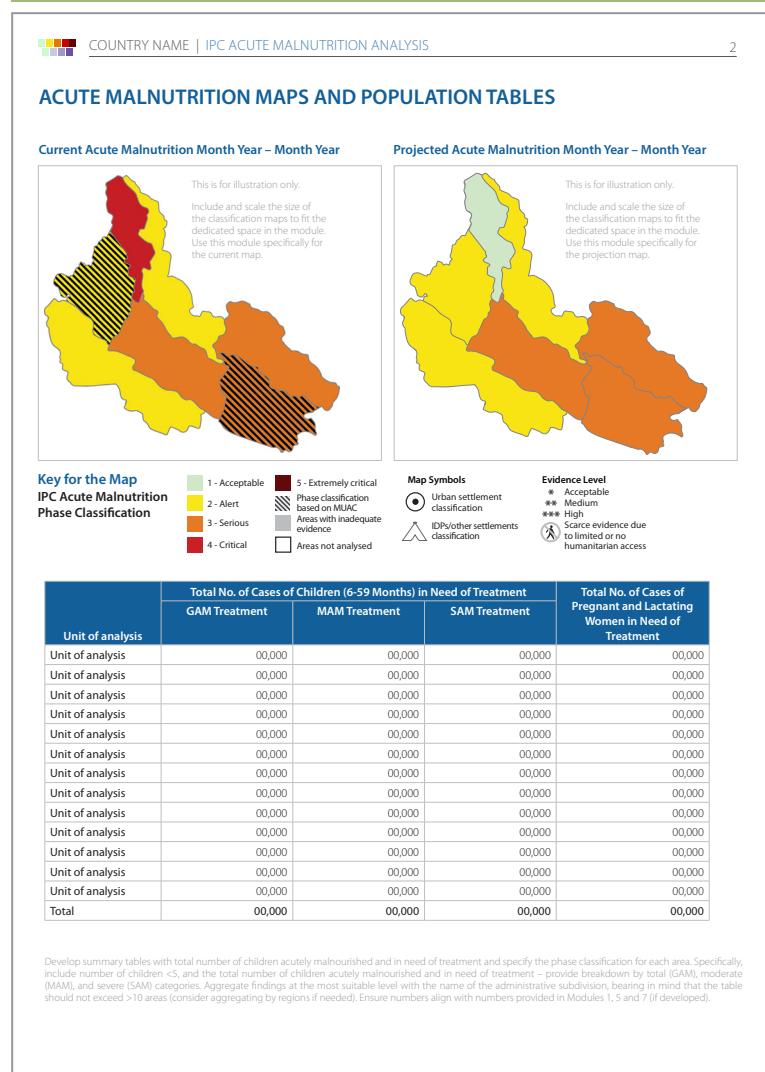
Purpose: To provide large-scale, more detailed classification maps for both the current and projected situation, and the estimated number of children acutely malnourished and in need of treatment (Figure 140).

Key information:

- **Classification maps:** Include and scale the classification maps to fit the dedicated space in the module. Use Module 2 specifically for current and projected maps. Insert a short text explaining the maps.

- **Total number of acutely malnourished children in need of treatment:** Develop a summary table with the total number of acutely malnourished children in need of treatment, specifically including the number of children under five. Provide a breakdown by total (GAM), moderate (MAM) and severe (SAM) categories. Aggregate findings at the most suitable level with the name of the administrative subdivision, bearing in mind that the table should not exceed ten areas (consider aggregating by regions if needed). Ensure the numbers align with the numbers provided in Modules 1, 5 and 7 (if developed). If aggregation is not possible, population tables should be presented in easily digestible graphics. Full population tables should then be shown in Module 5.

Figure 140: Communication Template Module 2



MODULE 3: SITUATION OVERVIEW AND KEY DRIVERS

Purpose: To provide a more detailed analysis of the current and projected classification to answer the five key questions of how severe, how many, where, when, and why, already briefly answered in module 1 (Figure 141).

Key information:

Current situation overview, considering:

- Context, including relevant historical information and trends;
- Summary of classification results in terms of where, how many and how severe, focusing on worst-affected areas and children;
- Current conditions, focusing on reference to acute malnutrition;
- Why, focusing on the key drivers, including the identification of the key shocks and vulnerabilities contributing to the situation; how different, providing a comparison with the previous IPC analyses to show any change over time and with other areas.

Projected situation overview, considering:

- Context, including seasonally and expected usual impact of shocks during the projected period;
- Key assumptions for the projected period, including:
 - an assessment of past and forecasted shocks, diseases, and food consumption patterns that are most likely going to impact acute malnutrition in the future;
 - critical reasoning for the conclusion on likely changes in acute malnutrition levels.

Figure 141: Communication Template Module 3

	COUNTRY NAME IPC ACUTE MALNUTRITION ANALYSIS	3
CURRENT SITUATION OVERVIEW Month Year - Month Year <ul style="list-style-type: none"> • Context, including relevant historical information and trends. • Summary of classification results in terms of where, how many and how severe, focusing on worst-affected areas and children. • Current conditions, focusing on reference to acute malnutrition. • Why and who, focusing on key drivers, including identification of key shocks and vulnerabilities contributing to the situation; how different, providing a comparison with the previous IPC analyses to show any change over time and with other areas. PROJECTED SITUATION OVERVIEW Month Year - Month Year <ul style="list-style-type: none"> • Context, including seasonally and expected usual impact of shocks during projected period. • Key assumptions for the projected period, including: <ul style="list-style-type: none"> ◦ Assessment of past and forecasted shocks, diseases, and food consumption patterns that are most likely going to impact future acute malnutrition. ◦ Critical reasoning for conclusion on likely changes in acute malnutrition levels. 		



Figure 142: Situation overview – Example

Based on the IPC Acute Malnutrition analysis, nine of the 18 provinces in Burundi are classified in IPC Phase 2 "Alert", while the other provinces are classified as being in IPC Phase 1 "Acceptable". Of the nine provinces classified in the "Alert" situation, three provinces (Karusi, Kayanza, and Kirundo) have relatively high levels of acute malnutrition, thus requiring particular attention. It should be recalled that at least three cases of Noma have been registered this year in Kirundo province. According to the IPC Acute Malnutrition scale, the IPC Phase 2 "Alert" situation requires strengthening response capacity and resilience, addressing contributing factors to malnutrition and monitoring the situation.

Approximately 125,000 children are expected to suffer from acute malnutrition in nine of the 18 provinces in the country. Available data on the coverage of acute malnutrition treatment suggest that the coverage is not optimal.

Major contributing factors to the alarming levels of acute malnutrition are: (i) very poor quality of food intake by children; (ii) relatively high prevalence of diseases (particularly malaria); and (iii) poor sanitation.

It should be noted that the quality of food intake by children is poor even in provinces where acute food insecurity is low. This suggests that it may be related to behaviour and/or lack of awareness of child feeding among caregivers. Poor quality of food in other provinces may likely be the result of food insecurity as well as behaviour and lack of awareness. Several structural issues, especially human, physical and financial capital, were also identified as major factors contributing to acute malnutrition in these areas. Anemia is a major public health problem that calls for urgent attention in all provinces.

According to the IPC Acute Malnutrition Projection Analysis, the situation is likely to remain the same in all nine provinces that are classified in IPC Phase 2 "Alert" during the upcoming rainy season (February – May 2018). However, a slight deterioration in acute malnutrition levels is likely in some provinces because of seasonality and disease trends (Central Africa Republic, IPC Acute Food Insecurity Analysis Report, March 2018).

Source: Burundi, IPC Acute Malnutrition Analysis Report, December 2017.

MODULE 4: RECOMMENDATIONS FOR ACTION

Purpose: To provide general recommendations for: (i) response priorities; (ii) situation monitoring and update; and (iii) data collection and information systems (Figure 143)..

Key information:

Response priorities:

- Identify immediate and short- and long-term response objectives, focusing on the acute malnutrition levels as well as the major contributing factors to acute malnutrition.

Situation monitoring and update:

- Identify IPC analysis plans to monitor the situation. Indicate the timing of a future IPC analysis.
- Identify key risk factors to monitor that would trigger the need to update the analysis. Particular attention should be paid to factors such as conflict, possible disease outbreaks, and the food security situation, which inform the key assumptions underpinning the phase classification.
- Identify recommendations for data collection and information systems, i.e. timing, coverage and indicators as relevant to fill the data quality and other gaps faced during the analysis.

Figure 143: IPC Communication Template Module 4

	COUNTRY NAME IPC ACUTE MALNUTRITION ANALYSIS	4
RECOMMENDATIONS FOR ACTION		
<p>Response Priorities</p> <ul style="list-style-type: none"> Identify populations in need of different strategic actions. Refer to the Priority Response Objectives of different IPC phases as detailed in the Reference Table. Defining specific modalities of response is not required and usually not possible at this stage of situation analysis. <p>Situation monitoring and update</p> <ul style="list-style-type: none"> Identify nutrition and IPC Analysis plans to monitor the situation. Indicate timing of future IPC analysis. Identify recommendations for data collection and information systems, i.e. timing, coverage and indicators as relevant to fill the data quality gaps and inadequacy faced during the analysis. <p>Risk factors to monitor</p> <ul style="list-style-type: none"> Identify key risk factors to monitor that would trigger the need to update analysis. Particular attention should be paid to factors such as conflict and rainfall, which inform key assumptions underpinning the phase classification. 		



MODULE 5: DETAILED NUMBER OF CHILDREN WHO ARE ACUTELY MALNOURISHED AND IN NEED OF TREATMENT

Purpose: To develop and share the estimates of the number of children who are acutely malnourished and in need of treatment (Figure 144).

Key information:

- An overview of methods for estimating the number of children in need.
- A brief methodological note on how the total number of children in need was estimated. The note should describe the approach used to estimate populations.
- Specification of what prevalence was used in the calculation of the total number of children in need – i.e. if GAM based on WHZ, or GAM based on MUAC, or a combination of the two was used to calculate the total number of children in need.
- A table indicating the number of children in need.
- A detailed table developed and inserted with the total number of GAM, MAM and SAM cases for each area of analysis. Also include the total number of population and number of children under-five for each area of analysis.
- Specification of the phase classification for each area analysed.
- If the population tables are longer than one page, they should be moved to the end of the report.

Figure 144: IPC Communication Template Module 5

COUNTRY NAME IPC ACUTE MALNUTRITION ANALYSIS										5
TOTAL NUMBER OF CHILDREN AFFECTED BY ACUTE MALNUTRITION AND IN NEED OF TREATMENT - MONTH YEAR										
<small>Provide a brief methodological note on how the total number of children in need was estimated. The note should describe the approach used to estimate populations. Specify if GAM based on WHZ or GAM based on MUAC or the combination of the two was used to calculate the total number of children in need.</small>										
Unit of analysis	Children under 5							Pregnant and Lactating women		
	Total #	Combined GAM % (95% CI)	Combined MAM % (95% CI)	Combined SAM % (95% CI)	Estimated number of GAM cases	Estimated number of MAM cases	Estimated number of SAM cases	Total #	AMN % (95% CI)	# of cases AMN
Unit of analysis	000 000	00 000	00%	00 000	00 000	00 000	00 000	00 000	00 000	00 000
Unit of analysis	000 000	00 000	00%	00 000	00 000	00 000	00 000	00 000	00 000	00 000
Unit of analysis	000 000	00 000	00%	00 000	00 000	00 000	00 000	00 000	00 000	00 000
Unit of analysis	000 000	00 000	00%	00 000	00 000	00 000	00 000	00 000	00 000	00 000
Unit of analysis	000 000	00 000	00%	00 000	00 000	00 000	00 000	00 000	00 000	00 000
Unit of analysis	000 000	00 000	00%	00 000	00 000	00 000	00 000	00 000	00 000	00 000
Unit of analysis	000 000	00 000	00%	00 000	00 000	00 000	00 000	00 000	00 000	00 000
Unit of analysis	000 000	00 000	00%	00 000	00 000	00 000	00 000	00 000	00 000	00 000
Unit of analysis	000 000	00 000	00%	00 000	00 000	00 000	00 000	00 000	00 000	00 000
Total	00 000 000	000 000	N.A.	000 000	000 000	000 000	000 000	00 000 000	00 000 000	00 000 000

Develop and insert a detailed table with the total number of GAM, MAM and SAM cases for each area of analysis. Also include total as well as under-5 population for each area of analysis. Specify the area phase classification for each area analysed.



MODULE 6: PROCESS AND METHODOLOGY

Purpose: To describe the IPC approach, the analysis process, the main data sources and key limitations (Figure 145).

Key information:

Process and methodology

- Detail the analysis process, including reference to the national Technical Working Group, institutional arrangements, training, and activities undertaken before, during and after analysis.
- Include a list of the main data sources used.

Limitations of the analysis

- Identify limitations of the analysis, including technical and process challenges, such as evidence gaps, institutional arrangements and participation.

Figure 145: IPC Communication Template Module 6

COUNTRY NAME IPC ACUTE MALNUTRITION ANALYSIS					6										
PROCESS AND METHODOLOGY															
<p>Detail the analysis process, including reference to the national TWG, institutional arrangements, training, and activities undertaken before, during and after analysis.</p>															
<p>Sources Include a list of main data sources used.</p>															
<p>Limitations of the analysis Identify limitations of the analysis, including technical and process challenges, such as evidence gaps, institutional arrangements and participation.</p>															
<p>What is the IPC and IPC Acute Malnutrition? The IPC is a set of tools and procedures to classify the severity and characteristics of acute food insecurity and acute malnutrition crises as well as chronic food insecurity based on international standards. The IPC consists of four mutually reinforcing functions, each with a set of specific protocols (tools and procedures). The core IPC parameters include consensus building, convergence of evidence, accountability, transparency and comparability. The IPC analysis aims at informing emergency response as well as medium and long-term food security policy and programming. The IPC Acute Malnutrition Classification provides information on the severity of acute malnutrition, highlights the major contributing factors to acute malnutrition, and provides actionable knowledge by consolidating wide-ranging evidence on acute malnutrition and contributing factors.</p>															
<p>Contact for further Information Surname, Name IPC function email@email.com IPC Global Support Unit www.ipcinfo.org</p>															
<p>This analysis has been conducted under the patronage of the(e.g. Ministry of Agriculture). It has benefited from the technical and financial support of(e.g. European Commission, UK Government). Classification of food insecurity and malnutrition was conducted using the IPC protocols, which are developed and implemented worldwide by the IPC Global Partnership - Action Against Hunger, CARE, CILSS, EC-IPC, FAO, FEWSNET, Global Food Security Cluster, Global Nutrition Cluster, IGAID, Oxfam, PROGRESAN-SICA, SADC, Save the Children, UNICEF and WFP.</p>															
<p>Acute Malnutrition Phase name and description</p> <table border="1" style="width: 100%; text-align: center;"> <thead> <tr> <th>Phase 1 Acceptable</th> <th>Phase 2 Alert</th> <th>Phase 3 Serious</th> <th>Phase 4 Critical</th> <th>Phase 5 Extremely Critical</th> </tr> </thead> <tbody> <tr> <td>Less than 5% of children are acutely malnourished.</td> <td>5–9.9% of children are acutely malnourished.</td> <td>10–14.9% of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised.</td> <td>15–29.9% of children are acutely malnourished. Widspread morbidity and/or very large individual food consumption gaps are likely evident.</td> <td>30% or more children are acutely malnourished. Widspread morbidity and/or very large individual food consumption gaps are likely evident.</td> </tr> </tbody> </table>						Phase 1 Acceptable	Phase 2 Alert	Phase 3 Serious	Phase 4 Critical	Phase 5 Extremely Critical	Less than 5% of children are acutely malnourished.	5–9.9% of children are acutely malnourished.	10–14.9% of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised.	15–29.9% of children are acutely malnourished. Widspread morbidity and/or very large individual food consumption gaps are likely evident.	30% or more children are acutely malnourished. Widspread morbidity and/or very large individual food consumption gaps are likely evident.
Phase 1 Acceptable	Phase 2 Alert	Phase 3 Serious	Phase 4 Critical	Phase 5 Extremely Critical											
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<p>IPC Analysis Partners:</p> <hr/>															



MODULE 7: SNAPSHOT

Purpose: Presents key results in easily accessible infographics (Figure 146).

Key information:

Graphic visual representation of the most important results/information of the IPC Analysis for the current and projected period (if available), specifically:

- **IPC map(s):** IPC map(s) of the current and projected period.

- **Population figures:** Insert the number of acutely malnourished children (divided into Moderate and Severe Acute Malnutrition) and, if available, pregnant or lactating women who are malnourished as in Module 1.

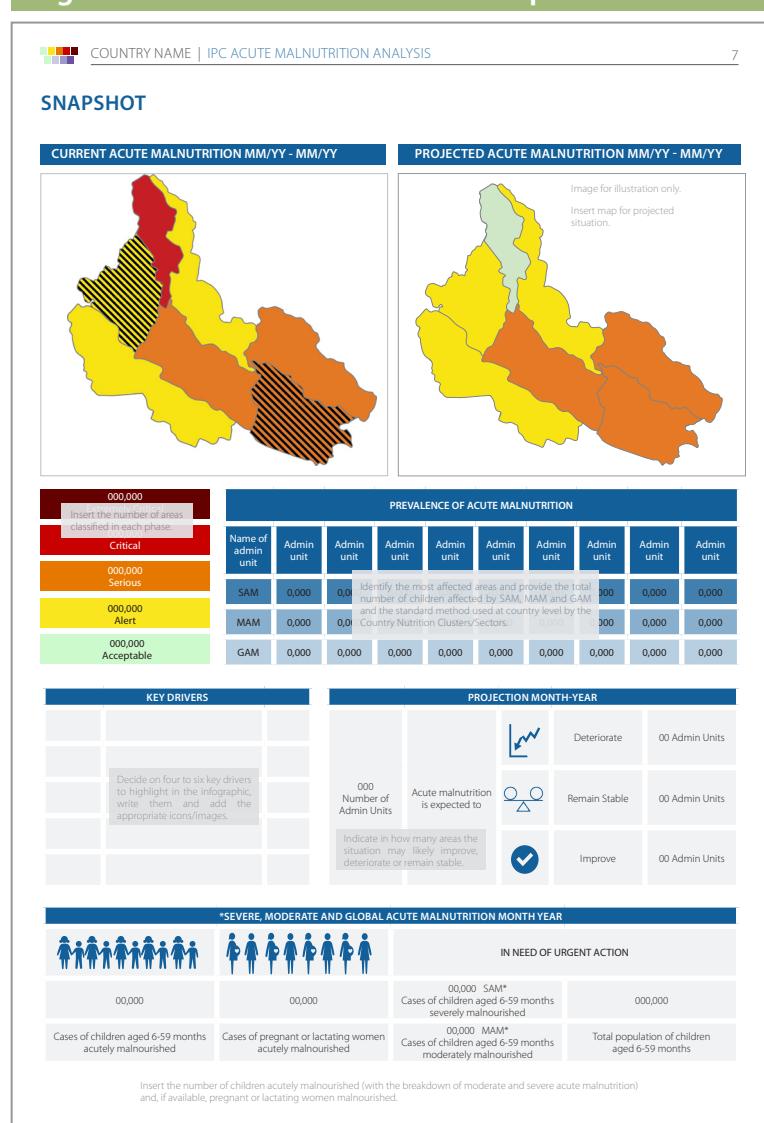
- **Area classification:** Insert the number of areas classified in each phase.

- **Prevalence of Acute Malnutrition in the most affected areas:** Provide the percentage of children affected by SAM, MAM and GAM.

- **Key drivers:** Decide on four to six key drivers to highlight in the infographic, write them down and add the appropriate icons/images.

- **Projection:** Indicate in how many areas the situation may likely improve, deteriorate or remain stable.

Figure 146: IPC Communication Template Module 7



MODULE 8: SUMMARY OF FACTORS CONTRIBUTING TO ACUTE MALNUTRITION

Purpose: To provide an overview of the key drivers triggering Acute Malnutrition (Figure 147).

Key information:

For the areas classified in IPC Acute Malnutrition Phase 3+, use the table provided in the module to indicate the major, minor and non-contributing factors as well as no data availability per area.

Figure 147: IPC Communication Template Module 8

		COUNTRY NAME IPC ACUTE MALNUTRITION ANALYSIS	FACTORS CONTRIBUTING TO ACUTE MALNUTRITION								
			Admin Unit	Admin Unit	Admin Unit	Admin Unit	Admin Unit	Admin Unit	Admin Unit	Admin Unit	Admin Unit
	Food consumption	Minimum Dietary Diversity (MDD)									
		Minimum Meal Frequency (MMF)									
		Minimum Acceptable Diet (MAD)									
		Minimum Dietary Diversity – Women (MDD-W)									
		Others									
		Health status	Diarrhoea	For the areas classified in IPC AMN Phase 3+, use the table provided in the module to indicate the major, minor and no contributing factors as well as no data availability per area.							
		Dysentery									
		Malaria									
		HIV/AIDS prevalence									
		Acute Respiratory Infection									
		Disease outbreak									
		Others									
	Food security	Outcome of the IPC for Acute Food Insecurity analysis									
		Caring and feeding practices	Exclusive breastfeeding under 6 months								
			Continued breastfeeding at 1 year								
			Continued breastfeeding at 2 years								
			Introduction of solid, semi-solid or soft foods								
			Others								
	Health services & environmental health	Measles vaccination									
		Polio vaccination									
		Vitamin A supplementation									
		Skilled birth attendance									
Legend		Major Contributing Factor	Minor Contributing Factor	No Contributing Factor	No data						



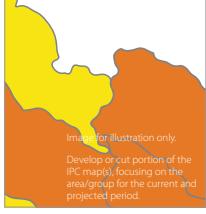
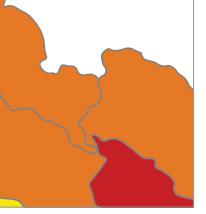
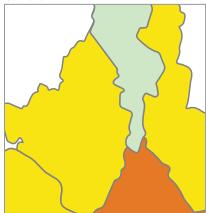
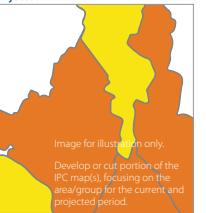
MODULE 9: PROFILES OF THE MOST AFFECTED AREAS

Purpose: To present the key findings and observations for each area or group of major concern (Figure 148).

Key information:

- Provide an overview of the current and projected conditions, including references to evidence, and answer the five key questions (how severe, how many, why, when, where) specifically for that area/group. Provide recommendations for action as relevant.
- Develop or cut the portion of the IPC map(s) focusing on the area for the current and projected period.
- Fill in the table with total number of children affected by GAM, SAM and MAM, and pregnant and lactating women if available.
- Insert icons representing two to four key driving factors for that area.

Figure 148: IPC Communication Template Module 9

COUNTRY NAME IPC ACUTE MALNUTRITION ANALYSIS		PROFILE OF THE MOST AFFECTED AREAS			10																														
Name of the Affected Area/Group <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Current  <small>Image for illustration only. Develop or cut portion of the IPC map(s) focusing on the area/group for the current and projected period.</small> </div> <div style="text-align: center;"> Projected  <small>Image for illustration only. Develop or cut portion of the IPC map(s) focusing on the area/group for the current and projected period.</small> </div> </div> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Children acutely malnourished and in need of treatment</th> <th>Pregnant or lactating women acutely malnourished and in need of treatment</th> <th>GAM%</th> <th>SAM%</th> <th>MAM%</th> </tr> </thead> <tbody> <tr> <td>000</td> <td>000</td> <td>00%</td> <td>00%</td> <td>00%</td> </tr> <tr> <td>Major contributing factors</td> <td> Insufficient health services</td> <td>Icon Contributing factor</td> <td>Icon Contributing factor</td> <td>Icon Contributing factor</td> </tr> </tbody> </table> <p>Provide an overview of the current and projected conditions, including references to evidence and attempting to answer the five key questions (how severe, how many, why, when and where) specifically for that area/group. Provide recommendations for action as relevant.</p> <p>Fill out the table with number of children affected by GAM, SAM, and MAM, and pregnant or lactating women if available. Insert icons representing two to four key driving factors for that area.</p> <div style="border-top: none;"> Name of the Affected Area/Group <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Current  <small>Image for illustration only. Develop or cut portion of the IPC map(s) focusing on the area/group for the current and projected period.</small> </div> <div style="text-align: center;"> Projected  <small>Image for illustration only. Develop or cut portion of the IPC map(s) focusing on the area/group for the current and projected period.</small> </div> </div> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Children acutely malnourished and in need of treatment</th> <th>Pregnant or lactating women acutely malnourished and in need of treatment</th> <th>GAM%</th> <th>SAM%</th> <th>MAM%</th> </tr> </thead> <tbody> <tr> <td>000</td> <td>000</td> <td>00%</td> <td>00%</td> <td>00%</td> </tr> <tr> <td>Major contributing factors</td> <td> Insufficient health services</td> <td>Icon Contributing factor</td> <td>Icon Contributing factor</td> <td>Icon Contributing factor</td> </tr> </tbody> </table> <p>Provide an overview of the current and projected conditions, including references to evidence and attempting to answer the five key questions (how severe, how many, why, when and where) specifically for that area/group. Provide recommendations for action as relevant.</p> <p>Fill out the table with number of children affected by GAM, SAM, and MAM, and pregnant or lactating women if available. Insert icons representing two to four key driving factors for that area.</p> </div>						Children acutely malnourished and in need of treatment	Pregnant or lactating women acutely malnourished and in need of treatment	GAM%	SAM%	MAM%	000	000	00%	00%	00%	Major contributing factors	 Insufficient health services	Icon Contributing factor	Icon Contributing factor	Icon Contributing factor	Children acutely malnourished and in need of treatment	Pregnant or lactating women acutely malnourished and in need of treatment	GAM%	SAM%	MAM%	000	000	00%	00%	00%	Major contributing factors	 Insufficient health services	Icon Contributing factor	Icon Contributing factor	Icon Contributing factor
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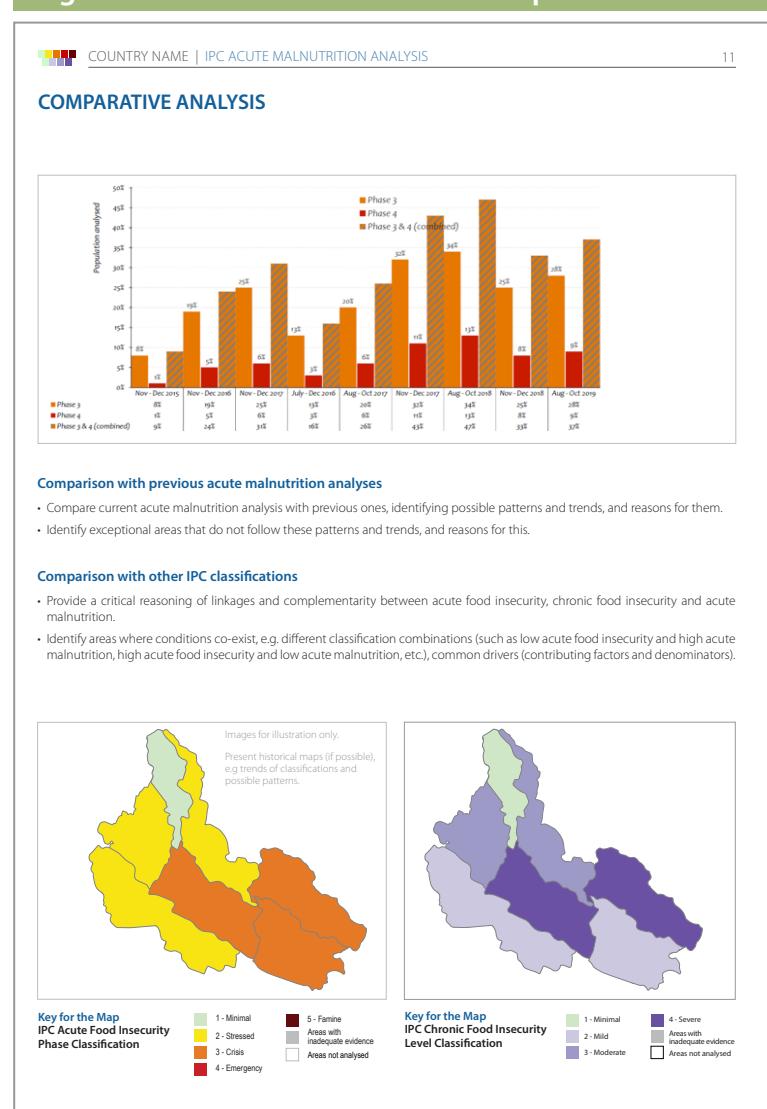
MODULE 10: COMPARATIVE ANALYSIS

Purpose: To contextualize the current classification in relation to the relevant IPC Acute Food Insecurity and/or Chronic Food Insecurity Analysis, presenting the linkages and complementarity between them, as well as providing trends over time (Figure 149).

Key information:

- Provide a critical reasoning of linkages and complementarity between Acute Food Insecurity, Chronic Food Insecurity and Acute Malnutrition.
- Identify areas where conditions co-exist, such as different classification combinations (e.g. low Acute Food Insecurity and high Acute Malnutrition, high Acute Food Insecurity and low Acute Malnutrition), and common drivers (contributing factors and denominators).
- Present historical maps (if possible) side by side, such as on trends of classifications and possible patterns, especially those for Acute Food Insecurity and Acute Malnutrition and possible patterns.
- Although this module is not mandatory, it is highly recommended that a comparative analysis with previous analyses is made, especially in the case of high concern countries.

Figure 149: IPC Communication Template Module 10





PROTOCOL 3.2: ADHERE TO MAPPING STANDARDS

Figure 150: Mapping standards (Tool 11)

**Key for the Map
IPC Acute Malnutrition Phase Classification**

- 1 - Acceptable
- 2 - Alert
- 3 - Serious
- 4 - Critical
- 5 - Extremely critical
- Phase classification based on MUAC
- Areas with inadequate evidence
- Areas not analysed

Map Symbols

- Urban settlement classification
- ▲ IDPs/other settlements classification

Evidence Level

- * Acceptable
- ** Medium
- *** High
- Scarce evidence due to limited or no humanitarian access

Area-specific call-out box (ISS map digital version)

Area Name	IPC Acute Malnutrition Phase
#,###/#,###	# cases of acute malnutrition/ population under 5
#,#/10,000	Crude Death Rate: # cases / 10,000 people per day

The following parameters need to be adhered to in all IPC Acute Malnutrition classifications:

- Areas should be mapped according to the standardized RGB colour scheme: Phase 1 (205, 250, 205); Phase 2 (250, 230, 030); Phase 3 (230, 120, 000); Phase 4 (200, 000, 000); and Phase 5 (100, 000, 000).
- Areas are only classified and mapped if they meet the minimum evidence requirements. If requirements are not met, they should be mapped using a grey colour (RGB 166, 166, 166) indicating "inadequate evidence".
- Areas that are not included in the analysis should be coloured white (RGB 255, 255, 255) indicating "Area Not Analysed".
- In the case of classifications of **urban areas, IDPs and other settlements**, specific symbols should be used as illustrated in Figure 150. The colour of the symbol should be chosen according to the phase classified.
- If classification is carried out with less than adequate evidence (in areas with **limited or no humanitarian access**), a specific symbol should be put on the concerned area as per Figure 150.
- The evidence level of analysis should be added in the map through the use of *Acceptable, **Medium, and ***High. If not possible, the evidence level of analysis should be added in the map key or in a note under the map.
- Digital maps may have further information included. Further information may include the number of cases of acute malnutrition, CDR, IPC Chronic Food Insecurity and IPC Acute Food Insecurity classifications.

PROTOCOL 3.3: STRATEGICALLY SHARE COMMUNICATION PRODUCTS IN A TIMELY MANNER

IPC communication products, including the IPC Analysis Report and maps, need to be shared with relevant stakeholders as soon as finalized, preferably within 15 days of analysis completion. Given the humanitarian imperative, the Technical Working Group should aim, upon consensus, to release analysis results that include final classifications, population estimates and key messages, in the shortest time possible.

Should the Technical Working Group require more time to organize the release of the analysis, preliminary results should be shared with national stakeholders and published on the IPC website, preferably within 21 days after completion of the analysis process using the following disclaimer: *Preliminary findings pending official release at the country level*. Once an official release has taken place, then the disclaimer will be removed.

Three key activities should be implemented to accomplish the protocol and are described in Figure 151.

Figure 151: Communication activities required for effective dissemination (Tool 12)

- Presentation of the results to national and regional stakeholders: At least one presentation of the key findings needs to be given to relevant stakeholders and decision-makers. This dissemination can be extended by communications officers in key participating organizations.
- Sharing of communication products with the IPC Global Support Unit: The Technical Working Group shares communication products with the IPC Global Support Unit for posting on the IPC website and further dissemination at global levels as applicable.
- Dissemination of key IPC communication products such as maps, number of children acutely malnourished, and reports to key IPC audiences (donors, organizations, the media, the technical community, academia and governments) through appropriate channels such as mailing lists, social media and the IPC website.

FUNCTION 4: QUALITY ASSURANCE

Function 4 ensures the technical rigour and neutrality of an analysis as well as learning for future improvements. This is achieved through self-assessments and, if necessary, external quality reviews. By completing Function 4, analysts assess whether they have followed all IPC protocols included in Functions 1, 2 and 3, and identify areas for future improvements. If all 13 protocols have been followed, the resulting product can be labelled IPC. Therefore, by putting the IPC logo onto a report, the Technical Working Group recognizes its accountability, confirming that the classification was based on a consensual and unbiased analysis developed according to IPC protocols.

Further to Function 4, the IPC initiative aims to support countries to produce analyses that meet high-quality standards. To this end, the IPC Quality and Support Strategy has been developed around three additional components: (i) Capacity Development; (ii) Country Technical, Implementation and Strategic Support; and (iii) Technical Standards and Guidelines.



Figure 152: Protocols for Function 4

Protocol	Procedure	Tool
4.1 Conduct a self-assessment of the analysis.	Complete Self-Assessment Tool through a participatory process.	Tool 13: Self-Assessment Tool 
4.2 Request and engage in an external quality review if necessary.	Contact IPC Global Support Unit with concerns.	Quality Assurance Assurance@ipcinfo.org

Protocols For Completing Function 4

There are two protocols for Function 4: the first focuses on self-assessment, and the second entails requesting and engaging in an external quality review if deemed necessary (Figure 152).

PROTOCOL 4.1: CONDUCT A SELF-ASSESSMENT OF THE ANALYSIS

A self-assessment needs to be conducted at the end of all analyses to reflect critically on the extent to which the IPC protocols for Functions 1, 2 and 3 were followed, and to identify areas for future improvements. To this end, the analysis team needs to complete the Self-Assessment Tool (Figure 153). The tool should be completed based on a collective discussion involving all analysis team members. To facilitate the discussion and completion of the tool, guiding questions are provided in Figure 154. As an optional step, the tool can also be completed by individual analysis team members or facilitators to provide feedback to the national Technical Working Group and/or the Global Support Unit on the process, and suggestions on how to improve future IPC analyses, tools, procedures, specific guidance and/or implementation processes.

The Self-Assessment Tool serves two purposes:

- To identify how well protocols have been followed. In the event that they have not been followed, the analysis team should revise the analysis to ensure adherence to all protocols and the quality of IPC products. If the protocols cannot be entirely adhered to, the analysis team should provide a reasonable explanation. Should the outcomes of the self-assessment raise serious concerns, an external quality review may be initiated.
- When planning a new IPC analysis, the IPC Technical Working Group should reflect on the content of previous self-assessments to ensure that lessons learned in previous analyses are applied.

Once completed by the analysis team, the Self-Assessment Tool should be submitted to the IPC Global Support Unit via the ISS (when used for the analysis) or via email (Quality.Assurance@ipcinfo.org).

Figure 153: The Self-Assessment Tool (Tool 13)

Country: _____ Date: _____		Organizations Participating in the Self-Assessment:		
IPC Protocols		Specify if the protocol was completed 1. Yes 2. Partially 3. No	If partially or not completed, explain why	Provide recommendations for improvements to future analyses
Function 1: Build Technical Consensus	1.1 Compose the analysis team with relevant sectors and organizations.			
	1.2 Conduct analysis on a consensual basis.			
Function 2: Classify Severity and Identify Key Drivers	2.1 Use the IPC Analytical Framework to guide the convergence of evidence.			
	2.2 Compare evidence against the Reference Table.			
	2.3 Adhere to the parameters for analysis.			
	2.4 Evaluate evidence reliability.			
	2.5 Meet the minimum evidence and analysis requirements.			
	2.6 Methodically document evidence and analysis, and provide them upon request.			
Function 3: Communicate for Action	3.1 Produce the IPC Analysis Report.			
	3.2 Adhere to mapping standards.			
	3.3 Strategically share communication products in a timely manner.			
Function 4: Quality Assurance	4.1 Conduct a self-assessment of the analysis.			
	4.2 Request and engage in an external quality review if necessary.			



Figure 154: The Self-Assessment Tool – Guiding questions

IPC Protocols		Guiding Questions
Function 1: Build Technical Consensus	1.1 Compose the analysis team with relevant sectors and organizations.	<p>Was the analysis team composed of relevant sectors and organizations? Were different relevant stakeholder organizations (e.g. government, United Nations agencies, international and national NGOs, and technical agencies) and sectors (e.g. nutrition, food security/livelihoods, health, WASH, gender, and communication) represented? Areas for improvement/learning: Which organization's and/or sector's participation should be further promoted?</p>
	1.2 Conduct the analysis on a consensual basis.	<p>Was the analysis conducted on a consensual basis? Did IPC analysts review, discuss and debate the preliminary IPC classifications and population estimates, reach consensus and agree on the final results? If different views were expressed by any analysis team member(s) on the results, were they addressed? Areas for improvement/learning: Are changes in the process needed to facilitate consensus-building?</p>
	2.1 Use the IPC Analytical Framework to guide the convergence of evidence.	<p>Was the analysis of contributing factors for all areas based on convergence of evidence? Was convergence of evidence used for MUAC-based classifications? Was all available evidence used in the analysis? Was there contradictory evidence, and if so, how was this addressed in the analysis? Areas for improvement/learning: Was the relationship between MUAC and WHZ in each area of analysis established before the MUAC-based classification was carried out? Were contributing factors taken into account when a final phase was assigned to an area based on MUAC? Was this process documented in the Analysis Worksheet?</p>
	2.2 Compare evidence against the Reference Table.	<p>Has direct evidence been compared against the Reference Table by taking into account the globally comparable cut-offs for the outcome indicators? Was evidence analysed and made available to allow comparison against Reference Table cut-offs? Areas for improvement/learning: Have the indicative phases of GAM based on MUAC been assessed against the Acute Malnutrition Reference Table, also even when evidence on GAM based on WHZ was available?</p>
	2.3 Adhere to parameters for analysis.	<p>Were all IPC analytical parameters respected? Was the relationship between MUAC and WHZ always established before a MUAC-based classification was performed? Have contributing factors also been used in all GAM based on MUAC classifications? Areas for improvement/learning: In particular, can adherence to the following parameters be improved: preference for GAM based on WHZ, MUAC-based classification based on an analysis of the relationship between WHZ and MUAC, and convergence of evidence; total number of children acutely malnourished and in need of treatment based on the country standard method; the validity period; and specific considerations for current and projected classifications?</p>
	2.4 Evaluate evidence reliability.	<p>Was all evidence assessed against methodological and time validity? Were the evidence reliability criteria correctly used? Were reliability scores allocated to all pieces of evidence? Areas for improvement/learning: Have methodological notes on the sources of evidence been made available to analysts? Could the soundness of method and time-relevance of the evidence be improved through better planning? If so, how?</p>
Function 2: Classify Severity and Identify Key Drivers	2.5 Meet minimum evidence and analysis requirements.	<p>Were the minimum evidence and analysis requirements met? Was there sufficient evidence for all the classified areas to meet minimum evidence requirements? Areas for improvement/learning: What were the key issues relating to data? Was any key evidence missing, outdated, or not representative of the areas analysed? Which information was available but not very recent/not from the same season?</p>
	2.6 Methodically document evidence and analysis, and provide them upon request.	<p>Were the evidence and analysis methodically documented and made available? Were the convergence of evidence (when required) and conclusions documented? Was all the evidence coded and made available to all analysts? Were these pieces of evidence accessible? Areas of improvement/learning: Was the reasoning behind the convergence of evidence (for MUAC-based classifications) documented and, for the projected analysis, linked to the most likely scenario?</p>

Function 3: Communicate for Action	3.1 Produce IPC Analysis Report.	Is the minimum information on the seven topics provided in the IPC Report? Has the guidance for the content of each topic been followed? Areas for improvement/learning: Did the analysis team ensure that there were no calculation errors and/or inconsistencies in the calculation of children affected by acute malnutrition? Were the key messages discussed and agreed in plenary during the analysis? Was the IPC Modular Communication Template used?
	3.2 Adhere to mapping standards.	Do the map and legend follow standard requirements? Mapping standards: (i) standardized Red-Green-Blue colours should be used; (ii) areas that do not meet minimum evidence requirements should be mapped in grey; (iii) areas that are not analysed should be mapped in white; (iv) urban areas, IDP and other settlements as well as areas with limited or no humanitarian access must be indicated using the standard mapping symbols; and (v) the evidence level of analysis should be indicated on the map for each area using the standard mapping symbols. Areas for improvement/learning: Do the mapped areas correspond to the units of analysis?
	3.3 Strategically share communication products in a timely manner.	Will IPC communication products be shared strategically and in a timely manner? Is there a plan in place for sharing the analysis products with relevant stakeholders? Is this expected to occur within 15 days after completion of the analysis? Areas for improvement/learning: Was a communication plan (including dissemination) developed and discussed with Technical Working Group members prior to the IPC analysis? Will analysis results be presented to key stakeholders/decision-makers prior to public release?
Function 4: Quality Assurance	4.1 Conduct a self-assessment of the analysis.	Was the self-assessment tool completed based on a collective discussion?
	4.2 Request and engage in an external quality review if necessary.	If quality review criteria were met, was a quality review requested? If so, were the quality review recommendations followed?
For learning purposes, add any relevant notes on country implementation issues, including for different stages of the analysis cycle:		
Planning	Has the analysis been planned and timed taking into account data availability, context (seasonality or sudden shock) and decision-makers' information needs (e.g. the process for developing the Humanitarian Response Plan)?	
Preparation	Did the analysis planning and preparation allow for the optimal participation of all stakeholders, including timely communication on the dates of training (if any) and analysis events, access to data for analysts, and so on?	
Learning	Have key challenges and gaps (including resources, capacity and evidence gaps) been identified to inform future improvements?	



PROTOCOL 4.2: REQUEST AND ENGAGE IN AN EXTERNAL QUALITY REVIEW IF NECESSARY

Figure 155: External Quality Reviews – Objective, modality and focus

Objective: To ensure the overall quality, technical rigour and neutrality of analyses and related products.

Modality: External quality reviews are carried out within a short timeframe (3–5 days) prior to the finalization and release of the final IPC product. They are conducted remotely by a team of officers from the IPC Global Support Unit and, whenever possible, from IPC Global Partners, who are not involved in the analysis. External quality reviews consist of a review of the documented analysis (optimally using the IPC Analysis Worksheets), including all the evidence used. The Technical Working Group is consulted and provides inputs throughout the process, as needed.

Focus: External quality reviews focus on assessing adherence to all protocols.

Technical Working Groups, analysis team members or facilitators are provided with the opportunity to communicate directly with the Global Support Unit regarding any major concerns relating to the IPC analysis. The communication must include a short explanation of the concern as well as basic information on the analysis and must be submitted to the relevant regional Global Support Unit officer. Should there not be one available, it must be submitted to the Global Support Unit at Quality.Assurance@ipcinfo.org.

External quality reviews are carried out to ensure overall quality, technical rigour and neutrality under the following specific circumstances:

- When there is a breakdown in the technical consensus regarding the actual or potential classification of areas in Phase 4 or 5; or
- When the classification is performed with scarce evidence in areas with no or limited access that did not receive support from the Global Support Unit during the analysis; or
- Based on the review of the completed Self-Assessment Tool by the Global Support Unit or communication to the Global Support Unit from the analysis team members or facilitator(s) expressing concerns about the lack of adherence to protocols especially for the actual or potential classification of areas in Phase 4 or 5.

Figure 155 provides an overview of the objectives and implementation modalities of external quality reviews. While external quality reviews are a valuable mechanism for supporting the analysis teams in resolving technical disagreements and overcoming major analytical challenges, they are a last resort action. Other steps should thus be taken upstream, such as requesting real time technical support for the preparation and implementation of the analysis.

IPC CLASSIFICATION IN AREAS WITH LIMITED OR NO HUMANITARIAN ACCESS – SPECIAL ADDITIONAL PROTOCOLS

The IPC analysis is also needed in situations where **limited access prevents humanitarian organizations from collecting suitable evidence**. For classification of areas with limited or no humanitarian access, where IPC standard data requirements cannot be met, classification can still be completed provided that the additional specific protocols are followed for each function.

Limited humanitarian access refers to those areas to which access to collect evidence is either non-existent or very restricted, usually due to a conflict or a major natural disaster.

Function 1: Build Technical Consensus

- When analyses are to be carried out in areas with limited or no humanitarian access, it is imperative that the analysis team also include people with an in-depth understanding of the context. As much as possible, key analysts should participate in data collection exercises and bring their expert assessment to the analysis.

Function 2: Classify Severity and Identify Key Drivers

- R_0 evidence can be used to support the IPC analysis, provided it follows the parameters stipulated in Figure 156.
- A combination of sources of evidence should be used to the extent possible (e.g. data collected during a helicopter mission to an area affected by conflict, assessment of new arrivals by area of residence and travel time, evidence from similar nearby areas, historical trend analysis, and evidence from distribution points).
- Minimum evidence level includes at least GAM based on MUAC with R_0 evidence as detailed in Figure 156.
- The number of children with acute malnutrition may be estimated through GAM based on MUAC estimates and used as working estimates to determine the response required.
- The time validity of the analysis should be short, and projection updates are not allowed.



Figure 156: Reliability Score R₀ – Guidance for data collection

Validity of rapid ad hoc methods:

- Estimates should reflect an overview of the overall malnutrition situation given the limited window of opportunity to collect data and conduct some observations (usually hours).
- Methods may include rapid and non-representative assessments carried out in small geographical areas such as villages and camps. The results of rapid assessments are only applicable to the assessment area or to similar areas (e.g. estimates from an IDP camp may be used to infer the situation in other similar camps provided that expert knowledge and other evidence indicates similarity between camps).
- Results from several of these small geographical units may be used to express the situation in a larger geographical area such as district or county if at least three sites are surveyed in the target area.
- The type of malnutrition that is of concern in these types of conditions is acute malnutrition, which is assessed through MUAC screening. If possible, oedema should also be checked for.
- In general, data collection should involve collecting information from as many individuals as possible following as many different simultaneous approaches.
- The sample should be optimally selected either exhaustively or randomly. If possible, the assessment should include interviews/measurements at a central place and in residences. Estimates made at the intervention points (e.g. food distribution points, and health care admission screening points) should be contextualized due to known selection bias and used together with evidence from community screening.
- If data come from both household and central point screening, merging them may not be valid. Each sample should be described separately, and then the best estimate is produced by understanding the selection biases of both samples; this may require advanced analytical skills and a clear understanding of actions/activities on the ground and how they were implemented.
- With respect to mortality assessments, the type of mortality that is of interest is CDR. A mix of qualitative and quantitative methods such as interviews with key informants, grave counting and a review of hospital or health centre records is used.
- The approach to sample design and selection can be ad hoc since it uses the opportunities on the ground to quickly access subjects (such as distribution campaigns, health clinic services, and available key informants) and may include measuring anthropometric indicators in non-conventional target groups, such as adults rather than children. When using these types of approaches to sampling, the limitations, potential biases or restricted conclusions should be clearly indicated.
- Anthropometric measurements of new arrivals to neighbouring areas can provide evidence on the likely conditions of their place of origin if information on the length of journey is considered to ensure that the condition of those newly arrived can inform the conditions expected in those inaccessible areas.
- The IPC guidelines only provide basic guidance, and the methods may need to be adapted to the situation on the ground. It is absolutely critical to thoroughly document the methods and procedures used for data collection in this situation to clearly understand possible limitations and selection biases of the sampling methods used. It is crucial to thoroughly document all activity in the community (e.g. distributions, vaccination, health clinic activities and access) and to exhaustively describe the activities that were carried out during the assessment, including why and how they were carried out.
- An external IPC quality review needs to be conducted for all classifications in areas with limited humanitarian access that did not receive external support during the analysis. A Famine Review should be conducted if analysts suspect famine in these areas.

Time relevance:

- Given the high volatility of areas with limited or no humanitarian access, current classifications should be based on data collected within the previous three to five months of classification, and not necessarily from the same season of analysis.
- Evidence collected during times when estimates are expected to be different from the current time (either because of seasonality or negative shocks) should be extrapolated to their potential current values.

Figure 157: Minimum evidence level for areas with limited or no humanitarian access

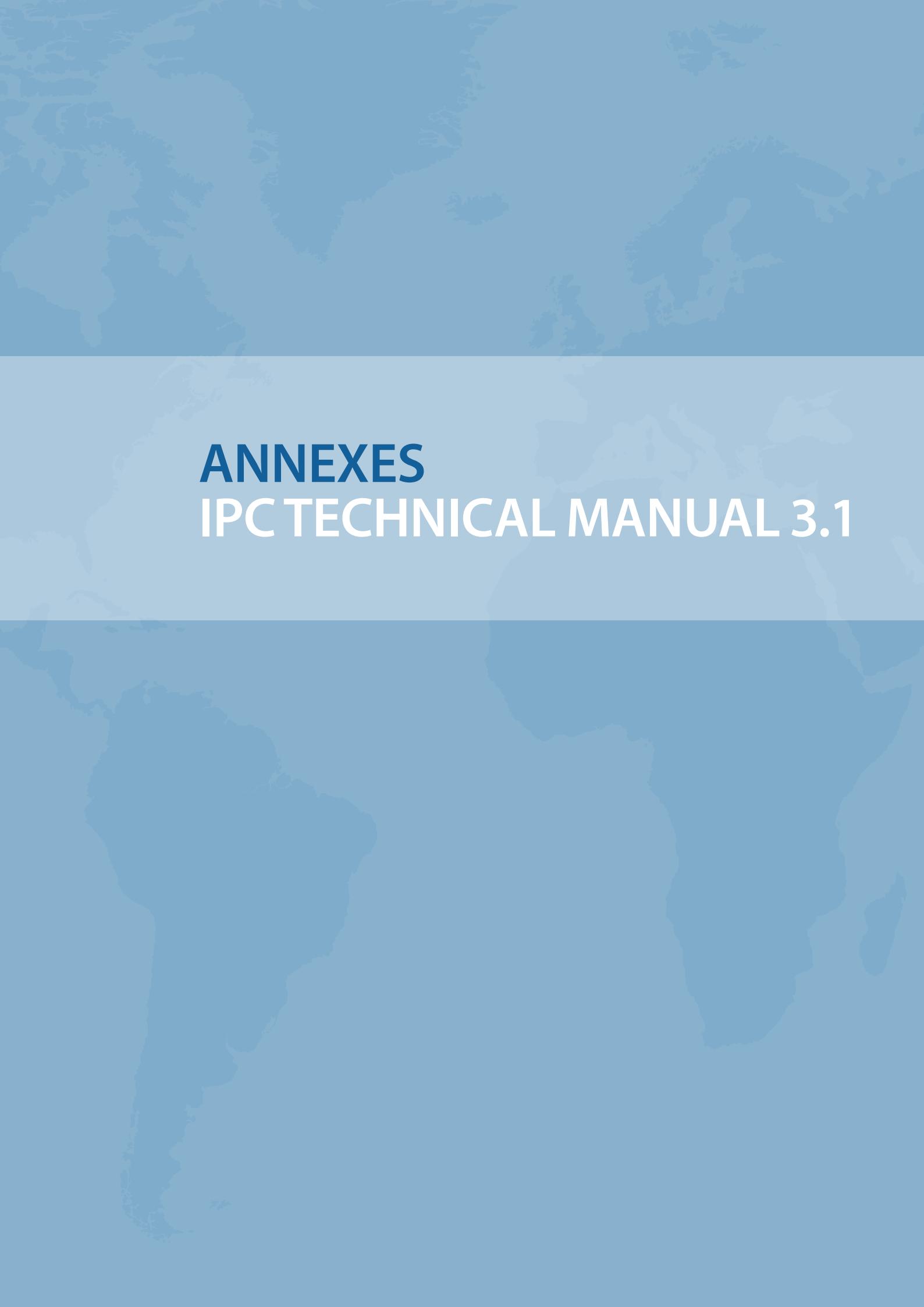
Evidence Level	Criteria	
	Current classification	Projected classification
 Reduced evidence due to limited or no access	1. At least Global Acute Malnutrition based on MUAC with R ₀ level evidence + 2. Two pieces of R ₁ evidence on contributing factors	1. IPC current classification adhering to the evidence level with limited humanitarian access + 2. Evidence used for the current classification at most 12 months old at the end of projection period + 3. Two pieces of R ₁ evidence presented with clear assumptions on forecasted trends

Function 3: Communicate for Action

- Communications should clearly highlight the fact that the area was classified with reduced evidence due to difficult humanitarian access; specific mapping protocols should be used.

Function 4: Quality Assurance

- An external quality review needs to be conducted when the evidence is reduced due to limited or no humanitarian access and the analysis team did not receive external support from the Global Support Unit. See Function 4 under IPC Acute Malnutrition protocols for details on external quality reviews.



ANNEXES

IPC TECHNICAL MANUAL 3.1

ANNEX 1: IPC TECHNICAL MANUAL VERSION 3.1 DEVELOPMENT PROCESS

The IPC multi-agency partnership leads the technical development of protocols for classification of food insecurity and malnutrition through global Working Groups. The IPC Global Support Unit coordinates and chairs the Working Groups, and also documents their recommendations for guidance. Two working groups, i.e. Food Security Working group and Nutrition Working Group, have been in existence throughout the development of IPC Manual 3.0 since 2016. Combined meetings between the two groups are frequently held and called the Harmonization Meetings. The logos of the current members of the groups are included below:

IPC FSWG Partners



IPC NWG Partners



The IPC Technical Manual Version 3.0 is based on the principles and guidance introduced in the IPC Technical Manual Version 2.0 and in Addendums prepared for IPC Chronic Food Insecurity Analysis and IPC Acute Malnutrition Analysis. This guidance has been updated for the IPC Technical Manual Version 3.1 based on the discussions and decisions taken by the Working Groups and the IPC Global Support Unit, new developments in the field of food and nutrition security, and on applied research conducted by IPC partner agencies and the IPC Global Support Unit.

The IPC Technical Manual Version 3.0 was prepared by Leila Oliveira, Kaija Korpi and Douglas Jayasekaran between 2017 and 2019, with valuable comments, inputs and documentation received from IPC partners and in particular members of the IPC Working Groups and the colleagues of the IPC Global Support Unit.



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ANNEX 2: LIST OF ACRONYMS

AAH	Action Against Hunger
BMI	Body Mass Index
CDR	Crude Death Rate
CFSAM	Crop and Food Supply Assessment Mission
FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agriculture Organization of the United Nations
FCS	Food Consumption Score
FEWS NET	Famine Early Warning Systems Network
FIES	Food Insecurity Experience Scale
GAM	Global Acute Malnutrition
HAG	Household Analysis Group
HAZ	Height-for-Age Z-score
HDDS	Household Dietary Diversity Score
HEA	Household Economy Analysis
HHS	Household Hunger Scale
IDP	Internally Displaced Person
IGAD	Intergovernmental Authority on Development
IPC	Integrated Food Security Phase Classification
ISS	Information Support System
JRC	Joint Research Centre
Kcal	Kilo-calories
LCS	Livelihood Coping Strategies
MAHFP	Months of Adequate Household Food Provisioning
MAM	Moderate Acute Malnutrition
MDD-W	Minimum Dietary Diversity for Women
MUAC	Mid-Upper Arm Circumference
NDC	Non-Defining Characteristic
NGO	Non-Governmental Organization
NPL	National Poverty Line



OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PoU	Prevalence of Undernourishment
rCSI	reduced Coping Strategies Index
SAM	Severe Acute Malnutrition
SICA	Sistema de la Integración Centroamericana (Central American Integration System)
SSR	Starchy Staple Ratio
SSEXR	Starchy Staples Expenditure Ratio
U5DR	Under-five Death Rate
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization
WHZ	Weight-for-Height Z-score

ANNEX 3: GLOSSARY

Access (see food access)

Anthropometric indices – combinations of human body measurements and their comparison to reference data. For example, measurements of weight and height may be combined to produce Body Mass Index (weight/ height² - see definition below) or weight may be related to height through the use of reference data that have been developed/adopted by the World Health Organization. (UNICEF)

Assets – in broad terms, assets are considered to be anything that is valuable or useful, such as a skill, a quality, a commodity, etc. (Chambers Compact Dictionary). In the Sustainable Livelihoods Framework, assets are defined under the following five categories:

- Human: health and nutrition status; physical capacity; skills; level of education; etc.
- Social: household, gender, kinship and other networks; community groups; values and attitudes; etc.
- Financial: income; credit and loans; savings; liquid assets; etc.
- Physical: productive assets, such as tools and equipment; stores; housing; livestock; infrastructure; etc.
- Natural: land; water; forests; etc. (WFP. Food Security Assessment Learning Repository).

Body Mass Index – an index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m²).

Cash Transfers – sums of money provided to recipients. The total amount of money provided is linked to the objective of the transfer. When intended to provide access to food (i.e. for food assistance), the amount of cash is generally equal to the local market value of food transfers. Cash transfers can also be provided for non-food purposes (e.g. for shelter or to meet other basic needs), hence entailing different amounts of money to beneficiaries. (WFP)

Chronic Food Insecurity – a long-term or persistent inability to meet minimum food requirements.

Coping Strategies – activities to which people resort in order to obtain food, income and/or services when their normal means of livelihood have been disrupted or other shocks/hazards decrease their access to basic needs.

Coping Strategies Index – a methodology for estimating the food security status of households based upon the reversibility of coping strategies to which they resort. (Coping Strategies Index Field Methods Manual)

Daily Caloric Requirement – the minimum number of calories needed to sustain normal levels of activity and health, taking into account age, gender, body weight and climate; on average 2,350 kcals per day. Note: Estimates of daily caloric requirements vary; in emergencies, a plan of 2,100 kcals/person/day is a typical planning figure used.

Dietary Quality – the extent to which the diet is optimal in delivering essential nutrients, including the types and forms of nutrients. This includes dietary adequacy of vitamins, minerals, energy and protein, but also the specific form of fats, carbohydrates and proteins. Both quantity and nutrient density are important determinants of dietary quality. Nutrient requirements are based upon a number of criteria, depending upon the specific nutrient. In addition to nutrients, fibre is a necessary component of a healthy diet.



Disaster – a situation that causes widespread human, material, economic or environmental damage, threatening human lives and/or livelihoods and exceeding the coping capacities of the affected communities and/or government. (World Food Programme, Food Security Assessment Learning Repository)

Disaster risk – the potential disaster losses in lives, health status, livelihoods, assets and services which could occur to a particular community/society over some specified future time period. Disaster risk comprises different types of potential losses, some of which are often difficult to quantify. Nevertheless, with knowledge of the prevailing hazards and the characteristics of population and socioeconomic development, disaster risks can be estimated and mapped. with varying levels of confidence. (United Nations International Strategy for Disaster Reduction (UN/ISDR)).

Disaster Risk Reduction – the concept and practice of reducing disaster risks through systematic efforts to analyse and manage the determinants of disasters, including through reduced exposure to hazards, lessened vulnerability of people and property, management of land and environment, and improved preparedness for adverse events. (United Nations International Strategy for Disaster Reduction (UN/ISDR)).

Drought – a temporary reduction in water or moisture availability significantly below the normal or expected amount (norm) for a specified period. The key assumptions of such a definition are:

- the reduction is temporary (if the reduction were permanent, then terms such as "dry" and "arid" would be more appropriate)
- the reduction is significant
- the reductions is defined in relation to a "norm", i.e. normal expectation
- the period taken as the basis for the norm is specified (United Nations Disaster Management Training Programme. Drought and Famine)

(United Nations Disaster Management Training Programme. Drought and Famine)

Early Warning Systems – information collection, analysis and use aimed at predicting, preventing and mitigating the effects of future hazards and risks. (FEWS NET)

Famine – absolute inaccessibility of food to an entire population or sub-group of a population, potentially causing death in the short term. (ACF)

Food Access – access by households/individuals to adequate resources (entitlements) for acquiring appropriate foods for a nutritious diet. Entitlements are defined as the set of all commodity bundles over which a person can establish command given the legal, political, economic and social arrangements of the community in which he/she lives (including traditional rights such as access to common resources). (FAO Policy Brief on Food Security. 2006)

Food Availability – the availability of sufficient quantities of food of appropriate quality, supplied through domestic production or imports (including food aid). (FAO Policy Brief on Food Security. 2006)

Food Consumption – the amount of food consumed by individuals, households, communities and nations. Indicators capture the amount of foods consumed in a population, often using indirect indicators associated with food availability. Food consumption per person is the amount of food, in terms of quantity, of each commodity and its derived products for each individual in the total population. The dietary energy consumption per person is the amount of food, in kcal per day, for each individual in the total population. (FAO)

Food Consumption Gap – the gap between the level of food consumption required to meet nutrition needs and actual food consumption. (World Food Programme. Food Security Assessment Learning Repository)

Food Consumption Score – a proxy indicator that represents the energy (calories) and nutrient (macro- and micronutrient content) value of the food that households eat. It is calculated based on the type of foods and the frequency with which households consume them over a seven-day period. (World Food Programme. Food Security Assessment Learning Repository)

Food Insecurity – the state in which people are at risk or actually suffering from inadequate consumption to meet nutritional requirements as a result of the physical unavailability of food, their lack of social or economic access to adequate food, and/or inadequate food utilization (Global Forum on Food Security. FAO).

- **Chronic food insecurity** – long-term or persistent inability to meet minimum food consumption requirements.
- **Transitory food insecurity** – short-term or temporary inability to meet minimum food consumption requirements, indicating a capacity to recover. As a rule of thumb, short periods of food insecurity related to sporadic crises can be considered transitory.
- **Cyclical food insecurity** – habitual, most often seasonal, variations in food security. As a rule of thumb, if seasonal food insecurity is present for a total of at least six months a year, it can be considered chronic; if it lasts for a total of less than six months a year, it can be considered transitory. (FAO)

Food Security – a situation that exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. (State of Food Insecurity. 2001). However, measurement of food security proves to be elusive. In contrast, food security is most frequently based upon the absence of food insecurity (see above).

Fortification – the practice of deliberately increasing the nutritional quality of a food by enhancing essential micronutrients, i.e. vitamins and minerals (including trace elements) in the food, so as to improve the nutritional quality of the food supply and provide a public health benefit with minimal risk to health. (UNICEF)

Hazard – a dangerous phenomenon, substance, human activity or condition that can cause or precipitate disaster. Hazards can include environmental threats such as climate, weather, topographic or seismologic features. They can also include hazards of human origin such as economic, disease, chemicals, biological agents, nuclear radiation and human conflict.

Health – a state of complete physical, mental well-being and not simply the absence of disease or infirmity. (World Health Organization). Like food security, health often is defined in terms of the absence of disease or infirmity. Common indicators of health in populations include life expectancy at birth, under-five mortality, infant mortality:

- **Life expectancy at birth (years)** – the number of years a newborn infant would live if prevailing patterns of mortality at the time of birth were to stay the same during the lifespan.
- **Under-five mortality rate** – the probability of dying between birth and exactly five years of age, expressed per 1,000 live births.



- **Infant mortality rate** – the probability of dying between birth and exactly one year of age, expressed per 1,000 live births.

Household – a unit of people living together in a residence and “eating from the same pot”. Households and families are distinct concepts. Families may be living outside of the household but be active participants in the household economy. (FAO)

Household Food Security – a condition of security that depends on year-round access to an adequate supply of nutritious and safe food to meet the needs of all household members. While food security is defined in its most basic form as access by all people at all times to the food needed for a healthy life, the focus of household food security is on the household or family as the basic unit of activity in society. (WFP)

Humanitarian food assistance – any direct resource transfers in response to acute events that aim to reduce food gaps, and protect and save lives and livelihoods by facilitating households’ access to food. Humanitarian food assistance may include different modalities, such as transfers of food, cash, livestock and other livelihood assistance.

Livelihoods – the capabilities, assets – both material and social – and activities required for a means of living linked to survival and future well-being; and the policies and institutions that shape or constrain access to assets and choices about activities. (Sphere Handbook)

Livelihood Assets – in the Sustainable Livelihoods Framework, livelihood assets are defined under the following five categories:

- **Human** – health and nutrition status; physical capacity; skills; level of education; etc.
- **Social** – household, gender, kinship and other networks; community groups; values and attitudes; etc.
- **Financial** – income; credit and loans; savings; liquid assets; etc.
- **Physical** – productive assets such as tools and equipment; stores; housing; livestock; infrastructure; etc.
- **Natural** – land; water; forests; etc. (World Food Programme. Food Security Assessment Learning Repository)

Livelihood Group – a group of people who share the same basic means of livelihood and lifestyle – i.e. the same main subsistence activities, main income activities and social and cultural practices – and who face the same risks of food and nutrition insecurity. (World Food Programme. Food Security Assessment Learning Repository)

Livelihood Strategies – the ways in which households utilize and combine their assets to obtain food, income and other goods and services. (World Food Programme. Food Security Assessment Learning Repository)

Low Birth-weight – babies born weighing less than 2,500 grams (5 pounds, 8 ounces). These newborns are especially vulnerable to illness and death during the first months of life. (Center for Disease Control and Prevention. 2007)

Malnutrition – all deviations from adequate nutrition, including undernutrition (and overnutrition) resulting from inadequacy of food (or excess food) relative to need and or disease. Malnutrition is often categorized in the following:

- **Chronic malnutrition (stunting)** – reflected by growth retardation, meaning a height-for-age score below -1, -2 or -3 Standard Deviations from the reference population (mild, moderate and severe stunting). It is due to chronic or temporary nutritional deficiencies (energy and/or micronutrients) during critical times, and/or it also can be the result of repeated exposure to infections or even to generally poor living conditions.
- **Acute malnutrition (wasting)** – low weight in relation to height/length or the presence of bilateral oedema. It reflects the adequacy of muscle and fat tissue.
- **Growth retardation (underweight)** – a mixture of stunting and wasting, this indicator measures the prevalence of children that have a low weight in relation to other children of their age. The same metric, the Z score (see definition) and cut-points -1, -2 and -3 are used to define mild, moderate and severe underweight status.

(Center for Disease Control and Prevention. 2007).

Mortality Rate – a measure of the number of deaths (in general, or due to a specific cause) in a given population over the total population per unit time. (World Health Organization)

Response Analysis –the process by which a set of appropriate actions is identified and based on: (a) the needs and livelihoods of the affected population; and (b) the operating environment. Simply put, response analysis is the process of connecting needs assessment or situational analysis to programme design. (Interagency Food Security and Nutrition Response Analysis Workshop. FAO. 2011)

Resilience – the ability of a system to resist or return to a normal state when faced with a hazard/shock or ongoing stress.

Risk – the combination of the probability of an event and its negative consequences. (United Nations International Strategy for Disaster Reduction. 2009)

Safety Nets – non-contributory transfer programmes targeted in some manner to the poor and those vulnerable to poverty and shocks (World Bank. 2011)

Shocks – events with negative impacts on nutrition status and/or food security. They can be natural or caused by human action. (World Food Programme. Food Security Assessment Learning Repository)

Sustainable Development – development that meets the needs of the present without compromising the ability of future generations to meet their own needs (World Bank. 2000).

Targeting – the processes and tools aimed at identifying eligible programme beneficiaries. Key targeting methods include means-testing (e.g. based on verified income), proxy-mean tests (e.g. based on information on observable characteristics like dwelling, asset ownership or demographic structure), geographic, community-based participatory approaches, and self targeting. (From Food Aid to Food Assistance: Innovations in Overcoming Hunger. World Food Programme. Rome. 2010)

Vulnerability – vulnerability is in relation to a hazard/shock, which leads to the possibility of negative outcomes. Vulnerability is a function of exposure, susceptibility and resilience. (WFP)

Wealth Ranking (categories) – a way of categorizing people in a community according to community members' perceptions of how well-off or poor people seem to be (for example, categories are typically "very poor", "poor", "better off", and "well-off"). (World Bank)

Z score (or standard deviation score) in anthropometric assessment – the deviation of the value for an individual from the median value of the reference population, divided by the standard deviation for the reference population. (UNICEF)



ANNEX 4: BIBLIOGRAPHY

Bibliography for IPC Manual Part 2: Protocols for Acute Food Insecurity Classification

Ballard, Terri; Coates, Jennifer; Swindale, Anne; and Deitchler, Megan (2011). Household Hunger Scale: Indicator Definition and Measurement Guide. Washington, DC: Food and Nutrition Technical Assistance II Project, FHI 360.

<https://www.fantaproject.org/sites/default/files/resources/HHS-Indicator-Guide-Aug2011.pdf>

Cafiero, C. Viviani, S. & Nord, M. 2017. Food security measurement in a global context: The food insecurity experience scale.

<http://dx.doi.org/10.1016/j.measurement.2017.10.065>

Cooperative for Assistance and Relief Everywhere, Inc. (CARE) (2008). CSI Field Methods Manual, Second Edition.

https://documents.wfp.org/stellent/groups/public/documents/manual_guide_proced/wfp211058.pdf

FAO (2001). Human energy requirements. Report of a Joint FAO/WHO/ONU Expert Consultation, Rome October 2001. Food and Nutrition Series Technical Report 1.

IFPRI (2009). IFPRI Discussion Paper 00870: Validation of the World Food Programme's Food Consumption Score and Alternative Indicators of Household Food Security.

IPC Global Partners (2012). Integrated Food Security Phase Classification Technical Manual Version 2.0. Evidence and Standards for Better Food Security Decisions. FAO. Rome.

<http://www.ipcinfo.org/ipcinfo-website/resources/resources-details/en/c/1129190/>

RHVP, Food Economy Group and Save the Children (2015). The Practitioners' Guide to the Household Economy Approach

<http://foodeconomy.com/wp-content/uploads/2015/09/The-Practitioners-Guide-to-HEA.pdf>

Swindale, Anne, and Paula Bilinsky (2006). Household Dietary Diversity Score (HDDS) for Measurement of Household Food Access: Indicator Guide (v.2). Washington, D.C.: FHI 360/FANTA.

https://www.fantaproject.org/sites/default/files/resources/HDDS_v2_Sep06_0.pdf

United Nations World Food Programme (2015), Food security analysis (VAM). Consolidated Approach to Reporting Indicators of Food Security (CAR) Guidelines.

Vaitla, Bapu; Coates, Jennifer; and Maxwell, Daniel (2015). Comparing Household Food Consumption Indicators to Inform Acute Food Insecurity Phase Classification. Washington, DC: FHI 360/Food and Nutrition Technical Assistance III Project (FANTA).

<https://www.fantaproject.org/research/comparing-household-food-consumption-indicators-acute-food-insecurity>

Bibliography for IPC Manual Part 2: Protocols for Acute Malnutrition Classification

ACF – International, SMART Initiative at ACF – Canada and CDC Atlanta (2014). Guidelines, Rapid SMART surveys for Emergencies. Version 1. September 2014

Bilukha, O and Leidman, E (2017) Concordance between the estimates of wasting measured by weight-for-height and by MUAC for classification of severity of nutrition crisis.

https://ec.europa.eu/jrc/sites/jrcsh/files/oleg_bilukha_day2_session4_room2.pdf

Cogill, B (2003). Anthropometric Indicators Measurement Guide. Food and Nutrition Technical Assistance Project, Academy for Educational Development, Washington, D.C.

FAO and FHI 360. 2016. Minimum Dietary Diversity for Women: A Guide for Measurement. Rome: FAO.
<http://www.fao.org/3/a-i5486e.pdf>

Global Nutrition Cluster. Harmonised Training Package Version 2 Modules.
<https://www.ennonline.net/ourwork/capacitydevelopment/htpversion2>

ICF. Demographic and Health Surveys (DHS).
<https://www.dhsprogram.com/Data/>

Inter-Agency Standing Committee (2008). Nutrition Cluster. A Toolkit for Addressing Nutrition in Emergency Situations. June 2008.

Myatt, M (2012) A short guide to undertaking surveys using the Simple Spatial Survey Method (S3M).
http://www.validinternational.org/coverage/workshop/articles_files/pictureBookS3M.pdf

Myatt, M et al (2012) Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)/Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage (SLEAC) Technical Reference. Washington, DC: FHI 360/FANTA.

Standardized Monitoring and Assessment of Relief and Transitions. SMART Methodology.
<http://smartmethodology.org/about-smart/>

The Sphere Project (2011). Humanitarian Charter and Minimum Standards in Disaster Response. Edition 2011.

UNHCR. Standardised Expanded Nutrition Survey.
<http://sens.unhcr.org/>

UNICEF. Multiple Indicator Cluster Surveys.
<http://mics.unicef.org/>

UNICEF (1992). A UNICEF Policy Review. Strategy for Improved Nutrition of Children and Women in Developing Countries. Second printing October 1992.

WHO (2010) Indicators for assessing infant and young child feeding practices. Part 1. Definitions.
http://apps.who.int/iris/bitstream/10665/43895/1/9789241596664_eng.pdf

WHO (2010) Nutrition Landscape Information System (NLIS). Country Profile Indicators. Indicator Guide.
https://www.who.int/nutrition/nlis_interpretation_guide.pdf



Bibliography for IPC Manual Part 2: Protocols for Chronic Food Insecurity Classification

Arsenault, Joanne (2015). Literature Review Part 1: Review of methods used in food security assessment to measure food consumption and estimate energy intake of households or individuals. Washington DC: FEWS NET and Chemonics International Inc.

Arsenault, Joanne (2015). Literature Review Part 2: Review of adaptability of adults and children to short and long-term energy restriction. Washington DC: FEWS NET and Chemonics International Inc.

Ballard, Terri; Coates, Jennifer; Swindale, Anne; and Deitchler, Megan (2011). Household Hunger Scale: Indicator Definition and Measurement Guide. Washington, DC: Food and Nutrition Technical Assistance II Project, FHI 360.

<https://www.fantaproject.org/sites/default/files/resources/HHS-Indicator-Guide-Aug2011.pdf>

FAO (2001). Human energy requirements. Report of a Joint FAO/WHO/ONU Expert Consultation, Rome, October 2001. Food and Nutrition Series Technical Report 1.

FAO and FHI 360 (2016). Minimum Dietary Diversity for Women: A Guide for Measurement. Rome: FAO.
<http://www.fao.org/3/a-i5486e.pdf>

IPC Global Partners (2012). Integrated Food Security Phase Classification Technical Manual Version 2.0. Evidence and Standards for Better Food Security Decisions. FAO. Rome.

<http://www.ipcinfo.org/ipcinfo-website/resources/resources-details/en/c/1129190/>

RHVP, Food Economy Group and Save the Children (2015). The Practitioners' Guide to the Household Economy Approach

<http://foodeconomy.com/wp-content/uploads/2015/09/The-Practitioners-Guide-to-HEA.pdf>

Swindale, Anne, and Paula Bilinsky (2006). Household Dietary Diversity Score (HDDS) for Measurement of Household Food Access: Indicator Guide (v.2). Washington, D.C.: FHI 360/FANTA.

https://www.fantaproject.org/sites/default/files/resources/HDDS_v2_Sep06_0.pdf

WHO (2010) Indicators for assessing infant and young child feeding practices. Part 1. Definitions.

http://apps.who.int/iris/bitstream/10665/43895/1/9789241596664_eng.pdf



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