

Addendum to the IPC Technical Manual
Version 2.0

Evidence and Standards
for Better Food Security Decisions

Tools and Procedures for Classification of
Acute Malnutrition

Approved by IPC Technical Advisory Group and Cleared by the IPC Steering Committee

11 November 2016

IPC

Integrated Food Security Phase Classification

Addendum to the IPC Technical Manual
Version 2.0

Evidence and Standards
for Better Food Security Decisions

Tools and Procedures for Classification of Acute Malnutrition

The Integrated Food Security Phase Classification (IPC) Global Partners



IPC Nutrition Working Group Partners



with the support of the Resource Partners:



The Integrated Food Security Phase Classification (IPC) Technical Manual Version 2.0 was published in 2012 by the IPC Global Partners.

Please cite this document as:

IPC Global Partners. 2016. *Addendum to IPC Technical Manual Version 2.0: IPC Tools and Procedures for Classification of Acute Malnutrition*. Rome.

This addendum to the IPC Technical Manual version 2.0 results from the joint efforts of the IPC Global Partners, a group of 12 agencies and international non-governmental organizations (INGOs) including: Action Against Hunger (ACF), Care International, the Permanent Interstate Committee for Drought Control in the Sahel (CILSS), the Food and Agriculture Organization of the United Nations (FAO), the Famine Early Warning Systems Network (FEWS NET), the Global Food Security Cluster (FSC), the Intergovernmental Authority on Development (IGAD) in Eastern Africa, the Joint Research Centre of the European Commission (EC–JRC), Oxfam, Save the Children UK/US, the Central American Integration System (SICA) and the United Nations World Food Programme (WFP). The Addendum has been developed by the IPC Chronic Working Group which was coordinated by the IPC Global Support Unit (GSU) under strategic leadership from IPC Global Partners. Leila Oliveira, IPC Senior Food Security Officer, coordinated the overall development, revision and production process.

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Foreword

The need for the Integrated Food Security Phase Classification (IPC) for Acute Malnutrition was first highlighted during the implementation of the IPC for Acute Food Insecurity (IPC for AFI). During the implementation of IPC for AFI it was observed that the levels of acute food insecurity and the prevalence of acute malnutrition did not always match. It was noted that, in some settings, while there were high levels of food insecurity, the prevalence of acute malnutrition was low. In some other settings, the situation was reverse – i.e. low levels of acute food insecurity with high levels of acute malnutrition. The reason for these differences is the fact that acute malnutrition, as an outcome, is influenced by many different factors other than food security. While some of these factors have negative impact on acute malnutrition other factors have a protective and mitigating effect.

Since IPC was first developed to classify the severity of food insecurity, nutrition was included in IPC mainly in relation to food security. It was decided not to merge food security with nutrition in the IPC as the information and response needs of the decision makers involved in these two sectors are different. Additionally, although these sectors need to be well coordinated and linked, **food insecurity and malnutrition also need specific responses that are usually co-ordinated by different line ministries**. Thus, a full nutrition analysis which would take into account all factors contributing to malnutrition was not met within the IPC food security analysis. This left an information gap for decision makers with regards to assessing the severity of acute malnutrition and identifying the contributing factors to acute malnutrition.

To address this gap, the IPC Steering Committee (SC) in early 2014 endorsed the development of an IPC for Acute Malnutrition based on the nutrition classification tool that was developed and used by FAO Food Security and Nutrition Analysis Unit (FSNAU) in Somalia. An **IPC Global Nutrition Working Group** (NWG) was subsequently formed to lead the technical normative development of the IPC for Acute Malnutrition and, after nearly 2 years of pilot testing and revisions, the protocols for IPC for Acute Malnutrition have now been finalised and are ready for use.

The main value added of IPC for Acute Malnutrition is that it enables classification of areas based on different methods and indicators of acute malnutrition (with clear parameters for minimal reliability needed), and also allows analysis and identification of key contributing factors to acute malnutrition. Furthermore, the IPC for Acute Malnutrition also supports projection of the situation and communication of actionable information linking to decision making.

The IPC for Acute Malnutrition Classification complements the IPC for Acute Food Insecurity Classification by providing information on non-food security related factors that contribute to acute malnutrition. Additionally, the outcome of the IPC AFI classification is used as an input in the IPC for Acute Malnutrition. IPC for Acute Malnutrition should ideally be carried out at the same unit of analysis and at the same time as the IPC for Acute Food Insecurity in order to ensure this complementarity.

The details of the IPC for Acute Malnutrition have been summarised and included in an **addendum to the IPC Technical Manual Version 2.0**, which outlines the IPC principles, core functions, and tools & procedures (protocols) involved in the IPC classification as well as the IPC for Acute Food Insecurity classification. It should be noted that another addendum to the IPC Technical Manual Version 2.0, IPC for Chronic Food Insecurity (CFI), finalised in 2014, describes the tools and procedures for classifying Chronic Food Insecurity. Together with the

IPC Technical Manual Version 2.0 and the addendum on the IPC CFI, this addendum provides a suite of IPC scales that can be used to analyse food insecurity and acute malnutrition situations.

The IPC for Acute Malnutrition scale follows the same core IPC principles including technical consensus building, convergence of evidence, accountability, transparency and comparability, and is conducted according to the four core IPC functions such as (1) Building Technical Consensus, (2) Classifying Severity and Causes, (3) Communicating for Action, and (4) Quality Assurance. Each of these functions comes with a set of procedures. This addendum provides an introduction to the IPC for Acute Malnutrition scale and covers functions 2 and 3 in detail.

This addendum is intended as a guide to organise and carry out the IPC for Acute Malnutrition analysis, which would **typically be initiated by an existing IPC Technical Working Group (TWG)**. However, if there is no TWG in country, an IPC for Acute Malnutrition analysis can still be carried out by forming a TWG for the analysis. Because of the different sectorial expertise needed within the IPC TWG for nutrition and food security analysis, a nutrition-relevant TWG Matrix is presented as Annex 1 of this addendum.

This addendum covers only sections related to the classification of severity and identification of drivers as well as communication for action. For additional information on the general IPC principles, functions, and protocols, the IPC Technical Manual (Version 2.0) should be consulted. In order to get a full understanding of the IPC approaches and processes, it is highly recommended that this addendum is used along with the IPC Technical Manual (version 2.0). This addendum does not provide guidance for use of malnutrition evidence for food security classification, including: (i) potential use of BMI and child & adult MUAC in IPC Acute Food Insecurity classification, (2) Use of Under 5 Death Rate for declaring a Famine; and (3) potential declaration of famine only based on food consumption and mortality. These issues will be addressed in detail in forthcoming Harmonized IPC Technical Manual version 3.0.

This addendum was developed by the IPC Global Support Unit (GSU) under the technical guidance and oversight of the IPC Nutrition Working Group.

Acknowledgements

The development of IPC for Acute Malnutrition started in April 2014 with the establishment of an IPC Nutrition Working Group. A prototype IPC for Acute Malnutrition tool was developed under the technical leadership of the IPC NWG in June 2014 and underwent pilot testing and revisions. The final version of the IPC for Acute Malnutrition scale was completed in December 2015 after 3 rounds of pilots involving 7 countries plus technical meetings and revisions to the prototype with the NWG. The IPC for Acute Malnutrition was cleared by the IPC Technical Advisory Group (TAG) and endorsed by the IPC Steering Committee in June 2016.

The IPC NWG was behind every step of the IPC for Acute Malnutrition development process. The NWG was coordinated by Douglas Jayasekaran with support from Kaija Korpi and Leila Oliveira. The efforts of the following members of the IPC NWG are highly appreciated:

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Ana Victoria Román	INCAP	Judy Roberts	Save the Children
Andrea Spray	World Bank	Kaija Korpi	IPC GSU
Andrew Hall	Save the Children	Kate Ogden	WFP
Andrew Seal	Institute of Child Health	Leila Oliveira	IPC GSU
Anne-Claire Thomas	JRC	Maman Williams	CILSS
Anne Callanan	gFSC	Marzella Wustefeld	UNSCN
Baoua Issoufou	CILSS	Monika Bloessner	WHO
Britta Schumacher	WFP	Nicte Ramirez	INCAP
Cecile Basquin	ACF	Nina Dodd	FSNAU
Christine McDonald	FEWS NET	Oleg Bilukha	CDC
Danka Pantchova	ACF	Perrine Geniez	WFP
Diane Holland	UNICEF	Rachel Lozano	ACF
Dolores Rio	UNICEF	Ricardo Sibrián	PRESANCA
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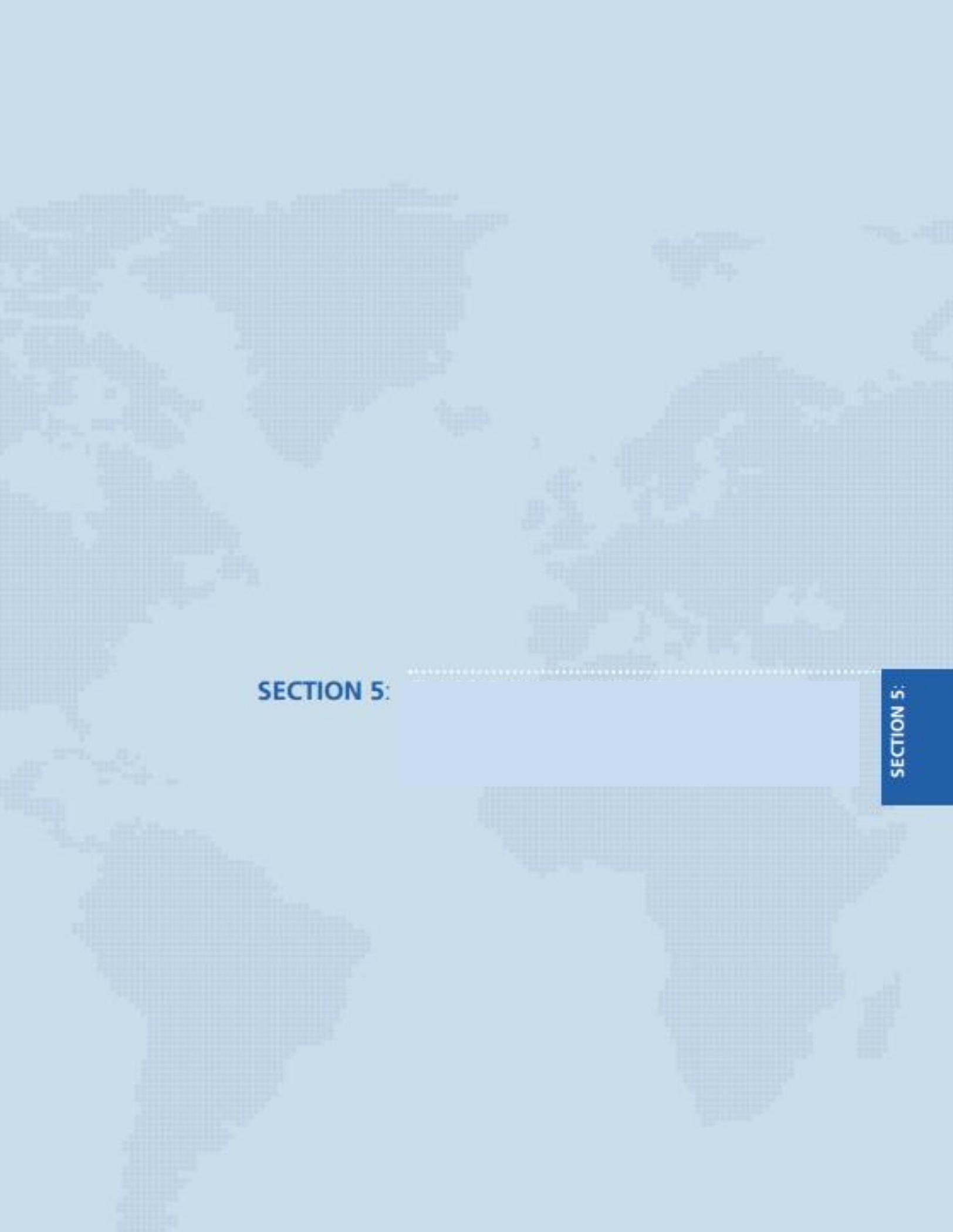
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Glossary of acronyms and abbreviations

AFI	Acute Food Insecurity
BCG	Bacille Calmette Guerin (Tuberculosis vaccine)
CDC	Centre for Disease Prevention and Control, Atlanta, USA
CFI	Chronic Food Insecurity
CDR	Crude Death Rate
CMAM	Community-based Management of Acute Malnutrition
DHS	Demographic and Health Survey
EPI	Expanded Program of Immunization
FSNAU	Food Security and Nutrition Analysis Unit
FSMS	Food Security Monitoring System
GAM	Global Acute Malnutrition
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
IDP	Internally Displaced Person/People
IPC	Integrated Food Security and Nutrition Phase Classification
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitude, and Practice
MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MDD	Minimum Dietary Diversify
MDD – W	Minimum Dietary Diversify - Women
MICS	Multiple Indicator Cluster Survey
MMF	Minimum Meal Frequency
MOH	Ministry Of Health
MUAC	Mid-Upper Arm Circumference
NGO	Non-Government Organization
NWG	Nutrition Working Group
S3M	Simple Spatial Surveying Method
SAM	Severe Acute Malnutrition
SC	Steering Committee
SD	Standard Deviation
SENS	Standardised Expanded Nutrition Survey
SMART	Standardized Methodology for Assessment in Relief and Transition
TAG	Technical Advisory Group
TWG	Technical Working Group
UN	United Nations
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children Fund
WFH	Weight-For-Height
WHO	World Health Organisation



SECTION 5:

Section 5B: Classifying Severity and Identifying Drivers of Acute Malnutrition

Why is the IPC for Acute Malnutrition Classification Needed?

IPC for Acute Malnutrition encompasses **classifying areas** based on the prevalence of acute malnutrition among children 6-59 months of age on a global scale, **identifying contributing factors** to acute malnutrition, and **recommending potential actions** to address acute malnutrition.

The IPC for Acute Malnutrition not only enables **classifications based on different methods and indicators of acute malnutrition** (with clear statements of the most reliable indicators), but also allows analysis and identification of key contributing factors to acute malnutrition. The IPC for Acute Malnutrition also permits projection of the situation, identification of data gap, and communication of actionable information linked to decision making.

The **IPC for Acute Malnutrition complements the IPC for Acute Food Insecurity** by providing information on non-food security related factors that contribute to malnutrition. Additionally, the outcome of the IPC for Acute Food Insecurity analysis is used as an input in the IPC for Acute Malnutrition. IPC for Acute Malnutrition should ideally be carried out at the same unit of analysis and at the same time as the IPC for Acute Food Insecurity in order to ensure this complementarity.

Specifically, IPC for Acute Malnutrition aims to answer the following questions:

- How severe is the acute malnutrition situation?
- Which geographical areas are worst affected by acute malnutrition?
- What are the contributing factors to acute malnutrition?

Key parameters in the IPC for Acute Malnutrition

Acute malnutrition is understood as a form of malnutrition¹ that occurs when an individual suffers from current, severe nutritional restrictions, a recent bout of illness, inappropriate childcare practices or, more often, a combination of these factors. It is characterised by extreme weight loss, resulting in low weight for height, and/or bilateral oedema, and, in its severe form, can lead to death². Although acute malnutrition can affect anyone, it is a particular problem among children less than 5 years of age. Acute malnutrition prevalence among children 6-59 months is also used as a good proxy for the nutrition situation in the entire population. The most visible consequences of acute malnutrition are weight loss (resulting in moderate or severe wasting) and/or nutritional oedema (i.e. bilateral swelling of the lower limbs, upper limbs and, in more advanced cases, the face).

Indicators used for classifying severity of Acute Malnutrition: In IPC for Acute Malnutrition, the classification is done based on the prevalence of Global Acute Malnutrition (GAM). GAM may be defined either by Weight-for-Height Z-score <-2 standard deviations and/or Oedema (referred to as GAM by WHZ in IPC) or Mid-Upper Arm Circumference (MUAC) <125mm and/or Oedema (referred to as GAM by MUAC in IPC). The preferred indicator in the IPC for Acute Malnutrition is GAM by WHZ and GAM by MUAC is only used when reliable evidence for WHZ is not available. Convergence of evidence is not used to classify severity of acute malnutrition in the IPC for Acute Malnutrition. When evidence is available on more than one indicator, classification will be based on one indicator

¹ Malnutrition encompasses both undernutrition, which include acute malnutrition, chronic malnutrition, and micronutrient deficiencies, as well as over-nutrition, which include overweight/obesity. IPC for Acute Malnutrition only focusses on acute malnutrition.

² Understanding malnutrition. Module 3. Harmonized Training Package. Version 2. 2011

to be selected in accordance with the preference ranking to arrive at the IPC Phase classification.

Five Phases: The IPC for Acute Malnutrition classifies the severity of acute malnutrition into five Phases. Classification of severity of acute malnutrition is done based on the prevalence of GAM, with higher prevalence characterizing the most severe phases.

Informing short and long term objectives to decrease acute malnutrition: Acute malnutrition as an outcome is affected by a range of factors. Some of these factors are structural such as maternal education while others are transitory such as disease epidemics and food crises. IPC for Acute Malnutrition has been developed in a way to inform both short term and long term objectives to address acute malnutrition. Although the classification also informs long term actions, these actions are aimed at decreasing acute malnutrition and not chronic malnutrition. Further complementary assessments and analysis of chronic malnutrition and chronic food insecurity should support design of interventions with middle and long-term objectives to decrease also chronic malnutrition.

Seasonality based analysis: Both the current as well as the projection analysis of the IPC for Acute Malnutrition are seasonality based – i.e. analysis should be based on a particular season such as lean season, dry season, harvest season, and so on. This is similar to a typical IPC for Acute Food Insecurity analysis. This facilitates the current as well as projection analysis since the acute malnutrition levels typically fluctuate between different seasons. Before any analysis is carried out, the seasons for the current analysis as well as for the projection must be clearly defined.

Unit of Analysis: Geographical areas, usually admin level 2 or 3, form the unit of analysis in the IPC for Acute Malnutrition.

Area Classification: Areas are classified into 5 different Phases based on the prevalence of GAM. The IPC for Acute Malnutrition does not enable classification of individuals or households (note that even though acute malnutrition is measured at the individual level, the total GAM prevalence is estimated for an entire area). However, acute malnutrition among specific population groups – for example Internally Displaced Persons (IDPs) in a camp or pastoralists – can be analysed and included in the maps if reliable evidence is available to support classification.

Minimum quality: Trustworthiness and methodology of the indicators are taken into account in IPC for Acute Classification through the use of reliability scores. Only areas with reliable information from the same season of analysis will be classified for current classification.

Data Sources: Data on GAM (either by WHZ or MUAC) used in the IPC for Acute Malnutrition can come from the following sources: (a) representative surveys, (b) sentinel sites, or (c) screening (either exhaustive or sample screening). IPC minimum criteria and reliability scores have been set for each source of data with the most reliable source of data being representative surveys.

A Snapshot in Time. The severity classification is a “snapshot in time” of acute malnutrition conditions that are: (1) currently happening; and/or (2) projected for a specified time in the future.

Projection: The projection is akin to an early warning statement but is not restricted to projecting when the situation might get worse. The time period for the projection is entirely up to the IPC analysts’ and decision-makers’ needs. For highly dynamic situations (e.g. floods, political unrest, etc.) the projection could be a matter of weeks into the future. And for slow onset situations it may be longer. Nevertheless, this should ideally match with a particular season. Projections can be still be done even if there are no GAM estimates for classification of current Phase, as long as there are at least 3 GAM estimates available for the same season in the past.

Timing of Analysis. IPC for Acute Malnutrition analysis should ideally be conducted simultaneously with IPC for Acute Food Insecurity analysis, so as to inform programme design and early warning that focus on improving acute food security and nutrition conditions.

Humanitarian Assistance. The classification of the current situation is referenced on actual outcomes (GAM by WHZ or GAM by MUAC) irrespective of whether humanitarian or development assistance is being provided. For projections, assistance is included in the most likely scenario if it is inter-annual (meaning it is provided every year on a regular basis) or if it is short-term humanitarian/emergency assistance that is currently programmed, funded, and is most likely to be continued into the projection period and reach beneficiaries. Newly planned or appealed for assistance is not included in the projected classification.

Evidence-based. Evidence in support of the classification must be documented in the IPC Analysis Worksheet, including an assessment of reliability of the evidence. There are minimum criteria that have been set up for the type of evidence that need to be used in the assessment of reliability.

Identification of contributing factors. The IPC for Acute Malnutrition provides tools and procedures for identifying contributing factors to acute malnutrition. Immediate causes, underlying, as well as basic causes of acute malnutrition are analysed so that major contributing factors can be identified. The identification of contributing factors is based on a convergence of evidence. This requires the whole body of evidence to be examined, including food and non-food security contributing factors and outcomes following the UNICEF Analytical framework (see Box 1 below for discussion on how the UNICEF Analytical framework is used to support IPC for Acute Malnutrition classification). Interventions can therefore be designed to address these contributing factors aiming to reduce levels of acute malnutrition.

Applicability of the Scale: The IPC for Acute Malnutrition scale is typically applicable to countries or areas within countries where acute malnutrition is of concern – i.e. GAM levels are more than 5%. However, the scale can also be used in places where acute malnutrition is increasing or when there is a value added of understanding the relationship between low levels of acute malnutrition and high severity of acute food insecurity to support more strategic decision making.

Multi-agency and multi-sectorial analysis: Like IPC for Acute Food Insecurity and IPC for Chronic Food Insecurity, the IPC for Acute Malnutrition is a multi-agency and multi sectorial analysis carried out under a technical working group – see Annex 1 for the Technical Working Group Matrix developed specifically for the NWG.

Box 1: Use of the UNICEF Conceptual Framework on Malnutrition to guide IPC for Acute Malnutrition

The IPC for Acute Malnutrition uses the UNICEF Conceptual Framework on Malnutrition (see below) as the analytical framework in the analysis. The different elements in the framework (such as manifestation, immediate causes, underlying causes, and basic causes) have been used to organize the analysis worksheet to facilitate the IPC for Acute Malnutrition analysis.

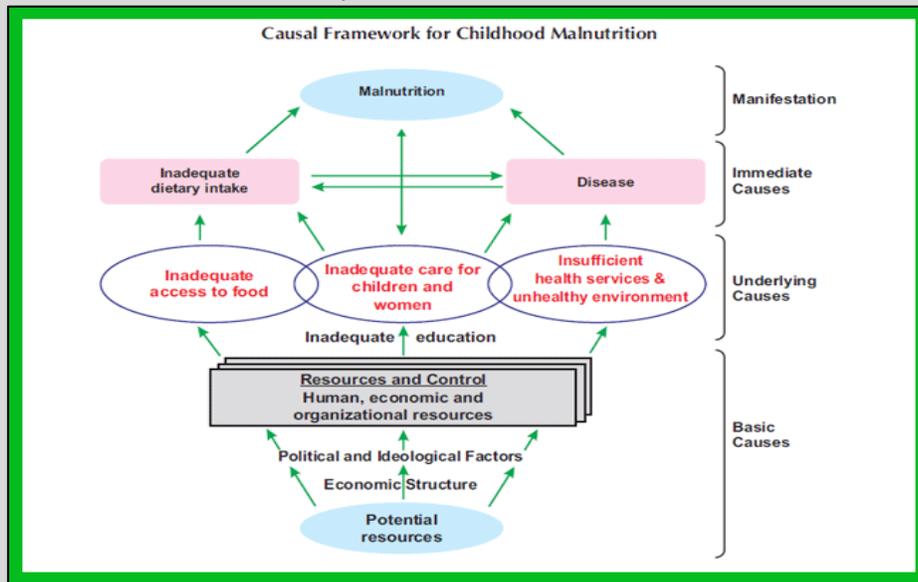


Figure 1: UNICEF Conceptual Framework on Malnutrition

Manifestation

Acute malnutrition is the final manifestation (or outcome) in the IPC for Acute Malnutrition scale. There are two outcome indicators (both measured on children between 6 to 59 months of age) that are looked at in the analysis: (1) Global Acute Malnutrition by Weight-for-Height Z-score (GAM by WHZ) and (2) Global Acute Malnutrition by Mid Upper Arm Circumference (GAM by MUAC). Based on the information available, one of these two outcome indicators is used to classify areas into one of the five IPC Phases.

Immediate, underlying, and basic causes

Following the UNICEF Conceptual Framework on Malnutrition, specific indicators have been identified and included under immediate, underlying, and basic causes in the analysis worksheet to guide analysis (see Diagram 1 below). These are collectively referred to as **contributing factors** in the IPC for Acute Malnutrition.

Tools for classifications and identifying contributing factors

The following tools are used for arriving at classification and identifying contributing factors to malnutrition: (1) IPC for Acute Malnutrition Reference Table, (2) IPC for Acute Malnutrition Table of Indicators for Contributing Factors and Other Issues, and (3) IPC for Acute Malnutrition Analysis Worksheet. Each of these tools is presented and explained in details below.

IPC for Acute Malnutrition Reference Table

The IPC for Acute Malnutrition Reference Table (see Diagram 1 below) provides names and descriptions of the 5 Phases as well as priority responses for each Phase. The Reference Table is used to classify an area into one of 5 Phases. Although the IPC for Acute Malnutrition typically classifies an area under consideration, there may be special population groups such as IDPs within an area and they may also be classified and highlighted separately if needed.

Diagram 1: IPC for Acute Malnutrition Reference Table

USAGE: Classification of areas based on the prevalence of Global Acute Malnutrition (GAM) measured either by Weight for Height Z-score and/or oedema (WHZ) or Mid-Upper Arm Circumference and/or oedema (MUAC).

PURPOSE: To guide decision-making on addressing acute malnutrition in the short and long term.

Phase Name and Description	PHASE 1 Acceptable	PHASE 2 Alert	PHASE 3 Serious	PHASE 4 Critical	PHASE 5 Extreme critical
		Less than 5% of children are acutely malnourished by GAM by WHZ measure or Less than 6% of children are acutely malnourished by GAM by MUAC measure	Even with any humanitarian assistance, about 5-10% of children are acutely malnourished by GAM by WHZ measure or about 6-11% of children are acutely malnourished by GAM by MUAC measure.	Even with any humanitarian assistance, about 10-15% of children are acutely malnourished by GAM by WHZ measure or about 6-11% of children are acutely malnourished by GAM by MUAC measure.	Even with any humanitarian assistance, 15-30% of children are acutely malnourished by GAM by WHZ measure or 11-17% of children are acutely malnourished by GAM by MUAC measure, showing conditions for excess mortality ³ .
Priority Response Objective to decrease Acute Malnutrition ⁴	Maintain the low prevalence of acute malnutrition	Strengthen existing response capacity and resilience. Address contributing factors to malnutrition. Monitor conditions and plan response as required.	Urgently reduce acute malnutrition levels through →		Addressing widespread acute malnutrition and death by all means. Also address all causes of malnutrition through greater scaling up of all public health programme interventions in close co-ordination with all other sectors.
GAM by WHZ) <-2 standard deviation and/or Oedema	< 5%	5.0 to 9.9%	10.0 to 14.9%	15.0 to 29.9%	≥30%
GAM by MUAC < 125 mm and/or Oedema	<6%	6.0 to 10.9%		11.0 to 16.9%	≥17%
Notes:					
1) The use of MUAC as an alternative for classification and the cut-offs are provisional and pending validation. The GAM by MUAC cut-offs are based on CDC analysis of survey data (unpublished) that best correlate with the WHZ thresholds. Further analyses are also currently underway to determine the need for regional thresholds and potential use of convergence of evidence for classification of severity of acute malnutrition. The application of these thresholds will be evaluated through IPC for Acute Malnutrition Lessons Learning Process in 2016/17. IPC for Acute Malnutrition done by MUAC will have a lower confidence level, which will be indicated by hash lines on the IPC maps.					
2) GAM by WHZ may come from representative surveys or sentinel sites and GAM by MUAC may come from representative surveys, sentinel sites, or screening (either exhaustive or sample screening). See box 2 below for details on reliability score, preference ranking as well as minimum criteria to be considered when conducting IPC for Acute Malnutrition.					
3) GAM by WHZ is preferred over GAM by MUAC. If GAM by WHZ and GAM by MUAC are both available, GAM by WHZ should be used in the classification. If information is available on multiple indicators preference ranking should be used to determine the final Phase.					

³ Refers to the increased risk of mortality with the increased levels of acute malnutrition

⁴ Priority response objectives recommended by the IPC for Acute Malnutrition 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, etc.

Box 2: Reliability Score, Preference Ranking, and Minimum Criteria for Outcome Indicators

Reliability Score

Reliability Score (RS) indicates the trustworthiness of the information used in the classification and it depends mainly on quality of data, which in turn depends on data collection methods and field practices. RS can be either very reliable (RS: 2) or reliable (RS: 1). Data on outcomes that does not have at least RS of 1 should not be used in the IPC for Acute Malnutrition. Information from representative surveys typically have RS of 2, unless they are 'validated with caution' – see details below. Reliability score should be highlighted in maps using asterisk (i.e. ** or *). Table 2 details RS for the different sources of data.

Preference ranking

The outcome indicators used in the IPC for Acute Malnutrition (i.e. GAM by WHZ and GAM by MUAC) may come from different sources such as representative surveys, sentinel sites, and screening. However, only **one** outcome indicator is used to determine the final Phase of an area. Preference Ranking should be used to select one outcome indicator and determine the final Phase when information is available on more than one indicator. Table 2 below provides details on the Preference Ranking.

Table 1: Reliability Scores and Preference Ranking for Use of Outcome Indicators

Indicator and Methods	Reliability Score 1=reliable 2=very reliable	Preference Ranking
GAM by WHZ from representative survey	2/1 ⁵	1
GAM by WHZ from sentinel sites	1	2
GAM by MUAC from representative survey	2	3
GAM by MUAC from exhaustive screening	2	4
GAM by MUAC from sentinel sites	1	5
GAM by MUAC from screening	1	6

Minimum Criteria for Different Source of Information Used in the IPC for Acute Malnutrition

A) Representative surveys:

(1) Surveys should be representative at the unit of analysis, validated by the in-country nutrition cluster or nutrition information working group, and from the same season (2) If surveys are 'validated with caution'⁶ and weight-for-height standard deviation (SD) is >1.2, the calculated prevalence (rather than the observed prevalence⁷) should be used; this will be highlighted in the maps, (3) If surveys are validated with caution but SD is <1.2, observed prevalence should be used, (4) Surveys from the same season of analysis validated with caution will get the reliability score of 1, (5) If there is no survey validation mechanism in place in a country, a survey should only be used in the classification based on the Plausibility Check results as follows: Plausibility check score <15: use without any restrictions – apply Reliability 2, Plausibility check score 15-25: use with caution – apply Reliability 1, Plausibility check score >25: do not use, (6) Anthropometric data coming from Food Security Monitoring Systems (FSMS) or other cross sectional surveys will be considered for classifications provided that they meet minimum standards for nutrition surveys as previously defined and observe the following: Sampling design is done at the unit of analysis, and have a minimum of 25 clusters per unit of analysis (if 20-24 clusters, seek expert advice from SMART technical group or UNICEF/nutrition cluster. If the number of clusters per unit of analysis is <20 clusters, the survey results should not be used), (7) If surveys are covering only part of the unit of analysis, only the area covered by the survey will be classified, (8) MUAC results from representative surveys at the unit of analysis should follow the guidance for surveys, (9) For Simple Spatial Surveying Method (S3M) surveys the following are recommended: Administrative level with at least 20 clusters/sites and at least 200 children can be used as a unit of analysis and aforementioned Plausibility check should be applied to the anthropometric data collected in S3M

B) Sentinel sites

(1) Sentinel sites are usually purposively selected based on some pre-set criteria, (2) Anthropometric data coming from sentinel sites should have: (a) at least 75 children who are randomly selected per site and (b) at least 4 sites per unit of analysis⁸, (3) Prevalence will be calculated by taking average from all sites in a given unit of analysis (no weights will be applied), (4) No trend data will be used in the classification however trend data may be used (same season in the previous year(s)) in the interpretation of the results, (5) Data from sentinel sites will be subjected to the same Plausibility Checks that of the surveys and be used only if the Plausibility Check Score is <15, (6) Repeated MUAC screening data from the same areas for referral purposes should be treated as sentinel site data, (7) Data can be either based on MUAC or weight-for-height

C) Screening:

(1) The selection of children should be random or exhaustive, (2) At least 200 children per site should be measured (or all children measured if exhaustive, in that case can be <200 per site) and there should be at least 3 different sites per unit of analysis, (3) The screening should have been carried out in the same season as analysis in all sites if seasonality is an issue, (4) Age distribution must not be skewed – check the quality of MUAC data using the CDC quality check for MUAC data, including digit preference for MUAC and age/sex ratios (5) Provided that MUAC screening is representative and exhaustive, raw data is available, and quality is checked, exhaustive MUAC screening at the unit of analysis level will get reliability score of 2, (6) Prevalence estimates from each screening site should be calculated separately, (7) If all prevalence estimates converge and indicate the same phase, it will be taken as the final phase; if not, final phase will be determined using consensus – if there's no consensus, this data will not be used in the analysis, (8) When there is no age information on MUAC data, the data will be used in the classification under the following conditions: (a) screening is exhaustive and (b) have at least 200 children measured per site with at least 3 different sites, (9) If screening is done on a monthly basis, the latest information from the season of analysis should be used, (10) Data from ad-hoc rapid assessments conducted to quickly assess the situation should be treated as screening.

Table of Indicators for the Analysis of Contributing Factors and Other Issues

The Table of Indicators for Contributing Factors & Other Issues provides a list of indicators (see Diagram 2 below) that, when available, should be assessed when conducting analysis of contributing factors. The Table of Indicators is organized as per the UNICEF Conceptual Framework on Malnutrition – i.e. immediate, underlying, and basic causes. The table also contains some other related outcomes, such as mortality, anaemia and low birth weight. Although these outcomes do not cause acute malnutrition and their occurrence may or may not be related to acute malnutrition, it is useful to assess co-existence of those and type of relationship to acute malnutrition so as to better inform decision making.

Diagram 2: Table of Indicators for the Analysis of Contributing Factors and Other Issues

USAGE: Help identify factors that may be contributing to acute malnutrition in an area; it also helps identify other key issues related to malnutrition such as anaemia that may be of concern in the area of analysis. For definition and sources of these indicators, see table 1.	
PURPOSE: To be used to facilitate analyses of contributing factors to support design and focus of response planning.	
C1. IMMEDIATE CAUSES: INADEQUATE DIETARY INTAKE	
C1.1	Minimum Dietary Diversity (MDD)
C1.2	Minimum Meal Frequency (MMF)
C1.3	Minimum Acceptable Diet (MAD)
C1.4	Minimum Dietary Diversity – Women (MDD-W) ⁹
C2. IMMEDIATE CAUSES: DISEASES	
C2.1	Diarrhoea
C2.2	Dysentery
C2.3	Malaria/fever
C2.4	Acute Respiratory Infection (ARI)
C2.5	HIV/AIDS prevalence
C2.6	Cholera or Acute Watery Diarrhoea (AWD)
C2.7	Measles
C3. UNDERLYING CAUSES: INADEQUATE ACCESS TO FOOD	
C3.1	The outcome of the IPC for Acute Food Insecurity analysis should be used in the analysis of food security as a contributing factor to acute malnutrition in the analysis
C4. UNDERLYING CAUSES: INADEQUATE CARE FOR CHILDREN AND WOMEN	
C4.1	Exclusive breastfeeding under 6 months
C4.2	Continued breastfeeding at 1 year
C4.3	Continued breastfeeding at 2 years
C4.4	Introduction of solid, semi-solid or soft foods by 6 months of age
C5. UNDERLYING CAUSES: INSUFFICIENT HEALTH SERVICES & UNHEALTHY ENVIRONMENT	
<i>Access to health and nutrition services</i>	
C5.1	Routine measles vaccination coverage
C5.2	Routine polio vaccination coverage
C5.3	Routine vitamin A supplementation coverage
C5.4	Campaign measles vaccination coverage

⁵ Nutrition surveys are validated by the national authorities 'with caution' for methodological issues or quality of data will get a RS of 1

⁶ In some cases, surveys are validated with caution by the in-country nutrition cluster or nutrition information working group because of concerns related to data quality, representativeness, etc.

⁷ Information on SD, calculated prevalence, and observed prevalence can be obtained from annex of a SMART survey report; for additional information on plausibility check, please visit: <http://smartmethodology.org/survey-planning-tools/smart-methodology/>

⁸ IPC NWG Recommendation

⁹ 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)]

C5.5	Campaign polio vaccination coverage
C5.6	Campaign vitamin A supplementation
C5.7	Measles vaccination coverage from surveys
C5.8	Polio vaccination coverage from surveys
C5.9	Vitamin A supplementation coverage from surveys
C5.10	Coverage of all basic vaccinations from surveys
C5.11	Skilled attendant at delivery
C5.12	Health seeking behaviour
C5.13	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both) ¹⁰
Access to safe WASH	
C5.14	Access to a sufficient quantity of water ¹¹
C5.15	Access to improved sanitation facilities
C5.16	Access to an improved source of drinking water
D1. OTHER ISSUES: OTHER OUTCOMES	
D1.1	Anaemia among children 6-59 months ¹²
D1.2	Anaemia among pregnant women ¹³
D1.3	Anaemia among non-pregnant women ¹⁴
D1.4	Vitamin A deficiency among pre-school children (6 – 71 months) ¹⁵
D1.5	Vitamin A deficiency among non-pregnant women (15 – 49 years) ¹⁶
D1.6	Low birth weight
D1.7	Fertility rate
D2. OTHER ISSUES: MORTALITY	
D2.1	Crude Death Rate (CDR) ¹⁷
D2.2	Under Five Death Rate (U5DR) ¹⁸

Wherever existent, international thresholds have been included in the Table of Indicators in order to help interpret the situation. Because only 10 out of the 39 indicators have internationally recognized thresholds, these were included as footnotes at the end of the table. Where there are no international thresholds, national thresholds where available and time-trend analysis may be used to interpret the results.

The Table of Indicators for the Analysis of Contributing Factors and Other Issues provides only a list of main indicators that should be assessed during the analysis of contributing factors to acute malnutrition. Other indicators that are not in the list may also be added and assessed during the analysis, if it is deemed necessary by the analysts and the IPC in-country TWG. For example, deworming coverage could be added and looked at as an additional indicator if worms are an issue in the area of analysis.

¹⁰ Rural areas: >50% | urban areas: >70% | camp situation: >90%. Sphere standard

¹¹ Phase 1: usually adequate (> 15 litres ppp day), stable | Phase 2: borderline adequate (15 litres ppp day); unstable | Phase 3: 7.5-15 litres ppp day, accessed via asset stripping | Phase 4: < 7.5 litres ppp day (human usage only) Phase 5: l. < 4 litres ppp day (human usage only). PC for Acute Food Insecurity Reference Table.

¹² Normal: ≤ 4.9% | Mild: 5 – 19.9% | Moderate: 20 – 39.9% | Severe: ≥ 40%

¹³ Normal: ≤ 4.9% | Mild: 5 – 19.9% | Moderate: 20 – 39.9% | Severe: ≥ 40%

¹⁴ Normal: ≤ 4.9% | Mild: 5 – 19.9% | Moderate: 20 – 39.9% | Severe: ≥ 40%

¹⁵ Mild: ≥2 – 10% | Moderate: ≥10 – <20% | Severe: ≥20%

¹⁶ Mild: ≥2 – 10% | Moderate: ≥10 – <20% | Severe: ≥20%

¹⁷ 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 in the map. IPC for Acute Food Insecurity

¹⁸ Minimal/stressed: <1 | Crisis: 1 to <2 | Emergency: 2 to <4 | Famine : >4. IPC for Acute Food Insecurity

The validity period for information on contributing factors is 3 years preceding the analysis – i.e. data on contributing factors from the last 3 years preceding the analysis can be used in the analysis. When information on a certain indicator is available at different time period within the last 3 years, the most recent information should be included in the analysis worksheet but trend-analysis should be used to assess current and seasonal levels. It should however be noted that the most recent data from the same season of analysis should be included in the analysis on indicators that are affected by seasonality (e.g. malaria outbreak).

Unlike the outcome indicators, information on contributing factors from a higher administrative unit may also be used in the analysis of contributing factors optimally accompanied by analysis on the expected difference between the two levels of administrative units. Analysis of observed difference should be based on the analysts' expert judgement of available evidence. For example, if information on exclusive breastfeeding is only available at the provincial level (administrative level 1) and the unit of analysis is district (administrative level 2), expert judgement based on evidence and knowledge should be made on the status of exclusive breastfeeding at the district level – i.e. whether it is similar, more or less than the provincial level estimate and the reason for this expert judgement should be documented. Similarly, when information on contributing factors is only available at a lower administrative level than the analysis unit, similar procedure should be followed.

It should be noted that the IPC for Acute Malnutrition does not employ any statistical procedures or mathematical modelling in the analysis of contributing factors. A simple analysis is carried out based on the prevalence or seasonal trends of each of these indicators, group discussions, and finally arriving at possible contributing factors to malnutrition in a given area through consensus – see below for details.

Table 2: Definition and potential sources of indicators used in IPC for Acute Malnutrition

B	ACUTE MALNUTRITION OUTCOME INDICATOR	DEFINITION	SOURCE	REMARKS
B.1	GAM by WHZ from Representative Survey	Percentage of children between 6-59 months with WHZ <-2 and/or oedema from representative surveys	SMART Surveys, Rapid SMART, FSMS, KAP surveys, S3M, national nutrition surveys, DHS, and MICS.	Refer to box 2 above for minimum criteria for this indicator – this is of particular important for Knowledge, Attitude, and Practice (KAP) surveys as they can be qualitative.
B.2	GAM by MUAC from Representative Survey	Percentage of children between 6-59 months with MUAC <125mm and/or oedema from representative surveys	SMART Surveys, Rapid SMART, FSMS, KAP surveys, S3M, and national nutrition surveys	Refer to box 2 above for minimum criteria for this indicator – this is of particular important for KAP surveys as they can be qualitative.
B.3	GAM by WHZ from Sentinel Site Data	Percentage of children between 6-59 months with WHZ <-2 and/or oedema from sentinel site data	Sentinel site information system	Refer to box 2 above for minimum criteria for this indicator
B.4	GAM by MUAC from Sentinel Site Data	Percentage of children between 6-59 months with MUAC <125mm and/or oedema from sentinel site data	Sentinel site information system	Refer to box 2 above for minimum criteria for this indicator
B.5	GAM by MUAC from Screening Data	Percentage of children between 6-59 months with MUAC <125mm and/or oedema from screening data	MUAC screening and rapid assessment	Refer to box 2 above for minimum criteria for this indicator
B.6	GAM by MUAC from Exhaustive Screening Data	Percentage of children between 6-59 months with MUAC <125mm and/or oedema from screening data	MUAC screening and rapid assessment	Refer to box 2 above for minimum criteria for this indicator

ANALYSIS OF CONTRIBUTING FACTORS BASED ON THE UNICEF CONCEPTUAL FRAMEWORK ON MALNUTRITION				
C1. IMMEDIATE CAUSES: INADEQUATE DIETARY INTAKE				
INDICATORS	DEFINITION	SOURCE	REMARKS	
C1.1	Minimum Dietary Diversity (MDD)	Percentage of children 6–23 months of age who receive foods from 4 or more food groups	SMART surveys, KAP surveys, S3M, IYCF assessments, DHS, and MICS	It is measured using 24 hour recall.
C1.2	Minimum Meal Frequency (MMF)	Percentage of breastfed and non-breastfed children 6–23 months of age who receive solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more	SMART surveys, KAP surveys, S3M, IYCF assessments, DHS, and MICS	MMF varies by age of the child and breastfeeding status – i.e. 2 times for breastfed infants 6–8 months; 3 times for breastfed children 9–23 months; and 4 times for non-breastfed children 6–23 months. It is measured using 24 hour recall.
C1.3	Minimum acceptable diet (MAD)	Percentage of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk)	SMART surveys, KAP surveys, S3M, IYCF assessments, DHS, and MICS	This is a composite indicator calculated using MDD and MMF – i.e. proportion of children who meet both MDD and MMF.
C1.4	Minimum Dietary Diversity – Women (MDD-W)	Percentage of women of reproductive age (15-49 years old) who consumed foods from at least 5 food groups the previous day, using a standardized list of 10 food groups	SMART surveys, KAP surveys, S3M, IYCF assessments, DHS, MICS, and Living Standards Survey	MDD-W is a new indicator. It is being integrated into living standard measurement surveys in some countries. It may be incorporated in other surveys as well.
C2. IMMEDIATE CAUSES: DISEASES				
INDICATORS	DEFINITION	SOURCE	REMARKS	
C2.1	Diarrhoea	Percentage of children 6-59 months who have had diarrhoea (3 or more loose or watery stools per 24 hour period) in the last two weeks prior to the survey	SMART surveys, KAP, S3M, DHS, and MICS	
C2.2	Dysentery	Percentage of children aged 6-59 months who had bloody diarrhoea in the last two weeks prior to the survey	SMART surveys, KAP, S3M, DHS, and MICS	
C2.3	Malaria/fever	Percentage of children aged 6-59 months who had malaria/fever in the last two weeks prior to the survey	SMART surveys, KAP, S3M, DHS, and MICS	
C2.4	Acute Respiratory Infection (ARI)	Percentage of children aged 6-59 months who had ARI in the last two weeks prior to the survey	SMART surveys, KAP, S3M, DHS, and MICS	
C2.5	HIV/AIDS prevalence	Percentage of adults (15-49 years) living with HIV/AIDS	HIV/AIDS surveys, DHS, and MOH reports	
C2.6	Cholera or Acute Watery Diarrhoea (AWD)	A case of cholera is confirmed when Vibrio cholera O1 or O139 is isolated from any patient with diarrhoea; Laboratory confirmation of the first 10–20 cases is essential to ascertain that this is a cholera outbreak	MOH reports	Any outbreak must be confirmed by the national health authorities. If there is cholera/AWD, additional include information on the scale (i.e. number of people affected) and any available response under remarks
C2.7	Measles	The definition of measles outbreak will vary according to the phase of measles control in a country.	MOH reports	Any outbreak must be confirmed by the national health authorities
C3. UNDERLYING CAUSES: INADEQUATE ACCESS TO FOOD				
OUTCOME OF THE IPC FOR ACUTE FOOD INSECURITY ANALYSIS	DEFINITION	SOURCE	REMARKS	
C3.1	Classification of the IPC for Acute Food Insecurity analysis – IPC Product or IPC Compatible, when IPC Product is unavailable	Refer to IPC for AFI	IPC for AFI communication template	
C4. UNDERLYING CAUSES: INADEQUATE CARE FOR CHILDREN AND WOMEN				
INDICATORS	DEFINITION	SOURCE	REMARKS	

C4.1	Exclusive breastfeeding under 6 months	Proportion of infants 0–5 months of age who are fed exclusively with breast milk.	SMART surveys, KAP, S3M, DHS, and MICS	
C4.2	Continued breastfeeding at 1 year	Proportion of children 12–15 months of age who are fed breast milk.	SMART surveys, KAP, S3M, DHS, and MICS	
C4.3	Continued breastfeeding at 2 years	Proportion of children 20–23 months of age who are fed breast milk.	SMART surveys, KAP, S3M, DHS, and MICS	
C4.4	Introduction of solid, semi-solid or soft foods by 6 months of age	Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods.	SMART surveys, KAP, S3M, DHS, and MICS	
C5. UNDERLYING CAUSES: INSUFFICIENT HEALTH SERVICES & UNHEALTHY ENVIRONMENT				
INDICATORS		DEFINITION	SOURCE	REMARKS
C5.1	Routine measles vaccination coverage	Proportion of children 12-23 months of age vaccinated against measles through routine immunisation services	EPI/MOH	These indicators shows how well the health facilities are functioning
C5.2	Routine polio vaccination coverage	Proportion of children 12-23 months of age vaccinated against polio (all 4 doses) through routine immunisation services	EPI/MOH	
C5.3	Routine vitamin A supplementation coverage	Proportion of children 6-59 months of age provided with vitamin A supplementation through routine immunisation services in the past 6 months	EPI/MOH	
C5.4	Campaign measles vaccination coverage	Proportion of children vaccinated against measles through immunisation campaigns	Coverage surveys, SMART surveys, KAP, S3M, DHS, and MICS	
C5.5	Campaign polio vaccination coverage	Proportion of children vaccinated against polio (all 4 doses) through immunisation campaigns	Coverage surveys, SMART surveys, KAP, S3M, DHS, and MICS	
C5.6	Campaign vitamin A supplementation	Proportion of children 6-59 months of age provided with vitamin A supplementation during immunisation campaigns in the past 6 months	Coverage surveys, SMART surveys, KAP, S3M, DHS, and MICS	
C5.7	Measles vaccination coverage from surveys	Proportion of children 12-23 months of age vaccinated against measles assessed from surveys	SMART surveys, KAP, S3M, DHS, and MICS	
C5.8	Polio vaccination coverage from surveys	Proportion of children 12-23 months of age vaccinated against polio (all 4 doses) assessed from surveys	SMART surveys, KAP, S3M, DHS, and MICS	
C5.9	Vitamin A supplementation coverage from surveys	Proportion of children 6-59 months of age provided with vitamin A supplementation assessed from surveys	SMART surveys, KAP, S3M, DHS, and MICS	
C5.10	Coverage of all basic vaccinations from surveys	Proportion of children aged 12-23 months vaccinated against all basic vaccines in the country assessed from surveys	SMART surveys, KAP, S3M, DHS, and MICS	According to WHO, children are considered to have received all basic vaccinations when they have received a vaccination against tuberculosis (also known as BCG), three doses each of the DPT-HepB-Hib (also called pentavalent) and polio vaccines, and a vaccination against measles
C5.11	Skilled attendant at delivery	Percentage of births attended by skilled health personnel (doctors, nurses or midwives)	SMART surveys, KAP, S3M, DHS, and MICS	
C5.12	Health seeking behaviour	Percentage of caregivers who sought treatment from health facilities for treatment for common childhood illnesses	SMART surveys, KAP, S3M, DHS, and MICS	Follow up question usually included for children who were sick in the last 2 weeks preceding the survey.
C5.13	Coverage of outreach programmes – CMAM programme	Proportion of children with acute malnutrition who receive CMAM care	Coverage surveys	

	coverage (SAM, MAM, or both)			
C5.14	Access to a sufficient quantity of water	Proportion of households that use an adequate quantity of water per person per day (for drinking, cooking, personal & domestic hygiene – minimum 15 litres per person per day)	SMART surveys, KAP, and S3M	Information on the quantity of water per person per day is usually limited. In these cases, distance to water source could be used as an additional indicator.
C5.15	Access to improved sanitation facilities	Proportion of households with access to improved sanitation facilities	SMART surveys, KAP, S3M, DHS, and MICS	An improved sanitation facility is one that hygienically separates human excreta from human contact. The types of toilets that are likely to meet this criterion are: flush to piped sewer system, flush to septic tank, pour flush to pit, composting toilet, VIP (Ventilated Improved Pit) latrine, and pit latrine with a floor/slab.
C5.16	Access to an improved source of drinking water	Proportion of households with access to an improved source of drinking water	SMART surveys, KAP, S3M, DHS, and MICS	Improved water sources include a piped water supply into the home or a yard/plot, a public tap/standpipe, a tube well/borehole (with pump), a protected dug well, a protected spring, bottled water, and rainwater collection
D1. OTHER ISSUES: OTHER OUTCOMES				
OTHER OUTCOMES		DEFINITION	SOURCE	REMARKS
D1.1	Anaemia among children 6-59 months	Proportion of children 6-59 months having anaemia	SMART surveys, SENS, KAP, S3M, DHS, and MICS	Hemoglobin levels are measured in grams per deciliter (g/dl); <11 g/dl is considered anaemia
D1.2	Anaemia among pregnant women	Proportion of pregnant women having anaemia	SMART surveys, SENS, KAP, S3M, DHS, and MICS	Hemoglobin levels are measured in grams per deciliter (g/dl) ; <11 g/dl is considered anaemia
D1.3	Anaemia among non-pregnant women	Proportion of non-pregnant women having anaemia	SMART surveys, SENS, KAP, S3M, DHS, and MICS	Hemoglobin levels are measured in grams per deciliter (g/dl) <12 g/dl is considered anaemia
D1.4	Vitamin A deficiency among pre-school children (6 – 71 months)	Proportion of pre-school children (6 – 71 months) with vitamin A deficiency	SMART surveys, SENS, KAP, S3M, DHS, and MICS	Measured by serum retinol; serum retinol 0.70 µmol/l or below constitutes deficiency
D1.5	Vitamin A deficiency among non-pregnant women (15 – 49 years)	Proportion of non-pregnant women (15 – 49 years) with vitamin A deficiency	SMART surveys, SENS, KAP, S3M, DHS, and MICS	Measured by serum retinol; serum retinol 0.70 µmol/l or below constitutes deficiency
D1.6	Low birth weight	Proportion of low live births out of the total of live births during the same time period	MOH records	Live births with less than 2.500 g are considered low birth weight
D1.7	Fertility rate	Mean number of children ever born to women age 40-49 years	DHS	
D2. OTHER ISSUES: MORTALITY				
MORTALITY		DEFINITION	SOURCE	REMARKS
D2.1	Crude Death Rate (CDR)	Total number of deaths per 10,000 people per day	SMART surveys	The CDR should exclude trauma related deaths
D2.2	Under Five Death Rate (U5DR)	Total number of deaths among children less than 5 years of age per 10,000 children less than 5 years of age per day	SMART surveys	The U5DR should exclude trauma related deaths

IPC for Acute Malnutrition Analysis Worksheet

The analysis worksheet (see Diagram 3 below – to be included) helps organise the information required for the analyses so that analysts can conduct a structured analysis. It has been designed in a way that both current as well as the projection analyses are carried out in the same analysis worksheet. Moreover, the analysis worksheet is also designed based on the UNICEF Conceptual Framework. One analysis worksheet must be filled in for each area of analysis.

Diagram 3: IPC for Acute Malnutrition Analysis Worksheet

IPC FOR ACUTE MALNUTRITION		
ANALYSIS WORKSHEET		
SECTION A: GENERAL ANALYSIS INFORMATION		
STEP 1: DEFINE ANALYSIS AREA		
A1. GENERAL INFORMATION	AREA OF ANALYSIS:	<i>[Write the name of area for which analysis is carried out]</i>
	DATE OF ANALYSIS	<i>[Write the date on which you are filling out this worksheet - (DD/MM/YYYY)]</i>
A2. CURRENT ANALYSIS	SEASON OF CURRENT ANALYSIS	<i>[Write the agricultural season for which the analysis is carried out – e.g. pre-harvest, post-harvest, lean, etc.]</i>
	VALIDITY OF CURRENT ANALYSIS	<i>[Specify months for which the current analysis is expected to be valid (e.g. from Jun. to Aug. 2016)]</i>
A3. PROJECTION ANALYSIS	SEASON OF PROJECTION ANALYSIS	<i>[Write the agricultural season for which the projection is carried out – e.g. pre-harvest, post-harvest, lean, etc.]</i>
	VALIDITY OF PROJECTION	<i>[Specify months for which the projection is expected to be valid (e.g. Sept. to Nov. 2016)]</i>
<p>DESCRIPTION OF THE ANALYSIS AREA AND POPULATION: <i>Describe the general characteristics of the area and the population. Indicate if it is an aid or semi-arid area, usual characteristics of the season (e.g. rainy season usually results in flooding); include information on the characteristics of the population in the area – e.g. pastoralists, agro-pastoralists, etc.; include total and under 5 population in the area.</i></p>		
STEP 2: DOCUMENT EVIDENCE IN REPOSITORY <i>[Fill out the document repository included at the end of this worksheet]</i>		

SECTION B: IPC FOR ACUTE MALNUTRITION PHASE CLASSIFICATION							
STEP 3: ANALYSE EVIDENCE ON ACUTE MALNUTRITION OUTCOME INDICATORS					STEP 8: IDENTIFY POTENTIAL CHANGES IN THE OUTCOME INDICATORS		
ACUTE MALNUTRITION OUTCOME INDICATORS [For definition and sources of these indicators, see Table 2 above]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC ¹⁹	PREVA- LENCE ²⁰	PHASE ²¹	TECHNICAL REMARKS ²²	POTENTIAL CHANGE ²³	EXPLANATION FOR THE PROJECTED CHANGE ²⁴
B.1	GAM by WHZ from Representative Survey (Reliability Score 2, Preference Ranking 1)						
B.2	GAM by WHZ from Sentinel Sites (Reliability Score 1, Preference Ranking 2)						
B.3	GAM by MUAC from Representative Survey (Reliability Score 2, Preference Ranking 3)						
B.4	GAM by MUAC from Exhaustive Screening (Reliability Score 2, Preference Ranking 4)						
B.5	GAM by MUAC from Sentinel Sites (Reliability Score 1, Preference Ranking 5)						
B.6	GAM by MUAC from Screening (Reliability Score 1, Preference Ranking 6)						

SUMMARY OF IPC FOR ACUTE MALNUTRITION			
STEP 4: DETERMINE PHASE (CURRENT)		STEP 9: MAKE PHASE CLASSIFICATION (PROJECTION)	
CURRENT SITUATION		PROJECTED SITUATION	
PHASE ²⁵	INDICATOR, RELIABILITY SCORE, AND PREFERENCE RANKING	PHASE ⁸	INDICATOR, RELIABILITY SCORE, AND PREFERENCE RANKING
	<i>Specify Indicator, Reliability Score, and Preference Ranking – e.g. GAM by WHZ from Representative Survey (Reliability Score 2, Preference Ranking 1)</i>		<i>Specify Indicator, Reliability Score, and Preference Ranking – e.g. GAM by WHZ from Representative Survey (Reliability Score 2, Preference Ranking 1)</i>

¹⁹ Documentation Code (DC): Write the document code given to this information in the document repository

²⁰ Write the prevalence estimate, without confidence intervals

²¹ Indicate the Phase, in number (between 1 and 5). Refer to IPC for Acute Malnutrition Reference Table for details.

²² Indicate issues with data quality, representativeness, etc.

²³ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

²⁴ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

²⁵ Indicate the Phase, in number (between 1 and 5)

SECTION C: ANALYSIS OF CONTRIBUTING FACTORS BASED ON THE UNICEF CONCEPTUAL FRAMEWORK ON MALNUTRITION

[ANALYSIS OF THESE INDICATORS WILL INFORM ON POTENTIAL CONTRIBUTING FACTORS TO ACUTE MALNUTRITION IN THE AREA OF ANALYSIS]

C1. IMMEDIATE CAUSES: INADEQUATE DIETARY INTAKE

STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – IMMEDIATE CAUSES				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES		
INDICATORS [For definition and sources of these indicators, see Table 2 above]		CURRENT SITUATION		PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC ²⁶	PREVA-LENCE ²⁷	TECHNICAL REMARKS ²⁸	POTENTIAL CHANGE ²⁹	EXPLANATION FOR THE POTENTIAL CHANGE ³⁰
C1.1	Minimum Dietary Diversity (MDD)					
C1.2	Minimum Meal Frequency (MMF)					
C1.3	Minimum Acceptable Diet (MAD)					
C1.4	Minimum Dietary Diversity – Women (MDD-W)					
<i>Other indicators (include any other indicator that may also be considered under inadequate dietary intake; add additional rows if necessary):</i>						
C1.5						

²⁶ Documentation Code (DC): Write the document code given to this information in the document repository

²⁷ Write the prevalence estimate, without confidence intervals

²⁸ Indicate issues with data quality, representativeness, etc.

²⁹ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

³⁰ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

³¹ Include any other information that should be considered in the projection

C2. IMMEDIATE CAUSES: DISEASES

STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – IMMEDIATE CAUSES (CONT.)				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)		
INDICATORS [For definition and sources of these indicators, see Table 2 above]		CURRENT SITUATION		PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC ³²	PREVA- LENCE ³³	TECHNICAL REMARKS ³⁴	POTENTIAL CHANGE ³⁵	EXPLANATION FOR THE POTENTIAL CHANGE ³⁶
C2.1	Diarrhoea					
C2.2	Dysentery					
C2.3	Malaria/fever					
C2.4	Acute Respiratory Infection (ARI)					
C2.5	HIV/AIDS prevalence					
<i>Disease outbreaks (are there disease outbreaks? If yes, include the following)</i>						
C2.6	Cholera or Acute Watery Diarrhoea (AWD) ³⁸					
C2.7	Measles					
<i>Other outbreaks (are there any other disease outbreak? If yes, include it in the row below ; add additional rows if necessary)</i>						
C2.8						
<i>Other indicators (include any other diseases that may also be relevant in the context of analysis; add additional rows if necessary)</i>						
C2.9						

³² Documentation Code (DC): Write the document code given to this information in the document repository

³³ Write the prevalence estimate, without confidence intervals

³⁴ Indicate issues with data quality, representativeness, etc.

³⁵ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

³⁶ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

³⁷ Include any other information that should be considered in the projection

³⁸ If there is cholera/AWD, additional include information on the scale (i.e. number. of people affected) and any available response under remarks

C3. UNDERLYING CAUSES: INADEQUATE ACCESS TO FOOD

STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – UNDERLYING CAUSES				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
OUTCOME OF THE IPC FOR ACUTE FOOD INSECURITY ANALYSIS		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC ³⁹	OUTCOME ⁴⁰	TECHNICAL REMARKS ⁴¹	POTENTIAL CHANGE ⁴²	EXPLANATION FOR THE POTENTIAL CHANGE ⁴³	PROJECTED PHASE ⁴⁴
C3.1	Classification of the IPC for Acute Food Insecurity analysis – IPC Product or IPC Compatible, when IPC Product is unavailable						

C4. UNDERLYING CAUSES: INADEQUATE CARE FOR CHILDREN AND WOMEN

STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – UNDERLYING CAUSES (CONT.)				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
INDICATORS [For definition and sources of these indicators, see Table 2 above]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC ²²	PREVALENCE ⁴⁵	TECHNICAL REMARKS ⁴⁶	POTENTIAL CHANGE ²⁴	EXPLANATION FOR THE POTENTIAL CHANGE ²⁵	REMARKS ⁴⁷
C4.1	Exclusive breastfeeding under 6 months						
C4.2	Continued breastfeeding at 1 year						
C4.3	Continued breastfeeding at 2 years						
C4.4	Introduction of solid, semi-solid or soft foods						
<i>Other indicators (include other indicators relevant for analysis of inadequate care for children and women; add additional rows if necessary)</i>							
C4.5							

³⁹ Documentation Code (DC): Write the document code given to this information in the document repository

⁴⁰ Indicate the overall Phase of the IPC for Acute Food Insecurity Analysis

⁴¹ Indicate specific food security issues most relevant to acute malnutrition, issues with data quality, representativeness, age of data, etc.

⁴² Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

⁴³ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

⁴⁴ If the IPC for Acute Food Insecurity analysis did not include projection analysis, determine the food security outlook for the projection period with the help of food security specialists.

⁴⁵ Write the prevalence estimate, without confidence intervals

⁴⁶ Indicate issues with data quality, representativeness, etc.

⁴⁷ Include any other information that should be considered in the projection

C5. UNDERLYING CAUSES: INSUFFICIENT HEALTH SERVICES & UNHEALTHY ENVIRONMENT

STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – UNDERLYING CAUSES (CONT.)							STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)		
INDICATORS [For definition and sources of these indicators, see Table 2 above]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]				
		DC ⁴⁸	PREVA-LENCE ⁴⁹	TECHNICAL REMARKS ⁵⁰	POTENTIAL CHANGE ⁵¹	EXPLANATION FOR THE POTENTIAL CHANGE ⁵²	REMARKS ⁵³		
Access to health and nutrition services									
C5.1	Routine measles vaccination coverage								
C5.2	Routine polio vaccination coverage								
C5.3	Routine vitamin A supplementation coverage								
C5.4	Campaign measles vaccination coverage								
C5.5	Campaign polio vaccination coverage								
C5.6	Campaign vitamin A supplementation								
C5.7	Measles vaccination coverage from surveys								
C5.8	Polio vaccination coverage from surveys								
C5.9	Vitamin A supplementation coverage from surveys								
C5.10	Coverage of all basic vaccinations from surveys								
C5.11	Skilled attendant at delivery								
C5.12	Health seeking behaviour ⁵⁴								
C5.13	Coverage of outreach programmes – CMAM (SAM, MAM, or both)								
Access to safe WASH									
C5.14	Access to a sufficient quantity of water								
C5.15	Access to improved sanitation facilities								
C5.16	Access to an improved source of drinking water								
Other indicators (include other indicators relevant under insufficient health services & unhealthy health environment; add additional rows if necessary):									
C5.17									

⁴⁸ Documentation Code (DC): Write the document code given to this information in the document repository

⁴⁹ Write the prevalence estimate, without confidence intervals

⁵⁰ Indicate issues with data quality, representativeness, etc.

⁵¹ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

⁵² [Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period]

⁵³ Include any other information that should be considered in the projection

⁵⁴ It may be reported for every single disease or in total; if it is reported by individual diseases, include each disease by adding additional rows

C6. BASIC CAUSES

STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – BASIC CAUSES				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)		
BASIC CAUSES ⁵⁵	CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
	DC ⁵⁶	COLOUR/SHADE THE CELL AS	SUMMARY CONCLUSIONS ⁵⁷	POTENTIAL CHANGE ⁵⁸	EXPLANATION FOR THE POTENTIAL CHANGE ⁵⁹	REMARKS ⁶⁰
		<div style="display: flex; flex-direction: column; align-items: center;"> <div style="width: 15px; height: 15px; background-color: red; margin-bottom: 2px;"></div> MAJOR <div style="width: 15px; height: 15px; background-color: yellow; margin-bottom: 2px;"></div> MINOR <div style="width: 15px; height: 15px; background-color: pink; margin-bottom: 2px;"></div> NOT A CONTRIBUTING FACTOR⁶¹ <div style="width: 15px; height: 15px; background-color: white; margin-bottom: 2px;"></div> NO DATA </div>				
C6.1 Human Capital <i>[Consider aspects of education and literacy rate, inter-generational knowledge transfer, presence of healthy working members and dependency ratio, limited human resources due to disease burden and lack of access to health care etc., and how these aspects contribute to acute malnutrition in your area of analysis; for e.g., if maternal education is poor, it's likely to be a cause of concern for acute malnutrition as there is a clear link between maternal education and child acute malnutrition]</i>						

⁵⁵ Consider how each of these capitals contributes to acute malnutrition in your area of analysis; there are specific issues listed below under each capital for consideration. Some of these aspects may be poor while others maybe in a better situation in the area of your analysis. Consider all aspects when determining whether a particular capital may be a major, minor, or not a contributing factor. Specify the aspects that indicates the worst situation under remarks

⁵⁶ Documentation Code (DC): Write the document code given to this information in the document repository

⁵⁷ Based on the available data, describe how a given capital is likely to impact on acute malnutrition

⁵⁸ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

⁵⁹ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

⁶⁰ Include any other information that should be considered in the projection

⁶¹ Based on available data and your discussion in the group decide if a given capital is a major, minor, or not a contributing factor; shade the corresponding cell accordingly; where data is available, include the prevalence estimates for the indicators you considered

C6.2	Physical Capital <i>[Consider constraints in terms of housing, water and sanitation facilities (including whether sharing or ownership), roads, markets and access to markets, time to collect water, availability and functionality of basic services such as health and education facilities etc., and how they may impact on acute malnutrition in your area of analysis; for e.g., poor sanitation facilities may lead to improper disposal of human waste, which in turn may cause diseases and acute malnutrition]</i>															
C6.3	Financial Capital <i>[Consider what income and cash resources the group has access to, including diversity and stability of income sources, access to microcredit, investment groups, resilience of sources to common shocks, access to loans, and savings among others; for e.g., there is an established link between poverty and acute malnutrition and cash transfers have positive impact on the reduction of acute malnutrition]</i>															
C6.4	Natural Capital <i>[Consider assets related to bio-physical environment, such as proximity to water bodies, forest, soil and climatic condition, access to forests, existence of minerals and other resources, arable land, etc. in your area of analysis and their impact on acute malnutrition; for e.g., while being close to water improves access to water it also reduces the time spent on collecting water, which in turn will increase the time available to care for children]</i>															
C6.5	Social Capital <i>[Consider social cohesion and the connectedness, discrimination of groups, such as women and ethnic minorities, community conversations, mother to mother and other support groups, beliefs on food, and social support with remittances. Consider cultural practices that have an impact on acute malnutrition; for e.g., women not being allowed to go outside home within the 30 days of delivery in some communities would likely result in better caring and improved nutrition of the children]</i>															
C6.6	Policies, Institutions and Processes (PIPs) <i>[Consider macro and micro-level policies and processes such as safety nets, school feeding, cash vouchers, food aid and other social safety nets, universal education policies and their possible impact on acute malnutrition;</i>															

	<i>for e.g., universal healthcare for children under 5 would likely lead to increased health seeking while children are sick and improved nutrition]</i>						
C6.7	Usual/Normal Shocks <i>[Consider common and usual shocks that do not result in crises but negatively impact on acute malnutrition – e.g. dry spells, lack of rainfall, human, livestock and plant diseases; for e.g., dry spells that may be cyclical (but not at crisis level) may still increase the incidence of diseases and acute malnutrition during that time period]</i>						
C6.8	Unusual Shocks <i>[Consider how much of a negative impact unusual crises have had on acute malnutrition; for e.g., unusual flooding may lead to increase of diseases and acute malnutrition]</i>						
Other Basic Causes (include other relevant basic causes)							
C6.9							

SECTION D: OTHER ISSUES							
D1. OTHER ISSUES: OTHER OUTCOMES							
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – OTHER OUTCOMES				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
OTHER OUTCOMES [For definition and sources of these indicators, see Table 2 above]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC ⁶²	PREVA- LENCE ⁶³	TECHNICAL REMARKS ⁶⁴	POTENTIAL CHANGE ⁶⁵	EXPLANATION FOR THE POTENTIAL CHANGE ⁶⁶	REMARKS ⁶⁷
D1.1	Anaemia among children 6-59 months						
D1.2	Anaemia among pregnant women						
D1.3	Anaemia among non-pregnant women						
D1.4	Vitamin A deficiency among pre-school children (6 – 71 months)						

⁶² Documentation Code (DC): Write the document code given to this information in the document repository

⁶³ Write the prevalence estimate, without confidence intervals

⁶⁴ Indicate issues with data quality, representativeness, etc.

⁶⁵ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

⁶⁶ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

⁶⁷ Include any other information that should be considered in the projection

D1.5	Vitamin A deficiency among non-pregnant women (15 – 49 years)						
D1.6	Low birth weight						
D1.7	Fertility rate						
Other indicators (include other nutrition related issues that may also be of concern; add additional rows if necessary)							
D1.8							

D2. OTHER ISSUES: MORTALITY							
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES - MORTALITY				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
MORTALITY [For definition and sources of these indicators, see Table 2 above]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC⁴²	DEATH RATE⁶⁸	TECHNICAL REMARKS⁶⁹	POTENTIAL CHANGE⁴⁵	EXPLANATION FOR THE POTENTIAL CHANGE⁴⁶	REMARKS⁴⁷
D2.1	Crude Death Rate (CDR)						
D2.2	Under Five Death Rate (U5DR)						

D. OTHER ISSUES: FEEDING PROGRAMMES							
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – FEEDING PROGRAMMES				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
FEEDING PROGRAMMES [For definition and sources of these indicators, see Table 2 above]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC⁷⁰	STATUS⁷¹	TECHNICAL REMARKS⁷²	POTENTIAL CHANGE⁷³	EXPLANATION FOR THE POTENTIAL CHANGE⁷⁴	REMARKS⁷⁵
D3.1	Feeding programme admission trends						

⁶⁸ Write the death rate, without confidence intervals

⁶⁹ Indicate severity, issues with data quality, representativeness, etc.

⁷⁰ Documentation Code (DC): Write the document code given to this information in the document repository

⁷¹ Increasing/decreasing/stable compared to the same season the previous year

⁷² Describe the main reasons for the increase/decrease/stable admission trends

⁷³ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

⁷⁴ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

⁷⁵ Include any other information that should be considered in the projection

SECTION E: PROTECTIVE FACTORS

STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – PROTECTIVE FACTORS				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
INDICATOR [For definition and sources of these indicators, see Table 2 above]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC ⁵⁰	YES/NO ⁷⁶	TECHNICAL REMARKS ⁷⁷	POTENTIAL CHANGE ⁵³	EXPLANATION FOR THE POTENTIAL CHANGE ⁷⁸	REMARKS ⁷⁹
E1.1	Social safety net programmes						
E1.2	Micronutrient supplementation programmes						
E1.3	Dietary supplementation programmes						

STEP 6: IDENTIFY MAJOR CONTRIBUTING FACTORS AND OTHER ISSUES				
SUMMARY CONTRIBUTING FACTORS [Based on the analysis above, indicate if each of the contributing factors is a major, minor, or not a contributing factor in the analysis area; note that, e.g. of all the indicators listed under inadequate dietary intake, some of them may be major while others may be minor or not contributing factors; justify your reasons under summary conclusions]		COLOUR/SHADE THE CELL AS		SUMMARY CONCLUSIONS
		 MAJOR	 MINOR	
		 NOT A CONTRIBUTING FACTO ⁸⁰	 NO DATA	
Inadequate dietary intake	Minimum Dietary Diversity (MDD)			
	Minimum Meal Frequency (MMF)			
	Minimum Acceptable Diet (MAD)			
	Minimum Dietary Diversity – Women (MDD-W)			
	Others			
Diseases	Diarrhoea			

⁷⁶ Indicate whether these exist in your area of analysis

⁷⁷ Describe the coverage, target group, etc. of these programmes

⁷⁸ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

⁷⁹ Include any other information that should be considered in the projection

⁸⁰ Based on available data and your discussion in the group decide if a given capital is a major, minor, or not a contributing factor; shade the corresponding cell accordingly; where data is available, include the prevalence estimates for the indicators you considered

	Dysentery		
	Malaria		
	HIV/AIDS prevalence		
	Acute Respiratory Infection		
	Disease outbreak		
	Others		
Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis		
Inadequate care for children	Exclusive breastfeeding under 6 months		
	Continued breastfeeding at 1 year		
	Continued breastfeeding at 2 years		
	Introduction of solid, semi-solid or soft foods		
	Others		
Insufficient health services & unhealthy environment	Measles vaccination		
	Polo vaccination		
	Vitamin A supplementation		
	Skilled birth attendance		
	Health seeking behaviour		
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)		
	Access to a sufficient quantity of water		
	Access to sanitation facilities		
	Access to an improved source of drinking water		
	Others		
Basic causes	Human capital		
	Physical capital		
	Financial capital		
	Natural capital		
	Social capital		
	Policies, Institutions and Processes		
	Usual/Normal Shocks		
	Recurrent Crises due to Unusual Shocks		
	Other basic causes		
Other nutrition issues	Anaemia among children 6-59 months		
	Anaemia among pregnant women		

	Anaemia among non-pregnant women		
	Vitamin A deficiency among children 6-59 months		
	Low birth weight		
	Fertility rate		
	Others		

STEP 10: IDENTIFY LIMITATIONS OF THE ANALYSIS

Limitations of the analysis
[What are the main limitations in the analysis?]:

-

STEP 11: SUGGEST PRIORITY RESPONSE

Priority response objectives:
[Based on the above analysis, suggest appropriate response objectives to the current situation; separate the objectives as immediate/short term and medium to long term categories]:

A) Immediate/short-term response objectives:
 -

B) Medium to Long term response objectives:
 -

IPC FOR ACUTE MALNUTRITION

DOCUMENT REPOSITORY

DOCUMENT CODE [Extend the table as needed]	REFERENCE				REMARKS AND RAW DATA EVIDENCE [Indicate representativeness, quality, etc. of the report; where possible, also include the raw evidence such as graph, image, table, etc.]
	NAME OF REPORT [Write the exact name of the report]	SOURCE OF REPORT [Write the name(s) of agency(ies) that published the report]	DATA COLLECTION PERIOD [Write the dates during which the data was collected]	DATE OF PUBLICATION [Write the date in which the report was published]	
1					
2					
3					
4					
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Procedures for arriving at classifications and identifying contributing factors

The following 11-Step analysis procedure has been developed to guide the classification of areas based on the prevalence of GAM, identifying major contributing factors to acute malnutrition, and preparing projections.

Table 3: IPC for Acute Malnutrition Analysis Steps

Analysis Step	Description
Step 1	Define analysis area and season of analysis
Step 2	Document evidence in repository
Step 3	Analyse evidence on outcome indicators
Step 4	Determine Phase (current)
Step 5	Analyse evidence on contributing factors and other issues
Step 6	Identify major contributing factors and other issues
Step 7	Forecast likely changes in the contributing factors and other issues
Step 8	Forecast likely changes in the outcome indicators
Step 9	Determine Phase (projection)
Step 10	Identify limitations of the analysis
Step 11	Suggest priority response objectives

Step 1: Define analysis area and season of analysis

The first step in the IPC for Acute Malnutrition analysis is the definition of the area and the season of analysis. Note that the season can be lean, dry, rainy, harvesting, etc. Since there is a relationship between acute malnutrition and seasonality, it is necessary to link an analysis to a particular season.

In IPC for Acute Malnutrition, the classification of areas can be done at any administrative level – i.e. province, district, county, etc. However, there is a need to ensure that the choice of analysis units complements the analysis units used for the IPC for Acute Food Insecurity classification, is relevant for decision making, and evidence is available at those levels to arrive at a classification. The season of the analysis should also be defined in step 1 since the IPC for Acute Malnutrition analysis is based on seasonality. Like the area of analysis, the seasonality of the analysis should also be synchronised with the IPC for Acute Food Insecurity analysis. The area of the analysis and the seasonality of the analysis should be documented in the analysis worksheet as follows:

- **General Information:** Indicate the area and the date of analysis. Note that one analysis worksheet must be filled in for each area of analysis and both current as well as projection analyses are carried out on the same analysis worksheet.
- **Current analysis:** Specify the season and validity period of the current analysis. The current analysis is usually valid for a specific season and it should be specified in calendar months.
- **Projection analysis:** Similar to the current analysis above, specify the season and validity period of projection analysis. Like the current analysis, validity period for the projection analysis is also usually a particular season that should be indicated in calendar months.
- **Description of the area and population:** Provide some general characteristics of the area and the population such as arid, semi-arid zone, pastoralist population, etc. Also include estimated total population and under 5 population.

Step 2: Document evidence in repository

All evidence relevant to the area of analysis should be gathered and referenced before any analysis is carried out. The evidence is organised with a document code that will be used to refer to the evidence in the analysis worksheet when the analysis is conducted. It is important to note that some evidence may be available at a different administrative level – e.g. exclusive breastfeeding may be available only at the provincial level while the analysis is carried out at the district level but it is important to include this in the document repository as it will be used in the analysis. It should also be noted that the validity period for the contributing factors is 3 years preceding the analysis. Therefore, all relevant information during the past 3 years should be included.

- **Name of report:** Write the title of the report as it appears in the report.
- **Source of report:** Indicate the name(s) of agency (ies) that published the report.
- **Data collection period:** Specify the dates during which the data was collected. Note that in the case of outcome indicators that are collected over more than one season, the season in which majority of the data was collected should be considered in the classification.
- **Date of publication:** Indicate the date on which the report was published
- **Remarks and evidence:** Include information on the representativeness of the data (if the report covers a different admin level than the one covered in the analysis), quality of the data, etc. If the results are available in graphs or table, insert them.

Step 3: Analyse evidence on outcome indicators

Insert available evidence on all six outcome indicators that meet the IPC for Acute Malnutrition criteria that are listed in step 3.

- **DC:** DC refers to Document code. Enter the document code for the evidence from the document repository. The order of the evidence in the repository does not matter.
- **Prevalence:** Specify the prevalence estimate for the indicator.
- **Phase:** Determine the IPC for Acute Malnutrition Phase based on the reference table and indicate the number (between 1 and 5).
- **Technical remarks:** Describe if there is any concern about the data quality, representativeness of the data, reliability of the evidence, etc.

Step 4: Determine Phase (current)

The final phase classification is arrived at using only **one** of the six outcome indicators. If information is available on more than one outcome indicator, the indicator for determining the classification should be selected based on the preference ranking detailed in table 1. For example, if information on GAM by WHZ from Representative Survey, GAM by WHZ from Sentinel Sites, and GAM by MUAC from Screening are all available, the final classification should be decided based on GAM by WHZ from Representative Survey as this has the preference ranking of 1.

- **Phase:** indicate the Phase as a number (between 1 and 5)
- **Indicator, reliability score, and preference ranking:** Specify the indicator that is used to determine the Phase and also specify the RS as well as the preference ranking for that indicator.

Step 5: Analyse evidence on contributing factors and other issues

In step 5, analysts insert and analyse data on the contributing factors to acute malnutrition as well as some other common issues that are of concern. While the contributing factors are organised based on the UNICEF Conceptual Framework on Malnutrition, the other issues are listed separately.

- **DC:** DC refers to Document code. Enter the document code for the evidence from the document repository.
- **Prevalence:** Specify the prevalence estimate for the indicator.
- **Technical remarks:** Describe if there are any concerns about the data quality, representativeness of the data, etc. If there are no such issues, there is no need to fill in this section.

It should be noted that Step 5 is organized into various topics such as immediate causes, underlying causes, basic causes, other issues. The DC, prevalence, and technical remarks (as mentioned above) are common to all indicators, except for C.3. Underlying causes: inadequate access to food, for C.6. basic causes, and for some sub-sections of D: other issues. The specific aspects that are considered under these topics are illustrated below:

- **Underlying Causes: Inadequate Access to Food**
 - **IPC Acute Food Insecurity Classification:** Inadequate access to food refers to the classification of the IPC for Acute Food Insecurity analysis for this area. This will be provided by the team conducting the food security analysis. Indicate the Acute Food Insecurity Phase number (1 to 5).
- **Basic Causes**
 - **Capitals:** Different capitals (human, financial, physical, social and natural) are looked at as possible contributing factors to malnutrition in the area of analysis. Each capital covers a range of issues that are relevant for acute malnutrition. Analysts should conclude to what extent these capitals contribute to acute malnutrition as they may be a major, minor, or not a contributing factor. For example, issues relevant for consideration under human capital include education and literacy rate, inter-generational knowledge transfer, presence of healthy working members and dependency ratio, limited human resources due to disease burden and lack of access to health care etc. Analysts should consider all aspects and decide on if, *overall*, a particular capital is a major, minor, or not a contributing factor to acute malnutrition. It should be noted that information may not be available on all aspects of capitals in all contexts. Therefore, expert judgement may be needed to arrive at a conclusion. Include the reasons for the conclusion.
 - **Summary conclusions:** Once all available information on a particular capital is reviewed and discussed summary conclusions about the overall capital as a contributing factor to acute malnutrition is determined and is included under the summary conclusions.
- **Other Issues:** Under other issues, there are 4 sections, namely D1: Other outcomes, D2: Mortality, D3: Feeding programmes, and D4: Protective factors. DC, prevalence, and technical remarks are the same for these issues as outlined above. The following are the other additional aspects that are looked at under these issues:
 - **Mortality – Death rate:** Although death is not a contributing factor to malnutrition, overall death rate in a population is a key public health indicator. Therefore, it is included under other issues. It should be noted that only non-trauma related deaths are looked at in the IPC for Acute Malnutrition.
 - **Feeding Programmes – Status:** the status (under feeding programme) refers to whether there is increase, decrease, or stability in the feeding programme admissions compared to the same season in the previous year(s). Indicate if there is any increase, decrease or stability in feeding programme admissions. Note that programme admissions can be affected by various factors, including opening/closing of programme sites, supply chain interruptions, accessibility to the areas, etc. All issues potentially affecting programme

admissions must be considered and discussed before a conclusion is reached on the programme admission trends.

- **Protective factors:** the existence of certain factors that are expected to have a positive impact on malnutrition is considered here. Indicate if any such programme exists in the area of analysis. If information is available, indicate the coverage of these programmes under the technical remarks column.

Step 6: Identify major contributing factors and other issues

After looking at all possible contributing factors to malnutrition and their status in the area of analysis in step 5, the major contributing factors are identified in step 6.

It should be noted that there is no statistical tests or mathematical modelling carried out to identify the major contributing factors. Rather, the major contributing factors are identified by looking at the current status of these indicators. For example, if there is a measles outbreak in the area of analysis, it would clearly be a major contributing factor to malnutrition. Where available, thresholds are provided in the reference table for some indicators. In these cases, the thresholds can be used to determine whether or not a particular indicator is a major contributing factor. In other cases, expert judgement should be used to make such a decision.

- **Colour/shade the cell:** Indicate whether each of the indicators looked at above is a minor, major, or not a contributing factor.
- **Summary conclusions:** Provide explanations for your decision – i.e. how each indicator is labelled as a major, minor, or not a contributing factor.

This section of the analysis worksheet from all areas of analysis will be combined and included in the communication brief as an annex (see below).

Step 7: Identify potential changes in the contributing factors and other issues

The projection analysis starts in step 7 (right hand side column of page 3 onwards in the Analysis Worksheet). In IPC for Acute Malnutrition, the projection analysis is carried out by first looking at how the contributing factors are expected to change in the projection period (compared to the current situation) and then by looking at how the changes in the contributing factors are likely to impact the acute malnutrition levels. IPC for Acute malnutrition assumes the most likely change and not necessarily the worse or best possible changes.

- **Most likely change:** Indicate how the indicator is likely to change in the projection period – i.e. is it like to improve, deteriorate, or to stay the same.
- **Explanation for the most likely change:** Explain how the likely change was determined.
- **Remarks:** Include any additional information such as assumptions that were made when deciding on the potential change.

It should be noted that there may be several factors that need to be considered when taking decision a on a change in a particular indicator. For example, although IYCF indicators generally take a relatively long time to change and it may therefore be argued that there may be no change in IYCF in a relatively short projection period, there may still be fluctuations in IYCF. For example, in a projection period that includes cultivation time, mothers may be busy working in the field and may not be able to take care of the children adequately and therefore IYCF may deteriorate.

Step 8: Identify potential changes in the outcome indicators

Step 8 involves identifying potential changes in the outcome indicators. This is done by looking at the changes in the contributing factors in step 7. All outcome indicators that have a current estimate (see

current analysis), should be looked at and the direction of the change in the projection period should be determined.

In some cases, there may be a change that would involve a Phase change depending on the changes in the contributing factors. For example, an area may move from Phase 3 to Phase 4. In some other cases there may be changes in the outcome indicator as a result of the changes in the contributing factors but these may not warrant an entire Phase change.

Step 9: Determine Phase classification (projection)

The final projected Phase is determined in step 9. The same indicator that is used to determine the current Phase is used to decide on the projection Phase.

- **Phase:** indicate the Phase as a number (between 1 and 5)
- **Indicator, reliability score, and preference ranking:** Specify indicator that is used to determine the classification and the reliability score as well as the preference ranking for that indicator.

Step 10: Identify limitations of the analysis

The main limitation(s) of the analysis are identified and listed in step 10 so that the analysis results can be interpreted accordingly. List all limitations of the analysis in this section. Additionally, these limitations can also be addressed in the next round of the analysis.

Step 11: Suggest priority response objectives

Step 11 gives a summary of key priority response objectives. It should be noted that these are response objectives and not programme interventions. There needs to be a response analysis to identify priority response interventions. It is suggested that the priority response objectives are divided into both short term and long term objectives.

Section 6B: Communicating for action

IPC for Acute Malnutrition follows the same communication parameters and principles that are used in the IPC Food Insecurity Classification. A communication brief is prepared for communicating the findings of the analysis.

Key parameters of communication brief

The IPC for Acute Malnutrition communication brief includes 4 parameters:

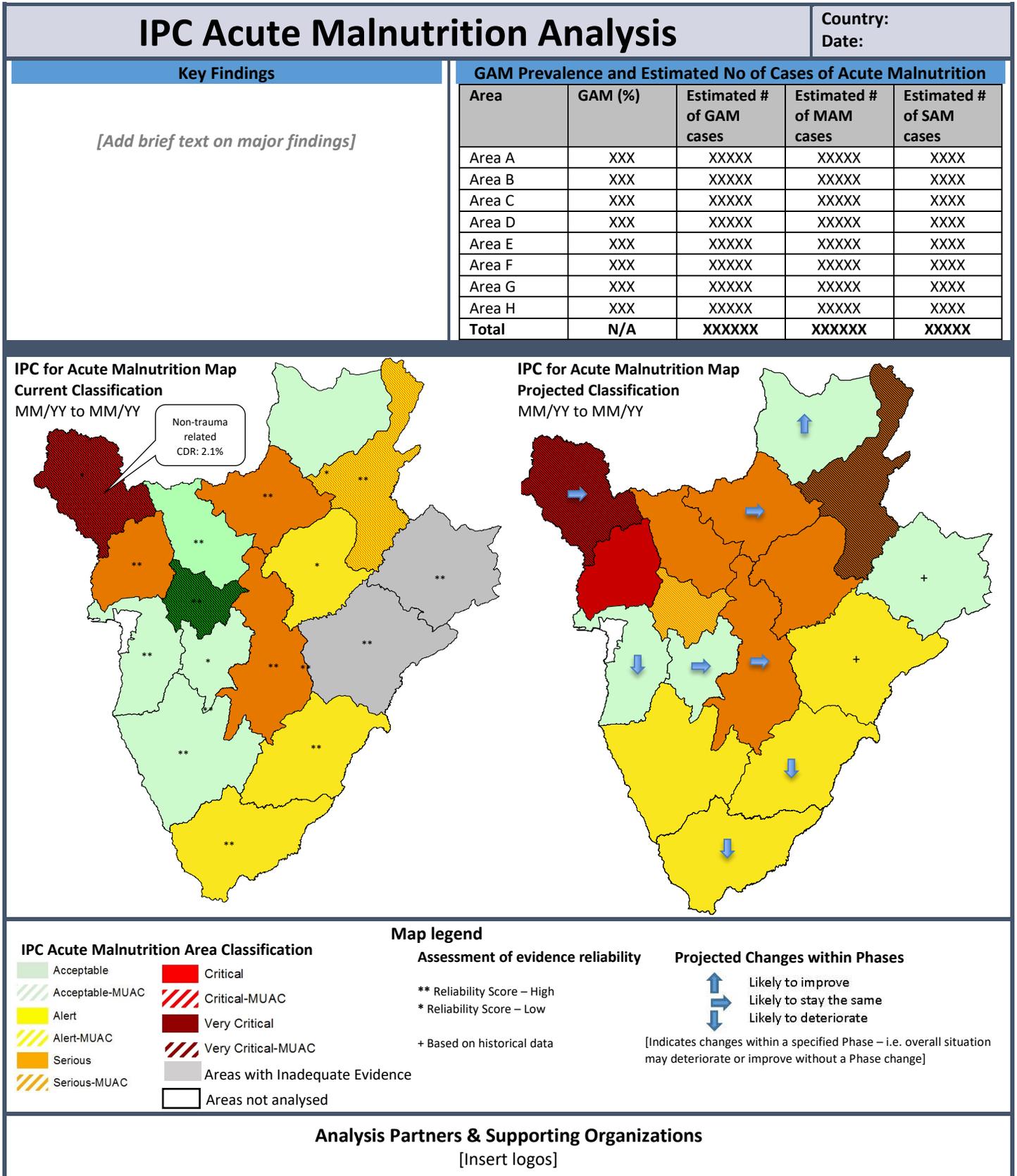
1. Maps
2. Prevalence of acute malnutrition and estimated number of cases
3. Summary texts
4. Summary contributing factors

It is important to note that while the prevalence of acute malnutrition in IPC for Acute Malnutrition indicates the severity of malnutrition, the estimated number of cases shows the magnitude of the problem. It should be noted that the estimated number of cases are not equivalent to the caseload that is usually calculated (using incidence and coverage) for programme purposes.

Tool for communicating for action

A communication template as described in Diagram 4 has been developed to summarise the analysis results and communicate key messages for strategic action.

Diagram 4: Communication brief



SUMMARY OF FINDINGS, METHODS, AND NEXT STEPS

Findings and Key Issues

[Briefly discuss key findings that will inform response; include in bullet points up to 5 major issues]

Methods & Processes

[Write a brief description of the methods used and challenges encountered during analyses]

Seasonality and Monitoring Implications

[Describe issues that are going to be major concerns and that need to be monitored and addressed in the upcoming season]

Recommendations and Next Steps for Analysis and Decision Making

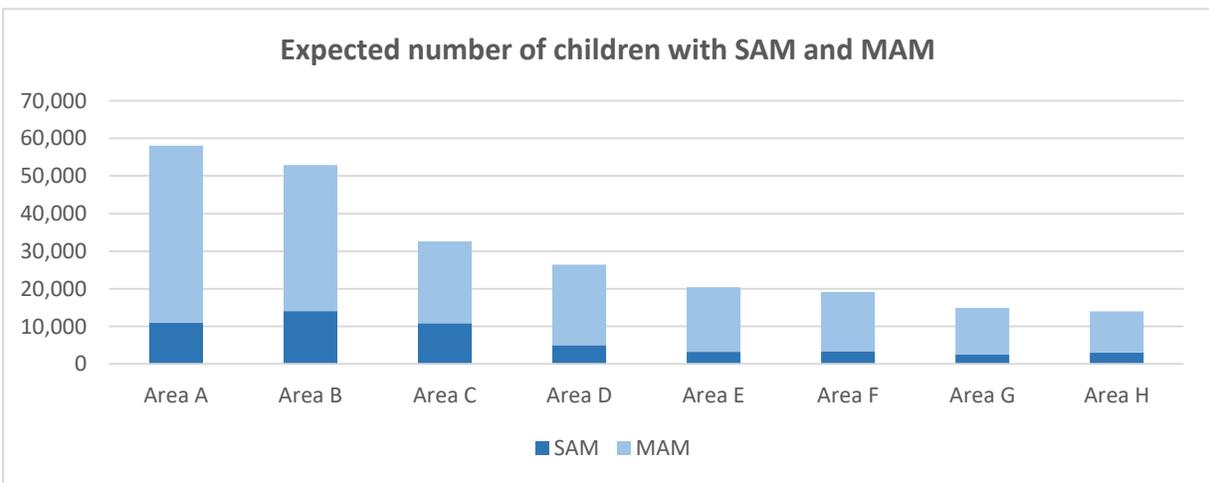
[Discuss expected and recommended next steps focusing on analytical activities, monitoring actions and linkages to action]

Contact for Further Information [Insert contact information]

Expected number of cases of acute malnutrition

(Based only on point estimates – not taking into account the incident (shown to illustrate the magnitude of the problem))

Area	Total population	6-59 Month Population	GAM %	Estimated no. of GAM cases	Estimate d no. of MAM cases	Estimate d no. of SAM cases
Area A	XXXXX	XXXXX	XXX	XXXXX	XXXXX	XXXX
Area B	XXXXX	XXXXX	XXX	XXXXX	XXXXX	XXXX
Area C	XXXXX	XXXXX	XXX	XXXXX	XXXXX	XXXX
Area D	XXXXX	XXXXX	XXX	XXXXX	XXXXX	XXXX
Area E	XXXXX	XXXXX	XXX	XXXXX	XXXXX	XXXX
Area F	XXXXX	XXXXX	XXX	XXXXX	XXXXX	XXXX
Area G	XXXXX	XXXXX	XXX	XXXXX	XXXXX	XXXX
Area H	XXXXX	XXXXX	XXX	XXXXX	XXXXX	XXXX
Total	XXXXX	XXXXX	XXX	XXXXX	XXXXX	XXXXX



Summary Contributing Factors

Summary of Contributing Factors by area		AREA A	AREA B	AREA C	AREA D	AREA E	AREA F	AREA G	AREA H
Inadequate dietary intake	Minimum Dietary Diversity (MDD)								
	Minimum Meal Frequency (MMF)								
	Minimum Acceptable Diet (MAD)								
	Minimum Dietary Diversity – Women (MDD-W)								
	Others								
Diseases	Diarrhoea								
	Dysentery								
	Malaria								
	HIV/AIDS prevalence								
	Acute Respiratory Infection								
	Disease outbreak								
	Others								
Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis								
Inadequate care for children	Exclusive breastfeeding under 6 months								
	Continued breastfeeding at 1 year								
	Continued breastfeeding at 2 years								
	Introduction of solid, semi-solid or soft foods								
	Others								
Insufficient health services & unhealthy environment	Measles vaccination								
	Polio vaccination								
	Vitamin A supplementation								
	Skilled birth attendance								
	Health seeking behaviour								
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)								
	Access to a sufficient quantity of water								
	Access to sanitation facilities								
	Access to an improved source of drinking water								
	Others								
Basic causes	Human capital								
	Physical capital								
	Financial capital								
	Natural capital								
	Social capital								
	Policies, Institutions and Processes								
	Usual/Normal Shocks								
	Recurrent Crises due to Unusual Shocks								
	Other basic causes								
	Other nutrition issues	Anaemia among children 6-59 months							
Anaemia among pregnant women									
Anaemia among non-pregnant women									
Vitamin A deficiency among children 6-59 months									
Low birth weight									
Fertility rate									
Others									

Legend for Limiting factors Matrix

 Major contributing factor	 Minor contributing factor	 Not a contributing factor	 No data
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ANNEX 1: TWG MATRIX FOR IPC FOR ACUTE MALNUTRITION

Building technical consensus refers to the process of getting multi-sectoral experts to provide inputs in the analysis and getting key stakeholders to endorse the process and outputs.

As malnutrition is an outcome of a range of elements involving different sectors and disciplines, it is vital to involve multi-sectoral experts in the analysis process in order to ensure a rigorous analysis. Additionally, involving experts from different sectors and organisations ensures that the output of the analysis is accepted, endorsed, and used.

In order to ensure that the IPC for Acute Malnutrition analysis is carried out through technical consensus, a Technical Working Group (TWG) for the analysis should be formed with the nutrition experts as well as experts from other sectors such as Health, WASH, Food Security, Gender, etc. Additionally, these experts should ideally come from different institutions such as the Government departments, UN, NGOs, and academia. The TWG should in principle be chaired by a Technical Officer from the Department of Nutrition. In all countries where the IPC for Acute Malnutrition tool is relevant, a mechanism for coordinating nutrition activities exists. These mechanisms include the Nutrition Cluster, Nutrition Sector, or Nutrition Working Group. The IPC for Acute Malnutrition analysis should be carried out under the technical leadership of these mechanisms.

In countries where there is an IPC TWG, the IPC for Acute Malnutrition would normally be initiated by this TWG. Nutrition sector experts are part of all existing IPC TWG. This expert pool needs to be expanded and experts from the other sectors should be brought in to form a TWG for the analysis of acute malnutrition. If these mechanisms are not part of the existing TWG structures currently, they should first be brought into the TWG before an acute malnutrition analysis is planned. If there is no IPC TWG in country, IPC for Acute Malnutrition can still be carried out by forming a TWG for the acute malnutrition analysis following the protocols outlined in this manual.

Technical Working Group (TWG) matrix

In order to ensure that there is representation from all relevant sectors and from all key stakeholders, the following TWG matrix should be filled in before the start of an analysis.

CHAIRPERSON & HOSTING ORGANIZATION:		STAKEHOLDER ORGANIZATION REPRESENTATION				
		[Aim to include at least one representative from all applicable groups]				
		National Government [At all relevant levels]	National NGOs/ Civil Society/ Private Sector	International/n ational NGOs	United Nations	Technical Agencies (national and international)
AREA OF EXPERTISE [include as relevant for analysis; one person can have expertise in several areas]	Nutrition					
	Food Security/ Livelihoods					
	Health					
	Water/Sanitation					
	Gender					
	Statistics					
	Other 1					
	Other 2					
	Other 3					

It should be noted that there may be multiple names in one cell and a single member can be repeated in different areas of sectoral expertise. Additionally, there should be at least one member representing each stakeholder group.