



IPC Communication Guidelines

version 1.1

IPC Communication Guidelines

**ACTION
AGAINST
HUNGER**



Food and Agriculture
Organization of the
United Nations

FEWS NET
Famine Early Warning Systems Network



FOOD SECURITY CLUSTER
Strengthening Humanitarian Response



Shaping practices influencing police treatment lines



THE WORLD BANK



World Health
Organization

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In partnership with
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FOREWORD

In a world where millions continue grappling with food insecurity and malnutrition; clear, timely and actionable information becomes the lifeblood of effective response.

With a profound sense of responsibility, I introduce the IPC Communication Guidelines for acute food insecurity and malnutrition to ensure accurate and consistent messaging on IPC analysis findings. The new guidelines have been developed in a widely consultative process involving food security and nutrition experts and communication professionals from IPC partner organizations.

These guidelines are designed to empower communicators, media professionals, technical officers and decision makers with the tools to communicate about IPC acute food insecurity and malnutrition findings with clarity and accuracy. Adhering to these shared principles can steer public discourse towards clear understanding and foster effective decision-making and response.

These guidelines cover various topics, including key concepts, definitions of IPC phases and different approaches to communicating effectively to the lay public. Because the world around us is constantly changing, this is a living document that will be honed on a regular basis to meet emerging communication challenges.

I extend my sincere thanks to all of those involved in developing these guidelines. Your dedication and hard work have resulted in a valuable resource that will undoubtedly make a difference.

I urge all partners involved in communication and advocacy and media professionals to use these guidelines as a reference tool to inform and educate the public about IPC findings. By doing so, we can work together to raise awareness, increase understanding and ultimately and effectively inform decisions to address food and nutrition crises worldwide.

José Lopez

IPC Global Programme Manager



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Overall technical guidance has been provided by Kamau Wanjohi, Kaija Korpi, Barbara Frattaruolo, Douglas Jayasekaran, Damien Pereyra Ngono, Mactar Moussa, Judith Munga and Tomas Zaba from the IPC Global Support Unit. The IPC Global Support Unit worked in close collaboration with the IPC Task Force for Enhancing the IPC Acute Malnutrition scale and the IPC Technical Advisory Group (TAG), comprised of the following 19 agencies and international organizations: Action Against Hunger, CARE International, *Comité Permanent Inter-États de Lutte Contre la Sécheresse au 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, the Global Nutrition Cluster, the Intergovernmental Authority on Development (IGAD), the International Food Policy Research Institute (IFPRI), the Joint Research Centre (JRC) of the European Commission, the Oxford Committee for Famine Relief (Oxfam), the Southern African Development Community (SADC), Save the Children, the *Sistema de la Integración Centroamericana* (SICA), the United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), the World Bank, the World Food Programme (WFP) and the World Health Organization (WHO). Special thanks go to the following TAG members: Alexandra Christina Horst, Anne Celine Delinger, Anne Wagner, Anteneh Dobamo, Carlo Cafiero, Cyril Lekiefs, Dalmar Ainashe, Damien Joud, Dan Gilligan, James Acidri, Jessica Fullwood-Thomas, Josey Kamanda, Joshua Leighton, Manuel Veiga, Marina Adrianopoli, Matthieu Tockert, Mohamed Salem, Ricardo Sibrián, and Tim Hoffine.

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The IPC Global Steering Committee – representing the 19 organizations named above – provided strategic oversight, stewardship and final endorsement of these guidelines.

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Once again, thank you for being an essential part of our team. We look forward to continuing this collaborative journey towards a more nourished and food-secure world.

Sincerely,

José Lopez

IPC Global Programme Manager

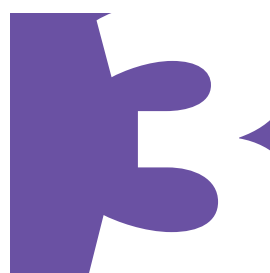
TABLE OF CONTENTS



Introduction	3
1.1 Background and purpose	3
1.2 What the IPC is	3
1.3 Foundational concepts	4
1.4 IPC processes	5
1.4.1 Who conducts IPC analyses?	5
1.4.2 Data used in IPC analyses	5
1.4.3 The analysis method	6
1.5 IPC parameters	7
1.5.1 Analysis period: current vs projected classifications	7
1.5.2 Unit of analysis	7
1.5.3 Evidence levels	7
1.5.4 Magnitude vs severity	8
1.6 IPC analysis outputs	8
1.6.1 Key messages	8
1.6.2 Maps	8
1.6.3 Population tables	9
1.6.4 IPC report	10
1.7 The role of strategic communication	11
1.8 Content	11



The IPC Acute Food Insecurity Classification	13
2.1 Overview of the IPC Acute Food Insecurity scale	13
2.2 Understanding the IPC Acute Food Insecurity classification	13
2.3 IPC Phase 5 (Catastrophe) vs IPC Phase 5 (Famine) and risk of Famine	14
2.4 Communicating the IPC Acute Food Insecurity phases	16
2.4.1 IPC Phase 1 (None/Minimal)	16
2.4.2 IPC Phase 2 (Stressed)	17
2.4.3 IPC Phase 3 (Crisis)	18
2.4.4 IPC Phase 4 (Emergency)	19
2.4.5 IPC Phase 5 (Catastrophe)	20
2.4.6 IPC Phase 5 (Famine)	21
2.4.7 Risk of Famine	23
2.4.8 IPC Phase 3 or above (Crisis or worse)	24



The IPC Acute Malnutrition Classification	26
3.1 Overview of the IPC Acute Malnutrition scale	26
3.2 Key definitions	26
3.3 Causes of acute malnutrition	27
3.4 Understanding the IPC Acute Malnutrition classification	28
3.5 Communicating the IPC Acute Malnutrition phases	29
3.5.1 Communicating the population in need of treatment	29
3.5.2 IPC AMN Phase 1 (Acceptable)	31
3.5.3 IPC AMN Phase 2 (Alert)	31



3.5.4 IPC AMN Phase 3 (Serious)	32
3.5.5 IPC AMN Phase 4 (Critical)	33
3.5.6 IPC AMN Phase 5 (Extremely Critical)	34

Appendices	35
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4.1 Glossary of Terms	35
4.2 Sources of Terms	39
4.3 List of Figures	40
4.4 IPC Acute Food Insecurity reference table	41
4.5 IPC Acute Malnutrition reference table	42
4.6 List of Acronyms	43

INTRODUCTION

1.1 Background and purpose

With food and nutrition crises persisting – affecting millions of people in different parts of the world – demand for actionable information has never been higher. Effective communication of acute food insecurity and malnutrition information must clearly and succinctly describe the context, causes and outcomes. Based on the IPC Technical Manual Version 3.1, these guidelines are intended for individuals involved in communication, advocacy, media reporting, humanitarian response planning, funding, and/or reporting. Their purpose is to assist communicators in effectively informing non-specialist audiences about IPC findings in a manner that is accurate, informative, accessible, and empowering, aiming to achieve the following objectives:

- ▶ **Knowledge:** clearly understand the IPC Acute Food Insecurity and Acute Malnutrition scales.
- ▶ **Accuracy:** communicate a true representation of the IPC findings.
- ▶ **Clarity:** communicate clearly, concisely and effectively to convey the urgency and scale of acute food insecurity and malnutrition.
- ▶ **Consistency:** communicate IPC findings in a consistent language and voice across all platforms, channels and products.
- ▶ **Empathy:** communicate while understanding and acknowledging that people are behind the figures.

1.2 What the IPC is

The Integrated Food Security Phase Classification (IPC) is a global multi-stakeholder initiative to improve analysis and decision-making on food security and nutrition. Using the IPC classification and analytical approach, governments, United Nations (UN) agencies, Non-Governmental Organizations (NGOs), and other stakeholders work together to determine the severity and extent of acute and chronic food insecurity and acute malnutrition situations within countries, according to internationally recognised standards.

In short, the IPC is:

- ▶ a Common Global Scale to classify food insecurity and malnutrition;
- ▶ a process to build evidence-based technical consensus among key stakeholders;
- ▶ an approach to consolidate wide-ranging evidence;
- ▶ a path to provide actionable knowledge for strategic decisionmaking;
- ▶ a platform to ensure rigorous analysis.

How to refer to the IPC

In the given context, the acronym “IPC” can denote two distinct notions: the IPC Partnership or the IPC analytical approach.

When citing the IPC, it should be specified as “the IPC Partnership.” For example, “The IPC Partnership warns that...”. If additional clarification is required, it can be noted that this partnership comprises UN agencies, NGOs, technical agencies and regional bodies.

When discussing the IPC as an approach, it can be referred to using one of the following options:



DOS

Appropriate reference to the IPC

- ▶ A global scale to classify food and nutrition crises;
- ▶ The global reference for analysis of food and nutrition crises;
- ▶ A global approach for food security and nutrition analysis;
- ▶ A global approach for food security and nutrition analysis;
- ▶ A globally recognized approach for food security and nutrition analysis.



DON'TS

The IPC may not be described as:

- ▶ A UN-led unit/initiative;
- ▶ A non-governmental organisation;
- ▶ An advocacy group;
- ▶ A panel;
- ▶ An indicator.

1.3 Foundational concepts

The IPC employs two distinct scales: the Acute Food Insecurity (AFI) scale and the Acute Malnutrition (AMN) scale. By classifying acute food insecurity and acute malnutrition, the IPC provides analyses designed to inform interventions appropriately tailored to the situation of concern.

Acute food insecurity

The IPC defines acute food insecurity as any manifestation of food insecurity at a specific point in time that is of a severity that threatens lives, livelihoods or both – regardless of the causes, context or duration.¹

In practice, the IPC AFI scale is most concerned with those populations who face difficulty meeting their basic caloric needs, and therefore, either face those caloric gaps outright or mortgage their livelihoods to mitigate those gaps.

Acute food insecurity is highly susceptible to change and can manifest in a population within a short amount of time, as a result of sudden changes or shocks that negatively impact the determinants of food security and nutrition.² Acute food insecurity may persist, however, especially in the presence of protracted or repeated shocks.

In popular discourse, a variety of terms are often applied to describe situations in which populations are considered to be facing difficulty obtaining or consuming a healthy diet. Acute food insecurity is not the same as hunger, for example. Hunger³ is an uncomfortable or painful physical sensation caused by insufficient dietary energy consumption, whereas acute food insecurity relates to either the inability to meet basic caloric needs or sacrificing future livelihood options in order to protect food consumption in the short term. Hunger may represent a persistent lack of food consumption but may also be the result of temporary and intentional (fasting, for example) or unintentional lack of food consumption unrelated to a household's ability to access food. While it is essential to recognize the nuances and distinctions between "hunger" and "food insecurity", for communication purposes, using these two terms interchangeably is acceptable.

Dietary intake

Adequate dietary energy intake⁴ relates to regular consumption – over a significant period – of an amount of food that provides the energy needed to cover the requirements for an active and healthy life. The selected dietary energy requirements are based on average requirements for an average individual (Body Mass Index of 21–22) engaged in a normally active life (physical activity level=1.75).⁵ To be considered in IPC Phase 1 (None/Minimal) of the IPC AFI scale, individuals consume an average of 2,350 kilocalories/day and have a sedentary lifestyle (physical activity level=1.55). To be considered in IPC Phase 2 (Stressed) individuals consume an average of 2,100 kilocalories/day.

Acute malnutrition

The IPC defines acute malnutrition (also referred to as wasting and nutritional oedema⁶) as when a person's body does not get enough energy or nutrients for a period of time. Acute malnutrition is usually caused by a sudden loss of food or an increase in food demand

¹ IPC Technical Manual Version 3.1, Part 2A, Acute Food Insecurity Classification.

https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/manual/IPC_Technical_Manual_3_Final.pdf

² IPC Technical Manual Version 3.1, Part 2A, Acute Food Insecurity Classification.

https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/manual/IPC_Technical_Manual_3_Final.pdf

³ Hunger and food insecurity:

<https://www.fao.org/hunger/en/#:~:text=A%20person%20is%20food%20insecure,at%20different%20levels%20of%20severity.>

⁴ IPC Technical Manual Version 3.1, Part 2A, the IPC Acute Food Insecurity Reference Table.

https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/manual/IPC_Technical_Manual_3_Final.pdf

⁵ Energy Requirements of Adults: <https://www.fao.org/3/y5686e/y5686e07.htm>

⁶ WHO guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years:

https://www.childwasting.org/_files/ugd/2b7a06_2cf788d9c0f342b89c054b288f4862e3.pdf



and/or a decrease in absorption of food due to illness, infection or other factors. Acute malnutrition can affect people of all ages but is particularly common in young children and pregnant and breastfeeding women (PBW). The symptoms of acute malnutrition include rapid weight loss, loss of muscle mass, fatigue, weakness and a weakened immune system that can increase the risk of infection. Acute malnutrition can lead to severe health complications and even death without prompt treatment. People with acute malnutrition have worse outcomes and are more likely to die when they fall sick.

For further terms, refer to the Glossary of Terms in Appendix 4.1.

Note: These guidelines focus on the IPC Acute Food Insecurity and Acute Malnutrition scales.

1.4 IPC processes

The IPC process offers a systematic approach to analysing a situation based on the available evidence. It is a structured framework to establish evidence-based technical consensus among key stakeholders. The IPC ensures a thorough analysis process by leveraging existing evidence and adhering to principles of transparency and rigour.

1.4.1 Who conducts IPC analyses?

IPC analyses are carried out by a team of technical experts, typically from various sectors and relevant stakeholder institutions at the country level, including government branches, regional bodies, UN agencies, international and national NGOs and/or technical agencies. These experts are technically proficient in their sector, have experience in conducting food security or nutrition analysis and are trained on IPC protocols. They are supported by senior IPC experts who facilitate the IPC analysis process, provide technical support to the IPC analysis team and ensure adherence to IPC standard protocols.

1.4.2 Data used in IPC analyses

The IPC acute food insecurity and malnutrition analyses are prepared with diverse data from various sources spanning multiple sectors. Typical data for IPC analyses encompass but are not limited to:

- ▶ **Household food security data:** The information is usually collected through seasonal assessments conducted at household level and includes household characteristics, experienced shocks, food consumption patterns, strategies used by households to cope with shocks and external assistance received by households.
- ▶ **Food production data:** This consists of estimates on crop, livestock and/or fisheries production often produced by Government agencies in collaboration with partners.
- ▶ **Nutrition data:** This includes anthropological measurements typically of children between 6 and 59 months and information on key drivers of malnutrition that are collected either through a nutrition survey or as part of a multi-sectoral assessment.
- ▶ **Market prices:** Information on prices of basic food and other essential items and availability of goods at markets is typically obtained through regular market monitoring.
- ▶ **Climate and NDVI data:** Meteorological data on rainfall, along with the Normalized Difference Vegetation Index (NDVI), is obtained through remote sensing methods and facilitates analysis on food availability.
- ▶ **Displacement:** Information on population displacement, whether in-country or across borders, is normally available through different agencies working with displaced populations.
- ▶ **Damage and destruction:** In contexts affected by conflict or natural disasters, information on damage and destruction of infrastructure and assets through surveys/assessments or satellite imagery can be available.



1.4.3 The analysis method

The IPC provides a global standard for classifying the severity and magnitude of food insecurity and acute malnutrition. It is applicable across and between regions and countries over time. Four functions must be followed to conclude classification and to generate IPC information products.

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

Each function has a specific purpose and a set of protocols to guide analysts. The completion of all 13 protocols is fundamental to the IPC as they ensure that analyses are rigorous, neutral and accountable. These protocols are described in detail in the [IPC Technical Manual Version 3.1](#). Below are some of the key features of the IPC analytical approach.

- ▶ **Consensus-based:** The IPC operates on the principle of consensus-building, which is pivotal for two primary reasons. Firstly, the analysis of food insecurity and malnutrition demands expertise from a diverse array of fields such as food security, livelihoods, nutrition, markets, agriculture, among others, contingent upon the specific context. This necessitates a consensus-based approach that convenes experts from various disciplines and viewpoints to assess and deliberate on the evidence, ultimately leading to the final classification. Secondly, the inclusion of technical experts from key stakeholder organizations in the analysis process ensures broad acceptance and coordinated action based on the results.
- ▶ **Evidence-based:** IPC classifications are based on the best available evidence in every context. The IPC partnership works to consolidate complex data from different sources across multiple sectors to provide a solid evidence base for every analysis and collaborates with partners to improve the availability of data wherever necessary. This evidence base allows for a transparent, trackable logical progression through to final classification, offsetting the risks of undue bias.

- ▶ **Convergence of evidence:** The IPC approach draws upon a wide range of data to classify and distribute households/areas into five phases of acute food insecurity and/or malnutrition. The IPC team of multisectoral experts critically reviews and evaluates the evidence to conclude on the distribution of the households/areas across IPC phases using a convergence of evidence approach. This is guided by the IPC Analytical Framework with a livelihood-based lens and a reference table which is based on generally accepted international standards and indicators directly measuring food security and nutrition outcomes as well as contributing factors in order to estimate the proportion of households in each phase of the IPC Acute Food Insecurity scale; and/or classify areas in one of the five phases of the IPC Acute Malnutrition scale.

1.5 IPC parameters

1.5.1 Analysis period: current vs projected classifications

An IPC classification is associated with a validity period during which the situation is generally not expected to change. IPC analyses are typically produced for at least two distinct periods – the current period and the projection period. The time validity of the classification can span short or extended periods, depending on the stability of the situation and the needs of decision makers (e.g. forward-looking analysis required to inform response plans for the following year). It may cover a period of a few weeks or up to a year, defined on a case-by-case basis. If the situation changes during the validity period of the analysis, an update or a new analysis may be required. Projections can be updated whenever there is a need, or when new information alters assumptions made during a previous analysis.

- ▶ **Current classification:** The analysis results are based on the actual conditions prevalent during the analysis period, using the most recent data and without removing the effects of any humanitarian assistance. The current classification is based on actual food insecurity and/or nutrition conditions and several contributing factors depending on available data (e.g. conflict, loss of food production, humanitarian assistance, etc.).



- **Projected classification:** Analysis results are based on the future's most likely or expected situation, based on available data. Projections should forecast the most likely conditions based on a sound understanding of the current situation, historical trends and explicit assumptions on the evolution of the situation, which past and future shocks may impact. The future projection includes anticipated effects of humanitarian assistance, which is regularly programmed/inter-annual, and any ad hoc assistance which is planned and likely to be funded and delivered in the projection period.

1.5.2 Unit of analysis

IPC AFI and AMN analyses are typically area-based. However, in certain contexts, additional analyses may involve the Household Analysis Group, as elaborated here:

Area-based analysis

A phase classification is determined for each area analysed within a country/territory. The determination of the areas which form the units of analysis usually corresponds to administrative boundaries at the subnational level (administrative level 2 or 3 – where the national level is 0), such as provinces or districts. However, depending on the needs, context and data available, the units of analysis can also correspond to livelihood or agro-ecological zones or camps/settlements of Internally Displaced Persons (IDPs) or refugees, among other things. In general, the analysis area is as homogeneous as possible with regards to likely food security or nutrition outcomes and causes.

Household Analysis Group (HAG) analysis

HAG analysis is performed considering relatively homogeneous group(s) of households with regards to food security and nutrition outcomes, based on a wide range of factors such as wealth, social affiliations, livelihoods or exposure to shocks. For example, displaced populations, subsistence farmers and the poorest households in a specific area may be identified as a relevant HAG for analysis.

Outputs of area-based vs household analysis group classification

For AFI area-based analysis, estimates of populations in each IPC phase (typically displayed in tables) and maps displaying the severity (phase) of the situation are generated. However, it is important to note that this approach may not be applicable to HAG analysis, as maps are only created in cases where the analysis is conducted on HAGs in clearly identifiable geographic locations (e.g. IDP camps). Even in cases where HAG analysis is not mapped, estimates of populations in each IPC phase are provided.

1.5.3 Evidence levels

IPC analyses require that the data used meet a set of minimum criteria. Evidence quality is assessed by considering the extent of data availability and reliability, considering the methodology employed and timeliness of data collection. This approach provides a basis for defining and distinguishing different levels of evidence: acceptable, medium or high. These evidence levels are communicated in both IPC AFI and AMN reports and displayed on the IPC maps.

1.5.4 Magnitude vs severity

For the purposes of the IPC, the concept of magnitude relates to the scale or scope of the issue, indicating the size of the population (either number or proportion) experiencing specific conditions. On the other hand, the concept of severity relates to how mild or severe of an outcome a given population or area is facing. In AFI terms, an example of severity would be the IPC phase in which households in the area are classified, whereas magnitude would be the number or proportion of households in that IPC phase. In AMN terms, severity would refer to whether a child is suffering from moderate or severe acute malnutrition, whereas magnitude would refer to the number or percentage of children suffering from acute malnutrition.



1.6 IPC analysis outputs

IPC analyses typically answer six key questions:

- ▶ How severe is the situation?
- ▶ How many people are/will be affected?
- ▶ When are they/will they be affected?
- ▶ Where is the response most required?
- ▶ Why is this occurring?
- ▶ Who are the most affected?

Upon completing an IPC analysis, several essential components are crafted to effectively convey these findings and enhance communication with decision makers and the general public. These components encompass key messages, maps and population tables.

1.6.1 Key messages

Food insecurity and malnutrition insights: Key messages are developed to highlight the prevailing circumstances regarding acute food insecurity and malnutrition. These messages comprehensively cover the current situation, key drivers of acute food insecurity and malnutrition, recommended actions and assumptions underpinning projections. Their role is pivotal in heightening awareness and disseminating vital information to the audience.

1.6.2 Maps

Geospatial visualization: Mapping is used to depict the results of the IPC analysis in relation to “how severe” the situation is. This involves plotting the severity of acute food insecurity and malnutrition as reflected by IPC phases across various administrative units such as regions, districts or other relevant unit of analysis (e.g. agro-ecological zone, livelihood zone, IDP camp).

IPC colour-coded clarity: Maps are colour-coded to represent the severity phase of acute food insecurity or malnutrition attributed to each area, from Phase 1 to Phase 5. This visual representation simplifies data comprehension for stakeholders and facilitates data interpretation.

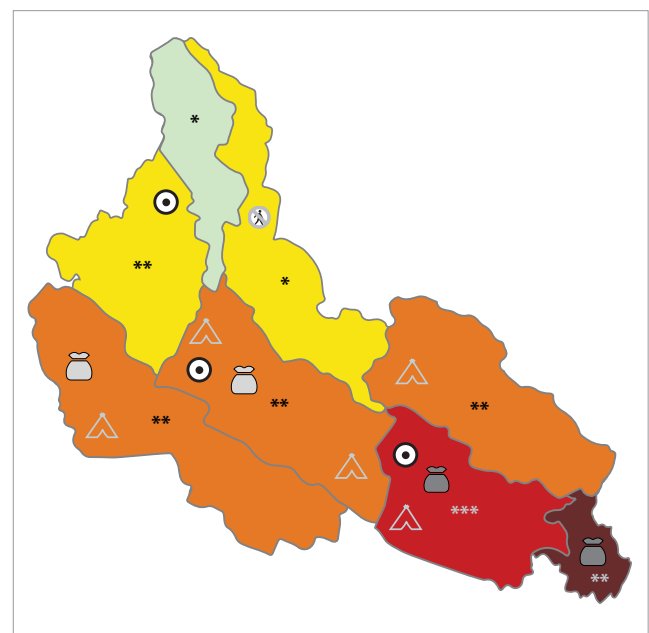
1.6.3 Population tables

Categorization: For AFI analyses, the population tables provide estimates (share and number of people) of affected populations according to the IPC phases. For AMN analyses, the population tables provide information on the estimated population (children under five and pregnant and breastfeeding women) suffering from acute malnutrition and needing treatment. For both IPC AFI and AMN analyses, a breakdown of these estimates by area is usually provided.

You can access IPC Acute Food Insecurity population data by visiting this link: <https://www.ipcinfo.org/ipc-country-analysis/population-tracking-tool/en/>

1.6.4 IPC report

Figure 1: IPC Acute Food Insecurity classification map



Key for the Map

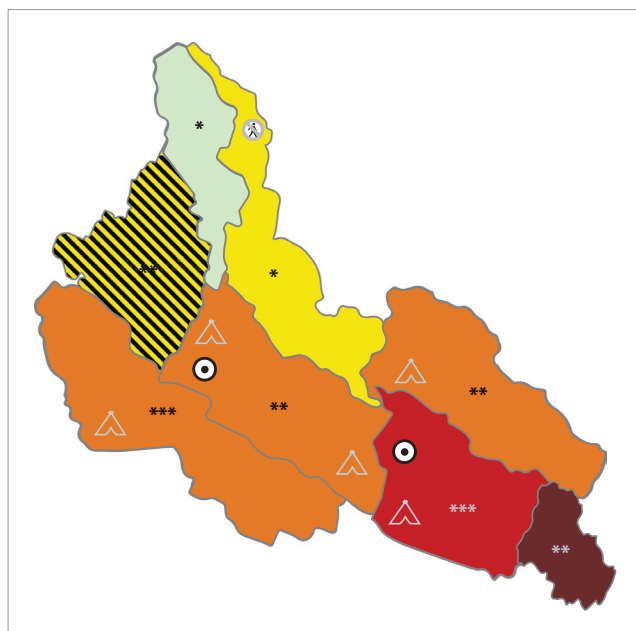
IPC Acute Food Insecurity Phase Classification

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

1 - Minimal	Areas with inadequate evidence	Area receives significant humanitarian food assistance (accounted for in Phase classification)
2 - Stressed	Areas not analysed	
3 - Crisis	Map Symbols	> 25% of households meet 25-50% of caloric needs through assistance
4 - Emergency	Urban settlement classification	> 25% of households meet > 50% of caloric needs through assistance
5 - Famine	IDPs/other settlements classification	Evidence Level
		* Acceptable
		** Medium
		*** High



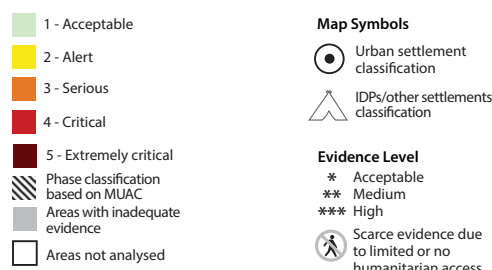
Figure 2: IPC Acute Malnutrition classification map



The key messages, maps and population tables are seamlessly woven into a comprehensive IPC report,

Key for the Map

IPC Acute Malnutrition Phase Classification



consolidating all pertinent information into a single, accessible document.

In order to make the technical key messages more

accessible, key findings of IPC analyses can be summarized into an IPC snapshot. This is a simplified and summarized rendition of the IPC report designed specifically for the lay public.

1.7 The role of strategic communication

Strategic communication and advocacy are essential for promoting and strengthening response to acute food insecurity and acute malnutrition. Effectively communicating information about these crises can raise awareness, facilitate decision-making and help guide the mobilization of appropriate resources. Strategic communication plays a crucial role in responding to acute food insecurity and acute malnutrition by effectively disseminating

Figure 3: IPC Acute Food Insecurity population table

Region	Total population analysed	Phase 1		Phase 2		Phase 3		Phase 4		Phase 5		Area Phase	Phase 3+	
		#people	%	#people	%	#people	%	#people	%	#people	%		#people	%
Region A	179,283	80,677	45	80,677	45	8,964	5	8,964	5	0	0	2	17,928	10
Region B	85,619	51,371	60	21,405	25	12,843	15	0	0	0	0	2	12,843	15
Region C	255,921	127,961	50	89,572	35	25,592	10	12,796	5	0	0	2	38,388	15
Region D	153,904	61,562	40	30,781	20	53,866	35	7,695	5	0	0	3	61,561	40
Region E	229,285	68,786	30	80,250	35	68,786	30	11,464	5	0	0	3	80,250	35
Region F	156,906	78,453	50	39,227	25	31,381	20	7,845	5	0	0	3	39,226	25
Region G	97,386	43,824	45	38,954	40	9,739	10	4,869	5	0	0	2	14,608	15
Region H	54,848	21,939	40	21,939	40	8,227	15	2,742	5	0	0	3	10,969	20
Region I	116,111	52,250	45	29,028	25	29,028	25	5,806	5	0	0	3	34,834	30
Region J	125,992	50,397	40	37,798	30	31,498	25	6,300	5			3	37,798	30
Grand Total	1,455,255	637,219	44	469,630	32	279,924	19	68,482	5	0	0		348,406	24



Figure 4: IPC Acute Malnutrition population table

Region	Total No. of Cases of Children (6-59 Months) in Need of Treatment			Total No. of Cases of Pregnant and Lactating Women in Need of Treatment
	GAM Treatment	MAM Treatment	SAM Treatment	
Region A	5,474	4,551	923	0
Region B	4,744	3,698	1,046	462
Region C	1,111	878	233	162
Region D	663	478	184	0
Region E	2,627	1,993	634	118
Region F	584	487	97	355
Region G	691	502	188	310
Region H	79	79	0	0
Region I	1,258	572	686	796
Region J	80	65	15	18
All regions	17,311	13,303	4,006	2,221

information, raising awareness, mobilizing resources and influencing behaviour change. When directed towards high-level decision-makers, advocacy can result in government commitments that improve policy, nutrition programming and accountability. Here are some key aspects of the role of strategic communication in addressing these issues:

Raising awareness

Strategic communication can raise awareness about the severity, magnitude and causes of acute food insecurity and

Figure 5: IPC reports

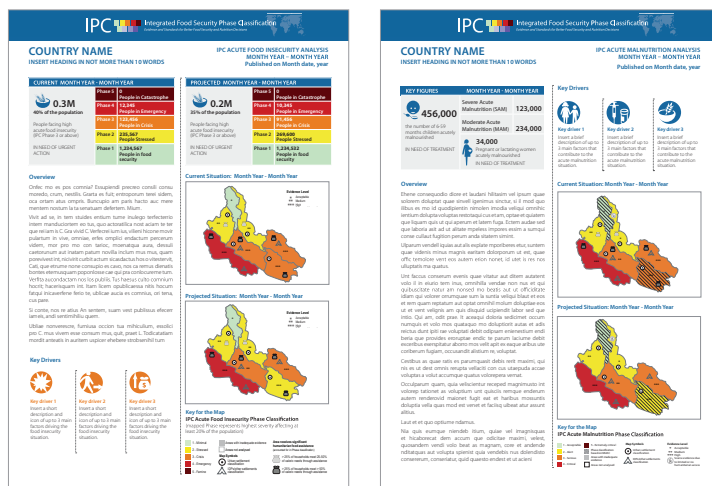
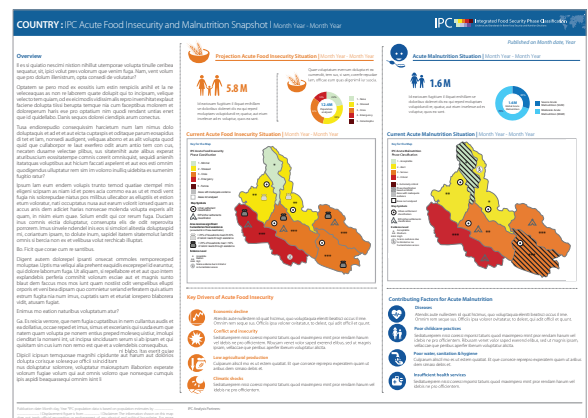


Figure 6: IPC snapshot





malnutrition. By highlighting the scale of the problem and its impact on people, communications can foster empathy and understanding – encouraging individuals, communities, organizations and governments to act.

Resource mobilization

Effective communication can attract financial and material support from donors, governments and philanthropic organizations. By presenting a compelling case for action and demonstrating the potential impact of investments, communications can mobilize resources for food security and nutrition interventions.

Early warning and information dissemination

Strategic communication can facilitate the timely dissemination of early warning information related to food and nutrition crises, or factors such as weather events (e.g. drought) or conflict, that are likely to drive these crises. This can enable timely responses and interventions to prevent the situation from occurring.

Behaviour change communication

Strategic communication can promote positive behaviour changes related to food consumption, agricultural practices and nutrition. In particular, positive messages around the benefits of balanced diets, breastfeeding practices and proper hygiene can help improve nutrition and prevent malnutrition.

1.8 Content

These guidelines provide key communication considerations to facilitate conversations with different stakeholders, particularly members of the lay public who are not experts or qualified in food and nutrition security and greatly vary in age, interests, experiences and opinions.⁷ To accommodate these differences, the communication guidelines suggest simplified approaches to communicating complex acute food insecurity and malnutrition analyses. The guidelines outline:

► **Technical description:** Technical messages

that describe the IPC phases and the outcomes experienced by households in a particular phase are vital in conveying critical information about the severity of the food security and nutrition situations in a given area. These messages reflect analysis that is based on a convergence of evidence involving an understanding of the local context and livelihoods.

- **Interpretation:** Simplified meaning of the technical description.
- **Call to action:**⁸ A communication term for any message designed to prompt an immediate response or action.
- **The cost of inaction:** The likely consequence that comes about from not acting. Estimating this cost relies on a broad estimation of how a situation might evolve. It is important to note that the content in the cost of inaction sections in this document is not based on the IPC protocols as per the IPC Technical Manual Version 3.1. It does not take into account the local context, nor is it based on specific technical parameters or the IPC analytical process. Communicators and other users of this document should refrain from directly copying the examples provided in this section. Instead, they should rely on context-specific information provided in IPC country analysis reports. Expert advice should be sought when making decisions in any specific situation.
- **Dos and Don'ts:** Provide guidance for appropriate and inappropriate word usage in each context. Dos encompass words and phrases recommended or encouraged, while Don'ts pertain to words and phrases that are cautioned against or should be avoided.
- **Messaging examples:** Provided under the Dos section, and while not tailored to specific contexts, they are shaped by the prevailing communication norms within media and other stakeholders who convey IPC findings. These examples serve as general references for communicators, providing a foundational structure that should be customized to align with specific circumstances, objectives and

⁷ Service to the Lay Public 1. Who is the "Lay Public"? United States National Library of Medicine: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC199853/pdf/mlab00220-0065.pdf>

⁸ Call to Action: When Trying to Get Buy-In, Give Your Audience a Clear Call to Action. Harvard Business Review. <https://hbr.org/tip/2017/02/when-trying-to-get-buy-in-give-your-audience-a-clear-call-to-action>



outcomes of IPC analyses. They are a valuable starting point for developing content that effectively caters to the communication needs and preferences of the intended audience while respecting the unique context of IPC protocols.

THE IPC ACUTE FOOD INSECURITY CLASSIFICATION



When communicating findings on the acute food insecurity situation in a given area – including estimates of food insecure populations – stakeholders are encouraged to ensure transparent communication on the source and method used. When findings are based on IPC analyses, reference to the IPC and use of standard IPC terminology (phase names, etc.) is essential. The section below provides guidance on how to ensure clear, consistent and accurate communication on findings from IPC AFI analyses.

2.1 Overview of the IPC Acute Food Insecurity scale

The IPC AFI scale uses a five-phase scale to classify the severity and magnitude of acute food insecurity. Analysts use evidence to determine which of these phases is most appropriate for a given area or population during a given period, and report those phases via maps, population tables, etc.

IPC AFI classifications are used to classify acute food insecurity both at the household level and at the area level. An area is classified in a specific IPC phase when at least 20 percent of households in the area are experiencing the outcomes related to that phase or more severe phases.⁹

2.2 Understanding the IPC Acute Food Insecurity classification

To facilitate use of a common language to describe similar food security outcomes across different contexts, the IPC AFI scale also provides an IPC phase name to accompany each IPC phase number. Each of the below phases has essential and distinct implications for where and how best to intervene.

The five IPC phases of severity are:

- **IPC Phase 1**, corresponding to No or Minimal Acute Food Insecurity (where *No* refers to household-level classifications and *Minimal* refers to area-level classifications).
- **IPC Phase 2**, corresponding to Stressed Acute Food Insecurity.

- **IPC Phase 3**, corresponding to Crisis Acute Food Insecurity.
- **IPC Phase 4**, corresponding to Emergency Acute Food Insecurity.
- **IPC Phase 5**, corresponding to Catastrophe/Famine (where *Catastrophe* refers to household-level classifications and *Famine* refers to area-level classifications).



DOS

IPC scales vs other methodologies

The IPC partnership promotes transparent communication regarding the methods and sources employed to assess food insecurity and malnutrition.



DON'TS

Inappropriate use of IPC terminology

The IPC partnership discourages relying on the following methods as the basis for (i) conveying population estimates in IPC Phases; and/or (ii) conveying classification of areas/population groups based on IPC Phases; and/or (iii) using IPC colour-coded maps:

- (a) Single indicators, including those outlined in the IPC Reference Table.
- (b) Other methodologies, such as composite indicators, indexes, matrices, or assessment results.

Furthermore, the IPC partnership advises against describing these methodologies as “equivalent to / indicative of / consistent / associated / aligned with” specific IPC Phases or using similar language to make such connections.

⁹ IPC Technical Manual 3.1, Part 2A. The IPC Acute Food Insecurity Reference Table.



Figure 7. IPC Acute Food Insecurity phases

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

2.3 IPC Phase 5 (Catastrophe) vs IPC Phase 5 (Famine) and risk of Famine

As shown in Figure 8, Catastrophe and Famine both refer to IPC Phase 5, indicating the most extreme food insecurity situations. However, there are notable differences between the two as Catastrophe is a household-level classification and Famine is an area-level classification.

IPC Phase 5 (Catastrophe)

In IPC Phase 5 (Catastrophe), household members experience an extreme lack of food and exhaustion of coping capacities; and face starvation and a significantly increased risk of acute malnutrition and death.

IPC Phase 5 (Catastrophe) can only be classified at the household level. Households may be classified in IPC Phase 5 (Catastrophe) even if the area is not classified in IPC Phase 5 (Famine). The latter is the case when less than 20 percent of the population is experiencing IPC Phase 5 (Catastrophe) conditions and/or when malnutrition and/or mortality levels have not (or not yet) reached famine thresholds.

IPC Phase 5 (Famine)

Famine is an IPC classification at the area level. The IPC defines Famine as a situation in which at least one in five (or 20 percent of the) households have an extreme lack of food and face starvation and destitution, resulting in extremely critical levels of acute malnutrition and death.

In this Phase, prevalence of acute malnutrition in children under five exceeds 30 percent, households have reached a point of destitution, and death, measured in the form of excess mortality (crude death rate must reach at least 2 deaths/10,000 people/day), is prevalent.

Whereas the IPC's role is to facilitate classification of acute food insecurity, governments and/or international agencies have typically taken on the role of making formal statements (often characterized as a "declaration") that Famine exists. In other words, the IPC does not "declare Famine" or issue "Famine declarations", but rather facilitates the analysis that allows governments, international/regional organizations and humanitarian agencies to issue more prominent statements or declarations.

Famine classification with solid or reasonable evidence

In April 2023, the IPC technical protocols were updated to simplify terminology related to Famine. The new terminology reflects a more nuanced approach to communicating the IPC Phase 5 (Famine) classification, based on the amount and quality of evidence available to support the statement.

Previously, the IPC used classifications of Famine (IPC Phase 5) and Famine Likely (also IPC Phase 5) to refer to the same severity of acute food insecurity – they differed only in the amount of evidence available for analysis. However, this approach created the impression among



the public and decision makers that different levels of severity were being classified. To avoid this confusion moving forward, all area-level classifications of IPC Phase 5 will simply be referred to as Famine.

In order to preserve the important distinction that different levels of evidence may be used to make this classification, the IPC now provides a more direct indication of the level of evidence available for classification.

An area is classified in **Famine with solid evidence** if there is clear and compelling evidence of food insecurity (food deprivation and livelihood collapse), acute malnutrition and mortality to support the classification.

An area is classified in **Famine with reasonable evidence** if minimally adequate evidence is available on two out of the three outcomes – food insecurity (food deprivation and livelihood collapse), malnutrition or mortality – to support the classification.

Famine with solid evidence and Famine with reasonable evidence are equally severe – the only difference is the amount of reliable evidence available to support the statement.

The risk of Famine

The IPC defines risk of Famine as the reasonable probability of an area going into Famine in the future (i.e. during the IPC projected period). While this is not the most likely scenario, it is one that generally has a realistic chance of occurring. It complements the IPC projections by providing insights into potential for Famine to occur if conditions evolve in a manner worse than anticipated. It differs from IPC Phase 5 (Famine) projections because it focuses on a worst-case scenario with a reasonable and realistic chance of happening, as opposed to the most likely scenario.

Risk of Famine is a statement about the potential deterioration of the situation. It is not a classification and it is not to be accompanied by estimates of populations facing this risk. It is a further assessment analysing if the area could realistically go into IPC Phase 5 (Famine) during the projected period.

Not all areas need to undergo assessment for risk of Famine but only areas where there are concerns that forecasts may evolve in a manner that is worse than anticipated (usually in the case of additional significant shocks) and under these conditions, the situation could evolve into a Famine.

Figure 8. Key differences between IPC Phase 5 (Catastrophe); IPC Phase 5 (Famine); and risk of Famine

Phase	Description
IPC Phase 5 Catastrophe 	IPC Phase 5 (Catastrophe) can only be classified at household level, not at area level. Households may be classified in IPC Phase 5 (Catastrophe) even if the area is not classified in IPC Phase 5 (Famine). This is the case when less than 20 percent of the population is experiencing IPC Phase 5 (Catastrophe) conditions and/or when malnutrition and/or mortality levels have not (or not yet) reached Famine thresholds.
IPC Phase 5 Famine Mapping Protocol  Mapping Protocol 	IPC Phase 5 (Famine) exists in areas where at least one in five (or 20 percent of) households has or is most likely to have an extreme lack of food and faces starvation, resulting in death, destitution and extremely critical levels of acute malnutrition. Famine with Solid Evidence: An area is classified in Famine with solid evidence if there is clear and compelling evidence of food insecurity, acute malnutrition, and mortality to support the classification. Famine with Reasonable Evidence: An area is classified in Famine with reasonable evidence if there is clear evidence that two of the three thresholds for food insecurity, acute malnutrition and mortality have been reached, and analysts reasonably assess from the broader evidence that the threshold from the third outcome has likely been reached.
Risk of Famine Mapping Protocol 	Risk of Famine refers to the reasonable probability of an area going into Famine in the projected period, when IPC Phase 5 (Famine) is not the most likely scenario. Unlike IPC Phase 5 (Catastrophe) and IPC Phase 5 (Famine), risk of Famine is only a statement and not a classification.



2.4 Communicating the IPC Acute Food Insecurity phases

IPC Acute Food Insecurity phase names

To establish a shared understanding among audiences, it is vital to use standardized terms and uniform language when referring to different levels of severity of acute food insecurity as defined by the IPC. The following outlines how IPC AFI classifications can be effectively communicated.

- ▶ Write/communicate an IPC phase (not a IPC phase).
- ▶ The IPC phases should be written as follows:
 - IPC Phase 1 (None/Minimal) OR None/Minimal (IPC Phase 1)
 - IPC Phase 2 (Stressed) OR Stressed (IPC Phase 2)
 - IPC Phase 3 (Crisis) OR Crisis (IPC Phase 3)
 - IPC Phase 4 (Emergency) OR Emergency (IPC Phase 4)
 - IPC Phase 5 (Catastrophe) OR Catastrophe (IPC Phase 5)
 - IPC Phase 5 (Famine) OR Famine (IPC Phase 5)
- ▶ At first mention, use the full phase name, e.g., IPC Phase 4 (Emergency). Following the first mention of a phase, it is acceptable to refer to the phase as Phase 1, Phase 2, etc., without the characterization (i.e. Phase name). However, this does not apply to IPC Phase 5, where there is a distinction between Famine and Catastrophe.
- ▶ The phase characterizations should not be used on their own to describe a phase, e.g. A third of the people of country x are in the emergency phase. Instead, correct wording should be: A third of the people of country x are in IPC Phase 4 (Emergency).
- ▶ When referring to populations classified in IPC Phase 3 (Crisis); IPC Phase 4 (Emergency); and IPC Phase 5 (Catastrophe/Famine), the formulation IPC Phase 3 or above (Crisis or worse) can be used to capture the overall situation.

Using qualifiers to describe phases

To assist IPC partners and other stakeholders in accurately and consistently describing IPC phases to their audiences, the IPC offers the general descriptors below as common-language ways of referring to each of these phases. This can help ensure the severity of the IPC AFI scale is communicated in terms familiar to lay readers and consistent across different contexts. In this way, the extent of severity in different situations can be easily compared while retaining a firm association with the underlying technical classifications.

It is important to note that these adjectives are only meant to describe the severity of the situation in any of the IPC phases of interest for media and general communication purposes and should not substitute or be confused with the official names of the IPC AFI phases, which should be used in all standard IPC communication products. When qualifying the phases, descriptors (low, mild, crisis, critical or catastrophic) are used on their own and not preceded by IPC phase numbers, therefore, they should not be capitalized.

- ▶ Low levels of acute food insecurity – IPC Phase 1
- ▶ Mild levels of acute food insecurity – IPC Phase 2
- ▶ Crisis levels of acute food insecurity – IPC Phase 3
- ▶ Critical levels of acute food insecurity – IPC Phase 4
- ▶ Catastrophic levels of acute food insecurity – IPC Phase 5

2.4.1 IPC Phase 1 (None/Minimal)

Technical description

IPC Phase 1 classification is applied to areas where at least 80 percent of households are able to meet their essential needs. Even if the area is classified in IPC Phase 1, a share of households that form less than 20 percent can still be classified in worse phases. An IPC Phase 1 classification is applied to households/people who are able to meet their essential food and non-food needs without engaging in atypical and unsustainable strategies to access food and income.

Interpretation

Acute food insecurity is low or non-existent. The overwhelming majority of households in a given area



are able to access enough food (in terms of quantity) to meet their basic needs and are able to do so without jeopardizing their future ability to access food and income. At the area level, fewer than one in five households fail to meet their needs in the manner described above.

Call to action

At this phase, urgent action¹⁰ is not required. In some contexts, poverty, poor quality of diet and limited options for accessing food and income may persist, even if households are able to meet their basic needs and are classified in IPC Phase 1. Action should focus on resilience building and disaster risk reduction to mitigate the potential for future shocks to drive these populations into acute food insecurity. Households in IPC Phase 1 may also have longer term needs (not captured in the IPC AFI classification) related to the quality of their diet.

2.4.2 IPC Phase 2 (Stressed)

Technical description

Areas are classified in IPC Phase 2 (Stressed) when at least 20 percent of households in these areas have minimally adequate food consumption but cannot afford some essential non-food expenditures without engaging in stress coping strategies. In this situation it is still possible to have some households (<20 percent) classified in a worse phase.

Interpretation

People in IPC Phase 2 eat minimally adequate diets but have to make choices (e.g. selling non-productive assets, spending savings or borrowing money) to afford other essential expenses (e.g. school fees or medical bills).

Call to action

In IPC Phase 2, action is required to enable households to sustain themselves and cope with any future shocks (e.g. natural disaster, economic crisis, conflict).

The cost of inaction

Failure to protect people's livelihoods and ability to cope with future shocks may force them to either sacrifice essential non-food expenditures (e.g. schooling, medication, etc.), or reduce their food consumption in order to sustain other needs. They may also engage in unsustainable coping strategies that will negatively affect their capacity to acquire food in the future, as well as other aspects of their lives, e.g. health due to reduced household expenditures on healthcare.



DOS

Appropriate reporting for IPC Phase 2 (Stressed)

Current Classification: Households in XXX and XXX regions of XXX republic are experiencing mild acute food insecurity or IPC Phase 2 (Stressed) driven by dry spells and increasing food prices. In Phase 2, people have minimally adequate diets but face challenges covering non-food expenses. They require livelihood support and disaster risk reduction measures to avert the risk of transitioning into more severe phases.

Projected Classification: About XX million people in XX and XX regions of XX republic will likely experience mild levels of acute food insecurity or IPC Phase 2 (Stressed) between June and August 20XX as food prices are expected to remain high and rains likely to fail. Interventions to protect livelihoods and mitigate the effects of future shocks are required to prevent further deterioration of the situation in the coming months.



DON'TS

Language to avoid

It is not recommended to describe the area as in crisis or critical levels of food insecurity or use adjectives that indicate high severity.

¹⁰ While the primary focus of this call to action is directed towards households in this phase, it is essential to recognise that a portion of households (less than 20 percent) may still be categorized in worse Phases. Consequently, the response actions tailored to households in these distinct phases may necessitate variations. This note applies to "Call to action" sections in this guidance from Phases 1 to 4.



2.4.3 IPC Phase 3 (Crisis)

Technical description

Areas are classified in IPC Phase 3 (Crisis) when at least 20 percent of households in these areas either:

- ▶ Have food consumption gaps reflected by high or above-usual acute malnutrition; or
- ▶ Are marginally able to meet minimum food needs but only by depleting essential livelihood assets or through crisis-coping strategies.

Even if the area is classified in Phase 3, a share of households that form less than 20 percent can still be classified in worse phases.

At the household level, Phase 3 outcomes are manifested by moderate food gaps, or by use of crisis level livelihood coping strategies (e.g. sale of productive assets) to mitigate food gaps.

Interpretation

In areas classified in Phase 3, households are already unable to meet their minimum food needs and either suffer from those food deficits outright or are forced to make the choice to protect food consumption by engaging in coping strategies that will harm their future ability to access food and sustain their livelihoods. For example, they may sell significant productive assets, forgo essential healthcare, or withdraw children from school so that they can eat. As households resort to increasingly severe coping mechanisms, the typically most nutritionally vulnerable (e.g. children and pregnant and breastfeeding women) may start to bear the consequences of food consumption gaps, resulting in high or above-average acute malnutrition levels. At this point, action is needed to ensure immediate relief and support households' ability to sustain themselves and protect families from the dilemma of making choices that will likely lead to worse outcomes in the future.

Call to action

Urgent action is required to reduce food consumption gaps at the household level and protect livelihoods. Implementing rapid response can effectively lessen food gaps, safeguard assets and livelihoods and prevent health and social risks. This is a more cost-effective approach compared to a delayed humanitarian

response that might see households/people slide into worse phases, which should be avoided at all costs.

The cost of inaction

Without timely and appropriate assistance, households will likely:

- ▶ Experience food consumption gaps that may lead to high levels of acute malnutrition.
- ▶ Continue employing harmful coping strategies limiting their future ability to access food (short / longer-term).
- ▶ Experience health and social risks because of desperate coping strategies.
- ▶ Slip into IPC Phase 4 (Emergency) and increasingly rely on humanitarian assistance.



DOS

Appropriate reporting for IPC Phase 3 (Crisis)

Current Classification: Over XX million people in the XXX republic are experiencing crisis levels of acute food insecurity, classified in IPC Phase 3, coinciding with a prolonged spate of drought and high food prices. In Phase 3, households are unable to meet their essential food requirements and resort to unsustainable coping measures. There is urgent need for food and livelihood assistance to prevent a further deterioration.

Projected Classification: About XX million people in XX and XX regions of XX republic will likely experience crisis levels of acute food insecurity between June and August 20XX as food prices are expected to remain high and rains likely to fail. Agencies are calling for urgent funding to prevent further deterioration in the coming months..



DON'TS

Language to avoid

It is inappropriate to use terms such as: critical / extreme hunger / catastrophic / on the verge of Famine / on the brink of Famine / one step away from Famine / at risk of Famine / pockets of Famine / classified in Famine. This terminology is only applicable to IPC Phase 5.



2.4.4 IPC Phase 4 (Emergency)

Technical description

Areas are classified in IPC Phase 4 (Emergency) when at least 20 percent of households in these areas have significant food consumption gaps, which are reflected in high acute malnutrition and excess mortality, or can only mitigate significant food consumption gaps by employing emergency livelihood strategies. In Phase 4, the prevalence of global acute malnutrition is often between 15 and 30 percent and often engagement in emergency coping strategies is not sufficient to alleviate food deficits. Even if the area is classified in IPC Phase 4, a share of the population can still be classified in IPC Phase 5 (Catastrophe).

Interpretation

In IPC Phase 4 (Emergency), households face large food shortages, which are either reflected in high acute malnutrition levels and excess mortality or mitigated by using emergency coping strategies that severely corrode their well-being and livelihoods. For instance, households may turn to eating seeds intended to be used for the next planting season, selling their last breeding animal, begging or selling their land or house to access food. Assistance is urgently needed in these cases to save households from mortgaging their futures and livelihoods to avoid hunger and preventable deaths.

Call to action

- Large-scale and urgent action is needed to reduce food consumption gaps and prevent livelihood depletion, starvation and further wasting and death – especially among children under five.

***Note on the role of communication in IPC Phase 4 (Emergency):** Communication plays a critical role in IPC Phase 4 (Emergency) in that it has the power to prevent an already precarious situation from deteriorating further and reaching IPC Phase 5, and potential Famine. Effective communication can help address immediate challenges, mobilize resources and implement timely intersectoral life-saving interventions to mitigate the severity of the crisis.*

The cost of inaction

Without immediate and appropriate assistance, households will likely:

- ▶ Face extreme food gaps and deterioration in nutrition status.
- ▶ Face starvation that leads to death.
- ▶ Continue resorting to destructive, irreversible coping strategies leading to an inability to access food (short and longer term).
- ▶ Risk slipping into IPC Phase 5 (Catastrophe) and face destitution, starvation and death.



DOS

Appropriate reporting for IPC Phase 4 (Emergency)

Current Classification: Over XX million people in the XXX republic are experiencing critical levels of acute food insecurity, IPC Phase 4 (Emergency), driven by high prices and widespread crop failure. This classification is characterized by large food gaps and high levels of acute malnutrition. Immediate, life-saving assistance is needed to prevent a catastrophe.

Projected Classification: About XX million people in the XXX republic will likely experience critical levels of acute food insecurity, IPC Phase 4 (Emergency), between June and August 20XX as food prices are expected to remain high and rains likely to fail.



DON'TS

Language to avoid

It is inappropriate to use terms such as: catastrophic / Famine / on the verge of Famine / on the brink of Famine / close to Famine / people are starving / starvation / one phase/step away from Famine / pockets of Famine / Famine is likely. Risk of famine should also be avoided as a way to refer to the Phase 4 classification. Shifting from IPC Phase 4 to IPC Phase 5 (Famine) entails a significant deterioration of the context, which tends to be exceptional.



2.4.5 IPC Phase 5 (Catastrophe)

Technical description

Households in IPC Phase 5 (Catastrophe) have an extreme lack of food and/or are unable to meet other basic needs even after full employment of coping strategies. Household members face starvation and a significantly increased risk of acute malnutrition and death.

Note: IPC Phase 5 (Catastrophe) is applied only to households and not as an area-level classification. Households may be classified in IPC Phase 5 (Catastrophe) even if the area is not classified in IPC Phase 5 (Famine). This is the case when less than 20 percent of households are experiencing IPC Phase 5 (Catastrophe) conditions and/or when malnutrition and/or mortality levels have not (or not yet) reached Famine thresholds.

Interpretation

Even when using all possible strategies to cope with the situation, people face an extreme lack of food and cannot meet their basic needs. Starvation and death are evident.

Call to action

Urgent and immediate action, including large-scale and multi-sectoral response and the protection of humanitarian access is needed to prevent the total collapse of livelihoods, increased starvation, death and possible deterioration into a full-blown Famine.

The cost of inaction

Without immediate large-scale and multi-sectoral assistance, households/the area will likely:

- ▶ Continue facing an extreme lack of food – resulting in rising acute malnutrition.
- ▶ Face increased destitution, starvation and death of adults and children.



DOS

Appropriate Reporting for IPC Phase 5 (Catastrophe)

Current Classification: Latest IPC data shows that about XX people in XXX region of XXX republic are experiencing catastrophic levels of hunger and a collapse of their livelihoods, driven by a severe drought. If these populations classified in IPC Phase 5 (Catastrophe) do not get immediate humanitarian assistance, many could die. A further XXX people classified in IPC Phase 4 (Emergency) also need urgent action to save lives and livelihoods.

Projected Classification: About XXX people in the XXX region of XXX republic will likely experience catastrophic levels of food insecurity, characterized by starvation and the collapse of livelihoods, between June and August 20XX, as rains are expected to fail. They are classified in IPC Phase 5 (Catastrophe), and urgent humanitarian action is needed to mitigate starvation and acute malnutrition and prevent further deaths.

Language to use

Area is one step away from Famine / on the brink of Famine / on the cusp of Famine / catastrophic levels of food insecurity / catastrophic food insecurity / catastrophic hunger / people are dying or facing death / people are starving or facing starvation / total collapse of livelihoods is evident.



DON'TS

Language to avoid

People are experiencing Famine / people are in Famine conditions / people are in Famine-like conditions / people are in Famine-likely conditions / parts or pockets of XX region are in Famine-like conditions.



2.4.6 IPC Phase 5 (Famine)

Famine is among the most loaded and overused terms in humanitarian communication. Experiences from Somalia and South Sudan Famines show that the word evokes strong emotional reactions and triggers some form of action. Recent years have seen an increase in and casual use of Famine messaging by humanitarian and development actors and, in most cases, backed by no concrete evidence. Whereas some food security situations may be critical – falsely or negligently making Famine statements poses a significant problem for those who make response decisions with limited resources. Learn more about what Famine is and how it is classified in [the IPC Famine Factsheet](#).

Consequences of the misuse or overuse of the word Famine are:

- ▶ The word Famine losing its resonance.
- ▶ Key stakeholders losing interest whenever a Famine alarm is sounded.
- ▶ Misallocation of scarce time, human and financial resources.
- ▶ The undermining of the reliability of humanitarian communication.
- ▶ Mistakenly establishing Famine as the threshold for when urgent humanitarian action begins to be needed.

Technical description

Famine is an IPC classification at the area level. Areas are classified in IPC Phase 5 (Famine) when at least one in five (or 20 percent) people or households have an extreme lack of food and face starvation and destitution, resulting in extremely critical levels of acute malnutrition and death. Famine can be classified based on two levels of evidence, which include:

Famine with solid evidence: An area is classified in Famine with solid evidence if there is clear and compelling evidence that the Famine thresholds for acute food insecurity (food deprivation and livelihood collapse), acute malnutrition and mortality have been reached.

Famine with reasonable evidence: An area is classified in Famine with reasonable evidence if there is clear evidence that two of the three thresholds for acute food insecurity (food deprivation and livelihood collapse), acute malnutrition and mortality have been reached, and analysts reasonably assess from the broader evidence that the threshold from the third outcome has likely been reached.

Interpretation

In IPC Phase 5 (Famine), even after full employment of strategies to cope with the situation, people face an extreme lack of food and cannot support their basic needs. Starvation and death are evident. An area is classified in IPC Phase 5 (Famine) based on the following criteria:

- ▶ At least 1 in 5 households face an extreme food shortage.
- ▶ Roughly 1 in 3 or a higher proportion of children are acutely malnourished.
- ▶ At least 2 in every 10,000 people are dying daily (or at least 4 in every 10,000 children under 5 are dying daily) because of outright starvation or the interaction of malnutrition and disease.

There are two subcategories for a Famine classification, including Famine with solid evidence and Famine with reasonable evidence. Both classifications are equally severe – the only difference is the amount of reliable evidence available to support the statement.

Whereas some emergencies occur suddenly – such as tsunamis, earthquakes and floods – Famine is unique. In most known cases, Famines gradually build up over time due to long-term drivers such as conflict, extreme drought, extreme poverty, the breakdown in government and institutions, etc. Famines are never inevitable – they are almost always foreseeable, preventable and man-made. It is important to note that Famine is a phase rarely classified and considered a failure of the humanitarian system.

Call to action

Immediate, large-scale, unobstructed multi-sector humanitarian assistance is needed to avert total collapse of livelihoods, starvation and further death. It is important to remember that stopping a **Famine** is a



race against time, and every effort by all actors counts. Timely and decisive actions can save lives and alleviate suffering.

For classifications in Famine with reasonable evidence, additional evidence – for example on mortality – should be collected to further assess the situation.



DOS

Language to use when Famine is classified: Famine is occurring / area is in Famine / people or children are dying / people or children are starving / widespread death and collapse of livelihoods is occurring / catastrophic hunger is occurring.

Language to use when Famine is projected: Famine is imminent / Famine is looming / area is projected to be in Famine in a given period.



DOS

Appropriate reporting for IPC Phase 5 (Famine) with solid evidence

Current Classification: Authorities in XXX Republic have declared a famine in XXX region, where around XXX people are experiencing catastrophic levels of food insecurity driven by a severe drought and the effects of the long-running conflict. The IPC analysis of food insecurity, acute malnutrition and mortality data shows that all three critical thresholds have been surpassed, confirming Famine with solid evidence. Urgent and immediate response is needed to prevent further starvation and deaths. An additional XXX people, classified in IPC Phase 4 (Emergency), also need urgent assistance to save lives and livelihoods.

Projected Classification: Experts warn that XX region will likely face a famine between June and July 20xx as conflict is expected to intensify and urgently needed assistance is unlikely to be delivered. This classification is characterized by a total collapse of livelihoods, starvation, extremely critical levels of acute malnutrition and death. During that time, XX people are expected to experience catastrophic levels of food insecurity. Urgent action is needed now to avert likely widespread starvation and death.



DOS

Appropriate reporting for IPC Phase 5 (Famine) with reasonable evidence

Current Classification: Authorities in XXX Republic have declared a famine in XXX region, where around XXX people are experiencing catastrophic levels of food insecurity driven by a severe drought and the effects of the long-running conflict. The IPC analysis shows that two out of three critical thresholds have been surpassed, confirming a Famine, based on reasonable evidence. Urgent and immediate response is needed to prevent further starvation and deaths. An additional XXX people, classified in IPC Phase 4 (Emergency), also need urgent assistance to save lives and livelihoods.

Projected Classification: Experts warn that there is reasonable evidence that XX region will likely face a famine between June and July 20xx as conflict is expected to intensify and urgently needed assistance is unlikely to be delivered. This classification is characterized by a total collapse of livelihoods, starvation, extremely critical levels of acute malnutrition and death. During that time, XX people are expected to experience catastrophic levels of food insecurity. Urgent action is needed now to avert likely widespread starvation and death.



DON'TS

The IPC only classifies a famine, it does not declare it. It is inappropriate to attribute a declaration to the IPC. While famine can be classified based on either solid or reasonable evidence, presenting these as distinct outcomes is incorrect. The severity of the situation remains the same.



The cost of inaction

Without the delivery of immediate, large-scale, multi-sector humanitarian assistance, the human cost will be extremely high. Mass starvation and the widespread death of adults and children will likely intensify – deepening and widening the Famine conditions.

2.4.7 Risk of Famine

The IPC defines risk of Famine as the reasonable probability of an area going into Famine in the projected period. While this may not necessarily be the most likely scenario, it is one that generally has a realistic chance of occurring. It complements the IPC projections by providing insights into potential Famine if conditions evolve in a manner worse than anticipated. It differs from IPC Phase 5 (Famine) projections because it focuses on a worst-case scenario with a reasonable and realistic chance of happening.

It is a statement about the potential deterioration of the situation. It is not a classification, and it is not to be accompanied by estimates of populations facing this risk. It is a further assessment focusing on analysing if the area could realistically go into IPC Phase 5 (Famine), during the projected period.



DOS

Appropriate Reporting for the Risk of Famine

Risk of Famine: XXX region in the north of XXX republic is classified in IPC Phase 4 (Emergency). However, the analysis also showed a risk of Famine in XXX region in the coming months if the conflict escalates and humanitarian assistance delivery plans are hampered, partners have warned. The agencies call for the urgent cessation of hostilities and for parties to the conflict to allow unimpeded humanitarian access to XXX to prevent potential widespread starvation and death.

Call for Prevention: Humanitarian agencies in XXX republic have called for urgent and immediate action to prevent a potential Famine that could affect hundreds of thousands of people. A combination of conflict, population displacement and failed rains is pushing people in the region into catastrophic levels of hunger and possible Famine.



DON'TS

A risk of Famine statement should not be communicated as a definite future outcome but one with a realistic chance of occurrence and a reference to the key drivers that might lead to a Famine.



2.4.8 IPC Phase 3 or above (Crisis or worse)

In countries grappling with high levels of acute food insecurity, the primary focus tends to be on the populations categorized within IPC phases 3 (Crisis), 4 (Emergency) and 5 (Catastrophe) as these populations urgently require interventions to safeguard livelihoods, mitigate food deficits and save lives. For communication purposes, the number of people classified in these IPC phases can thus be aggregated into a single number, corresponding to the number of people in IPC Phase 3 or above.

Technical description

Humanitarian response prioritizes populations/areas classified in IPC Phase 3 (Crisis), IPC Phase 4 (Emergency) and IPC Phase 5 (Catastrophe/Famine), due to the high severity of acute food insecurity in these phases. Identifying the total population in IPC Phase 3 or above (Crisis or worse) refers to those whose livelihoods are affected and/or who face significant food deficits and thus need urgent action. For the combination of these phases, it is essential to use words such as “high levels of acute food insecurity” or “severe food insecurity” to communicate the food security conditions accurately.

Interpretation

- ▶ People in Phase 3 are unable to meet their minimum food needs and are forced to make hard choices to be able to afford food. For example, they would engage in ways of coping that could harm their future ability to get food and sustain their families (e.g. selling their productive assets or withdrawing children from school so that they can eat).
- ▶ In Phase 4, people’s severe lack of food is reflected in high levels of acute malnutrition, excess mortality or resorting to coping strategies that severely corrode their wellbeing and income.
- ▶ In Phase 5, livelihoods have collapsed, people’s lives and futures have been lost and the social safety nets and networks have been significantly disrupted.
- ▶ Decision-makers should be informed that estimations refer to numbers of people in need of action further to the action already taken.

Call to action

Populations classified in IPC Phase 3 or above (Crisis or worse) require urgent response action to fill their food needs and to protect and save lives and livelihoods. Timely intervention in Phase 3 to reduce food consumption gaps at the household level and protect livelihoods can effectively lessen food gaps, safeguard assets and livelihoods, and prevent health and social risks. Implementing rapid response is essential to lower the cost of late humanitarian response to higher Phases. In areas with higher severity (Phase 4 and Phase 5), immediate, large-scale, unobstructed multi-sector humanitarian assistance is needed to avert a total collapse of livelihoods, starvation and further deaths.

The cost of inaction

The cost of inaction to acute food insecurity in IPC Phase 3 or above (Crisis or worse) can be high and long-lasting – affecting individuals, communities and entire countries. When people do not have access to adequate food, it can lead to severe and chronic food deficits and malnutrition. These conditions can cause physical and mental health problems, including stunted growth, weakened immune systems and impaired cognitive development. Unless action is taken at this critical stage, many more people could quickly fall into deeper poverty and further be exposed to health risks and food insecurity. In addition to the human toll, there are also economic costs associated with acute food insecurity. For example, when people are unable to work due to lack of energy, it can lead to lost productivity and reduced economic output. This can further exacerbate poverty and food insecurity, creating a cycle of deprivation that is difficult to break and can lead to migration. There are also broader societal and political implications of general inaction on acute food insecurity. For example, food shortages can lead to civil unrest and political instability, as people become increasingly desperate for basic necessities. In extreme cases, it can even lead to conflict, violence and forced displacement.



DOS

Appropriate reporting for IPC Phase 3 or above (Crisis or worse)

Current Classification: About XX million people in XX republic are going hungry and losing their livelihoods and income driven by a prolonged drought compounded by a food price surge. This includes XX million people classified in IPC Phase 4 (Emergency) and at least XXX people experiencing catastrophic conditions in IPC Phase 5 (Catastrophe). This population needs urgent lifesaving and livelihood assistance to prevent further deterioration.

Projected Classification: Approximately XX million people in XX republic will likely experience heightened hunger between XXX and XXX 20XX XXX and XXX. The IPC projects that XX million people will likely experience IPC Phase 3 (Crisis) and xx million people IPC Phase 4 (Emergency). Additionally, in the same period, at least XXX people in XXX locality are expected to face catastrophic hunger, classified in IPC Phase 5 (Catastrophe). To prevent this dire situation, urgent lifesaving and livelihood assistance is imperative.



DON'TS

The focus for urgent interventions is on the populations classified within IPC Phases 3 (Crisis), 4 (Emergency) and 5 (Catastrophe / Famine). It is not appropriate to include those in IPC Phase 2 (Stressed) here.



THE IPC ACUTE MALNUTRITION CLASSIFICATION

3.1 Overview of the IPC Acute Malnutrition Scale

Acute malnutrition is rising globally, affecting over 45 million children under 5 worldwide, according to the latest estimates by UNICEF, WHO and the World Bank,¹¹ and over 13 million of them are affected by severe acute malnutrition, a lethal form of malnutrition. Practical response actions to acute malnutrition require effective communication. The IPC Acute Malnutrition (IPC AMN) classification involves multiple complex technical terminologies. This section of the guidelines aims to translate technical complexity into simpler ways to communicate IPC AMN findings when engaging with non-specialist stakeholders like the media, policymakers, donors and the public.

3.2 Key definitions

Malnutrition occurs when an individual's diet lacks the necessary nutrients – such as proteins, carbohydrates, fats, vitamins and minerals – required for proper growth, development and maintenance of overall health. Malnutrition can manifest in different forms:

Acute malnutrition

Referred to as wasting and/or nutritional oedema,¹² acute malnutrition occurs when a person's body does not get enough energy or nutrients for a period of time. It is usually caused by a sudden loss of food or an increase in food demand or a decrease in absorption of food due to illness, infection or other factors. The symptoms of acute malnutrition include rapid weight loss, loss of muscle mass, fatigue, weakness and a weakened immune system that in turn can increase the risk of infection. Acute malnutrition can lead to severe health complications and even death without prompt treatment.

Acute malnutrition can affect people of all ages but is particularly common in children under five years of age and pregnant and breastfeeding women due to their higher nutritional needs and the detrimental effects of poor nutrition on their health:

- **Children:** all children under five years of age.
- **Pregnant and breastfeeding women:**¹³ Well-nourished women who are either pregnant or breastfeeding their infants need approximately an additional 300 to 400 kilocalories per day, compared with the amount they consumed before pregnancy.

The term acute malnutrition (wasting or nutritional oedema) is sometimes referred to as wasting.

Wasting

Wasting is defined as low weight-for-height – i.e. having a weight-for-height (WH) or weight-for-length (WL) z-score (Z) more than 2 standard deviations (SD) below the median of the WHO child growth standards (WHZ or WLZ < -2). It often indicates recent and severe weight loss, although it can persist for a long time (several weeks). Wasting can be moderate or severe. It usually occurs when a person has not had food of adequate quality and quantity and/or has had frequent or prolonged illnesses. Wasting in children is associated with a higher risk of death if not treated properly.¹⁴

UNICEF¹⁵ characterizes severe wasting as the most lethal form of undernutrition and one of the top threats to child survival. It is a condition caused by a lack of nutritious food and repeated bouts of childhood illnesses due to the compromised immunity. Severely wasted children succumb to these diseases because their bodies provide virtually no defence against bacteria, viruses or fungi that might infect them. A severely wasted child is reduced to the most basic bodily functions, and it takes all their energy to keep breathing and keep their heart beating.

¹¹ UNICEF-WHO-The World Bank: Joint Child Malnutrition Estimates (JME) — Levels and Trends – 2023 edition. <https://data.unicef.org/resources/jme-report-2023/>.

¹² Briefing note. WHO guidelines on the prevention and management of wasting and nutritional oedema (acute malnutrition in infants and children under 5 years https://www.childwasting.org/_files/ugd/2b7a06_2cf788d9c0f342b89c054b288f4862e3.pdf).

¹³ WHO guidelines on the prevention and management of wasting and nutritional oedema (acute malnutrition in infants and children under 5 years. <https://www.childwasting.org/normative-guidance>

¹⁴ WHO. Malnutrition: Wasting in children is associated with a higher risk of death if not treated properly. https://www.who.int/health-topics/malnutrition#tab=tab_1

¹⁵ UNICEF. Child alert: Severe wasting. <https://www.unicef.org/child-alert/severe-wasting>



MAM, SAM and GAM

Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM) are abbreviations used to categorize different levels of acute malnutrition in individuals, particularly children, based on their nutritional status. Global Acute Malnutrition (GAM) among children between 6-59 months is used as a proxy measure for the general health of the entire population. MAM and SAM are now referred to as moderate wasting and severe wasting or nutritional oedema, respectively.

- **Moderate Acute Malnutrition or moderate wasting (MAM):** Refers to a moderate degree of malnutrition where children have a significant but not severe deficiency of essential nutrients. Children with MAM often exhibit symptoms such as weight loss, loss of muscle mass and slowed growth. MAM is an indicator for which immediate action is required to prevent the condition from worsening to severe malnutrition. MAM among children 6-59 months is identified by weight-for height z scores (WHZ) < -2 and ≥ -3 (below the WHO child growth standards media), and/or by Mid-Upper Arm Circumference (MUAC) < 125 mm and ≥ 115 mm.
- **Severe Acute Malnutrition or severe wasting/nutritional oedema (SAM):** Represents the most severe form of malnutrition, characterized by a severe deficiency of nutrients and significant weight loss. Children with SAM usually experience severe wasting, stunted growth and other visible signs of malnutrition. SAM is a life-threatening condition that requires urgent medical attention and specialized treatment. SAM among children 6-59 months is identified by WHZ < -3 , or MUAC < 115 mm, and/or the presence of bilateral pitting oedema.
- **Bilateral pitting oedema:** Also known as nutritional oedema and oedematous malnutrition, bilateral pitting oedema is a type of severe acute malnutrition. It is identified when thumb pressure applied to the tops of both feet for three seconds, leaves an indentation in the foot after the thumb is lifted.
- **Global Acute Malnutrition (GAM):** Combines MAM and SAM and provides the most precise picture of acute malnutrition in a population at a specific time. GAM among children 6-59 months is measured by weight-for-height z-score and/or bilateral pitting oedema, as described above.

Weight-for-height/length

Weight-for-height/length is a measurement used to assess nutritional status and identify potential malnutrition or undernutrition in individuals. It is commonly used in children under the age of five and it compares a child's weight to their height/length and provides a standardized score called the Z-score.¹⁶ This score indicates how a child's weight compares to the average weight of children of the same height/length and sex. The Z-score helps identify if a child is wasted, normal, overweight or severely overweight (obese). The WHO provides growth standards and reference data to calculate the Z-scores for weight-for-height/length. These standards are based on a large sample of healthy children from different countries and ethnic backgrounds.

Mid-Upper Arm Circumference (MUAC)

MUAC is a simple measurement of the left mid-upper arm circumference that can identify children (6-59 months) who are acutely malnourished and at risk of dying. It typically uses colour-coded (based on the severity of acute malnutrition) tape wrapped around the left upper arm. Children whose arm circumference falls within the red or yellow indicator on the coloured tape are malnourished and should be referred to the nearest health or nutrition centre. MUAC is also used to assess acute malnutrition among pregnant and breastfeeding women. Pregnant and breastfeeding women with MUAC measurement of less than 230 mm typically considered as having acute malnutrition.

3.3 Causes of acute malnutrition

Acute malnutrition has many interrelated immediate and underlying causes that must be addressed effectively during an emergency. The IPC Acute Malnutrition Analytical Framework can be used to understand the many factors that impact acute malnutrition. It identifies three levels of causality: immediate, underlying and basic, which can all be exacerbated during emergencies.

- **Immediate causes:** The immediate-level causes of acute malnutrition include inadequate dietary intake and diseases. At this level, acute malnutrition results from an imbalance between the required

¹⁶ WHO. Child Growth Standards. <https://www.who.int/childgrowth/en/>



amount of nutrients by the body and the actual amount of nutrients introduced or absorbed by the body. Reduced dietary intake, reduced absorption of macro- and/ or micronutrients and increased energy expenditure in specific disease processes (including diarrhoea, dysentery, cholera, acute watery diarrhoea, malaria, acute respiratory infection, HIV/AIDS and measles) can all be immediate causes of acute malnutrition.

- **Underlying causes:** There are three leading underlying causes of acute malnutrition: (1) acute food insecurity; (2) inadequate care; and (3) inadequate health services and unhealthy environment.
- **Basic causes:** Basic causes of acute malnutrition include acute events or ongoing conditions, such as natural disasters (e.g. drought, floods), socio-economic instability (e.g. volatility in food prices), conflict, as well as structural factors that can have an impact on acute malnutrition such as policies, social norms and cultural practices (e.g. gender dynamics).

3.4 Understanding the IPC Acute Malnutrition classification

The IPC Acute Malnutrition (AMN) scale's main focus is on identifying areas with a high proportion of acutely malnourished children that require urgent action. The IPC AMN scale classifies the severity of the

acute malnutrition situation into five phases based on the prevalence of GAM, with higher prevalence characterizing the most severe phases. IPC AMN analyses also provide information on the total estimated population (both children under five and pregnant and breastfeeding women) suffering from acute malnutrition and needing treatment.

Acute malnutrition as an outcome is affected by a range of factors. Some of these factors are structural such as maternal education, while others may be transitory such as disease epidemics and food crises. The IPC AMN scale has been developed to inform both long- and short-term objectives to address structural and transitory issues, respectively.

The five IPC phases of severity are:

- **IPC AMN Phase 1** corresponding to Acceptable level of acute malnutrition
- **IPC AMN Phase 2** corresponding to an Alert level of acute malnutrition
- **IPC AMN Phase 3** corresponding to a Serious level of acute malnutrition
- **IPC AMN Phase 4** corresponding to a Critical level of acute malnutrition
- **IPC AMN Phase 5** corresponding to an Extremely Critical level of acute malnutrition

Figure 9. IPC Acute Malnutrition phases

Phase name and description	Phase 1 Acceptable	Phase 2 Alert	Phase 3 Serious	Phase 4 Critical	Phase 5 Extremely Critical
	Less than 5% of children are acutely malnourished.	5-9.9% of children are acutely malnourished.	10-14.9% of children are acutely malnourished.	15-29.9% of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised.	30% or more children are acutely malnourished. Widespread morbidity and/or very large individual food consumption gaps are likely evident.
	The situation is progressively deteriorating, with increasing levels of acute malnutrition. Morbidity levels and/or individual food consumption gaps are likely to increase with increasing levels of acute malnutrition.				
Priority response objective to decrease acute malnutrition and to prevent related mortality. ²	Maintain the low prevalence of acute malnutrition.	Strengthen existing response capacity and resilience. Address contributing factors to acute malnutrition. Monitor conditions and plan response as required.	Urgently reduce acute malnutrition levels through →		
			Scaling up of treatment and prevention of affected populations.	Significant scale-up and intensification of treatment and protection activities to reach additional population affected.	Addressing widespread acute malnutrition and disease epidemics by all means.
Qualifiers	low	mild	elevated	critical	extremely high



3.5 Communicating the IPC Acute Malnutrition phases

IPC AMN classifications are applied only to geographic areas (e.g. District X is in IPC Phase 1; Province Y is in Phase 2; IDP Camp Z is in Phase 3, etc.), based on the percentage of children under 5 suffering from acute malnutrition. Each phase denotes certain characteristics and calls for priority actions as described below.

The IPC AMN scale does not apply classifications to populations or individuals, because the prevalence of acute malnutrition is based on an already existing assessment and categorization of severity (e.g. moderate or severe acute malnutrition/wasting). As populations are not classified in any IPC AMN phases, using phase descriptors to describe any affected group is inappropriate.

Writing AMN phase names

When writing/communicating an IPC phase (not a IPC phase), the five IPC phases should be written as follows:

- ▶ IPC AMN Phase 1 (Acceptable) OR Acceptable (IPC AMN Phase 1)
- ▶ IPC AMN Phase 2 (Alert) OR Alert (IPC AMN Phase 2)
- ▶ IPC AMN Phase 3 (Serious) OR Serious (IPC AMN Phase 3)
- ▶ IPC AMN Phase 4 (Critical) OR Critical (IPC AMN Phase 4)
- ▶ IPC AMN Phase 5 (Extremely Critical) OR Extremely Critical (IPC AMN Phase 5)

At first reference in a section or a page, use the complete phase name, e.g. IPC AMN Phase 3 (Serious). Following the first mention of a phase, it is acceptable to refer to it as Phase 1, Phase 2, etc. without the characterization (phase name).

The phase characteristic (name) should not be used to describe a phase. E.g. This area is in the Serious phase.

Using qualifiers to describe phases

These guidelines outline specific qualifiers associated with each phase of the IPC AMN scale, along with technical key messages, simplified interpretations and recommended interventions. These qualifiers are not official IPC terminology and solely describe

the situation for media and general communication purposes regarding the relevant IPC AMN phases. Here are the corresponding phases and their classifications:

- ▶ Low levels of acute malnutrition – IPC AMN Phase 1 (Acceptable)
- ▶ Mild levels of acute malnutrition – IPC AMN Phase 2 (Alert)
- ▶ Elevated levels of acute malnutrition – IPC AMN Phase 3 (Serious)
- ▶ Critical levels of acute malnutrition – IPC AMN Phase 4 (Critical)
- ▶ Extremely high levels of acute malnutrition – IPC AMN Phase 5 (Extremely Critical)

3.5.1 Communicating the total population in need of treatment

Technical description

IPC AMN analyses provide information on the estimated population (both children under five and pregnant and breastfeeding women) suffering from acute malnutrition and needing treatment. This number combines SAM and MAM cases for children and pregnant and breastfeeding women and is provided for both the current and projected period by unit of analysis/area.

Interpretation

IPC AMN analyses report on the total number of acutely malnourished children and pregnant and breastfeeding women in the current period and those likely to remain or become malnourished through the projection period, usually over the next 12 months. This number includes children and pregnant and breastfeeding women expected to be moderately and severely malnourished during the same period. The prevalence of acute malnutrition may vary during the 12-month period.

Call to action

The call-to-action advocates for a package of interventions, prioritizing the treatment of children and pregnant and breastfeeding women for all forms of acute malnutrition and preventing others from relapsing/becoming acutely malnourished.



Cost of inaction

If preventive measures are not implemented, there is a risk of an increase in the number of acutely malnourished children and pregnant and breastfeeding women. Malnourished children and pregnant or breastfeeding women may not receive the vital nutrients necessary for healthy growth and development, potentially resulting in hindered physical and cognitive development as well as an elevated risk of morbidity and mortality.



DOS

Appropriate Reporting for Population in Need of Treatment

Current & Projected Population in need of

Treatment: The latest data shows that about (number) children under five and (number) pregnant and breastfeeding women in (country) are suffering from acute malnutrition in (months of the current period)—conditions expected to persist through (end of projection period). This includes (number) acutely malnourished children and (number) severely malnourished pregnant and breastfeeding women at risk of death.

Call to Action: Urgent and extensive humanitarian response action is needed to treat all forms of acute malnutrition and stop/prevent deaths. Response actions may involve but may not be limited to the implementation of blanket supplementary feeding in the most affected areas to protect children and pregnant and breastfeeding women from acute malnutrition and the deployment of a multi-sectoral approach to address the nutrition situation by incorporating livelihood/resilience activities into multi-sectoral nutrition response coupled with scaling up of mass screening, integrated outreach services, coordination and nutrition surveillance.



3.5.2 IPC AMN Phase 1 (Acceptable)

Technical description

The area has acceptable levels of acute malnutrition, IPC AMN Phase 1. Less than five percent of children are acutely malnourished.

Interpretation

The area has low levels of acute malnutrition since less than five percent of children are acutely malnourished.

Call to action

Priority response should include treatment of the children and pregnant and breastfeeding women that are acutely malnourished and prevent others from relapsing or becoming acutely malnourished. Access to healthcare and adequate nutrition needs to be prioritised for all children and pregnant and breastfeeding women.

Cost of inaction

Failure to address acute malnutrition in areas classified in IPC AMN Phase 1 (Acceptable) will likely result in worsening conditions and put some children, and pregnant and breastfeeding women at risk of disease and death.

3.5.3 IPC AMN Phase 2 (Alert)

Technical description

The area has Alert levels of acute malnutrition, IPC AMN Phase 2. Between 5 and 9.9 percent of children are acutely malnourished (GAM based on WHZ <-2 and/or the presence of oedema).

Interpretation

As the phase name indicates, alert is a state of careful observation and readiness to act – especially to prevent high levels of malnutrition. In this phase, the area has mild levels of acute malnutrition. Up to 1 out of 10 children are acutely malnourished, exhibiting low weight in relation to height/length or bilateral oedema – excess fluid in the lower extremities resulting in swelling of the feet and extending upward.

Call to action

Action is required to strengthen the existing capacity to:

- ▶ Provide treatment to children and pregnant and breastfeeding women who are acutely malnourished.
- ▶ Prevent others from becoming acutely malnourished
- ▶ Address causes of acute malnutrition.
- ▶ Monitor the situation and plan the required response. Prevent others from becoming acutely malnourished.

Cost of inaction

Failure to address acute malnutrition in areas classified in IPC AMN Phase 2 (Alert) may lead to the following:

- ▶ Impaired health and an increased risk of mortality among those suffering from acute malnutrition.
- ▶ An overall increase in acute malnutrition levels.
- ▶ Risk of area sliding into IPC AMN Phase 3 (Serious).



DO'S

Appropriate reporting for areas IPC AMN Phase 2 (Alert)

Current & Projected Classifications: Areas classified under IPC AMN Phase 2 (Alert) are experiencing or expected to face mild levels of acute malnutrition. This is characterized by at least one in every ten children under five suffering from acute malnutrition. To mitigate this situation, it is crucial to implement measures such as nutrition and health monitoring and early warning systems, prevention, management and treatment of acute malnutrition, promotion of improved feeding practices – including exclusive breastfeeding – and enhanced access to healthcare services. These steps are strongly recommended to prevent the nutrition situation from deteriorating further.



DON'TS

Language to avoid

The level of acute malnutrition in IPC AMN Phase 2 (Alert) is mild, and it is not appropriate to characterize it as elevated, high, critical or extremely high.



3.5.4 IPC AMN Phase 3 (Serious)

Technical description

The area has Serious levels of acute malnutrition, IPC AMN Phase 3. Between 10 and 14.9 percent of children are acutely malnourished (GAM based on WHZ <-2 and/or presence of oedema).

Interpretation

Even based on existing levels of humanitarian assistance, between 10 up to 15 children out of 100 are acutely malnourished. The area has elevated levels of acute malnutrition.

Call to action

Scale up existing capacity and response to all forms of acute malnutrition, including early detection, prevention and treatment and the provision and expansion of access to health services to address current and expected levels of acute malnutrition. Improving access to child and maternal health programmes, and improving childcare practices such as exclusive breastfeeding, complementary feeding, child bathing and cleaning and umbilical cord care is beneficial and helps prevent child malnutrition. Advocacy and expansion of immunisation and vaccination to prevent outbreaks are also essential.

Cost of inaction

Failure to respond to the serious levels of acute malnutrition in areas classified in IPC AMN Phase 3 (Serious) will likely leave children, and pregnant and breastfeeding women more susceptible to diseases and death. Failure to act may also further acute malnutrition and increase the risk of the area sliding into IPC AMN Phase 4 (Critical).



DOS

Appropriate reporting for areas in IPC AMN Phase 3 (Serious)

Current & Projected Classifications: Areas classified in IPC AMN Phase 3 (Serious) are facing/expected to face elevated levels of acute malnutrition, characterized by a high vulnerability to diseases among children, and pregnant and breastfeeding women – conditions expected to persist through (year). Urgent response actions, including treatment of acute malnutrition, promotion of improved feeding practices and better access to health services are recommended to prevent more widespread and more severe forms of malnutrition. Failure to act will likely lead to critical levels of acute malnutrition and death. Scaling up mass screening, integrated outreach services, coordination and nutrition surveillance will also go a long way in addressing and preventing acute malnutrition.



DON'TS

Language to avoid

It is inappropriate to use terms such as: very high / extremely high / critical / extremely critical as this terminology is applicable to IPC AMN Phases 4 and 5.



3.5.5 IPC AMN Phase 4 (Critical)

Technical description

The area has Critical levels of acute malnutrition, IPC Phase 4. Between 15 and 29.9 percent of children are acutely malnourished (GAM based on WHZ <-2 and/or presence of oedema). The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely compromised.

Interpretation

Up to three out of ten children suffer from acute malnutrition in areas classified in IPC AMN Phase 4 (Critical). Many children are acutely malnourished with low immunity, making them more susceptible to common childhood diseases such as dysentery, acute watery diarrhoea and measles.

Call to action

Immediate, significant scale-up and intensification of treatment and protection interventions (including prevention and management of acute malnutrition) should be rolled out to the affected population to prevent further deterioration of existing cases as well as new cases of acute malnutrition and death.

Cost of inaction

Failure to respond to conditions described in IPC AMN Phase 4 (Critical) will likely lead to the following:

- ▶ A further increase in already high acute malnutrition levels.
- ▶ More children dying as a direct result of common childhood diseases.
- ▶ Worsening of maternal health.
- ▶ Possible deterioration of the situation into IPC AMN Phase 5 (Extremely Critical).



DOS

Appropriate reporting for areas in IPC AMN Phase 4 (Critical)

Current & Projected Classifications: In areas classified in IPC AMN Phase 4 (Critical), levels of acute malnutrition among children are critical, characterized by widespread wasting as well as death from preventable diseases – conditions expected to persist through (year). Urgent response actions are needed, including supplementary feeding in the most affected areas to protect children and pregnant and breastfeeding women from acute malnutrition; improved access to child and maternal health services; and deployment of a coordinated multi-sectoral approach to address the nutrition situation coupled with scaling up of early detection and referral of acute malnutrition cases (e.g. mass screening), integrated outreach services, and nutrition and health surveillance.



DON'TS

Language to avoid

It is inappropriate to use terms such as: extremely critical / extremely high / widespread death. Shifting from IPC AMN Phase 4 to Phase 5 entails a significant deterioration of acute malnutrition conditions, which tends to be exceptional.



3.5.6 IPC AMN Phase 5 (Extremely Critical)

Technical description

The area has Extremely Critical levels of acute malnutrition, IPC AMN Phase 5. Even with humanitarian assistance, at least 30 percent of children are acutely malnourished (GAM based on WHZ <-2 and/or the presence of oedema). Note that in the absence of GAM based on WHZ <-2 and/or presence of oedema, MUAC of ≥15 percent may also be used along with contributing factors when classifying IPC AMN Phase 5.

Interpretation

This is the highest phase in the IPC AMN scale, where at least one out of three children are experiencing acute malnutrition, signalling the worst forms of human suffering and death. Diseases such as dysentery, cholera, acute watery diarrhoea and measles are prevalent, leading to widespread death.

Call to action

Halting the death of children and reversing widespread acute malnutrition is the immediate response priority. An urgent and large-scale multi-sectoral response is needed to address all causes of acute malnutrition through greater scaling up of all public health programme interventions in close coordination with all other sectors to prevent widespread death.

Cost of inaction

If nothing is done at this phase, the following will likely occur:

- ▶ Further deepening and widening of acute malnutrition beyond extremely critical levels.
- ▶ Possible deterioration of the situation into widespread death.



DOS

Appropriate reporting for areas in IPC AMN Phase 5 (Extremely Critical)

Current & Projected Classifications: High disease prevalence and widespread deaths characterize areas classified in IPC AMN Phase 5 (Extremely Critical) – the highest and most deadly classification. At least one out of three children are expected to be acutely malnourished, with many more children succumbing to/expected to die from preventable diseases, such as dysentery, cholera, acute watery diarrhoea and measles.

Urgent and wide-scale response actions are needed, including treatment of the most extreme cases of acute malnutrition; supplementary feeding in the most affected areas to protect children and pregnant and breastfeeding women from acute malnutrition; and deployment of a multi-sectoral approach to address the nutrition situation coupled with scaling up of mass screening and nutrition surveillance.



DON'TS

Language to avoid

As IPC Phase 5 (Extremely Critical) represents the most severe and life-threatening stage in the IPC AMN scale, it is inappropriate to use terms such as “mild” or “low”, which might downplay the seriousness of the situation. The language used in this phase must accurately and strongly reflect the gravity of the situation.



APPENDIX

4.1 Glossary of Terms

This glossary accompanies the IPC Communication Guidelines and is a compilation of information from various sources, including the IPC Technical Manual Version 3.1, the FAO Term Portal, the Global Health Education and Learning Incubator (GHELI) at Harvard University, the UNHCR Emergency Handbook, and the Global Report on Food Crises. References for the terms provided below are indicated in parentheses at the end of each entry. Further information can be located at the conclusion of this document.

Analysis period: The duration for which the classification remains valid can vary, spanning short to extended durations contingent upon the situation's stability and the decision-makers' requirements. This timeframe might encompass a few months to even a year. Should circumstances alter within the validity span of the assessment, an updated analysis or a fresh evaluation might become necessary. Generally, IPC analyses are generated for a minimum of two distinguishable timeframes—the current period and the projected period (IPC Technical Manual Version 3.1, 2021).

Body Mass Index (BMI): The ratio of weight for height, measured as the weight in kilograms divided by the square of height in meters (Food and Agriculture Organization of the United Nations, 2017).

Conflict: Struggles between interdependent groups that have either actual or perceived incompatibilities with respect to needs, values, goals, resources or intentions. This definition includes (but is broader than) armed conflict – that is organized collective violent confrontations between at least two groups, either state or non-state actors. [The report from which this definition is derived] focuses on conflicts that threaten or entail violence or destruction, including where fragility raises the risk of damaging conflicts and where protracted crises persist (Food and Agriculture Organization of the United Nations, 2017).

Dietary energy intake: Dietary energy intake refers to the amount of energy (calories) consumed from food and beverages. It is a measure of the energy content of the diet and is important for maintaining a healthy weight and meeting nutritional needs.

Dietary Energy Supply (DES): Food available for human consumption, expressed in kilocalories per person per day (kcal/person/day). At country level, it is calculated as the food remaining for human use after deduction of all non-food utilizations (i.e. food = production + imports + stock withdrawals – exports – industrial use – animal feed – seed – wastage – additions to stock). Wastage includes loss of usable products occurring along distribution chains from farmgate (or port of import) up to retail level (Food and Agriculture Organization of the United Nations, 2017).

Famine: The IPC defines Famine as a situation in which at least 20 percent of households face an extreme lack of food, resulting in extremely critical levels of global acute malnutrition (prevalence of acute malnutrition in children under five exceeding 30 percent) and very high excess mortality (the crude death rate must reach at least 2 deaths/10,000 people/day) (IPC Technical Manual 3.1, 2021).

Food availability and access: The quantity and diversity of the food items that are available in different food outlets (markets, stores, restaurants) and that can be physically accessed by the people living in the surrounding area. This concept can also be extended to other settings where people spend most of their time such as offices, schools and universities, where food is often acquired through vending machines, canteens, nearby kiosks and street food vendors (FAO, 2016; HLPE, 2017).

Food crises: Situations where acute food insecurity and malnutrition rise or are sustained at local or national levels, exceeding the local resources and capacities to respond and raising the need for emergency and external food assistance. They are more likely among populations already suffering from prolonged food insecurity



and malnutrition, and in areas where structural factors increase their vulnerability to shocks. The capacity of governments to respond can influence the magnitude and severity of food crises in a country. They can be temporary or protracted, and when they are repeated and/or sustained they can provoke chronic food insecurity (FAO, IFAD, UNICEF, WFP and WHO, 2023).

Food insecurity: A situation that exists when people lack secure access to sufficient amounts of safe and nutritious food for normal growth and development and an active and healthy life. It may be caused by unavailability of food, insufficient purchasing power, inappropriate distribution or inadequate use of food at the household level. Food insecurity, poor conditions of health and sanitation and inappropriate care and feeding practices are the major causes of poor nutritional status. Food insecurity may be chronic, seasonal or transitory (Food and Agriculture Organization of the United Nations, 2017).

Food security: A situation that exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. Based on this definition, four food security dimensions can be identified: food availability, economic and physical access to food, food utilization and stability over time (Food and Agriculture Organization of the United Nations, 2017).

Food security outcomes: Various conditions and states that individuals, households or communities experience in relation to their access to sufficient, safe and nutritious food. These outcomes are used to assess and measure the level of food security within a population. The outcomes can range from being well-nourished with consistent access to food to experiencing varying degrees of acute food insecurity, which can manifest as limited access to food, poor nutrition and hunger (IPC Technical Manual Version 3.1, 2021).

Fragility: Fragility is defined as the combination of exposure to risk and insufficient coping capacities of the state, system and/or communities to manage, absorb or mitigate those risks. The new OECD fragility framework is built on five dimensions of fragility – economic, environmental, political, societal and security – and measures each through the accumulation and combination of risks and capacity. See OECD, 2016. States of Fragility 2016: Understanding Violence. Paris. Available at www.oecd.org/dac/states-of-fragility-2016-9789264267213-en.htm (Food and Agriculture Organization of the United Nations, 2017).

Global Acute Malnutrition (GAM): Acute malnutrition is a condition that typically manifests when a person's body does not get enough energy or nutrients for a period of time. Acute malnutrition is usually caused by a sudden loss of food or an increase in food demand or a decrease in absorption of food due to illness, infection or other factors. Acute malnutrition encompasses both wasting [i.e. having a weight-for-height or weight-for-length z-score more than 2 standard deviations (SD) below the median of the WHO child growth standards (WHZ or WLZ < -2) and/or presence of bilateral pitting oedema and referred to as Global Acute Malnutrition (GAM)].

Healthy diet: A diet which promotes growth and development of children and prevents malnutrition in all its forms for all people. A healthy diet addresses four main components: adequacy, diversity, moderation and safety. Different sources of information help to define healthy diets, including the WHO recommendations for healthy diets; the Global Burden of Disease NCD Risk factor study; and analyses of health outcomes associated with whole dietary patterns. These emphasize the importance of increasing intake of plant foods such as fruits, vegetables (excepting starchy root vegetables), legumes, nuts and whole grains; limiting the intake of energy from free sugars and total fats; consuming unsaturated rather than saturated or trans fats; and limiting intake of salt, while using salt that is iodized as a defence against iodine deficiency. The risks associated with high consumption of processed meat are pointed to, as well as the need to shift toward plant foods and away from animal foods, excepting fish and seafood (FAO, 2019).



Kilocalorie (kcal): A unit of measurement of energy. One kilocalorie equals 1,000 calories. In the International System of Units (SI), the universal unit of energy is the joule (J). One kilocalorie =4.184 kilojoules (kJ) (Food and Agriculture Organization of the United Nations, 2017).

Lay public/audience/reader: The “lay” audience lacks specialized or expert knowledge and tends to engage with the human-interest elements of content. Typically, they require contextual information, anticipated thorough explanations and appreciate the inclusion of appealing visuals or graphics (Georgia State University, 2015).

Macronutrients: Refers to the proteins, carbohydrates and fats available to be used for energy. Measured in grams (Food and Agriculture Organization of the United Nations, 2017).

Malnutrition: An abnormal physiological condition caused by inadequate, unbalanced or excessive consumption of macronutrients and/or micronutrients. Malnutrition includes undernutrition and overnutrition as well as micronutrient deficiencies (Food and Agriculture Organization of the United Nations, 2017).

Morbidity: A state of being symptomatic or unhealthy for a disease or condition. It is usually represented or estimated using prevalence or incidence. Prevalence describes the proportion of the population with a given symptom or quality. Ischemic heart diseases, stroke, and chronic obstructive pulmonary diseases are the top diseases affecting the world population, according to the WHO. The most lethal common illnesses in children include pneumonia, diarrhoea, malaria, and measles. (The National Library of Medicine (USA), 2022).

Mortality: Mortality is a term used for the death rate or the number of deaths in a particular group of people in a certain period. Acute malnutrition, particularly in severe cases, can lead to various complications that may contribute to death. Several physiological processes are disrupted when the body does not receive adequate nutrients for an extended period, resulting in severe health consequences. (World Health Organization (WHO), 2022).

Nutrition security: A situation that exists when secure access to an appropriately nutritious diet is coupled with a sanitary environment, adequate health services and care, in order to ensure a healthy and active life for all household members. Nutrition security differs from food security in that it also considers the aspects of adequate caring practices, health and hygiene in addition to dietary adequacy (Food and Agriculture Organization of the United Nations, 2017).

Nutrition-sensitive interventions: Interventions designed to address the underlying determinants of nutrition (which include household food security, care for mothers and children and primary health-care services and sanitation) but not necessarily having nutrition as the predominant goal (Food and Agriculture Organization of the United Nations, 2017).

Nutritional status: The physiological state of an individual that results from the relationship between nutrient intake and requirements and from the body’s ability to digest, absorb and use these nutrients (Food and Agriculture Organization of the United Nations, 2017).

Obesity: See overweight and obesity (Food and Agriculture Organization of the United Nations, 2017).

Overweight and obesity: Body weight that is above normal for height as a result of an excessive accumulation of fat. It is usually a manifestation of expending fewer calories than are consumed. In adults, overweight is defined as a BMI of more than 25 but less than 30, and obesity as a BMI of 30 or more. In children under five years of age, overweight is defined as a weight-for-height greater than 2 standard deviations above the WHO Child Growth Standards median, and obesity as weight-for-height greater than 3 standard deviations above the WHO Child Growth Standards median (Food and Agriculture Organization of the United Nations, 2017).

People in Need (PiN): Estimates, used in HNOs, based on analysis that does not take into consideration humanitarian assistance. This is purely a figure for the number of people who would need assistance. The gap,



however, takes into consideration all existing and likely happening assistance, and bases the needs according to unmet needs. In cases where humanitarian food assistance is helping to cover some needs the gap figure is smaller than the PiN and should only reflect those who need assistance on top of the assistance already being provided. In cases where humanitarian food assistance is not meeting any needs or is not provided, the gap and the PiN should be equal (Inter-Agency Standing Committee (IASC), 2016).

Resilience: Resilience is the ability of individuals, households, communities, cities, institutions, systems and societies to prevent, resist, absorb, adapt, respond and recover positively, efficiently and effectively when faced with a wide range of risks, while maintaining an acceptable level of functioning and without compromising long-term prospects for sustainable development, peace and security, human rights and well-being for all (United Nations, 2017).

Strategic communication: Planned and intentional use of communication by an organization to achieve its mission and objectives. Employing information, imagery and symbols to encourage and sway audiences to take action, evoke emotions, foster creativity, cultivate goodwill and more (Harvard Kennedy School Executive Education, 2022).

Stunting: Low height for age, reflecting a past episode or episodes of sustained undernutrition. In children under five years of age, stunting is defined as a height-for-age less than –2 standard deviations below the WHO Child Growth Standards median (Food and Agriculture Organization of the United Nations, 2017).

Undernourishment: A state – lasting for at least one year – of inability to acquire enough food, defined as a level of food intake insufficient to meet dietary energy requirements. For the purposes of this report, hunger is defined as being synonymous with chronic undernourishment (Food and Agriculture Organization of the United Nations, 2017).

Undernutrition: The outcome of poor nutritional intake in terms of quantity and/or quality and/or poor absorption and/or poor biological use of nutrients consumed as a result of repeated disease. It includes being underweight for one's age, too short for one's age (stunted), dangerously thin for one's height (wasted) and deficient in vitamins and minerals (micronutrient malnutrition) (Food and Agriculture Organization of the United Nations, 2017).

Underweight: In adults, underweight is defined as a BMI of less than 18.5, reflecting a current condition resulting from inadequate food intake, past episodes of undernutrition or poor health conditions. In children under five years of age, underweight is defined as weight-for-age less than –2 standard deviations below the WHO Child Growth Standards median and is thus a manifestation of low height for age and/or low weight for height (Food and Agriculture Organization of the United Nations, 2017).

Vulnerability: The conditions determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards (UN Office for Disaster Risk Reduction (UNDRR), 2023).

Wasting: Wasting is defined as low weight-for-height. It often indicates recent and severe weight loss, although it can also persist for a long time. It usually occurs when a person has not had food of adequate quality and quantity and/or they have had frequent or prolonged illnesses. Wasting in children is associated with a higher risk of death if not treated properly (WHO, 2023).

Disclaimer: While the terms defined in this glossary have been chosen from what are believed to be dependable sources, there is no guarantee, either explicitly or implicitly, about the accuracy, comprehensiveness, legality, reliability, timeliness or utility of the provided information.



4.2 Sources of Terms

Dutko P et al. Characteristics and Influential Factors of Food Deserts. United States Department of Agriculture 2012. Page iii. https://www.ers.usda.gov/webdocs/publications/45014/30940_err140.pdf.

The State of Food Security and Nutrition in the World 2017: Building Resilience for Peace and Food Security. Food and Agriculture Organization of the United Nations, International Fund for Agricultural Development, United Nations Children's Fund, World Food Programme, World Health Organization 2017. Pages 107-108. <http://www.fao.org/3/a-l7695e.pdf>.

FAO Term Portal. Food and Agriculture Organization of the United Nations. <http://www.fao.org/faoterm/en>.

Food Sovereignty: A Right for All. NGO/CSO Forum for Food Sovereignty 2002. <https://nyeleni.org/spip.php?article125>.

Emergency Handbook. United Nations High Commissioner for Refugees 2018. <https://emergency.unhcr.org/entry/86022/acute-malnutrition-threshold>.

United Nations. 2017. Annex III. CEB/2017/6 (6 November 2017). New York, USA. <https://digitallibrary.un.org/record/3844899>

Integrated Food Security Phase Classification (IPC) Technical Manual Version 3.1 by the IPC Global Support Unit. https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC-Manual-Version-3.1.pdf

Food Security Information for Decision Making: Concepts, Guidelines, and User Guide" by the Food and Agriculture Organization of the United Nations (FAO). <http://www.fao.org/3/y5160e/y5160e00.htm>



4.3 List of Figures

Figure 1: IPC Acute Food Insecurity classification map

Figure 2: IPC Acute Malnutrition classification map

Figure 3: IPC Acute Food Insecurity population table

Figure 4: IPC Acute Malnutrition population table

Figure 5: IPC report

Figure 6: IPC snapshot

Figure 7: IPC Acute Food Insecurity phases

Figure 8: Key differences between IPC Phase 5 (Catastrophe); IPC Phase 5 (Famine); and risk of Famine.

Figure 9: IPC Acute Malnutrition phases



4.4 IPC Acute Food Insecurity reference table

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

Phase name and description	Phase 1 None/Minimal	Phase 2 Stressed	Phase 3 Crisis	Phase 4 Emergency	Phase 5 Catastrophe/ Famine		
	Households are able to meet essential food and non-food needs without engaging in atypical and unsustainable strategies to access food and income.	Households have minimally adequate food consumption but are unable to afford some essential non-food expenditures without engaging in stress-coping strategies.	Households either: • Have food consumption gaps that are reflected by high or above-usual acute malnutrition; or • Are marginally able to meet minimum food needs but only by depleting essential livelihood assets or through crisis-coping strategies.	Households either: • Have large food consumption gaps which are reflected in very high acute malnutrition and excess mortality; or • Are able to mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation.	Households have an extreme lack of food and/or other basic needs even after full employment of coping strategies. Starvation, death, destitution and extremely critical acute malnutrition levels are evident. (For Famine Classification, an area needs to have extreme critical levels of acute malnutrition and mortality)		
Priority response objectives	Action required to build resilience and for disaster risk reduction	Action required for disaster risk reduction and to protect livelihoods	Urgent action required to: Protect livelihoods and reduce food consumption gaps				
			Save lives and livelihoods	Revert/prevent widespread death and total collapse of livelihoods			
First-level outcomes refer to characteristics of food consumption and livelihood change. Thresholds that correspond as closely as possible to the Phase description are included for each indicator. Although cut-offs are based on applied research and presented as global reference, correlation between indicators is often somewhat limited and findings need to be contextualized. The area is classified in the most severe Phase that affects at least 20% of the population.							
Food security first-level outcomes	Food consumption (focus on energy intake)	Quantity: Adequate energy intake Dietary energy intake ⁱ : Adequate (avg. 2,350 kcal pp/day) and stable Household Dietary Diversity Score ⁱⁱⁱ : 5-12 food groups and stable Food Consumption Score ⁱⁱⁱ : Acceptable and stable Household Hunger Scale ⁱⁱⁱ : 0 (none) Reduced Coping Strategies Index ⁱⁱⁱ : 0-3 Household Economy Analysis ⁱⁱⁱ : No livelihood protection deficit Food Insecurity Experience Scale ⁱⁱⁱ : (FIES 30 days recall): < -0.58	Quantity: Minimally Adequate Dietary energy intake: Minimally adequate (avg. 2,100 kcal pp/day) Household Dietary Diversity Score: 5-FG but deterioration ≥1 FG from typical Food Consumption Score: Acceptable but deterioration from typical Household Hunger Scale: 1 (slight) Reduced Coping Strategies Index: 4-18 Household Economy Analysis: Small or moderate livelihood protection deficit <80% FIES: Between -0.58 and 0.36	Quantity: Moderately Inadequate – Moderate deficits Dietary energy intake: Food gap (below avg. 2,100 kcal pp/day) Household Dietary Diversity Score: 3-4 FG Food Consumption Score: Borderline Household Hunger Scale: 2-3 (moderate) Reduced Coping Strategies Index: ≥ 19 (non-defining characteristics (NDC) to differentiate P3, 4 and 5) Household Economy Analysis: Livelihood protection deficit ≥80%; or survival deficit <20% FIES: > 0.36 (NDC to differentiate between Phases 3, 4 and 5)	Quantity: Very Inadequate – Large deficits Dietary energy intake: Large food gap; well below 2,100 kcal pp/day Household Dietary Diversity Score: 0-2 FG (NDC to differentiate P4 and 5) Food Consumption Score: Poor (NDC to differentiate P4 and 5) Household Hunger Scale: 4 (severe) Reduced Coping Strategies Index: ≥ 19 (NDC to differentiate P3, 4 and 5) Household Economy Analysis: Survival deficit ≥20% but <50% FIES: > 0.36 (NDC to differentiate between Phases 3, 4 and 5)	Quantity: Extremely Inadequate – Very large deficits Dietary energy intake: Extreme food gap Household Dietary Diversity Score: 0-2 FG Food Consumption Score: Poor (NDC to differentiate P4 and 5) Household Hunger Scale: 5-6 (severe) Reduced Coping Strategies Index: ≥ 19 (NDC to differentiate P3, 4 and 5) Household Economy Analysis: Survival deficit ≥50% FIES: > 0.36 (NDC to differentiate between Phases 3, 4 and 5)	
	Livelihood change (assets & strategies)	Livelihood change: Sustainable livelihood strategies and assets Livelihood coping strategies ⁱⁱⁱ : No stress, crisis or emergency coping observed	Livelihood change: Stressed strategies and/or assets; reduced ability to invest in livelihoods Livelihood coping strategies: Stress strategies are the most severe strategies used by the household in the past 30 days	Livelihood change: Accelerated depletion/erosion of strategies and/or assets Livelihood coping strategies: Crisis strategies are the most severe strategies used by the household in the past 30 days	Livelihood change: Extreme depletion/ liquidation of strategies and assets Livelihood coping strategies: Emergency strategies are the most severe strategies used by the household in the past 30 days	Livelihood change: Near complete collapse of strategies and assets Livelihood coping strategies: Near exhaustion of coping capacity	
	Second-level outcomes refer to area-level estimations of nutritional status and mortality that are especially useful for identifying more severe phases when food gaps are expected to impact malnutrition and mortality. For both nutrition and mortality area outcomes, household food consumption deficits should be an explanatory factor in order for that evidence to be used in support of the classification.						
	Nutritional status ^{iv}	Global Acute Malnutrition (GAM) based on Weight-for-Height Z-score (WHZ) ^v	Acceptable: <5%	Alert: 5-9.9%	Serious: 10-14.9% or > than usual	Critical: 15-29.9% or > much greater than usual	Extremely Critical: ≥30%
		Global Acute Malnutrition based on Mid-Upper Arm Circumference (MUAC) ^{vi}		<5%	5-9.9%	10-14.9%	≥15%
		Body Mass Index (BMI) <18.5 ^{vi}	<5%	5-9.9%	10-19.9%, 1.5 x greater than baseline	20-39.9%	≥ 40%
		Mortality	Crude Death Rate ⁱⁱⁱ : <0.5/10,000/day Under-five Death Rate ⁱⁱⁱ : <1/10,000/day	Crude Death Rate: <0.5/10,000/day Under-five Death Rate: <1/10,000/day	Crude Death Rate: 0.5-0.99/10,000/day Under-five Death Rate: 1-1.99/10,000/day	Crude Death Rate: 1-1.99/10,000/day OR >2x reference Under-five Death Rate: 2-3.99/10,000/day	Crude Death Rate: ≥2/10,000/day Under-five Death Rate: ≥4/10,000/day
	Food security contributing factors	For contributing factors, specific indicators and thresholds for different phases need to be determined and analysed according to the livelihood context; however, some general descriptions for contributing factors are provided below.					
		Food availability, access, utilization, and stability	Adequate to meet short-term food consumption requirements Safe water ⁱⁱⁱ ≥15 litres pp/day	Borderline adequate to meet food consumption requirements Safe water marginally ≥15 litres pp/day	Inadequate to meet food consumption requirements Safe water > 7.5 to 15 litres pp/day	Very inadequate to meet food consumption requirements Safe water >3 to <7.5 litres pp/day	Extremely inadequate to meet food consumption requirements Safe water ≤3 litres pp/day
		Hazards and vulnerability	None or minimal effects of hazards and vulnerability on livelihoods and food consumption.	Effects of hazards and vulnerability stress livelihoods and food consumption.	Effects of hazards and vulnerability result in loss of assets and/or significant food consumption deficits.	Effects of hazards and vulnerability result in large loss of livelihood assets and/or extreme food consumption deficits.	Effects of hazards and vulnerability result in near complete collapse of livelihood assets and/or near complete food consumption deficits.



4.5 IPC Acute Malnutrition reference table

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

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

Notes:

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

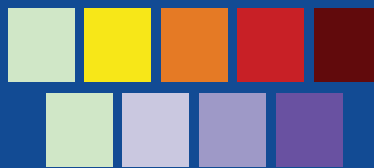


4.6 List of Acronyms

AAH	Action Against Hunger
AFI	Acute Food Insecurity
AMN	Acute Malnutrition
BMI	Body Mass Index
CDR	Crude Death Rate
CFI	Chronic Food Insecurity
FAO	Food and Agriculture Organization of the United Nations
FEWS NET	Famine Early Warning Systems Network
GAM	Global Acute Malnutrition
HAG	Household Analysis Group
IDP	Internally Displaced Person
IGAD	Intergovernmental Authority on Development
IPC	Integrated Food Security Phase Classification
JRC	Joint Research Centre
Kcal	Kilo-calories
LCS	Livelihood Coping Strategies
MAM	Moderate Acute Malnutrition
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organization
SAM	Severe Acute Malnutrition
SICA	Sistema de la Integración Centroamericana
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization
WHZ	Weight-for-Height Z-score
WLZ	Weight-for-Length/Height Z score

IPC

Integrated Food Security Phase Classification



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