



# NUTRITION HUMANITARIAN NEEDS ANALYSIS GUIDANCE

## Steps to conducting a Nutrition Humanitarian Needs Analysis

The purpose of this working guidance is to outline the steps (summarized in Figure 1 below) for conducting a Nutrition Situation Analysis, identifying information for the Humanitarian Needs Overview (HNO), which feeds into response plans and updates, whether IASC Cluster system has been activated or not. This includes the development and implementation of an annual nutrition assessment plan and a nutrition situation analysis (or align it with IPC's Acute Malnutrition (AMN) results) along with major contributing factors, and calculation of the number of People in Need (PiN) and other key figures for the HNO.



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## LIMITATIONS

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This global-level guidance note is a dynamic document aimed at streamlining Nutrition Humanitarian Needs Analysis that will be revised based on results and lessons learned from its use. Nonetheless, it is important to take note of its limitations: 1) a number of the “core” indicators from the other sectors (WASH, Food Security, Health) proposed in Table 1 should be discussed with corresponding Cluster/Sector counterparts before including them into the Nutrition Situation Analysis; 2) the preliminary scoring table put forward in Scenario 3’s Nutrition Situation Analysis is not based on hard evidence, rather a three-tiered system that associates more points to certain “core” indicators versus others (details provided on p.16) with proposed cut-offs based on rough simulations and will be adjusted based on the results from its use; 3) countries may choose to adapt this guidance according to their needs and context and therefore may lose comparability across countries. For any suggestions or recommendations on how to further improve this guidance, please contact the GNC-CT.

# ABBREVIATIONS

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<b>4W</b>	Who, What, Where and When	<b>LW</b>	Lactating Women
<b>AMN</b>	Acute Malnutrition	<b>MAM</b>	Moderate Acute Malnutrition
<b>BMS</b>	Breastmilk Substitute	<b>MICS</b>	Multiple Indicator Cluster Survey
<b>BSFP</b>	Blanket Supplementary Feeding Programme	<b>MUAC</b>	Mid Upper Arm Circumference
<b>CDC</b>	CDC – Centers for Disease Control and Prevention	<b>NCC</b>	Nutrition Cluster Coordinator
<b>CMAM</b>	Community Management of Acute Malnutrition	<b>NiE</b>	Nutrition in Emergencies
<b>ENA</b>	Emergency Nutrition Assessment (software)	<b>NIS</b>	Nutrition Information System
<b>ENAs</b>	Essential Nutrition Actions	<b>NIS TWG</b>	Nutrition Information System Technical Working Group
<b>cGAM</b>	combined Global Acute Malnutrition (aggregate indicator by combining GAM based on WHZ and GAM based on MUAC)	<b>OCHA</b>	(United Nations) Office for the Coordination of Humanitarian Affairs
<b>GAM</b>	Global Acute Malnutrition	<b>OTP</b>	Outpatient Therapeutic Programme
<b>GBV</b>	Gender-Based Violence	<b>PIN</b>	People in Need
<b>GNC</b>	Global Nutrition Cluster	<b>PLW</b>	Pregnant and Lactating Women
<b>GNC-CT</b>	Global Nutrition Cluster Core Team	<b>PLWHIV</b>	Pregnant and Lactating Women with HIV
<b>GSU</b>	Global Support Unit	<b>PW</b>	Pregnant Women
<b>GTAM</b>	Global Technical Assistance Mechanism for Nutrition	<b>RUSF</b>	Ready-to-Use Supplementary Food
<b>HAZ</b>	Height-for-Age Z-score	<b>RUTF</b>	Ready-to-Use Therapeutic Food
<b>HINI</b>	High Impact Nutrition Interventions	<b>SADD</b>	Sex-and Age-Disaggregated Data
<b>HNO</b>	Humanitarian Needs Overview	<b>cSAM</b>	combined Severe Acute Malnutrition (aggregate indicator that combines SAM based on WHZ and SAM based on MUAC)
<b>HRP</b>	Humanitarian Response Plan	<b>SAM</b>	Severe Acute Malnutrition
<b>IASC</b>	Inter-Agency Standing Committee	<b>SMART</b>	Standardized Monitoring and Assessment of Relief and Transitions
<b>IFE</b>	an expert advocacy and resource group on	<b>U2</b>	(Children aged) Under Two
<b>Core Group</b>	IYCF-E.	<b>U5</b>	(Children aged) Under Five
<b>IPC</b>	Integrated Food Security Phase Classification	<b>UNICEF</b>	United Nations Children's Fund
<b>IPC AMN</b>	Integrated Food Security Phase Classification for Acute Malnutrition	<b>VAD</b>	Vitamin A Deficiency
<b>IYCF</b>	Infant and Young Child Nutrition	<b>WASH</b>	Water, Sanitation and Hygiene
<b>IYCF-E</b>	Infant and Young Child Nutrition in Emergencies	<b>WHO</b>	World Health Organization
<b>JIAF</b>	Joint Inter-sectoral Analysis Framework	<b>WFP</b>	World Food Programme
		<b>WHZ</b>	Weight-for-Height Z-score
		<b>WRA</b>	Women of Reproductive Age

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# GLOSSARY

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- **Acute Malnutrition:** caused by a (sudden and) drastic reduction in food intake and/or illness, often aggravated by suboptimal infant and young child feeding practices, leading to a significant loss of body weight (with severe health consequences). There are two levels of classification of acute malnutrition within an individual: severe and moderate. Acute malnutrition is of key concern because children who suffer from severe acute malnutrition (SAM) face a 9 times higher chance of dying compared to children who do not suffer from acute malnutrition<sup>1</sup>. Global Acute Malnutrition (GAM) among children 0-59 months is assessed using the nutritional indices of weight-for-height or weight-for-length (WHZ), mid-upper arm circumference (MUAC), and signs of bilateral pitting oedema known as either GAM based on WHZ, GAM based on MUAC or an aggregate indicator of both known as cGAM.
- **Analysis Framework:** the methodological ecosystem aimed at approaching a problem with logic and guiding sense-making processes based on theoretical (a general and visual representation of what will be investigated) and conceptual frameworks (how the data will be obtained and analysed) required to estimate and understand the humanitarian conditions of the affected population.
- **Anthropometric measurements:** assessment of the size, shape, and proportions of the human body (e.g. height, weight, Mid-Upper Arm Circumference - MUAC) to determine the nutritional status of an individual or population by comparing indices (e.g. weight-for-height) to standards, references or cut-offs<sup>2</sup>.
- **Breastmilk substitutes:** any food marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose.
- **Chronic Malnutrition:** classified by stunting levels in terms of the standardized index of height-for-age z-score among children (height or length for specific sex and age). Stunting is the measure of growth retardation due to persistent inability to meet minimum micro- and macro-nutrient absorption requirements, frequent recurrence of acute malnutrition episodes, or a combination of these.
- **Complementary Feeding:** defined as the process starting when breastmilk alone is no longer sufficient to meet the nutritional requirements of infants, and therefore other food and liquids are needed, along with breastmilk.
- **Coordinated Assessments:** also considered as Joint or Multi-sectoral, these occur when assessments are planned and carried out in partnership with other humanitarian actors, with the results shared for the benefit of the broader humanitarian community to identify the needs of the affected population of a humanitarian situation.
- **Disability Inclusion:** achieved when persons with disabilities (see definition below) meaningfully participate in all their diversity, when their rights are promoted, and when disability-related concerns are addressed in compliance with the Convention on the Rights of Persons with Disabilities, known as CRPD.
- **Exclusive Breastfeeding:** defined as no other food or drink, not even water, except breast milk (including milk expressed or from a wet nurse) for 6 months of life, but allows the infant to receive ORS, drops and syrups (vitamins, minerals and medicines)<sup>3</sup>.
- **Gender Based Violence:** an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females.
- **Gender Norms:** standards and expectations to which women and men generally conform, within a range that defines a particular society, culture and community at that point in time. Internalised early in life, gender norms can establish a life cycle of gender socialisation and stereotyping. Although gender norms are learned, they are neither static nor universal and change over time.
- **Incidence:** a measure of the proportion of new cases in a population during a specific time period (generally one year) who will develop a certain disease or condition.
- **Integrated Food Security Phase Classification (IPC):** common global scale for classifying the severity and magnitude of food insecurity and malnutrition, including a process

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<sup>1</sup> Olofin I, McDonald CM, Ezzati M, Flaxman S, Black RE, et al. (2013) [Associations of Suboptimal Growth with All-Cause and Cause-Specific Mortality in Children under Five Years: A Pooled Analysis of Ten Prospective Studies](#).

<sup>2</sup> For more information on indices, references and cut-offs: Cashin, K. & Oot, L. (2018) [GUIDE TO ANTHROPOMETRY A practical tool for Program Planners, Managers and Implementers](#).

<sup>3</sup> As defined by World Health Organization in their [infant feeding recommendation](#).

to build evidence-based technical consensus among key stakeholders, an approach to consolidate wide-ranging evidence, a path to provide actionable knowledge for strategic decision-making, and a platform to ensure a rigorous, neutral analysis.

- **Infant and Young Child Nutrition (IYCF):** term to describe the recommended feeding practices of infants (aged less than 12 months) and young children (aged 12-23 months). Programmes focus on the protection, promotion and support of breastfeeding and exclusive breastfeeding; timely, safe and appropriate introduction of complementary feeding and continued breastfeeding; and issues of policy and legislation around creating enabling environments for women and their children, covering critical aspects like infant and young child feeding in emergencies (IYCF-E), compliance with the IYCF-E operational guidance, the marketing of infant formula, BMS, commercial complementary foods for infants and young children, protocols and guidelines in the health system, communities, workplace and working conditions for women.
- **Harmonized Assessments:** when agencies collect, process and analyse data separately, but where the collected data is sufficiently comparable (because of the use of common operational data sets, key indicators, and geographical and temporal synchronisation) to be compiled into a single database and used in a shared analysis.
- **Micronutrient deficiency:** when certain essential vitamins and minerals are deficient, due to insufficient dietary intake and/or insufficient absorption and/or suboptimal utilization of the vitamins or minerals. Specific clinical signs and symptoms may develop.
- **Mid-Upper Arm Circumference (MUAC):** measured on a straight left arm midway between the tip of the shoulder (acromion) and the tip of the elbow (olecranon) and used to assess acute malnutrition or wasting. In children 6-59 months of age, MUAC < 115mm indicates a child is severely malnourished, and MUAC between 115mm and < 125mm indicates a child is moderately malnourished. Low MUAC (< 125mm) combined with the presence of bilateral pitting edema is reported as GAM based on MUAC.
- **Needs Assessment:** the set of activities necessary to understand a given situation that entails the collection, up-dating and analysis of data pertaining to the population of concern (needs, capacities, resources, etc.).
- **Nutrition-specific Interventions:** address the immediate determinants of fetal and child nutrition and development (i.e. adequate food and nutrient intake, feeding, caregiving and parenting practices, and low burden of infectious diseases).
- **Nutrition-sensitive Interventions:** address the underlying determinants of malnutrition respectively (i.e. food security; adequate caregiving resources at the maternal, household and community levels; and access to health services and a safe and hygienic environment).
- **Oedema:** excessive accumulation of extracellular fluid in the body. Bilateral pitting oedema (fluid retention on both sides of the body) is a clinical sign of severe acute malnutrition and is referred to as nutritional oedema.
- **Older People:** refers to people aged 50 and above, taking into account the social construction of ageing in low-to middle-income countries in contrast to the retirement-from-work age applied in high-income countries.
- **Overweight:** occurs when a person has too much body fat and weighs more than would be expected for a healthy person of the same height, with obesity being its severe form<sup>4</sup>. Overweight and obesity are complex conditions with multiple causes, including an imbalance between calories consumed and calories expended, low levels of physical activity, medical conditions, and genetics, among others. Although undernutrition is still the primary concern in developing countries, globally, overweight and obesity are associated with more deaths than underweight. What was previously only considered an issue for high-income countries is now an emerging public health threat in countries across the globe, creating a double burden of malnutrition in many developing countries that continue to have a high prevalence of undernutrition.
- **Persons with disabilities:** persons who have long-term sensory, physical, psychosocial, intellectual or other impairments that, in interaction with various barriers, prevent them from participating in, or having access to, humanitarian programmes, services or protection. Persons with disabilities are a diverse group. They have different impairments and diverse identities (as women, indigenous persons, children, etc.).
- **Prevalence:** a measure of the proportion of individuals in a population who have a certain disease or condition at a specific point in time.

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<sup>4</sup> Cashin, K. & Oot, L. (2018) [GUIDE TO ANTHROPOMETRY A practical tool for Program Planners, Managers and Implementers.](#)



- **Screenings:** rapid population-based assessments, primarily conducted to identify people who may be malnourished and refer them for more detailed assessment and treatment, often done in a health facility or in a community setting.
- **Seasonality:** seasonal variation of various factors affecting nutrition status, such as disease, weather, migration, sources of food, and the agricultural cycle.
- **Sex and age disaggregated data:** one of the most effective ways to understand different needs within a population is to collect data by sex and age (SADD), and to analyse the data, in part, using a gender gender (socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for males and females) and generational analysis that is situated within the context of the particular country, region, and crisis.
- **Situation Analysis:** a deliberate process whereby the current incident humanitarian situation, the factors that are relevant to the incident, their consequences are reviewed, alternative strategies are assessed, and an incident plan is recommended.
- **Undernutrition:** consequence of inadequate nutrition intake and/or absorption, and/or illness or disease, with major types including – acute malnutrition (wasting, thinness, and/or bilateral pitting oedema), chronic malnutrition (stunting), underweight (a composite of stunting and wasting) and micronutrient deficiencies (e.g. deficiencies in vitamin A, iron).



# PURPOSE, AUDIENCE AND SCOPE

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The purpose of this step-by-step guidance is to provide those involved in nutrition coordination with relevant tools, information and resources for conducting a Nutrition Situation Analysis, identifying information for the Humanitarian Needs Overview (HNO), which feeds into response plans and updates including the Humanitarian Response Plan (HRP). Applicable across the range of country contexts and different types of humanitarian situations, spanning acute-onset/slow-onset, natural disasters, conflict and protracted crises, this document complements the existing IASC's [Humanitarian Programme Cycle guidance](#) aimed at ensuring an evidence-based and results-oriented collective response to which Clusters and organizations contribute. Sections of this guidance are organized according to a scenario-based approach: Scenario 1 in situations where an IPC Acute Malnutrition analysis can be conducted or utilized, Scenario 2 in situations where an IPC Acute Malnutrition analysis cannot be conducted and GAM for children U5 ( $\geq 5\%$ ) is of primary concern, or Scenario 3 for situations where GAM  $< 5\%$  (summarized in Figure 1 above) with the following steps for a given country:

- Develop the annual nutrition assessment plan;
- Conduct a Nutrition Situation Analysis according to one of these three scenarios;
- Prepare key nutrition figures for the HNO and subsequent HRP (only applicable to IASC Clusters).



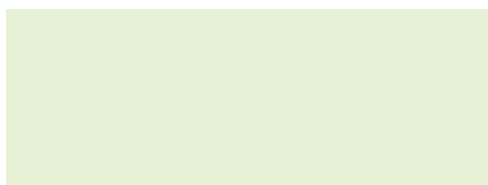


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Using an indicative timeline, this guidance should serve as a **guide for discussions and consensus-building on situation analysis and nutritional needs analysis in crisis situations and response planning and monitoring**, whether the IASC Cluster system has been activated or not.

This guidance was devised to be used in conjunction with:

- the accompanying spreadsheet tool, **Nutrition Cluster Nutrition Humanitarian Needs Analysis Calculation Tool**.
- marked with ► symbols or key steps outlined in special boxes.
- Further reading, tools and resources are also provided in Boxes,



- along with key points highlighted by: ■ s.

Among others involved in nutrition coordination in humanitarian situations, **this operational guidance note is primarily aimed at Nutrition Cluster Coordinators (NCCs), Information Management Officers (IMOs), Nutrition Cluster partners and staff within the Cluster Lead Agency**. It is also pertinent for coordination teams and partners of the Nutrition Sectors and partners from other Clusters/Sectors; in particular those having relevant links to nutrition outcomes, who are responsible for the consolidation and situation analysis of nutrition-related needs of affected populations. The outputs stemming from this guidance are relevant to all humanitarian actors, including but not limited to decision-makers, humanitarian coordinators, Humanitarian Coordination Teams (HCTs), humanitarian organizations contributing to coordinated assessments, policy-makers, donors, national and local authorities during both inter-agency preparedness and response phases in humanitarian situations.

**Addendum 1 provides details on how these figures contribute to the Joint Inter-sectoral Analysis Framework (JIAF).**

# 1 | DEVELOP THE ANNUAL NUTRITION ASSESSMENT PLAN



# 1. DEVELOP THE ANNUAL NUTRITION ASSESSMENT PLAN

*Indicative timeline: Last quarter of previous year/first months of current year*

A NIS is an integrated and centrally coordinated set of processes to continuously collect, analyze and interpret nutrition-related data, transform it into tangible information and disseminate it for making timely and effective decisions to improve the nutritional health of a population. In order to inform appropriate response strategies, the development and regular maintenance of an annual nutrition assessment plan (see guidance provided in Annex 2) ensures up-to-date and quality data are used for nutrition situation (or trend) analyses, to help target areas or vulnerable populations that are at increased risk or in heightened need of nutritional assistance. When the IASC Cluster system has been activated, this plan should be directly linked to the Humanitarian Programme Cycle, taking into account seasonal considerations and input from decision-makers as they play an important role in defining units of analysis, geographical coverage and subsequent preparation of Humanitarian Needs Overview and Response Plans.

Considerations for the eventual development of an IPC annual calendar may also be applicable given the humanitarian situation – see Box A for more details.

## BOX A. DEVELOPMENT OF AN IPC ANNUAL CALENDAR

In contexts where an IPC Acute Malnutrition analysis may be necessary (i.e. GAM  $\geq$  5%), it is important to start discussions with the GNC-CT and the IPC GSU on the necessary resources, timeline and financial requirements for the eventual implementation of the IPC in-country.

Led by the in-country NIS TWG (Technical Working Group) or equivalent<sup>5</sup>, the following steps are recommended to support the contextualization of their nutrition assessment plan:

01

Discuss what nutrition outcome data (see Annex 1) is available, including disaggregation by sex, age, disability and other diversity characteristics, as well as what is missing and needed for decision-making and planning.

02

Discuss which indicators for the key contributing factors (i.e. causes/drivers of malnutrition – see Table 1 below and Annex 1) are available, missing and needed. Agree with other Clusters/Sectors on which nutrition-sensitive indicators will be included in their assessment methodologies and the rationale for their collection and use. When needed, agree whether or not some of these indicators can/should be collected as a part of nutrition assessments (e.g. measles vaccination) to avoid any duplication of efforts.

When reviewing primary data needs, keep in mind the importance of sex, age, and disability disaggregated data. It is also important to consider gender-based barriers (see Annex 2) and gender norms that may negatively impact on nutrition outcomes. For example, women may not have a decision-making power at home about what they eat or how they use money, or there could be dietary taboos or cultural feeding practices related to food consumption that can disadvantage young girls. Consider consultations<sup>6</sup> and other qualitative methods, such as focus group discussions, to obtain voices and opinions from the community, providing information on who is impacted differently and why;

03

Identify critical data gaps based on the above and discuss the means to address these directly through primary data collection, often feasible using the recommended [SMART methodology](#). This may change depending on the humanitarian situation, particularly during an outbreak or pandemic<sup>7</sup>.

04

Develop and coordinate an annual (harmonized with other Sectors) nutrition assessment plan (see Annex 3) to support the coordination of nutrition assessments and their results, taking into account timelines for data analysis, key considerations

<sup>5</sup> Further details on the roles and responsibilities of the NIS TWG can be found [here](#).

<sup>6</sup> Further tips on consultations with women and girls can be found [here](#).

<sup>7</sup> Considerations for primary data collection during the COVID-19 pandemic can be found [here](#).

05

(see Box B below) and the reliability of certain collection methods over others (see Figure 2). Additional guidance can be found on pages 161-162 in the [IPC technical manual version 3.0](#). All assessments should preferably be conducted during the same season for improved comparability, and data should be analysed as soon as possible after data collection.

Review assessment tools and questionnaires and modify them as needed to ensure that the full set of nutrition-specific and nutrition-sensitive indicators is accounted for.

06

Ensure implementation of the plan and timely validation of data collected.

07

Ensure results are being shared with relevant stakeholders and stored in a consolidated manner to facilitate any subsequent trend and/or Nutrition Situation Analyses.

#### BOX B. KEY CONSIDERATIONS WHEN REVIEWING DATA FOR DECISION-MAKING AND PLANNING

- **Accessibility:** in some instances, the nature of the humanitarian crisis (e.g. conflict) may limit the access of organizations to collect suitable evidence and affect the geographical coverage. Alternative considerations should be followed — see IPC’s summary guidance for data collection in areas with limited/no humanitarian access (pages 193-195 in the IPC technical manual version 3.0; more detailed guidance is available from IPC GSU upon request).
- **Appropriateness:** it is better to choose a small number of well-established indicators based on prior experience and expert consensus.
- **Contextual factors:** context (e.g. double burden of malnutrition, measles epidemics, malaria), events (e.g. political events), changes in nutrition programme activities, shortage in supplies.
- **Demographic coverage:** whether selected indicator(s) can be used as a proxy for the needs of the entire population group’s needs or only subset (e.g. U5 SAM prevalence).
- **Disaggregation:** can be done by population group, age category, sex, disability, other diversity characteristics (e.g. IDP/host community status, rural/urban, ethnic or religious identities) or by administrative level at which results from a survey can be representative at the unit of analysis. It is important to always consider how and why different groups may be affected differently.
- **Representativeness:** a measure of how well or accurately a sample reflects the population from which it is drawn, often ensured by probability (random) sampling methods.
- **Seasonality:** malnutrition fluctuations due to seasonal changes; information on the influence of seasonality can be established based on feeding centre admission data or national nutrition surveillance data.
- **Sound statistical and data management methods:** use of appropriate statistically viable methods used to collect, analyse, and manage data to ensure accurate interpretation of information.
- **Transparency:** clarity on the sources, the methods used to collect the data, the calculations and any technical and methodological notes used.
- **Unit(s) of analysis:** for Nutrition, the majority of indicators are at individual-level (e.g. GAM), aggregated at geographical and/or affected group level in terms of representativeness of findings - see Table 3 below.

Figure 2. IPC Acute Malnutrition Reliability Score Table for nutritional need evidence

$R_2$ = Reliable $R_1$ = Somewhat reliable		Time Relevance (T)	
		Good ( $T_2$ )	Limited( $T_1$ )
Soundness of method (M)	Good ( $T_2$ )	$R_2$	$R_1 -$
	Limited( $T_1$ )	$R_1 +$	X
Part B: General Guidance for Evaluation of M and T			
Soundness method (M)	Good ( $M_2$ )	<p>GAM based on WHZ from surveys representative at the unit of analysis with adequate precision and validated by an authority in the country.</p> <ul style="list-style-type: none"> <li>Cluster surveys with <math>\geq 25</math> clusters.</li> <li>Simple or systematic surveys with <math>\geq 150</math> observations.</li> </ul>	
	Limited( $M_1$ )	<p>GAM based on WHZ that partially meets representativeness and quality standards or GAM based on MUAC from minimally acceptable methods.</p> <ul style="list-style-type: none"> <li><b>Surveys representative at the unit of analysis.</b> <ul style="list-style-type: none"> <li>Estimates “validated with caution” (for GAM based on WHZ only).</li> <li>Estimates of GAM based on MUAC from surveys rated good method.</li> </ul> </li> <li><b>GAM based on WHZ from disaggregated surveys representative at a higher administrative unit.</b> <ul style="list-style-type: none"> <li><math>\geq 5</math> clusters and <math>\geq 100</math> observations.</li> </ul> </li> <li><b>GAM based on WHZ/MUAC from Sentinel sited.</b> <ul style="list-style-type: none"> <li><math>\geq 5</math> sites per unit of analysis with <math>\geq 200</math> total observations (if the area is pastoral, <math>\geq 5</math> sited with 100 observations os acceptable).</li> </ul> </li> <li><b>GAM based on MUAC from Screening.</b> <ul style="list-style-type: none"> <li>Exhaustive screening (door to door) carried out at the unit of analysis (&gt;80% coverage) or unit of analysis and <math>\geq 200</math> observations selected randomly or exhaustively (&gt;80% coverage) from each site and with convergence of estimates from these sites.</li> </ul> </li> <li><b>Surveys from similar areas.</b> <ul style="list-style-type: none"> <li>GAM based on WHZ from a survey with Good Method from a similar area.</li> </ul> </li> </ul>	
Time relevance (T)	Good ( $M_2$ )	<p>Evidence reflecting current conditions.</p> <ul style="list-style-type: none"> <li>Evidence collected during the same season of analysis, when there is seasonality.</li> <li>Evidence collected anytime during the previous 12 months when there is <b>no seasonality or significant shock to acute malnutrition contributing factor.</b></li> </ul>	
	Limited( $M_1$ )	<p>Evidence inferred to reflect current conditions.</p> <ul style="list-style-type: none"> <li>Inferred estimates of evidence collected within the last 6 months but not from the same acute malnutrition season (12 months for areas with no seasonality).</li> <li>Historical evidence collected during the same acute malnutrition season from at least 2 similar years in the last 5 years — only to be used in the absence of any unusual shocks.</li> </ul>	

# 2 | CONDUCT A NUTRITION SITUATION ANALYSIS





## 2. CONDUCT A NUTRITION SITUATION ANALYSIS

*Indicative timeline: 1-3 months per analysis cycle depending on the undernutrition seasonal calendar, geographical coverage and other parameters; this excludes time required for its planning. In countries with recurring HNO/HRP processes, this tends to take place between August-October.*

The purpose of a Nutrition Situation Analysis is to define/classify the severity of a given humanitarian situation across affected geographical areas based on the magnitude of the nutritional needs of the population in order to guide strategic and operational decision-making. It addresses the following questions: How severe? When and Where are the worst affected areas? How many? Why? Who? What are the key characteristics of the situation?

This analysis aims to build consensus on classifying the severity based on the magnitude of nutritional needs (e.g. prevalence of different forms of malnutrition) of vulnerable population groups (i.e. those more at risk/affected) and their key drivers (contributing factors) into meaningful categories to support the response. This entails a critical review of the available data (e.g. results from the annual nutrition assessment plan), context and existing trends for each affected geographical area. Nuanced information may also be needed to inform the need for action to scale up malnutrition treatment and prevention for affected populations based on the following questions:

- What is the prevalence of different forms of malnutrition (e.g. acute and chronic malnutrition outcomes, micronutrient deficiencies) in the geographical areas of interest? Are there important differences by age group (e.g. infants, chronically ill adults, older people) or by sex to consider (e.g. are U5 girls more likely to suffer from malnutrition)?
- Are certain geographical areas more affected than others by malnutrition accompanied by high or increasing levels of its drivers (e.g. individual food consumption gaps)?
- Are certain livelihoods, socio-economic, age or gender groups (e.g. adolescent PLW) more affected by malnutrition than others? What factors make them vulnerable to malnutrition (e.g. social norms related to diets)?
- Are there any trends, seasonal and/or long term, in the prevalence of malnutrition?

Based on the framework in Annex 1 and different steps according to various scenarios (Figure 1), this analysis is generally led by the Nutrition Cluster Coordinator and co-lead by national government representatives in partnership with the Cluster partners such as civil society institutions/organizations, resource partners, UN agencies, members of the NIS TWG or equivalent, and only if applicable – the IPC Technical Working Group (see Box C).

These representatives should come together to agree on the scope and focus of the nutrition situation analysis, and determine which scenario (1, 2 or 3) is most relevant to their context. **Only one scenario should be chosen for the entire country.** If GAM for U5 children hovers around 5% (being the cut-off between Scenarios 2 and 3) for the affected areas of interest and an IPC AMN analysis (Scenario 1) is not feasible, it is the majority prevalence across the affected areas that determines which scenario should be used.

Once a scenario has been agreed upon, these representatives should then discuss the following recommended list of “core” indicators around agreed population groups, geographic areas and/or thematic issues when consolidating available and reliable<sup>8</sup> evidence. When selecting indicators for the nutrition situation analysis, it is important to keep in mind the importance of sex, age, and disability disaggregated data. Although disaggregated data does not factor into the severity classification, it will play an important role in estimating the magnitude of nutritional needs. For example, drawing from Table 1 below, indicators relating to the access WASH may be very different for men compared to adolescent girls.

<sup>8</sup> Reliability of the nutrition outcome data in terms of time relevance and soundness of method described in Figure 2 above.

### BOX C. IPC TECHNICAL WORKING GROUP

Formed at either regional, national, or sub-national level, the IPC TWG should be hosted within an existing structure instead of creating a parallel single-purpose coordination body. Clear Terms of Reference (ToR) should be devised to ensure commitment to the IPC partnership; this includes purpose and memberships, roles and responsibilities of its members, chair, and co-chair, and its structure and working modalities. Formal agreement or signing of the ToR by senior management of all member organizations is strongly encouraged. For further information on this TWG, please contact the IPC GSU.

## RECOMMENDED “CORE” NUTRITION INDICATORS FOR RESPONSE PLANNING

This recommended list of indicators was prepared by the GNC HNO Taskforce and NISWG members for phase characteristics and thresholds of international standards for GAM and its key contributing factors. It is meant to **streamline this analysis process and is not intended to override the extensive list of nutrition indicators that can be used for programming or monitoring purposes**<sup>9</sup> – See ► [Indicator Registry worksheet of the Nutrition Cluster Nutrition Humanitarian Needs Analysis Calculation Tool](#).

<sup>9</sup> See the [Global Nutrition Cluster indicators registry](#) with needs assessment and performance monitoring indicators.

In alignment with the aforementioned IPC AMN Analytical Framework, Table 1 (also available in ► [Classification Thresholds](#) worksheet) suggests a core list of indicators, described according to:

- **Category:** primary nutrition outcomes, optional contextual factors focusing on common vulnerable groups that can be considered to help guide decisions around what types of interventions may be better suited for a given humanitarian situation, and key contributing factors selected by the Taskforce;
- **Alignment with IPC AMN’s Analytical framework** (Annex 1): nutritional status indicators, mortality indicators, immediate and underlying causes, and other issues;
- **Humanitarian consequences:** relevant for nutrition “Physical and Mental Well-being” and “Living Standards” which will be important later in the analysis when determining key population figures for response planning. These may differ depending on whether GAM for U5 is ≥5% (Scenarios 1 and 2) or <5% (Scenario 3);
- **Thresholds and their sources:** available for each indicator applied in the severity phases (based on IPC/OCHA terminology). It may also include preliminary thresholds used only in cases where global thresholds for that indicator are currently unavailable. This is an important technical limitation particularly when assessing acute and/or chronic malnutrition as **primary outcomes**.

The GNC recognizes and advocates for the treatment of all forms of acute malnutrition, including all children with low MUAC, low WHZ or bilateral pitting oedema – known as combined GAM (cGAM)<sup>10</sup>. However, for the purpose of this situation analysis, a preference for GAM based on WHZ is applied; GAM based on MUAC must only be used in the absence of GAM based on WHZ<sup>11</sup>, and always using convergence of evidence with contributing factors to arrive at the final conclusion of the situation analysis.

<sup>10</sup> cGAM will be preferred in Section 3 of this guidance when calculating the number of people in nutritional need for the HNO and HRP. [ENA for SMART software \(Version 2020\)](#) automatically produces these figures in Tables 3.7 and 3.8 in its survey report.

<sup>11</sup> In alignment with IPC AMN, GAM based on MUAC classification is based on an analysis of the relationship between WHZ and MUAC in the analysis area and convergence of evidence. In exceptional conditions where GAM based on MUAC portrays a much more severe situation than GAM based on WHZ (i.e. two or more phases), GAM based on MUAC should also be taken into account in the phase classification. MUAC-based classifications should be supported by the relationship between GAM based on WHZ, and GAM based on MUAC in the area of analysis. Convergence of evidence should focus on assessing the status of contributing factors (e.g. disease outbreak, food security crisis) as well as historical trends.

Table 1. List of Core Nutrition Indicators to guide the Nutrition Situation Analysis

			Humanitarian Consequence		Severity Scale based on IPC/OCHA phases						
Category	Alignment with IPC AMN Analytical framework	Core Nutrition Indicators to guide response planning	U5 GAM ≥5% (Scenarios 1 and 2)	U5 GAM < 5% (Scenario 3)	Phase 1 Acceptable/ Minimal	Phase 2 Alert/ Stress	Phase 3 Serious/ Severe	Phase 4 Critical/ Extreme	Phase 5 Extremely Critical/ Catastrophic	Sources used for the thresholds	
Nutrition outcomes	Acute and chronic malnutrition	Prevalence of GAM based on WHZ<-2 and/or bilateral pitting oedema among children 0-59 months (if no data, use 6-59 months)	Physical and Mental Well-being		<5%	5-9.9%	10-14.9%	15-29.9%	≥30%	PC Global Partners (2019) <a href="#">Integrated Food Security Phase Classification Technical Manual Version 3.0.</a>	
		Prevalence of GAM based on MUAC <sup>12</sup> <125mm and/or bilateral pitting oedema among children 6-59 months	Physical and Mental Well-being		<5%						Preliminary thresholds suggested by IPC Global Partners (2019) <a href="#">Integrated Food Security Phase Classification Technical Manual Version 3.0.</a>
					5%-9.9%						
					10%-14.9%				≥15%		
Prevalence of GAM based on MUAC<210-230mm (depending on the country's guidelines) among PLW	Physical and Mental Well-being		<12.6%	12.6-19.9%	20-24.9%	25-34.9%	≥35%	Preliminary thresholds based on Somalia's Food Security and Nutrition Analysis Unit (FSNAU)			
		Prevalence of stunting based on HAZ <-2 among children U5	Living Standards	Physical and Mental Well-being	<2.5%	2.5-9.9%	10-19.9%	20-29.9%	≥30%	De Onis et al (2018) <a href="#">Prevalence thresholds for wasting, overweight, and stunting in children under 5 years</a>	
	Other causes	Prevalence of overweight based on WHZ>2 among children 0-59 months	Living Standards	Physical and Mental Well-being	<2.5%	2.5-4.9%	5-9.9%	10-14.9%	≥15%	De Onis et al (2018) <a href="#">Prevalence thresholds for wasting, overweight, and stunting in children under 5 years</a>	
(Contextual factors)	Acute malnutrition	Prevalence of GAM based on BMI-for-Age Z-Score<2 among Adolescents <sup>13</sup>	Physical and Mental Well-being		<2.5%	2.5-4.9%	5-9.9%	10-14.9%	≥15%	Preliminary thresholds suggested by Taskforce and NISWG members	
		Prevalence of GAM based MUAC<210mm among Older People	Physical and Mental Well-being		<5%	5-9.9%	10-14.9% or 5-9.9% <sup>14</sup>	≥15% or 10%-14.9%lb		HelpAge (2013) Nutrition <a href="#">Interventions for Older People in Emergencies</a>	
	Micronutrient deficiencies	Prevalence of anemia (Hb <11g/dL) in pregnant women	Physical and Mental Well-being		<5%	5-19.9%	20-39.9%	≥40%		WHO (2011) Haemoglobin concentrations for the diagnosis of anaemia and assessment of severity	
		Prevalence of anemia (Hb <11g/dL) in children 6-59 months	Physical and Mental Well-being		<5%	5-19.9%	20-39.9%	≥40%			
Mortality indicators	Crude Death/Mortality Rate (deaths/ 10,000 persons/ day)	Physical and Mental Well-being		<0.5		0.5-0.9	1-1.9	≥2	IPC Global Partners (2019) <a href="#">Integrated Food Security Phase Classification Technical Manual Version 3.0.</a>		
	Under-five Death/Mortality Rate (deaths/ 10,000 children U5/ day)	Physical and Mental Well-being		<1			1-1.9	≥4			
Key contributing factors	Immediate causes (Food consumption)	Minimum Dietary Diversity in children 6 to 23 months	Living Standards		>70%	40-70%	20-39.9%	10-19.9%	<10%	Preliminary thresholds suggested by IFE Core Group	
		Minimum Acceptable Diet in children 6 to 23 months*	Living Standards		>70%	40-70%	20-39.9%	10-19.9%	<10%	Preliminary thresholds suggested by IFE Core Group	
		Exclusive breastfeeding for infants 0-5 months	Living Standards		>70%	50-70%	30-49.9%	11-29.9%	<11%	Adapted from UNICEF Breastfeeding Score Card	
	Underlying causes (Caring and feeding practices)	Infants 0-5 months that are not breastfed who have access to Breast Milk Substitutes supplies and support in line with the Code and the <a href="#">IFE Operational Guidance's</a> standards and recommendations	Living Standards		>60%	40-60%	20-39.9%	10-19.9%	<10%	Preliminary thresholds suggested by IFE Core Group	
Infants 6-11 months that are not breastfed who have access to Breast Milk Substitutes supplies and support in line with the Code and the <a href="#">IFE Operational Guidance's</a> standards and recommendations		Living Standards		>60%	40-60%	20-39.9%	10-19.9%	<10%	Preliminary thresholds suggested by IFE Core Group		

Key contributing factors	Underlying causes (WASH)	Number of HHs having access to an improved water source	Living Standards	Water comes from an improved water source which is located on premises	Water comes from an improved water source, provided collection time is not more than 30 minutes for a roundtrip, including queuing	Water comes from an improved source for which collection time exceeds 30 minutes for a roundtrip, including queuing	Water comes from an unimproved water source	Water comes directly from rivers, lakes, ponds, etc	Corresponds to the number of households allocated to each answer choice in WASH specific assessments/ MSNA/ DTM or included in area-level assessments like SMART surveys as suggested by WASH colleagues for Joint Inter-sectoral Analysis Framework (JIAF). The majority percentage of HHs falling into one phase indicates the overall phase classification – see Limitations p.3. Please liaise with local Global WASH Cluster colleagues if using this indicator in the contributing factor analysis
		Number of HHs having access to an improved water source	Living Standards	Enough water for drinking, cooking, personal hygiene and other domestic purposes OR more than 50 l/d/p	Enough water for drinking AND cooking AND personal hygiene, BUT NOT for other domestic purposes OR 15 or more but less than 50 l/d/p	Enough water for drinking AND EITHER cooking OR personal hygiene OR 9 or more but less than 15 l/d/p	Enough water for drinking BUT NOT for cooking AND personal hygiene OR 3 or more but less than 9 l/d/p	Not enough water for drinking OR Less than 3 l/d/p	
		Number of HHs having access to a functional and improved sanitation facility	Living Standards	Access to improved sanitation facilities, not shared with other households	Access to improved sanitation facilities, shared with less than 20 people	Access to improved sanitation facilities, shared with more than 20 people	Access to unimproved facilities OR access to improved facilities shared with more than 50 people	Disposal of human faeces in open spaces or with solid waste	
		Number of HHs with access to functioning handwashing facilities, with water and soap available or % of HHs with access to soap	Living Standards	Soap is available at home AND handwashing facility is on premises with soap and water available		Soap is available at home BUT no handwashing facility on premises with soap and water		Soap is not available at home	
Underlying causes (Immunization)	Coverage of DTC3 (DPT3 / PENTA3) in <1 year old, by administrative unit	Physical and Mental Well-being	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	This data may be available through projections, but if so, the quality of the data should be checked and noted. In some surveys data is collected from children aged 12-23 months. Please be sure to reference the age range that is the focus of the data. Only the first threshold has been tested and has evidence behind it. The others have been arbitrarily selected and should not be considered accurate measures at this stage	
	Routine measles vaccination coverage (%)	Physical and Mental Well-being			No thresholds proposed				
	Routine polio vaccination coverage (%)	Physical and Mental Well-being			No thresholds proposed				
	Routine Vitamin A supplementation coverage (%)	Physical and Mental Well-being			No thresholds proposed				
	Campaign measles vaccination coverage (%)	Physical and Mental Well-being			No thresholds proposed				
	Campaign polio vaccination coverage (%)	Physical and Mental Well-being			No thresholds proposed				
	Campaign Vitamin A supplementation coverage (%)	Physical and Mental Well-being			No thresholds proposed				
	Measles vaccination coverage from surveys (%)	Physical and Mental Well-being			No thresholds proposed				
Polio vaccination coverage from surveys (%)	Physical and Mental Well-being			No thresholds proposed					
Not from the official GHC list of 'core' health indicators. Use of consensus and expert judgement based on country-level experts for the analysis of contributing factors									

	Vitamin A supplementation coverage from surveys (%)	Physical and Mental Well-being	No thresholds proposed					Not from the official GHC list of 'core' health indicators. Use of consensus and expert judgement based on country-level experts for the analysis of contributing factors	
	Coverage of all basic vaccinations from surveys (%)	Physical and Mental Well-being	No thresholds proposed						
	Percentage of children aged six months to 15 years who have received measles vaccination	Physical and Mental Well-being	>95% in camps / urban areas  >90% in scattered or rural areas	<94-85% urban and camps  <89 - 84% in scattered or rural areas	75%-85%	65%-75%	<65%	This indicator is used to estimate vaccine coverage of the total EPI strategy. To avoid overestimation, measles vaccination coverage is used as proxy since it is usually lower than DPT3 coverage. Both indicators should be calculated on a yearly basis and can provide good indication of health system performance.  It is necessary to assess the quality of the available data. Only the first threshold has been tested and has evidence behind it. The others have been arbitrarily selected and should not be considered accurate measures at this stage	
Key contributing factors	Number of cases or incidence rates for selected diseases relevant to the local context (cholera, measles, acute meningitis, others)	Physical and Mental Well-being	No thresholds proposed, use of consensus and expert judgement	This indicator is primarily a country-level measurement and cannot be easily aggregated for use at higher levels.  The list of diseases is context specific.  Data collection can be problematic as health facility surveillance may have low sensitivity for conditions that do not commonly go to clinic. Access to health services is another factor	Number of cases for selected diseases relevant to the local context (e.g. cholera, measles, acute meningitis, COVID-19)	Physical and Mental Well-being	No thresholds proposed, use of consensus and expert judgement	This indicator is primarily a country-level measurement and cannot be easily aggregated for use at higher levels. The list of diseases is context specific. Data collection can be problematic as health facility surveillance may have low sensitivity for conditions that do not commonly go to clinic. Access to health services is another factor. Please liaise with local GHC colleagues if using this indicator in the contributing factor analysis	
	Immediate causes (Health status)	Case Fatality Ratio (CFR) for most common diseases	Physical and Mental Well-being	No thresholds proposed					Mixture of disease severity and of quality of health care. Most likely will be biased upwards because only more severe cases normally go to clinic. This indicator is primarily a country-level measurement and cannot be easily aggregated for use at higher levels. The list of diseases is context specific. Data collection can be problematic as health facility surveillance may have low sensitivity for conditions that do not commonly go to clinic. Access to health services is another factor. Please liaise with local GHC colleagues if using this indicator in the contributing factor analysis
		Proportion of children U5 with diarrhea in the last two weeks	Physical and Mental Well-being	No thresholds proposed					
		Prevalence of HIV/AIDS	Physical and Mental Well-being	No thresholds proposed					Not from the official GHC list of 'core' health indicators. Use of consensus and expert judgement based on country-level experts for the analysis of contributing factors
		Proportion of children U5 with fever in malaria-risk areas	Physical and Mental Well-being	No thresholds proposed					
		Proportion of children U5 who had Acute Respiratory Infections (ARI) in the last 2 weeks	Physical and Mental Well-being	No thresholds proposed					
		Number of reported cases of cholera or Acute Watery Diarrhea (AWD)	Physical and Mental Well-being	No thresholds proposed					

Key contributing factors	Underlying causes <sup>15</sup> (Availability of and access to health services)	Percentage of healthcare facilities that deliver essential package of health services (including nutrition)	Living Standards	No thresholds proposed					Not from the official GHC list of 'core' health indicators. Use of consensus and expert judgement based on country-level experts for the analysis of contributing factors
		Health-seeking behaviour from population-based surveys	Living Standards	No thresholds proposed					Not from the official GHC list of 'core' health indicators. Use of consensus and expert judgement based on country-level experts for the analysis of contributing factors
		Percentage of population that can access primary healthcare within one hour's walk from dwellings	Living Standards	≥ 80%	75% - 80%	70% - 75%	65% - 70%	< 65%	As per JIAF guidance. Only the first threshold has been tested and has evidence behind it. The others have been arbitrarily selected and should not be considered accurate measures at this stage
		Number of HF with Basic Emergency Obstetric Care/ 500,000 population, by administrative unit	Living Standards	4+	3 - 4	2 - 3	1 - 2	< 1	As per JIAF guidance. Proxy indicators for the physical availability and geographical accessibility of emergency obstetric services and their distribution across districts in the affected areas. An unbalance between the availability of BEmOC and CEmOC (with too few BEmOC) is often observed.  Only the first threshold has been tested and has evidence behind it. The others have been arbitrarily selected and should not be considered accurate measures at this stage
		Number of skilled birth attendant personnel (doctors, nurses, certified midwives) per 10,000 people	Living Standards	≥ 23	≥ 20	≥ 17	≥ 14	≥ 11	As per JIAF guidance. Only the first threshold has been tested and has evidence behind it. The others have been arbitrarily selected and should not be considered accurate measures at this stage
	Immediate causes (Food consumption)	<b>PRIORITY:</b> Food Security Cluster/ Sector Analysis	Living Standards	1	2	3	4	5	To align with the final analysis in terms of phases provided by the in-country Food security colleagues or IPC Acute Food Security Analysis
		Food Consumption Score	Living Standards	Acceptable and stable	Acceptable but deterioration from typical	Borderline	Poor	Poor	Subset suggested by Food Security colleagues for JIAF – see Limitations p.3
		Household Hunger Scale	Living Standards	0 (none)	1 (slight)	2 or 3 (moderate)	4 (severe)	5 or 6 (severe)	
		Reduced Coping Strategies Index	Living Standards	0 to 3	4 to 18	≥ 19	≥ 19	≥ 19	
	Household Dietary Diversity Score	Living Standards	5-12 food groups and stable	5-FG but deterioration ≥1 FG from typical	3-4 FG	0-2 FG	0-2 FG		

\*Requires Minimum Meal Frequency in children 6-23 months to derive along with Minimum Dietary Diversity in children 6-23 months. See Box E below.

<sup>12</sup> See Box E below.

<sup>13</sup> Generally include individuals aged 10-19 years. Further details on BMI-for-Age charts for boys and girls based on 2007 WHO Growth Reference can be found on p.94 of [GUIDE TO ANTHROPOMETRY A practical tool for Program Planners, Managers and Implementers](#).

<sup>14</sup> If presence of aggravating factors which include: a general food ration below 2,100kcal per person per day; a disease outbreak (i.e cholera or malaria); inadequate safe water supplies and sanitation; inadequate shelter; war and conflict, civil strife, migration and displacement.

<sup>15</sup> Further information on potential indicators relating to gender inequality are detailed in Annex 2.

The following set of standardized steps according to scenario aims to provide a **common approach** for classifying the severity of malnutrition and identifying its key drivers in order to ensure applicability across contexts allowing decision-makers to compare situations between one area and another, both within and across countries. For Scenarios 1 & 2 where GAM prevalence is  $\geq 5\%$ , an IPC AMN analysis should be ideally used or planned for – see Box D below for more details.

#### BOX D.

#### PREPARATION FOR AN IPC ACUTE MALNUTRITION ANALYSIS

*Indicative timeline: usually April-October, depending on the seasonality and availability of assessment data.*

A request to the IPC Global Support Unit and the GNC-CT starts the discussion on whether support would be available to conduct a quality IPC AMN analysis within feasible timelines. An IPC AMN analysis requires:

- adequately trained analysts (i.e. technical officers) from relevant agencies and sectors, along with a chairperson from the government when feasible;
- in-country and/or regional stakeholders informed about the analysis process and potential dates for the analysis workshop;
- clear consensus on the unit of analysis, geographical scope and validity period to ensure that minimum evidence requirements are met when evaluating against the reliability criteria (Figure 2);
- logistical and financial arrangements for the analysis workshop – this depends on the availability of financial and human resources to conduct analysis at the level of the intended unit of analysis, and the feasibility of the number of units to be analysed and classified should be considered;
- preparation of the IPC AMN protocols (i.e. analysis worksheets, communication templates, etc).



A number of key considerations and potential adaptations (Table 3) when consolidating available and reliable<sup>16</sup> evidence may be required prior to achieving consensus for the Nutrition Situation Analysis. Aimed at building consensus, the time required and the contextual factors at play when classifying and describing malnutrition conditions and their key contributors as accurately as possible need to be well understood at the onset. Achieving mutual agreement based on the available data and a good understanding of the context of the area analyzed isn't always obvious and requires careful stewardship to mitigate against bias, encourage openness and in some cases, reconcile interpersonal conflicts. This is of particular importance when using outdated nutrition outcome data<sup>17</sup> in conjunction with recent data on contributing factors – see Box E below.

<sup>16</sup> Reliability of the nutrition outcome data in terms of time relevance and soundness of method described in Figure 2 above.

<sup>17</sup> This may be the case during a health epidemic or pandemic, or others events causing widespread mobility restrictions that would affect primary data collection – further details on recommendations can be found [here](#).

**BOX E.**  
KEY CONSIDERATIONS WHEN USING OUTDATED  
NUTRITION OUTCOME DATA

In situations where there is a lack of up-to-date nutrition outcome data (i.e. GAM dating from  $\geq 2$  years ago), it is important to consider the following when conducting your nutrition situation analysis:

1. Review outdated GAM prevalence along with results from contributing factors during that same period and draw some initial assumptions while taking into account the context;
2. Using the IPC AMN analytical framework, review this set of initial assumptions on what may be the current level of GAM (e.g. reduction/constant/deterioration expected) that take into account:
  - availability of recent data on contributing factors (e.g. infant and young child feeding practices, dietary intake, morbidity, access to health and WASH services, household food security, feeding and care practices, poverty etc.) and whether similar trends from the outdated GAM may apply;
  - review of recent performance data from programmes and routine systems (i.e. CMAM data, IYCF counselling and sessions, growth monitoring, immunization, micronutrient supplementation, social protection, etc.) and compare to previous years to identify any changes in trends of changes on nutrition outcome data other than seasonal changes;
3. Discuss amongst representatives how these preliminary assumptions would affect the outdated nutrition outcomes data in terms of severity classification (i.e. if any changes in phases);
4. Document the final assumptions agreed upon by the representatives and how, if any, these assumptions adjusted the severity classification for the current nutrition situation analysis and its effects on the calculation of the number of people in nutritional need. These considerations may differ slightly in contexts conducting an IPC AMN analysis when discussing projections.





Table 3. List of considerations and adaptations when conducting the Nutrition Sectoral Analysis

Unit of Analysis	Key Considerations and Potential Adaptations to Available Nutrition Data
<p><b>Affected geographical area</b></p> <p>(Provinces, districts, sub-districts, municipalities, villages, settlements, etc.)</p>	<p>Based on available nutrition outcome data collected by reliable population-based surveys, ideally representative for a given affected geographical area.</p> <p><b>For Scenarios 1 &amp; 2</b>, GAM based on WHZ<sup>18</sup> data from surveys designed to be representative at a higher administrative level than the unit of analysis, under some specific circumstances (see below), can be re-analysed to obtain estimates for lower administrative units and used in the analysis. The main deciding factor in the case of disaggregated survey data is the <b>design effect</b><sup>19</sup>:</p> <ul style="list-style-type: none"> <li>• If the design effect of the GAM based on WHZ from the higher administrative-level survey is &lt;1.3, this higher administrative-level estimate can be used for all lower administrative levels without disaggregating the data.</li> <li>• If the design effect of the GAM based on WHZ obtained at the higher administrative level is between 1.3 and 1.7, the data should be disaggregated for lower administrative levels with ≥5 clusters and ≥100 observations, and the disaggregated estimates can be used based on the design effect: <ul style="list-style-type: none"> <li>• If design effect ≤1.7: use the point estimate.</li> <li>• If the design effect &gt;1.7, use the lower bound of 95% confidence interval as the minimum phase (Note that minimum phase refers to the phase that an area would be classified as being in based on the lower bound of the Confidence Interval – i.e. the area would be at least in this phase). This is only an indicative phase. The final phase for the area should be decided by taking into account this indicative phase as well as the phases based on the point estimate and the upper Confidence Interval and with convergence of evidence with the contributing factors.</li> </ul> </li> <li>• If the design effect of the GAM based on WHZ obtained at the higher administrative level is &gt;1.7, these survey data should not be disaggregated for lower administrative levels.</li> </ul> <p><b>For Scenarios 2 and 3 ONLY</b>, if there is a gap in recent population-based survey data, consider using historical data to determine the severity classification based on the 5-phases per relevant indicator (see Table 1). Alternatively, consider using existing survey data from comparable areas to identify which phase classification of severity would be relevant for the affected geographical area in question.</p> <p><b>For Scenario 3</b>, similar considerations can be done for Chronic Malnutrition (Prevalence of stunting based on HAZ&lt;-2) and relevant Micronutrient Deficiencies data (and only when applicable, Overnutrition can be taken into account) among children U5 and vulnerable groups based on the reliability of the data in terms of time relevance and soundness of method (see Figure 2 above).</p>
<p><b>Affected groups</b></p> <p>(IDPs, host communities, refugees, non-displaced affected populations, etc)</p>	<p>Based on available nutrition outcome data collected by reliable population-based surveys, ideally representative for a given affected geographical area.</p> <p><b>For all Scenarios</b>, if the survey objectives did not disaggregate results by affected population group, then one cannot assume differences between affected groups and the results are representative across all affected groups present in the surveyed areas unless other reliable data shows otherwise. Therefore, the prevalence data can be repeated for each affected group present within a given geographical area.</p> <p>If data is available per different affected group (i.e. host communities and refugees), disaggregate raw data accordingly per affected geographical area. Ensure that the subsequent steps follow the same disaggregation since evidence is available to support findings.</p>

<sup>18</sup> Similarly to IPC AMN's parameters for analysis, a preference for GAM based on WHZ is put forward. GAM based on MUAC may only be used in the absence of GAM based on WHZ. In exceptional cases where GAM based on MUAC portrays a much more severe situation than GAM based on WHZ (i.e. two or more phases higher), GAM based on MUAC should also be taken into account along with a critical analysis of the contributing factors before a final phase is determined.

<sup>19</sup> Based on the IPC AMN guidance. If ever these considerations based on the design effect cannot be undertaken, access the raw data and re-run the analysis to obtain the design effect. Based on the obtained design effect, apply the key considerations listed above.

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<p><b>Demographic groups</b></p> <p>(Sex, age disaggregated by relevant year intervals)</p>	<p>Based on available nutrition outcome data collected by reliable population-based surveys, ideally representative for a given affected geographical area and disaggregated by sex and age groups (automatically available in SMART survey reports).</p> <p>If not readily available, access to the raw survey data can facilitate these changes by uploading the data into ENA for SMART software and running the reports again. Otherwise, the country-level percentage of boys vs. girls under-five (OCHA generally has this information) can be applied to the results based on the total U5 population to obtain sex-disaggregated results.</p> <p>For age disaggregated data, having U5-specific data and results should be sufficient. For further disaggregation, rough estimates should be available at country-level for 0-5 months, 6-23 months and 24-59 months; this breakdown is generally generated automatically in the SMART survey reports.</p>
<p><b>Groups with specific needs</b></p> <p>(PLW, Older People, disability, etc.)</p>	<p>Based on available nutrition outcome data collected by reliable population-based surveys. For Nutrition, PLW and in certain contexts, Older People, are common, nutritionally vulnerable target groups and therefore to ensure that their nutritional needs have been accounted for when conducting the Nutrition Situation Analysis.</p> <p>For disability-disaggregated data, rough estimates should be available at country-level (check with the Protection Cluster); otherwise one can assume 15% of the total population and 10% for the children population. Therefore, these percentages can be applied to the overall results for the total target population groups to obtain disability-disaggregated results.</p>
<p><b>Specific contextual or vulnerability categories</b></p> <p>(Rural/urban, specific ethnic/minority groups, etc.)</p>	<p>Based on available nutrition outcome data collected by reliable population-based surveys. For each of these vulnerabilities, rough estimates should be available at country-level by the Protection Cluster. These estimates can be applied to the overall results per population target group to obtain disaggregated results.</p>

## SCENARIO 1

Humanitarian situations where the prevalence of U5 GAM is  $\geq 5\%$  with an existing IPC Acute Malnutrition (AMN) analysis

1. Access and review the existing IPC AMN classification already conducted at country-level based on the IPC Acute Malnutrition Reference Table for phase characteristics, and thresholds of international standards;
2. Review the indicators used for the IPC AMN analysis, with GAM for U5 girls and boys being at the forefront. Ensure to include different lenses when analyzing the data while accounting for the ratio between boys and girls. For example, female-headed households may have lower food consumption scores than their male counterparts. Similarly, the female eco-stability principle in certain circumstances of food scarcity<sup>20</sup> may contribute to higher levels of malnutrition in boys than in girls;
3. Review the validity period of existing IPC AMN severity classification. If situation has significantly changed, use IPC guidance on updating the analysis;
4. Use the results of the IPC AMN analysis for your Nutrition Situation analysis.



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## SCENARIO 2

Humanitarian situations where the prevalence of U5 GAM is  $\geq 5\%$  and no IPC AMN analysis can be conducted

1. Contact the GNC-CT to discuss the feasibility of preparing an IPC AMN analysis – see Box D on key steps and considerations. If feasible and in accordance with the GNC-CT, conduct an IPC AMN and use its results.

**Otherwise**, the GNC-CT can support the following steps—please note that this is an exceptional option and can only be used after consultation with the GNC-CT wherein no possible option to conduct the IPC AMN in-country was found.

2. Use the IPC Acute Malnutrition Framework (see Annex 1) to guide the convergence of evidence for this analysis;
3. Respect the key parameters as the rules for severity classification – see ► **Scenario 2 Nut. Analysis** worksheet of the **Nutrition Cluster Nutrition Humanitarian Needs Analysis Calculation Tool**:

3.1 Conduct the **severity classification** of GAM based on the thresholds from Table 1

- ► Insert the prevalence per geographical area for U5 GAM based on WHZ in **column B**. This prevalence will be the primary source for the classification, done automatically in **column E**.
- In cases where U5 GAM based on WHZ is not available, ► insert U5 GAM based on MUAC in **column C**. A prompt to “provide justification for value” is given where details should be included in **column F**.
- ► Insert the prevalence of PLW GAM based on MUAC in **column D**. Only in rare cases where neither U5 GAM based on WHZ or MUAC are available will this be used for classification, otherwise it will be used for the upcoming PiN calculation.

<sup>20</sup> Further details on the female eco-stability principle can be found [here](#).

3.2 Conduct an analysis of key contributing/contextual factors based on thresholds from Table 1 using ► **Scenario 2 Contributing Fact.** of the **Nutrition Cluster Nutrition Humanitarian Needs Analysis Calculation Tool** based on the following:

- ► Insert the prevalences per geographical area for available Contextual factors and Living Standards indicators in **columns B-L**. Note that Minimum Meal Frequency for children 6-23 months is used here over the composite indicator Minimum Acceptable Diet in children 6-23 months.
- ► Insert the death rates per geographical area for available Crude Death Rate and U5 Death Rate indicators in **columns M-N**.
- ► Insert the corresponding phase number (see ► **Classification thresholds** worksheet for details) per relevant Food Security, WASH, and Health indicators for each geographical area in **columns O-AN**.
- A qualitative analysis of key contributing factors will be done per completed column similar to the IPC AMN analysis based on the following cut-offs:

4. Ensure to include different lenses when analyzing the data while accounting for the ratio between boys and girls; for example, the access to nutrition services may be different for men and women;
5. Prepare the report using the **consensus** of severity classification and its key contributing factors for geographical prioritization – review Box E above in case of outdated nutrition outcome data;
6. Summarize the reliability of all evidence used in ► **Reliability of Evidence Used** worksheet based on the scores provided in the aforementioned IPC AMN’s Figure 2;
7. Present findings<sup>21</sup> to decision-makers based on key points from Annex 5 while highlighting any population movements and accessibility issues to take into consideration;
8. Document any resource gaps, including capacity and evidence gaps, to inform future Nutrition Situation Analyses to the GNC-CT and/or IPC Global Support Unit on any technical and implementation issues for the development and review of existing guidance and training materials.

<b>Phase 1 Acceptable/ Minimal</b>	<b>Phase 2 Alert/ Stress</b>	<b>Phase 3 Serious/ Severe</b>	<b>Phase 4 Critical/ Extreme</b>	<b>Phase 5 Extremely Critical/ Catastrophic</b>	<b>No data</b>
No contributing factor	Minor contributing factor	Major contributing factor	Critical contributing factor		

<sup>21</sup> Including details on the critical reasoning used for the current period, particularly when convergence of evidence is used to arrive at a conclusion, sources of evidence used and its analysis, brief description of the population characteristics per geographical area, time period of the analysis (i.e. validity period), key drivers of acute malnutrition and any limitations of the situation analysis.

**SCENARIO 3**

Humanitarian situations where the prevalence of U5 GAM is <5%

1. Use the IPC Acute Malnutrition Framework (see Annex 1) to guide the convergence of evidence for this analysis;

In the ► **Scenario 3 Nut. Analysis** worksheet, conduct the severity classification using a preliminary scoring system in **columns P-U** that takes into account both vulnerability of the target groups and reliability of these 10 indicators<sup>22</sup> (taking note of using Minimum acceptable Diet for children 6-23 months if available) deemed relevant for this scenario. An optional 11th

indicator with fixed number of associated points (see last row below) is included for country inputs if deemed necessary given its context - for example, the prevalence of acute malnutrition based on WHZ (see Table 1 above for other indicators to consider). It is not recommended to include mortality indicators unless only non-traumatic deaths are accounted for. By default, Phase 1 is assumed for all of these indicators for Scenario 3's preliminary scoring system (see Limitations)

PRELIMINARY SCORING SYSTEM	Phase 1 Acceptable/ Minimal	Phase 2 Alert/ Stress	Phase 3 Serious/ Severe	Phase 4 Critical/ Extreme	Phase 5 Extremely Critical/ Catastrophic	
100.00	1,00	5,00	14,00	30,00	50,00	
Prevalence of exclusive breastfeeding for children 0-5 months	0,11	0,55	1,54	3,30	9,17	55%
Minimum Dietary Diversity in children 6-23 months (if available, use Minimum Acceptable Diet children 6-23 months)	0,11	0,55	1,54	3,30	9,17	
Stunting prevalence (HAZ) for children 0-59 months	0,11	0,55	1,54	3,30		
Prevalence of overweight in children 0-59 months	0,11	0,55	1,54	3,30	9,17	
Prevalence of anemia in children 6-59 months	0,11	0,55	1,54	3,30		
Prevalence of anemia in pregnant women	0,10	0,50	1,40	3,00		30%
% of infants 0-5 months that are not breastfed who have access to BMS supplies and support	0,10	0,50	1,40	3,00	7,50	
% of infants 6-11 months that are not breastfed who have access to BMS supplies and support	0,10	0,50	1,40	3,00	7,50	
GAM prevalence % for Older People (MUAC<210mm)	0,05	0,25	0,70	1,50		15%
GAM prevalence % for Adolescents (BMI-for-Age)	0,05	0,25	0,70	1,50	3,75	
For country inputs (if relevant)	0,05	0,25	0,70	1,50	3,75	

<sup>22</sup> The rationale is based on a three-tiered scoring system proposed by the GNC Taskforce where the indicators in purple represent 55% of the total amount of points per phase, those in blue 30% and those in green only 10%. For example, if the Stunting prevalence in U5 is in Phase 3, this will receive 1,54 points versus the prevalence of GAM in Older People only receiving 0.7 points. For any missing data, the accompanying Spreadsheet tool will automatically assume a Phase 1 for that indicator. This breakdown is not based on hard evidence, rather the assumed vulnerability and reliability of these 10 indicators for this scenario – see Limitations on p.3.

1.1 ► Insert the prevalence per geographical area for any of the readily available indicators in **columns B-L**.

1.2 An automatic classification based on thresholds from Table 1 will be done in these columns. Based on this classification, the associated number of points will be taken and added in **column M**.

1.3 Based on the total number of points calculated, the associated severity classification per geographical area will be automatically provided in **column N** using the following preliminary cut-offs (see Limitations):

TABLE OF INTERPRETATION	Phase 1 Acceptable/ Minimal	Phase 2 Alert/ Stress	Phase 3 Serious/ Severe	Phase 4 Critical/ Extreme	Phase 5 Extremely Critical/ Catastrophic
Preliminary cut-offs based on score	<=4	5-13	14-29	30-49	>=50

2. Conduct an analysis of key contributing/contextual factors based on thresholds from Table 1 using ► **Scenario 3 - Contributing Fact** of the **Nutrition Cluster Nutrition Humanitarian Needs Analysis Calculation Tool** based on the following:

- Insert the death rates per geographical area for available Crude Death Rate and U5 Death Rate indicators in **columns B-C**.
- Insert the corresponding phase number (see ► **Classification thresholds** worksheet for details) per relevant Food Security, WASH, and Health indicators for each geographical area in **columns D-AC**.

- A qualitative analysis of key contributing factors will be done per completed column similar to the IPC AMN analysis based on the following cut-offs:

Phase 1 Acceptable/ Minimal	Phase 2 Alert/ Stress	Phase 3 Serious/ Severe	Phase 4 Critical/ Extreme	Phase 5 Extremely Critical/ Catastrophic	No data
No contributing factor	Minor contributing factor	Major contributing factor	Critical contributing factor		

3. Ensure to include different lenses when analyzing the data while accounting for the ratio between boys and girls. For example, female-headed households may have lower food consumption scores than their male counterparts;
4. Prepare the report using the consensus of severity classification based on ► **Scenario 3 Nut. Analysis** and its key contributing factors for geographical prioritization - review Box E above in case of outdated nutrition outcome data;
5. Summarize the reliability of all evidence used in ► **Reliability of Evidence Used** worksheet based on the scores provided in the aforementioned IPC AMN's Figure 2;
6. Present findings<sup>23</sup> to decision-makers based on key points from Annex 5 while highlighting any **population movements and accessibility issues** to take into consideration;
7. Document any resource gaps, including capacity and evidence gaps, to inform future Nutrition Situation Analyses to the GNC-CT on any technical and implementation issues for the development and review of existing guidance and training materials.

<sup>23</sup>Including details on the critical reasoning used for the current period, particularly when convergence of evidence is used to arrive at a conclusion, sources of evidence used and its analysis, brief description of the population characteristics per geographical area, time period of the analysis (i.e. validity period), key drivers of acute malnutrition and any limitations of the situation analysis.



3

# PREPARE KEY NUTRITION FIGURES FOR THE HUMANITARIAN NEEDS OVERVIEW AND SUBSEQUENT RESPONSE PLAN





### 3. PREPARE KEY NUTRITION FIGURES FOR THE HUMANITARIAN NEEDS OVERVIEW AND SUBSEQUENT RESPONSE PLAN (ONLY APPLICABLE TO IASC CLUSTERS)

*Indicative timeline: In parallel with the Nutrition Situation Analysis.*

The results of the Nutrition Situation analysis feed into the HNO and HRP population figures defined in Figure 3 and Table 2 in Annex 4, where this commonly requested information in humanitarian situations provides the backbone to any humanitarian operation. Inconsistent terminology, unclear methodologies and a lack of transparent, coordinated and standardized data gathering frequently result in humanitarian actors operating with different information. In parallel, understanding the magnitude of the situation at different levels of severity supports the response planning by identifying the number of People in Need (PiN), conducted per sector and inter-sectorally (addressed in Addendum 1 on JIAF).

For the Nutrition Cluster, PiN is a sum of the number of persons in nutritional need, by humanitarian consequence, in each geographical area based on the situation analysis of data/information. Using the **Nutrition Cluster Nutrition Humanitarian Needs Analysis Calculation Tool**, the PiN needs to be calculated for each specific nutritional need and expressed as such, where the HNO already serves as a projection of nutritional needs for the coming year. Once the PiN is derived, an estimation on the PiN facing humanitarian access constraints can be determined. The calculation is based on the estimated incidence or prevalence of people that need the specific service (e.g. the number of U2 children that are affected by the humanitarian situation and need nutritional support through an IYCF programme). Regardless of the nature of the humanitarian situation, diverse Essential Nutrition Actions (ENAs)<sup>24</sup> would affect the determinants of optimum nutrition, growth and development through nutrition-specific and nutrition-sensitive interventions (Figure 4).



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<sup>24</sup> World Health Organization (2019) [Essential nutrition actions: mainstreaming nutrition through the life-course](#)

Figure 4. Subset of areas of focus drawn from WHO's ENAs

	Context (all settings vs targeted)	Essential Nutrition Actions	Others sectors Involved
<b>1. Infants</b>	All	A. Optimal timing of umbilical cord clamping	
	All	B. Protecting, promoting and supporting breastfeeding	Labour (maternity protection), water, sanitation and hygiene (WASH)
	Targeted	C. Care of low-birth-weight and very low-birth-weight infants	
	Targeted	D. Assessment and management of wasting	
	Targeted	E. Vitamin A supplementation for infants under 6 months of age	
<b>2. Children</b>	All	A. Appropriate complementary feeding	Education, trade and industry
	All	<b>B. Growth monitoring and assessment</b>	<b>Education</b>
	Targeted	C. Assessment and management of wasting	Education, trade and industry
	Targeted	D. Iron-containing micronutrient supplementation	Education, trade and industry
	Targeted	E. Vitamin A supplementation	Education, trade and industry
	Targeted	F. Iodine supplementation	Education, trade and industry
	Targeted	G. Zinc supplementation in the management of diarrhoea	Education, trade and industry
<b>3. Adolescents</b>	Targeted	A. Iron-containing micronutrient supplementation	Education, trade and industry
<b>4. Adults</b>	All	<b>A. Nutritional care of woman during pregnancy and postpartum</b>	<b>Education, trade and industry</b> <b>Labour (maternity protection and parental leave)</b>
	Targeted	B. Iron-containing micronutrient supplementation	Education, trade and industry
	Targeted	C. Iodine supplementation	Education, trade and industry
<b>5. Older persons</b>	Targeted	A. Nutritional care for at-risk older persons	Education, trade and industry

With the changing dynamics in humanitarian conditions and context, the HNO (template provided by OCHA and/or government at country-level) is an **iterative** output to support all humanitarian actors, local and national authorities, civil society and affected communities in developing a shared understanding of the impact and **evolution of a humanitarian situation**.

The results of the Nutrition Situation Analysis lay the foundation for a coherent and efficient humanitarian response based on the magnitude identified, namely through the HRP, and its monitoring based on 4W along with other reporting and monitoring tools. Whenever applicable, information concerning refugees and their distinct context, needs, vulnerabilities, and situation should also be incorporated.<sup>25</sup> Furthermore, the needs of persons with disabilities should be accounted for to ensure that this vulnerable, at-risk group are not being left behind in the humanitarian response (see Box F).

Based on the humanitarian situation, it is important to start with what is already known for the different population groups and sub-groups (e.g. persons with disabilities), the gender dynamics, geographic areas and/or specific issues. Taking stock of existing nutrition interventions helps identify the key questions needed to inform response planning and decision-making, based on their achievements, gaps and how they have influenced the **humanitarian consequences** – an important differentiation for the development of HNOs and HRPs. As cited previously, Nutrition focuses on the following two humanitarian consequences:

- **“Physical and Mental Well-being”**: these consequences have a direct effect on people’s survival, mental and physical integrity and/or dignity in the short term (within the next six months), recognizing they also have longer term effects (e.g. acute and/or chronic malnutrition, death and morbidity). For Nutrition, “Physical and Mental Well-being” consequences are based on anthropometric data. The urgency of the response can differ based on the timeframe of their effect (short term versus longer term survival) and their degree of irreversibility in the absence of response.
- **“Living Standards”**: these consequences have a direct effect on people’s ability to pursue their normal productive and social activities and meet their basic needs in an autonomous manner. They manifest in different types of deficit and the use of various coping mechanisms to meet basic needs (e.g. lack of food, income, access to health

#### BOX F. DISABILITY INCLUSION

Persons with disabilities are estimated to represent 15% of the world’s population. In humanitarian contexts, they may form a much higher percentage. They are among the most marginalized people in crisis-affected communities and are disproportionately affected by conflict and emergency situations. In disasters, their mortality rate is two to four times higher than that of persons without disabilities. In many contexts, disability disaggregated data (such as administrative data or national prevalences) will be non-existent or unreliable. Primary data to inform local disability estimations should be ideally collected using internationally recognized methods, such as the Washington Group Set tools. In cases where primary data collection is not feasible, **it is recommended to assume 15% of PiN will have some form of disability (same percentage applies for PLW) and 10% of PiN for children to be used in planning for disability inclusion.** These estimations are used in the HNO and for planning purposes; these estimations should be not used to report persons with disabilities reached by nutrition services – see [tips on the integration of disability in HNOs](#) and [guidance on disability inclusive monitoring frameworks](#).

care, water, sanitation, shelter and education). and how these may be different for various population groups. Tables 4A, 4B, 4C below outline three categories of nutritional needs respectively: Acute and chronic undernutrition, overnutrition; IYCF Practices; and Micronutrient Deficiency. PiN calculations for particular population groups for a minimum sub-set of key nutrition-specific interventions (e.g. IYCF support, treatment of MAM and SAM<sup>26</sup>, blanket or targeted supplementary feeding, vitamin A supplementation) are also provided in these three tables.

<sup>25</sup> This document and templates will not prejudice the [Joint OCHA-UNHCR Note on Mixed Situations](#).

<sup>26</sup> Note: the number of cases identified suffering from MAM or SAM that creates the base for PiN for treatment can be calculated through the use of combined prevalence of SAM/MAM identified by WHZ and/or MUAC (i.e. cGAM). The legend needs to explain the method.

**Please note that the contents of Tables 4A, 4B, 4C are not meant to be comprehensive (i.e they do not include nutrition-sensitive interventions) and should be taken into account with the given context, existing national guidelines and nature of the crisis situation.**

Before proceeding to reviewing the automatic calculations, insert the following demographic information in ► **Population Figures** worksheet to derive subsequent PiNs:

For each Admin 2 for “Affected” areas of interest and population figures (from OCHA and/or government); collate all available demographic information for U5 children, broken down by relevant age categories and **disaggregated against relevant dimensions including gender, disability and other diversity characteristics** if available:

- If no information is available for 0-5 months and 6-11 months, we can assume each represent 1.8% of the total percentage as per cohort data<sup>27</sup>;
- If no information is available for 6-23 months, we can assume based on the aforementioned cohort data that it represents 5.4% of the total population,
- If no information is available on disability, we can assume 15% of the adult PiN (same percentage applies for PLW) has a disability and 10% of the children PiN.
- If no information is available for PLW, we can assume this group represents 7% of the total population, with 4% of PW.

Each of these tables summarizes key considerations when calculating PiN per nutritional need based on the following:

- **Nutritional need (Essential Nutrition Actions):** based on the three categories detailed above and the corresponding ENAs (if available);
- **Alignment with a subset of High Impact Nutrition Interventions:** a series of nutrition-specific interventions promoted by the WHO to address these nutritional needs;
- **Potential population groups to include:** population groups in need of specific NiE interventions, with children aged 0-23 months, 0-59 months (U5), PLW, older people being a few examples. The decision on the selection of the groups to be included should be based on the analysis of the nutrition situation and other relevant information;
- **Indicators and key considerations:** list of core (with GAM being split by SAM and MAM) and other relevant indicators taken from the Global Nutrition Cluster’s [Indicator Registry and Framework](#) with key considerations in their estimation. If cGAM<sup>28</sup> is available at country level, **cGAM (along with its derivatives of cMAM and cSAM) will be preferred for Nutrition PiN calculations;**
- **PiN Calculation formulas:** Clear formulas per relevant indicator are included. Disaggregation by sex, age group and disability should be done when data are available. **The Nutrition Cluster HNO Calculation Tool Version 1**, derived from the Global Nutrition Cluster’s Indicator Registry and Framework and its Caseload Calculation Tool, can be used to automatically calculate the number of persons based on a series of detailed steps using ► **PiN** worksheets. The process must be well documented to show where the numbers stop being representative and where the expert opinion beings to have equal influence.

■ For the internal Nutrition Cluster analysis for the HNO and HRP, there is no need to consolidate PiNs per nutritional need by humanitarian consequence. A Total Nutrition PiN is useful for the HRP preparation and for the Joint Intersectoral Analysis Framework (see Addendum 1).

<sup>27</sup> Taken from Annex 2 in WHO’s [Rapid health assessment protocols during emergencies](#).

<sup>28</sup> cGAM: aggregate indicator by combining GAM based on WHZ and GAM based on MUAC).

Table 4A. Summary of PiN calculations for acute and chronic undernutrition, overnutrition

Nutritional need (Essential Nutrition Actions)	Alignment with a subset of High Impact Nutrition Interventions	Potential population groups to include	(Core) Indicators and key considerations	PiN Calculation formulas
	Nutrition Screening and referral	All children U5 PLW Adolescents Older people <sup>29</sup>	<ul style="list-style-type: none"> <li>Number of U5 children to be screened for malnutrition</li> <li>Number of PLW to be screened for malnutrition</li> <li>Number of Adolescents to be screened for malnutrition</li> <li>Number of Older People to be screened for malnutrition</li> <li>100% of the estimated children should be targeted for screening.</li> </ul> <p>Where a nutrition program already exists and data is available from last year to define the proportion of population for each group in the area of intervention</p>	<p><b>Number of children to be screened for malnutrition (disaggregated by sex) =</b> Population figures from “Affected” areas x % of children U5</p> <p><b>Number of PLW to be screened for malnutrition =</b> Population figures from “Affected” areas x % of PLW</p> <p><b>Number of Adolescents to be screened for malnutrition (disaggregated by sex) =</b> Population figures from “Affected” areas x % of Adolescents</p> <p><b>Number of Older People to be screened for malnutrition (disaggregated by sex) =</b> Population figures from “Affected” areas x % of Older People</p>
<b>Acute Malnutrition (AMN)</b> (Management of Wasting)	Inpatient management of SAM (Stabilization centres -SC)	<p>All infants below 6 months of age with SAM At high risk mother/infant pairs Girls and boys between 6 and 59 months of age who have severe bilateral pitting oedema (+++) or severe acute malnutrition with medical complications PLW with SAM and medical complications</p> <p>If relevant: Older women and men with SAM Adolescent girls and boys with SAM and medical complications</p> <p><i>For behaviour changes activities: Caretaker benefiting from communication for development (behaviour changes) activities at facility level should be included. Estimates of one caretaker per child (the child admitted for SAM treatment either as inpatient SC or CMAM)</i></p>	<ul style="list-style-type: none"> <li><u>Prevalence of cSAM in U5 children (if not available, then use 6-59 months)</u></li> <li><u>Prevalence of SAM in children 0-59 months based on WHZ and/or bilateral pitting oedema (if not available, then use 6-59 months)</u></li> <li><u>Prevalence of SAM in children 6-59 months based on MUAC and/or bilateral pitting oedema</u></li> <li>Prevalence of SAM in Older People based on MUAC</li> <li>Prevalence of SAM in Adolescents based on BMI-for-Age</li> </ul> <p>If GAM is known but the SAM prevalence is not known, consider using on average an estimate of 20% of GAM patients are suffering from SAM.</p> <p>On average, a 5-20% of children with SAM are expected to be referred to inpatient treatment. This proportion will depend on the status of the CMAM program.</p>	<p><b>Number of SAM U5 children in need<sup>30</sup> (disaggregated by sex) =</b> cSAM prevalence x population of U5 from “Affected” areas x k (SAM incident factor)</p> <p><b>Number of SAM U5 in need of Inpatient Treatment<sup>31</sup> (disaggregated by sex) =</b> Number of SAM cases (based on cSAM by default) x Expected proportion of SAM cases for Inpatient treatment</p> <p><b>Number of Older People in nutritional need (disaggregated by sex) =</b> SAM prevalence based on MUAC x population of Older People from “Affected” areas</p> <p><b>Number of Adolescents in nutritional need (disaggregated by sex) =</b> SAM prevalence based on BMI-for-Age x population of Adolescents from “Affected” areas</p>
	Outpatient Management (CMAM, Outpatient Therapeutic Program- OTP)	<p>Girls and boys between 6 and 59 months of age who have mild/moderate bilateral oedema (+, ++) or severe wasting without any medical complications PLW with SAM without any medical complications</p> <p><i>If relevant: Adolescent girls and boys with SAM without medical complications</i></p>	<p>At the beginning of a CMAM program a high number of complicated cases can be expected to be referred to the SC, so the proportion will be high and might be around 15 to 20%. In a well-functioning CMAM program, this proportion can decrease over the time and be around 5 to 10%.</p>	<p><b>Number of SAM children 6-59 months in need of Outpatient Treatment<sup>31</sup> (disaggregated by sex) =</b> cSAM prevalence x population of children 6-59 months from “Affected” areas x k (SAM incident factor) x Expected proportion of SAM cases for Outpatient treatment</p> <p><b>Same calculations details above for PLW and Adolescents.</b></p>
	Treatment of MAM	<p>Moderately acutely malnourished girls and boys aged 6-59 months Acutely malnourished (severe and moderate) PLW with infants 0-5 months, Severely, moderately and mildly acutely malnourished PLWHIV</p>	<ul style="list-style-type: none"> <li><u>Prevalence of cMAM in U5 (if not available, then use 6-59 months)</u></li> <li><u>Prevalence of MAM in U5 based on WHZ (if not available, then use 6-59 months)</u></li> <li><u>Prevalence of MAM in children 6-59 months based on MUAC</u></li> <li><u>Prevalence of MAM in PLW based on MUAC</u></li> <li>Prevalence of GAM in PLWHIV based on MUAC &lt;210mm</li> </ul> <p>If MAM prevalence is not known, consider using on average an estimate of 80% of GAM patients are suffering from MAM.</p>	<p><b>Number of MAM children 6-59 months in need (disaggregated by sex) =</b> cMAM prevalence (by default) x population of children 6-59 months from “Affected” areas x k (MAM incident factor)</p> <p><b>Number of MAM children 6-59 months in need of programming (disaggregated by sex) =</b> cMAM prevalence (by default) x population of children 6-59 months from “Affected” areas x k (MAM incident factor) x Expected proportion of MAM cases for programming</p> <p><b>Number of MAM PLW in need =</b> MAM prevalence x population of PLW from “Affected” areas</p>
	Blanket Supplementary Feeding Programmes (BSFP)	<p>Girls and boys aged 6-23 months PLW.</p> <p><i>If resources allow, consider including U5 children and Older People.</i></p>	<ul style="list-style-type: none"> <li>Proportion of children 6-23 months in need of BSFP</li> <li>Proportion of PLW in need of BSFP</li> </ul> <p>70-80% of U2 and PLW estimated should be targeted for BSFP.</p>	<p><b>Number of children 6-23 months in need of BSFP (disaggregated by sex) =</b> Population of children aged 6-23 months from “Affected” areas x Expected coverage for BSFP</p> <p><b>Number of MAM PLW in need of BSFP =</b> population of PLW from “Affected” areas x Expected coverage for BSFP</p>
<b>Chronic Malnutrition</b>	Prevention of malnutrition	Girls and boys between 0 and 59 months	<u>Prevalence of Stunting in U5 children based on HAZ</u>	<b>Number of Stunted children U5 in need (disaggregated by sex) =</b> Stunting prevalence x population of U5 from “Affected” areas
<b>Overweight</b>	Prevention of malnutrition	Girls and boys between 0 and 59 months	<u>Prevalence of overweight in U5 children based on WHZ</u>	<b>Number of Overweight children U5 in need (disaggregated by sex) =</b> Overweight prevalence x population of U5 from “Affected” areas



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<sup>29</sup> The UN definition for older people is people aged 60 years of age and above ( $\geq 60$ ). However, you might wish to adapt this definition according to the context: in some countries (e.g. Sub Saharan Africa), old age is more of a social or cultural concept (e.g. retiring, or getting white hair...), and it makes sense to target people when they reach the age of 50 or 55 years. Some countries have their own definition. If there is no national definition of older people, use the UN definition ( $\geq 60$ ).

<sup>30</sup> This will be revised based on upcoming UNICEF's Guidance for Estimating the Number of Children in Need of Treatment for Wasting based on research data on children 6-59 months.

<sup>31</sup> To consult the upcoming UNICEF's Guidance for Estimating the Number of Children in Need of Treatment for Wasting based on research data on children 6-59 months.

Table 4B. Summary calculations of PiN per IYCF practice

Nutritional need (Essential Nutrition Actions)	Alignment with a subset of High Impact Nutrition Interventions	Potential population groups to include	(Core) Indicators and key considerations	PiN Calculation formulas
<b>IYCF practices</b>  (Protection, promotion and support of optimum breastfeeding)	Establishment of IYCF safe spaces	PLW Caregivers with U2 girls and boys <i>If feasible, access via community leaders and champions</i>	<ul style="list-style-type: none"> <li>Proportion of PLW counselled on IYCF</li> <li>Proportion of PLW participating in group sessions on IYCF</li> <li><u>Exclusive breastfeeding (EBF) for children 0-5 months</u></li> <li><u>Infants (children 0-5 months) who are not breastfed who have access to BMS supplies and support in line with the Code and the IFE Operational Guidance's standards and recommendations</u></li> <li><u>Infants (children 6-11 months) who are not breastfed who have access to BMS supplies and support in line with the Code and the IFE Operational Guidance's standards and recommendations</u></li> <li>Proportion of non-breastfed children 0-11 months (disaggregated by sex)</li> <li>Continued breastfeeding at 1 year of age (Proportion of children 12-15 months who are fed breastmilk)</li> </ul> Where data is unavailable, assume: <ul style="list-style-type: none"> <li>0-5 months comprise 1.8% of population;</li> <li>6-11 months comprise 1.8% of population;</li> <li>PLW combined comprise around 7% of population.</li> </ul>	<p><b>Number of PLW counselled (one-on-one) on IYCF = Population figures from "Affected" areas x % of PLW x Proportion of PLW individually counselled on IYCF</b></p> <p><b>Number of PLW participating in group sessions on IYCF = Population figures from "Affected" areas x % of PLW x Proportion of PLW participating in group sessions on IYCF</b></p> <p><b>Number of children 0-5 months in need of EBF support (disaggregated by sex) = Population figures from "Affected" areas x % of children 0-5 months x (1- EBF proportion)</b></p> <p><b>Number of non-breastfed children aged 0-5 months in need of BMS supplies and support<sup>32</sup> (disaggregated by sex) = Population figures from "Affected" areas from "Affected" areas x (# of non-breastfed children 0-5 months in need of BMS supplies and support surveyed / total children 0-5 months surveyed)</b></p> <p><b>Number of non-breastfed children aged 6-11 months in need of BMS supplies and support<sup>32</sup> (disaggregated by sex) = Population figures from "Affected" areas x (# of non-breastfed children 6-11 months in need of BMS supplies and support surveyed / total children 6-11 months surveyed)</b></p> <p><b>Number of non-breastfed children aged 0-11 months (disaggregated by sex) = Population figures from "Affected" areas x (# of non-breastfed children 0-11 months / total children 0-11 months surveyed)</b></p> <p><b>Number of children still breastfeeding at 1 year of age (disaggregated by sex) = Population figures from "Affected" areas x (# of children 12-15 months who are fed breastmilk / total children 12-15 months surveyed)</b></p>
	<b>Counselling (one-on-one)</b> Community Nutrition and Health facilities Other settings (e.g. food and cash distributions, women-friendly spaces) as applicable			
	<b>Counselling (group sessions)</b> Community Nutrition and Health facilities Other settings (e.g. food and cash distributions, women-friendly spaces) as applicable			
	Specialized support for non-breastfed/partially breastfed infants* (i.e. infant formula dependant children) <i>* may include provision and support with BMS and BMS kit</i>	PLW Caregivers of non-breastfed girls and boys 0-5 months, 6-11 months, and nutritionally vulnerable infants		
<b>IYCF practices</b>  (Appropriate complementary feeding)	Promotion and support to appropriate, timely and safe complementary feeding	Families with U2 girls and boys PLW Blanket coverage may be an option when it is too difficult to target specific group of beneficiaries	<ul style="list-style-type: none"> <li><u>Minimum dietary diversity in children 6-23 months</u></li> <li><u>Minimum meal frequency in children 6-23 months</u></li> <li><u>Minimum acceptable diet in children 6-23 months</u></li> </ul> Where data is unavailable, assume: <ul style="list-style-type: none"> <li>6-23 months comprise 5.4% of population.</li> </ul>	<p><b>Number of children 6-23 months in need of Minimum Dietary Diversity support (disaggregated by sex) = Population figures from "Affected" areas x % of children 6-23 months x (1- MDD proportion)</b></p> <p><b>Number of children 6-23 months in need of Minimum Meal Frequency support (disaggregated by sex) = Population figures from "Affected" areas x % of children 6-23 months x (1- MMF proportion)</b></p> <p><b>Number of children 6-23 months in need of Minimum Acceptable Diet support (disaggregated by sex) = Population figures from "Affected" areas x % of children 6-23 months x (1- MAD proportion)</b></p>
	Access to specialised nutrition commodities		Refer to either BSFP PiN in Table 4A above, or Micronutrient Supplementation PiN in Table 4C below	
	Appropriate complementary feeding through cash "plus" and voucher initiatives	Precise targeting criteria must be established at country level in case of cash and voucher initiatives. Targeting criteria should be based on vulnerability criteria = target at risk population (PLW, U2)		
	Appropriate complementary feeding through food distributions (in kind)			

<sup>32</sup> **Note of caution:** The number of infants and young children aged 0-5 or 6-11 months in need of BMS supplies and support should be used to guide programmatic priorities and not to estimate or request supplies. The interpretation of this number should help in strategizing priorities for infant feeding including to ensure that the most vulnerable caregivers and their infants receive the needed support which may consist of quality IYCF counselling and considering options like relactation, wet nursing, and donor breastmilk depending on what is culturally acceptable and feasible. Provision and support of BMS should be done as a last resort, fulfilling strict criteria and in line with the recommendation and standards provided in the Operational Guidance for Infant and Young Child Feeding in Emergencies.

**Table 4C. Summary calculations of PiN per micronutrient deficiency**

Nutritional need (Essential Nutrition Actions)	Alignment with a subset of High Impact Nutrition Interventions	Potential population groups to include	(Core) Indicators and key considerations	PiN Calculation formulas
<b>Micronutrient deficiencies</b> (Iron-containing micronutrient supplementation for children, adolescents, women during pregnancy and postpartum)	Iron or iron/folic acid supplementation	Girls and boys 6-23 months of age (If resources allow, 6-32 or 6-59 months can be considered) PW WRA in populations where the prevalence of anaemia among non-pregnant women is 20% or higher Women postpartum Older women and men	<ul style="list-style-type: none"> <li>Prevalence of anemia Hb&lt;11g/dl in children 6-59 months</li> <li>Prevalence of anemia Hb&lt;11g/dl in PW</li> <li>Proportion of children 6-59 months of age receiving micronutrient supplements that contain adequate iron</li> <li>Proportion of PW having received iron-folic acid supplementation daily in previous 6 months/during pregnancy</li> </ul> In areas with high GAM prevalence rate, do not forget to subtract children with GAM as they receive RUTF/RUSF that already contain adequate iron	<b>Number of anemic children 6-59 months (disaggregated by sex) = Population figures from "Affected" areas x % of children 6-59 months x U5 anemia prevalence</b> <b>Number of anemic PW = Population figures from "Affected" areas x % of PW x PW anemia prevalence</b> <b>Number of children 6-59 months in need of iron supplementation (disaggregated by sex) = Population figures from "Affected" areas x % of children 6-59 months x (1- Proportion of children 6-59 months having received micronutrient supplements that contain adequate iron)</b> <b>Number of PW in need of iron supplementation = Population figures from "Affected" areas x % of PW x (1- Proportion of PW having received micronutrient supplements that contain adequate iron)</b>
	Calcium supplementation during pregnancy	PW	<ul style="list-style-type: none"> <li>Proportion of PW having received calcium supplementation during pregnancy</li> <li>Proportion of PW having received multiple micronutrient supplementation during pregnancy</li> </ul> If no data exists assume PW comprise 5% of population (low income countries only) as per WHO guidance ( <i>Annex 2 of Rapid assessment in emergencies</i> )	<b>Number of PW in need of calcium supplementation = Population figures from "Affected" areas x % of PW x (1- Proportion of PW having received calcium supplements during pregnancy)</b>
	Multiple micronutrient supplementation in pregnancy			
	Balanced energy protein supplementation during pregnancy and breastfeeding	PLW	<ul style="list-style-type: none"> <li>Proportion of PLW having received balanced energy protein supplementation during pregnancy/breastfeeding</li> </ul> If no data exists assume around 7% PLW (low income countries only)	<b>Number of PLW in need of balanced energy protein supplementation = Population figures from "Affected" areas x % of PLW x (1- Proportion of PLW having received balanced energy protein supplements during pregnancy and breastfeeding)</b>
<b>Micronutrient deficiencies</b> (Vitamin A supplementation)	Vitamin A administration and prevention of Vitamin A Deficiency (VAD)	Girls and boys 6-59 months, disaggregated as 6-11 months and 12-59 months in populations where the prevalence of night blindness is 1% or higher in children 24-59 months of age or where the prevalence of VAD is 20% or higher in infants and children 6-59 months of age <i>If relevant:</i> PW in populations where the prevalence of night blindness is 5% or higher in pregnant women or children 24-59 months of age Girls and boys with measles Girls and boys with SAM (see existing protocol at national or international level regarding administration of Vitamin A and management of SAM cases) Older women and men	<ul style="list-style-type: none"> <li>Prevalence of sub-clinical Vitamin A deficiency in children 6-59 months</li> <li>Proportion of children 6-59 months having received vitamin A in previous 6 months</li> </ul> Liaise with Health Cluster as often Vitamin A distribution takes place during immunisation campaigns or during the Child Health Days and is provided to children with measles as part of treatment for measles	<b>Number of VAD children 6-59 months in need (disaggregated by sex) = Population figures from "Affected" areas x % of children 6-59 months x VAD prevalence for children 6-59 months</b> <b>Number of children 6-59 months in need of Vitamin A supplementation (disaggregated by sex) = Population figures from "Affected" areas x % of children 6-59 months x (1- Proportion of children 6-59 months having received vitamin A in previous 6 months)</b>
<b>Micronutrient deficiencies</b> (Iodine supplementation)	Iodine supplementation and salt iodization	Girls and boys aged 6-23 months for iodine supplementation in countries with iodised salt consumption less than 20% PLW for iodine supplementation in countries with iodised salt consumption less than 20%. In cases where it is difficult to reach pregnant women, supplementation to all WRA is advised. Older women and men <i>If relevant:</i> All households for iodised salt distribution in countries with iodised salt consumption 20% or more.	<ul style="list-style-type: none"> <li>Prevalence of iodine deficiency in children 6-23 months</li> <li>Prevalence of iodine deficiency in PLW</li> <li>Prevalence of iodine deficiency in Older People</li> </ul>	<b>Number of iodine deficient children 6-23 months (disaggregated by sex) = Population figures from "Affected" areas x % of children 6-23 months x iodine deficiency prevalence for children 6-23 months</b> <b>Number of iodine deficient PLW = Population figures from "Affected" areas x % of PLW x iodine deficiency prevalence for PLW</b> <b>Number of iodine deficient Older People (disaggregated by sex) = Population figures from "Affected" areas x % of Older People x iodine deficiency prevalence for Older People</b>
<b>Micronutrient deficiencies</b> (Zinc supplementation in the management of diarrhea)	Zinc supplementation in children aged 6-59 months	Girls and boys aged 6-59 months with diarrhoea management	<ul style="list-style-type: none"> <li>Proportion of children 6-59 months having received Zinc in previous 6 months</li> </ul> If no data exists, estimate children aged 6-59 months comprise 18-21% of the population (in low income countries only). Apply diarrhoea prevalence based on the WHO data	<b>Number of children 6-59 months in need of zinc supplementation (disaggregated by sex) = Population figures from "Affected" areas x % of children 6-59 months x (1- Proportion of children 6-59 months having received zinc supplementation)</b>
<b>Other micronutrient deficiencies</b> (e.g. Pellagra)	Not applicable	Target group	<ul style="list-style-type: none"> <li>Proportion of target group(s) being deficient in a given micronutrient</li> </ul>	<b>Number of target group(s) in need of a given micronutrient supplementation (disaggregated by sex) = Population figures from "Affected" areas x target group(s) x prevalence of a given micronutrient deficiency</b>
<b>Disease prevention and management</b>	Deworming (e.g. schistosomiasis, soil transmitted helminthes)	Girls and boys 6-59 months School-age girls and boys Adolescent girls and boys PW Older women and men	<ul style="list-style-type: none"> <li>Proportion of target population group having received deworming</li> </ul>	<b>Number of children 12-59 months in need of deworming (disaggregated by sex) = Population figures from "Affected" areas x % of children 12-59 months x (1- Proportion of children 12-59 months having received deworming)</b> <b>Same calculations per other population groups.</b>



## CALCULATING PIN FOR SCENARIOS 1 AND 2

1. Insert key population figures for relevant population groups by **sex, age category, and disability** if available in ► **Population Figures worksheet**;
2. Review automatic calculations of the number of individuals in nutritional need based on relevant interventions detailed in Tables 4A-4B-4C using ► **PiN worksheets**;
3. Ensure the number of individuals in nutritional need disaggregated against relevant dimensions including gender (accounting for the sex ratio between boys and girls), age, disability and other diversity characteristics;
4. Review these Scenarios 1&2 PiN estimates by target group, sex and disability generated in the ► **PiN Total worksheet** along with the sources of information and their reliability based on the minimum reporting requirements detailed in Annex 5;
5. Share this report with relevant colleagues to contribute to the overall HNO analysis.

## CALCULATING PIN FOR SCENARIO 3

1. Insert key population figures for relevant population groups by **sex, age category, and disability** if available in ► **Population Figures worksheet**;
2. Review the automatic calculation of the number of individuals in nutritional need based on relevant interventions detailed in Tables 4A-4B-4C in ► **PiN worksheets**;
3. Ensure the number of individuals in nutritional need disaggregated against relevant dimensions including gender (accounting for the sex ratio between boys and girls), age, disability and other diversity characteristics;
4. Review these Scenario 3 PiN estimates by target group, sex and disability generated in the ► **PiN Total worksheet** along with the sources of information and their reliability based on the minimum reporting requirements detailed in Annex 5;
5. Share this report with relevant colleagues to contribute to the overall HNO analysis.



## INPUTS TO THE HRP

Based on the understanding of the magnitude of nutritional needs and its key drivers from the previous Nutrition Situation Analysis and PiN calculations per intervention, priority response objectives guide the development of HRP to determine the specific interventions and activities that are best suited to address malnutrition in each area of interest. This prioritisation of people in need and geographical areas in the HRP should be based on severity, magnitude (estimated numbers of people in need), underlying causes, people's own priorities and the analysis of the most likely evolution of the situation while time-criticality informs the layering and sequencing of interventions within the HRP.

A barrier analysis (see Annex 2) including gender-based violence (GBV) related safety risks in nutrition services is important information to guide the development of response strategies in the HRP. Without addressing barriers and GBV-related safety risks in nutrition services/facilities, the target populations (e.g. persons with disabilities) may not be able to access nutrition services or could face GBV when they do. These barriers and risks identified by Nutrition may require collaboration with other sectors. For example, imbalanced power dynamics between women and men for decision-making at home can be a significant barrier to improve nutritional status but difficult to address by nutrition actors alone. In this case, a joint planning with other actors like GBV actors would be helpful. GBV actors may look into supporting behaviour change to transform the gender norms related to decision making while nutrition actors could target both women and men on good food consumption for better nutrition outcomes.

### BOX G. TIPS ON NUTRITION INTERVENTIONS FOR THE HUMANITARIAN RESPONSE PLAN

Developed by the GNC, this **guidance** provides tips for nutrition clusters and its partners to facilitate the planning of a collective response and the development of NiE interventions once the specific sectoral objectives and type of emergency interventions have been agreed upon. It aligns with the key response areas outlined in Tables 4A/4B/4C, in addition to cluster coordination, accountability to affected population, nutrition survey, nutrition surveillance, and programme coverage evaluation.

On the basis of the above, Nutrition inputs for the HRP should focus on the identified population sub-groups (disaggregated by sex, age, and disability) based on **geographical prioritization to deliver the full package of nutrition interventions**. Both prevention and treatment of malnutrition are important considerations in humanitarian crises: chronic malnutrition can be prevented, but there is limited evidence that it can be reversed or treated; acute malnutrition – which may be triggered during a crisis – can be prevented and treated with the right nutrition responses.

Considering delivery-related issues, such as government and agencies' capacity, funding, insecurity in the area, it is important to review existing GNC guidance (see Box G) for the preparation of specific objectives, indicators and monitoring framework for the response analysis in the HRP.

For each of the nutritional needs identified above, the NCCs, Nutrition Cluster partners and staff within the Cluster Lead Agency and partners from other Clusters, are then responsible for the estimation of how many people are targeted for a specific nutrition service (i.e. what percentage of those in need for nutrition services). Humanitarian response targets that are set in nutrition planning processes define the proportion of the Population in Need (PiN) to be reached collectively by all humanitarian partners for a specific result. They form the basis of response plans and funding appeals. A summary sheet of all PiNs calculated provides the basis for the HRP inputs and tracking – see ► **PiN Total worksheet** with the percentage targeted being captured.

In line with the SDG commitment of “leave no one behind” and humanitarian principles, especially the principle of impartiality, humanitarian response targets **must be defined based on humanitarian needs alone**, prioritizing the most vulnerable (e.g. persons with disabilities) and guarding against any practices which would distort or mask humanitarian needs. Taking into account accessibility (e.g. due to insecurity) and time constraints (e.g. time-bound limitations in initial planning documents, such as the first month of a response), it is recommended to estimate a more nuanced, needs-based target, where all humanitarian responses should strive towards a 100% target. Program coverage surveys can assess these targets. Operational capacity and the funding trends for a given humanitarian situation should not be considered when determining this needs-based target.

**Therefore, based on the SPHERE guidelines, acute malnutrition programmes should aim for at least: 50% in rural areas, 70% in urban areas, and 90% in camp settings.**

## CONCLUSION

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This working guidance and accompanying tool aim at streamlining the process for discussions and consensus-building, of conducting a Nutrition Humanitarian Needs Analysis for response planning. Lessons learned will be gathered on a yearly basis to feed into subsequent versions, along with *Addendum 1* and details on how these figures contribute to the Joint Intersectoral Analysis Framework.

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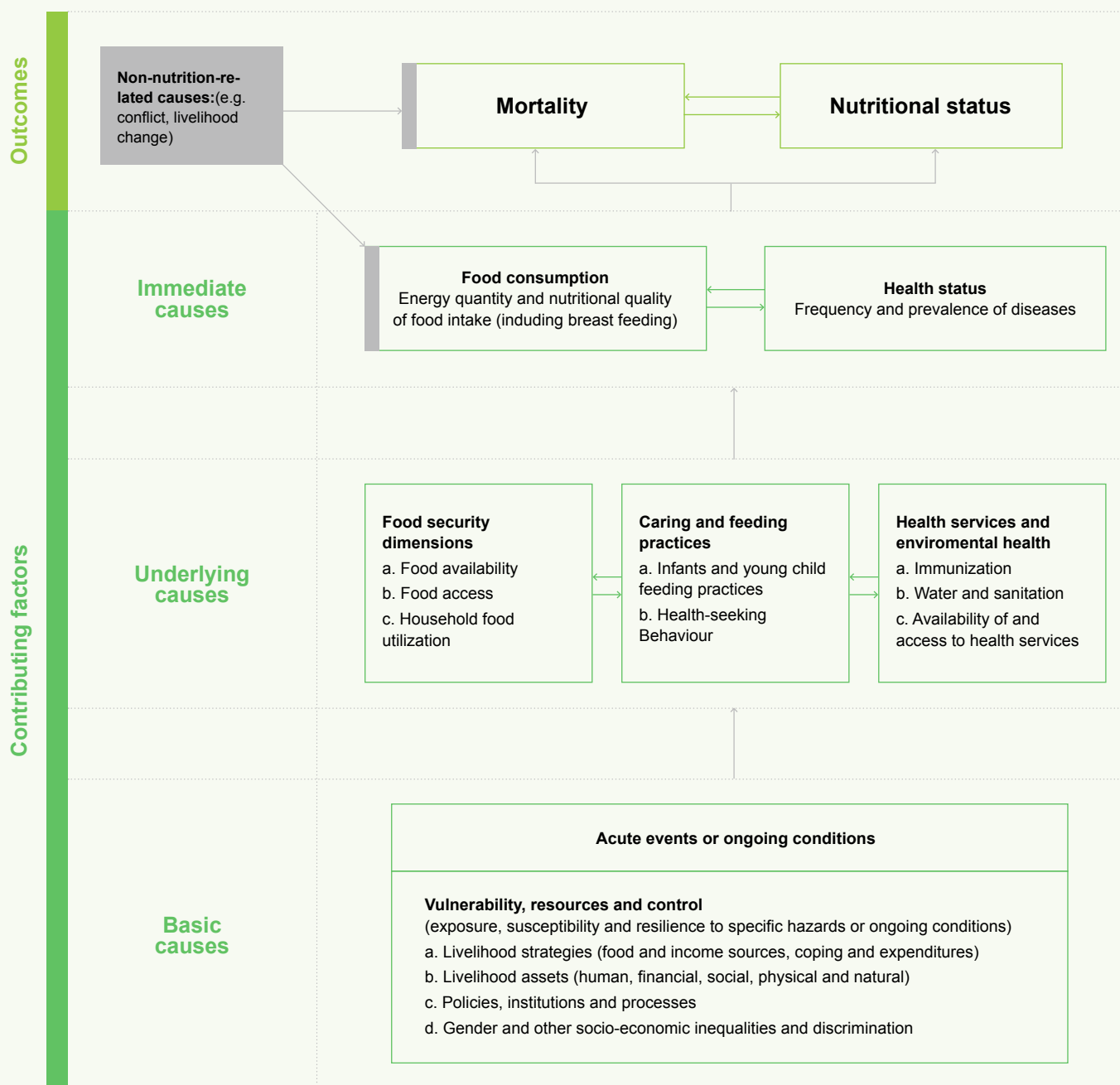
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# ANNEX 1

## KEY COMPONENTS OF THE IPC ACUTE MALNUTRITION ANALYTICAL FRAMEWORK

Fused with UNICEF’s updated conceptual framework of the determinants of maternal and child nutrition (UNICEF, 2019), this adapted IPC framework presents the relationships among contributing factors of malnutrition and related outcomes to facilitate the understanding of its complex realities, process and linkages according to this simplified diagram:



## OUTCOMES

Aimed at improved survival, health, physical growth, cognitive development, school readiness and school performance in children and adolescents; improved survival, health, productivity and wages in women and adults; and improved prosperity and cohesion in societies

### Nutritional status indicators

- Acute Malnutrition
- Chronic Malnutrition
- Micronutrient deficiencies

### Mortality indicators

- Crude Death Rate
- Under-five Death Rate

## CONTRIBUTING FACTORS OR DETERMINANTS

### Immediate Causes<sup>33</sup>

#### Food Consumption-focus on diets' quality and quantity

Minimum Dietary Diversity in women and children, Minimum Meal Frequency, Minimum Acceptable Diet, Exclusive Breast-feeding under 6 months.

#### Health Status

Diarrhea, dysentery, malaria/fever, acute respiratory infection.

#### Frequency and Prevalence of Diseases

HIV/AIDS prevalence, Cholera or acute watery diarrhea, measles.

### Underlying Causes focusing on adequate food and feeding, and a healthy environment

#### Caring and Feeding Practices

- IYCF: Continued Breastfeeding at 1 and/or 2 year(s), introduction of solid, semi-solid or soft foods by 6 months of age.
- Health-seeking behaviour
- Intra-household resource allocation
- Cultural beliefs

#### Health Services and environmental health

- Immunization: routine measles/polio vaccination coverage, routine vitamin A supplementation coverage, campaign measles/polio vaccination coverage, campaign vitamin A supplementation, coverage of all basic vaccinations from survey data or reports;
- Availability of and access to health services: skilled attendant at delivery, health-seeking behavior, coverage of outreach programme (e.g. CMAM programme coverage).
- WASH: access to a sufficient quantity of water, access to improved sanitation facilities, access to an improved source of drinking water.

### Basic Causes or enabling determinants

#### Acute events or ongoing conditions

(Natural, socio-economic, conflict, disease and other)

#### Vulnerability, resources and control

livelihood strategies (food and income sources, coping, and expenditures); livelihood assets (human, financial, social, environmental); policies, institutions, political and financial processes, and multi-sectoral commitments to advance the right to nutrition; gender and other socio-economic inequalities and discrimination including social and cultural commitments to advance children's and women's right to nutrition.

Nutrition-specific contributing factors (trauma, violence, GBV, genetics, etc.) are also considered.

<sup>33</sup> Note a reciprocal and complex relationship between the two: it is expected that people who live in households that have an inadequate quantity or quality of food for consumption are more likely to become ill. Furthermore, they are more likely to eat less, while their disease can impact the ability of households to access and utilize food, either due to a weakened immune system, or to a weakened ability to engage in productive activities.

# ANNEX 2

## GENDER CONSIDERATIONS FOR NUTRITION NEEDS ASSESSMENTS AND ANALYSES

When reviewing data needs for upcoming analyses, keep in mind the importance of qualitative methods to complement data on nutrition outcomes, particularly when conducting a gender analysis. A nutrition-focused gender analysis may include the following information:

- Gender roles and responsibilities with regards to nutrition (e.g. food preparation);
- Decision making at household- and community- levels for nutrition-related aspects (e.g. who decides on when and what to eat, breastfeeding, access and use of nutrition facilities, etc);
- Access and control over resources (e.g. money, markets, land, etc);
- Social norms (e.g. food-related taboos and norms for the different groups - like who eats first and more, etc);
- Gender Based Violence and the identification of which forms exist in the context (including the denial of resources like food or education) and the GBV risks associated with nutrition interventions/facilities and their potential creation of tensions at HH or community level, for example).

Consultations, focus group discussions, key informant interviews, safety audits in health/nutrition facilities or barrier analyses (see Box H) also provide valuable insight on who is impacted differently and why in a given context. For nutrition, it is important to look at barriers of caregivers (both men and women) of children U5 as they are the ones who decide and bring children to nutrition services. In addition, it helps identify risks that women and children face when trying to access services. These could also include risks to GBV. One of common barriers and GBV risks that women face is lack of husband's approval to access nutrition services. This type of barrier is not as obvious as a distance to the service but extremely important to understand wide range of barriers that men, women and children face in accessing nutrition services.

### BOX H. BARRIER ANALYSIS

A **barrier analysis** should be conducted to assess the barriers that affected populations may face in accessing nutrition services. A barrier analysis typically looks at least four different aspects: Availability, Accessibility, Acceptability, and Quality of services:

- **Availability:** There are sufficient quantity of functioning nutrition facilities, goods and services, and programs which cover gaps and ensure an acceptable ratio of skilled nutrition workers to the population needs
- **Accessibility:** There are nutrition facilities, goods, and services that are safely accessible, affordable and that there is enough information about them communicated to the population without discrimination
- **Acceptability:** There are nutrition facilities, goods, and services that are culturally appropriate, sensitive to gender and age, respect confidentiality and improve the nutrition status of those concerned
- **Quality:** There are nutrition facilities, goods, and services that are scientifically and medically approved and of good quality.

These can differ greatly for different population groups and their access to nutrition services. A barrier analysis can help identify the difficulties for (mostly) women, persons with disabilities and children to access nutrition services.

## COLLECTING GENDER-RELATED INFORMATION TO GUIDE NUTRITION RESPONSE PLANNING

Similar to the indicators recommended in Table 1 above, the following list of potential indicators provide valuable information when collected in your population-based surveys (i.e. SMART surveys) or through the aforementioned qualitative methods. It is important to consider the following when planning its collection:

- To determine the most appropriate target audience (individuals/users vs. households) given your context;
- To capture the consequences on other children and workload when visiting nutrition services;
- To specify the type of services and facilities;
- To include protocols when administering the questionnaire so that respondents may speak freely to the enumerators;
- To disaggregate findings by male and female head of households when feasible and relevant;
- To consult [GBV measurement page](#) for further information;
- To be aware of the limitations of this data.

Potential Gender-related Indicators to guide nutrition response planning	Humanitarian Consequence	Severity Scale based on IPC/OCHA phases					Comments/Sources used for the thresholds
		Phase 1 Acceptable/ Minimal	Phase 2 Alert/ Stress	Phase 3 Serious/ Severe	Phase 4 Critical/ Extreme	Phase 5 Extremely Critical/ Catastrophic	
Percentage of HH/ individuals/users (men and women) feeling safe when accessing health/ nutrition facilities	<i>Living Standards</i>	>80%	60-79%	40-59%	20-39%	<20%	Preliminary thresholds suggested by Gender Specialists.
Percentage of HH/ individuals/users (men and women) reporting issues/problems when accessing health/nutrition facilities	<i>Living Standards</i>	>80%	60-79%	40-59%	20-39%	<20%	Preliminary thresholds suggested by Gender Specialists.
Number of hours per day demonstrating women's aggregated workload	<i>Living Standards</i>	12	13	14	15	16	Part of a gender analysis, whether through primary data collection or review of secondary sources, when designing nutrition interventions.
Number of Gender based discrimination and social norms related to nutrition practices	<i>Living Standards</i>	No	No	Yes (1 type*)	Yes (2 types)	Yes (more than 2 types)	Part of a gender analysis, whether through primary data collection or review of secondary sources, when designing nutrition interventions. Examples of types* may include preference for boys or girls feeding; food taboos negatively affecting women, men, girls and/or boys food intake; negative caring practices for girls and/or boys, etc.

Adolescent Birth rate	<i>Living Standards</i>	≤16	16-42	42-67	67-80	≥80	Proxy indicator that can be obtained at the <a href="#">Gender Inequality Index</a>
Population with at least some secondary education	<i>Living Standards</i>	≤80%	70-80%	40-70%	30-40%	≥30% for each sex	Proxy indicator that can be obtained at the <a href="#">Gender Inequality Index</a> . When reviewing this indicator for women and men, the lowest percentage whether for women or men prevails: for example, if men is at 80% yet for women only at 50%, then 50% is retained for this indicator.
Maternal mortality	<i>Living Standards</i>	≤13	13-63	63-180	180-543	≥543	Proxy indicator that can be obtained at the <a href="#">Gender Inequality Index</a>

## ONE STEP CLOSE TO GENDER-TRANSFORMATIVE NUTRITION INTERVENTIONS<sup>34</sup>

These aforementioned considerations would support measures to change social structures, cultural norms, and gender relations in order to achieve more shared and equal power dynamics and control of resources, decision making, and support for women’s empowerment when planning nutrition interventions and response.

<sup>34</sup> For further details on the [Gender-transformative framework for nutrition](#).



# ANNEX 3

## EXAMPLE OF AN ANNUAL NUTRITION ASSESSMENT PLAN

The development and maintenance of an annual nutrition assessment plan aims to streamline and prioritize the planning, implementation and reporting of nutrition assessments to ensure timely availability of quality information for decision-making. Certain details change between surveys, contexts and countries but the details given below are general and should be applied to all nutrition assessments.

The importance of nutrition assessments should be discussed with the persons responsible in the government/Ministry of Health and members of the local NIS TWG or equivalent to ensure that nutrition assessments are included in the government annual work plan for the Nutrition Sector. This should be completed as **early as possible** to ensure adequate preparation, funding and effective organization of the assessments (budget, administration, logistical planning, training of survey teams, etc). All data collected should undergo a transparent validation process (e.g. using the SMART *Plausibility Check* for anthropometric data) to ensure validity of survey methods and should be centralized to facilitate its utilization and dissemination for action. In turn, the centralization of data and nutrition assessment results would also strengthen multi-sectoral linkages on nutrition assessment and information of other nutrition-sensitive Clusters such as Health, WASH and Food Security. Furthermore, in rapid-onset emergencies, it is important to ensure that the annual nutrition assessment plan feeds into existing information management system to avoid developing a parallel system.

It is important to note that in some countries, nutrition data are considered sensitive data and all necessary authorisations from the relevant institutions red whenever collecting, analysing and publishing data and their results.

**Starting with the Global Nutrition Cluster's [Surveys Database \(Version 2 – April 2020\)](#) in Excel, NIS TWG members can adapt and customize this database to meet the needs and demands of the country's context.** It should includes the following types of surveys: anthropometric, IYCF, and micronutrient as appropriate. For the collection of anthropometric data, the use of the [SMART methods](#) and the ENA for SMART software (Version 2020) is recommended, along with Demographic Household Surveys (DHS) and Multiple Cluster

Indicator Survey (MICS) when applicable. Specific IYCF or micronutrient indicators can be added to nutrition assessments using SMART methods (while recognizing the important caveat of small sample sizes) or collected separately, depending on the prioritization and timeline required for data use.

**The annual nutrition assessment plan is broken down by the 4W:**

- **Who:** donor, funding through UN agencies (e.g. UNICEF), agency implementing the survey, other agencies/authorities involved, name of focal point for the survey, email of the focal point and their supervisor;
- **Where:** geographical area(s), areas or villages excluded from geographical areas, number of Clusters planned, number of HHs planned, number of survey subjects (e.g. children) to be measured, comments;
- **When:** expected/actual start date and end date, season, status of the survey;
- **What:** type of nutrition assessment, methodology used (e.g. SMART/Rapid SMART), indicators to be included, status of data analysis, status of data validation, dissemination activities.

# ANNEX 4

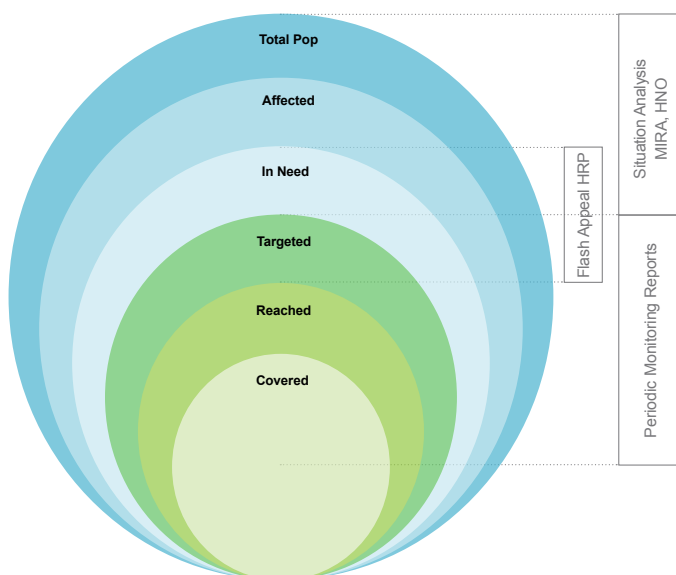
## KEY TERMINOLOGY OF HUMANITARIAN NEEDS OVERVIEW AND RESPONSE PLAN

Determining an overall, inter-sectoral number of people for establishing number of people “Affected” and “People in Need” (PiN), separated by those who are accessible and those facing humanitarian access constraints, is a key requirement in the HPC and its corresponding HNO and HRP seen in Figure 3. Based on the derived PiN, the number of people “Targeted” and “Reached” then feed into the HRP, where the number of individuals “Covered” is periodically monitored. The PiN figure, as well as those “Targeted”, “Reached” and “Covered” per service<sup>35</sup> should be calculated by each Cluster and at the inter-cluster level. Each of these humanitarian population figures are further defined in Table 2 below.

■ During the process of HNO development, it is important all sector and inter-sector figures are ALL based on the same conceptual approach to ensure comparability and consistency. For example, total population and population affected should be the same for all nutrition calculations and should be in line with the figures used in other clusters.

Following the Nutrition Situation Analysis, its results will feed into each of these humanitarian population figures, where these most commonly requested information in humanitarian situations provides the backbone to any humanitarian operation. Inconsistent terminology, unclear methodologies and a lack of transparent, coordinated and standardized data gathering frequently result in humanitarian actors operating with different information. Failure to establish and regularly update well-defined population figures not only demonstrates a weak evidence-base but may have a negative impact on resource allocation.

**Figure 3. Representation of overall humanitarian population figures categories**



<sup>35</sup> Especially IYCF services need always to be specified: what are the services and who are the ones in need or who are the recipients: PLW, children 0-23 months, caretakers of infants and young children < 24 months, caregivers and other family members receiving counseling, recipients of BMS

Table 2. Definitions of humanitarian population figures categories

Categories	Definition	Working example
<b>Total Population</b>	All people living within the administrative boundaries of a nation state; there can be a crisis-specific strategic decision to calculate the total population looking only at sub-national level.	8 million people live in Country X hit by a humanitarian situation, including 500,000 refugees who came one year ago.  This information is usually provided by a central authority to all clusters /sectors (e.g. OCHA, Central statistics organisation)
<b>Affected</b>	<p>Number of people whose lives have been impacted as a direct result of the humanitarian situation – often defining the scope or boundary of a needs assessment:</p> <ul style="list-style-type: none"> <li>• Being in close geographical proximity to a humanitarian situation;</li> <li>• Physically/emotionally impacted, including exposed to a human rights violation/ protection incident;</li> <li>• Experiencing personal loss or loss of capital and assets as a direct result of the crisis (e.g. family member, livestock);</li> <li>• Being faced with an immediate threat from a humanitarian situation.</li> </ul> <p>Estimates of those “Affected” are among the very first information requirements at the onset of a humanitarian situation, being derived from the “Total Population” based on affected geographical areas or population groups.</p> <p>“Affected” = sum of displaced (IDPs, refugees, asylum seekers) and non-displaced (host and non-host) persons</p>	5 million people of Country X including 200,000 refugees living in 3 provinces were exposed to damages and destruction following an earthquake, including injuries, damage to dwellings and a high risk of aftershocks.  Population “Affected” equals 5 million people and 200,000 refugees.  This information is usually provided by a central authority to all clusters /sectors (e.g. OCHA, Central statistics organisation, etc.)
<b>In Need (PiN)</b>	<p>Number of people in need of humanitarian nutrition assistance (e.g. nutrition interventions/programmes, also known as “services”) which is a sub-set of “Affected”, being defined as people:</p> <ul style="list-style-type: none"> <li>• Whose physical security, basic rights, dignity, living conditions or livelihoods are threatened or have been disrupted, AND</li> <li>• Whose current level of access to basic services, goods and social protection is inadequate to re-establish normal living conditions with their accustomed means in a timely manner without additional assistance.</li> </ul> <p>PiN will need to be monitored and adjusted over time. This helps to define the magnitude of a crisis and the overall cost estimate of a humanitarian response. Identifying the number of PiN is also essential to determine priority areas for interventions, when those are defined as a function of people in need, access and likely deterioration, etc.</p>	<p>In the most populous provinces, where 3 million people out of the 5 million “Affected” reside, its under-five population represents 15% of the population (750,000 children under-five) are exposed to a severe food shortage and limited access to clean water following the earthquake’s destruction. A large number of the earthquake’s fatalities were caregivers of young children.</p> <p>Out of the 750,000 children under-five, the number of those who are in need of acute malnutrition treatment is estimated at 89,250.</p>
	Number of people in need <b>facing humanitarian access constraints</b> (i.e. how many from the PiN are accessible).	All 89,250 in need of acute malnutrition treatment do not face humanitarian access constraints.
<b>Targeted</b>	Number of people targeted for a specific nutrition intervention/programme which humanitarian actors within the Nutrition Cluster aim or plan to assist. Beginning during the prioritisation stage to identify which population groups, humanitarian consequences and geographic areas are prioritized out of the range of needs identified in the HNO, this is a sub-set of “PiN”, being typically smaller as it is rare that international humanitarian actors can meet all needs given available resources and access constraints. The calculation of how many people are targeted for a specific nutrition intervention/programme is done within the Nutrition Cluster.	Based on the humanitarian situation and resources available, it is estimated that 62,475 will be targeted for GAM treatment (including inpatient and outpatient-OTP).
<b>Reached</b>	<p>Number of people admitted/enrolled/having received some form of nutrition intervention/programme (to avoid double counting), i.e. whose nutrition needs are met. This identifies where these nutrition interventions/programmes need to be scaled up or down.</p> <p>‘People reached’ is an inclusive measure, as it includes all people reached by any activity; whereas ‘people covered’ is an exclusive measure, as it excludes all people unless they are fully covered by all activities (which targeted them).</p>	The number of people “Reached” by OTP services (from Jan-June) are all those that were newly admitted in this time period plus those that were already admitted at 1 Jan. This means that deaths whilst in the programme, defaulters, etc will be taken into account in this calculation.
<b>Covered</b>	Number of people receiving a specific type of assistance during a certain time period, i.e. people whose nutrition-specific needs met per intervention (see diagram above). It is recommended not to use the term people covered (despite OCHA using it); coverage in the SAM/MAM in the CMAM context is well defined by UNICEF.	5,000 children under-two’s nutritional needs were met by the OTP treatment programmes for the months of January and June.

Figure 3. Representation of overall humanitarian population figures categories



# ANNEX 5

## MINIMUM INFORMATION REQUIRED FOR NUTRITION SECTION OF HNOs

Sectoral sections in HNOs usually consist of a two-page analysis supported by the following information:

- **Summary table with the following key figures:**
  1. PiNs per population group **disaggregated by sex, age and disability** for *Physical and Mental Well-being* and conclusions from the severity classification;
  2. PiNs per population group **disaggregated by sex, age and disability** for *Living Standards* and key contributing factors based on the results from the Nutrition Situation Analysis;
  3. If any population movements and accessibility issues, PiNs facing humanitarian access constraints;
  
- **Assessment registry reporting the sources of information used and their reliability:**
  - Repository and reliability of nutrition-related evidence used (see ► [Evidence Repository, Reliability worksheet](#));
  - Demographic data used/provided by OCHA/national government and any adjustments (e.g. population growth rate used);
  - Analysis Team Composition (see ► [Analysis Team Composition worksheet](#));
  
- **Key challenges and lessons learned identified:**
  
- **Information gaps and mitigation measures in place for collection of these data for the next Nutrition Humanitarian Needs Analysis.**

The contact information of the Nutrition Cluster Coordinator along with the chairs from the NIS TWG should be provided in case of follow-up.



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