



Guidelines for Conducting Nutrition Humanitarian Needs Assessment and Analysis

Version 2.0, 2024

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ABBREVIATIONS

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

GLOSSARY

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 malnutrition¹.

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-offs².

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.

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 Oral Rehydration Solutions, drops and syrups (vitamins, minerals and medicines)³.

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 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 Feeding (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.

Joint and Intersectoral Analysis Framework (JIAF): A global interagency standards for the analysis and estimation of humanitarian needs and protection risks. The ultimate aim of the JIAF is to improve the way humanitarian actors jointly plan and respond to crises. By better understanding who is affected, how, and why, JIAF outputs can help inform joined-up and cross-sectoral responses, such as multi-purpose cash assistance and area-based programming.

1 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](#).

2 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](#).

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

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 form⁴. 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.

Prevalence: a measure of the proportion of individuals in a population who have a certain disease or condition at a specific point in time.

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 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).

4 Cashin, K. & Oot, L. (2018) [Guide to Anthropometry: A practical tool for Program Planners, Managers and Implementers](#)

PURPOSE, AUDIENCE AND SCOPE

This guidance is a revised version of the GNC Nutrition/ Humanitarian Needs Analysis (NHNA) Guidelines, first published in 2020. The revision was initiated to incorporate lessons learned from the implementation of Joint and Intersectoral Analysis Framework(JIAF) 1.0, as well as the subsequent development and publication of JIAF 2.0⁵. Additionally, it was necessary to integrate new technical recommendations from the nutrition sector related to needs assessment and analysis, including the estimation of people in need of wasting treatment using treatment coverage data and the context-specific incidence of severe wasting.

This guidance provides a comprehensive step-by-step approach for conducting coordinated nutrition needs assessments and analysis to support strategic decision-making within the nutrition sector. It is aligned with JIAF 2.0's purpose, outputs, analysis toolkit, overarching analytical framework, and analysis process workflow. Additionally, it incorporates relevant elements of the Inter-Agency Standing Committee (IASC) Operational Guidance for Coordinated Assessments in Humanitarian Crises.⁶ Acknowledging the unique context of each country, this guidance serves as a general framework for discussions and consensus-building on coordinated nutrition needs assessment and analysis in crisis situations, whether the IASC Cluster system has been activated or not.

The primary objective is to equip nutrition sector partners and coordination teams at the country level with the necessary tools, information, and resources to conduct a nutrition needs assessment and analysis, contribute to the intersectoral Humanitarian Needs Overview (HNO), and provide evidence for strategic decision-making in nutrition response planning through the Humanitarian Response Planning (HRP) process. The guidance is also applicable in countries where ad hoc needs analysis is required to inform strategic decision-making for developing flash appeals.⁷

While the guidance note is primarily aimed at Nutrition Cluster Coordinators (NCCs), Information Management Officers (IMOs), Nutrition Cluster partners, and staff within the Cluster Lead Agency(CLA), it is also pertinent for coordination teams and partners of the Nutrition Sectors and partners from other Clusters/ Sectors, particularly those with relevant links to nutrition outcomes and those 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, Coordinators(HCs), Humanitarian Coordination Teams (HCTs), Humanitarian organizations contributing to coordinated assessments, policy-makers, donors, and national and local authorities during both inter-agency preparedness and response phases in humanitarian situations.

The guidance is structured into two primary sections. Part 1 offers a conceptual overview of risk within humanitarian settings, along with key IASC guidelines on coordinated risk and needs assessment and analysis. It explains the approach to risk analysis in crisis situations, provides an overview of a coordinated needs assessment process, and details the roles and responsibilities of cluster/sector coordination teams and partners. Additionally, it introduces the JIAF 2.0 framework, highlighting how the nutrition needs analysis is linked to and fits within the Humanitarian Needs Overview (HNO). Part II provides a step-by-step approach for conducting humanitarian nutrition needs analysis, covering the planning and implementation of assessments, as well as scenario-based guidance for analyzing nutrition needs in various contexts. This guidance is designed to be used in conjunction with the accompanying **The Nutrition Cluster Nutrition Humanitarian Needs Analysis Tool and the JIAF 2.0 Analysis Platform** available at <https://analysis.jiaf.info>⁸

5 Joint and Inter-Sectoral Analysis Framework (JIAF 2.0) Questions and Answers, JIAF Global Partnership , 2023

6 Guidance Coordinated Assessments in Humanitarian Crisis , IASC Task Force On Needs Assessment, March 2012

7 IASC Flash Appeals Guidelines , 2009, A flash appeal is an inter-agency humanitarian response strategy to a major disaster that requires a coordinated response beyond the capacity of the government plus any single agency. The appeal addresses acute needs for a common planning horizon, normally up to six months

8 The JIAF Analysis Platform is the one-stop place for analysts to conduct JIAF analysis. The analysis platform is a web-based online cloud-based system accessible at <https://analysis.jiaf.info/> with the **username: student and password 123456**.



PART 1: OVERVIEW OF THE HUMANITARIAN NEED ASSESSMENT AND ANALYSIS

1. Risk Assessment: Conceptual Basis for Humanitarian Needs Assessment and Analysis

Risk in the humanitarian and development context refers to the potential losses in lives, health status, livelihoods, assets, and services that could occur within a specific community or society over a defined future period (UNISDR, 2009). Risk Management involves applying policies and strategies to prevent new crisis risks, reduce existing risks, and manage residual risks, ultimately enhancing resilience and minimizing losses. A key component of the risk management process is risk assessment, evaluated through the Hazards and Vulnerability Framework (UNDRR, 2009). This framework demonstrates that the risk of a negative outcome, including its probability and severity, results from the interaction between a hazard or shock (such as floods, conflicts, droughts, or economic shocks) and the vulnerability of the affected population and systems/capacity (such as infrastructure, healthcare, and schools) (JIAF 2.0)⁹. The humanitarian and development

community strongly recommends that humanitarian actors adopt a comprehensive risk assessment approach within the Humanitarian Programme Cycle (HPC), ensuring that humanitarian response plans are based on coordinated evidence generation and risk analysis before and during crises.^{10,11,12}

Nutrition programs are designed to address needs throughout the disaster/crisis risk management cycle, which encompasses prevention, preparedness, response, and recovery.¹³ Each phase of this cycle requires comprehensive risk assessment information for informed decision-making.¹⁴ Adopting a risk-centered approach in Nutrition Humanitarian Needs Analysis has significant implications which includes:

- Expanded Scope of Nutrition Needs Analysis:** The analysis should shift from predominantly focusing on late indicators of nutritional risk outcomes (such as nutrition status and mortality indicators like wasting and mortality rates) to including both nutritional and mortality risk intermediary and outcome indicators.

⁹ Joint and Inter Sectoral Analysis Framework (JIAF 2.0) Technical Manual, JIAF Global Partnership, 2024

¹⁰ UNDRR (2023), Strengthening risk analysis for humanitarian planning Integrating disaster and climate risk in the Humanitarian Programme Cycle, United Nations Office for Disaster Risk Reduction (UNDRR)

¹¹ IASC (Inter-Agency Standing Committee). 2015. IASC Reference Module for the Implementation of the Humanitarian Programme Cycle, Version 2.0.

¹² Risk analysis and risk-informed planning – Humanitarian Programme Cycle (hpc.tools)

¹³ OECD Risk Management: Strategic Crisis Management, OECD, 2013

¹⁴ Marin-Ferrer, M., Vernaccini, L. and Poljansek, K., Index for Risk Management INFORM Concept and Methodology Report — Version 2017, EUR 28655 EN, doi:10.2760/094023

This approach may involve assessing the severity and magnitude of needs using underlying and immediate causes of malnutrition, especially in the absence of nutrition and mortality outcome data.

- **Integration of Crisis Impact and Risk Evolution:** The risk-centric analysis should incorporate the impact of crises on nutrition and anticipate the evolution of nutrition risk over time. This analysis is crucial for informing comprehensive emergency preparedness and response planning.

In light of this, the guidance and accompanying analysis tools have been revised to adopt a comprehensive risk-centric approach to nutrition needs analysis, aligning with the Global Nutrition Cluster (GNC) strategy to support countries in preparing for, responding to, and recovering from nutrition emergencies.

2. Overview of the IASC Guidelines on Needs Assessment and Analysis

The GNC NHNAA Guidelines and tools are designed to be used alongside the IASC guidance on the humanitarian programming cycle, the JIAF process, sectoral and intersectoral coordinated assessments, and related cross-cutting agenda guidances. The following section provides an overview of the IASC guidelines, helping users of the GNC NHNAA guidelines understand the overarching and broader inter-agency conceptual, methodological, and procedural matters that directly impact how needs assessment and analysis should be conducted at sectoral and inter-sectoral levels.

2.1. Needs Assessment and Analysis in the Humanitarian Programming Cycle

The Humanitarian Programme Cycle encompasses a coordinated set of actions undertaken by humanitarian actors to enhance the predictability, speed, and effectiveness of their emergency responses. The HPC follows a six-step process: emergency response preparedness, needs assessment and analysis, strategic response planning, resource mobilization, implementation, monitoring and evaluation, and reporting. Needs assessment and analysis are critical steps within this process. At the country level, cluster and sector coordination teams are tasked with coordinating sector-specific assessments and analyses. This process is essential for informing strategic decision-making by the Humanitarian Coordinator (HC) and the Humanitarian Country Team (HCT), ensuring the identification of needs and response gaps both within and across sectors. Nutrition sector and cluster coordination teams are required to align with IASC processes when conducting these assessments.

2.2. Coordinated Assessments

In the humanitarian context, coordinated assessments refer to assessment efforts that are systematically planned and collaboratively executed by humanitarian actors. The results are shared with the broader humanitarian community to accurately identify the needs of affected populations. These assessments can be part of inter- and intra-cluster/sector joint assessments or harmonized single-agency assessments (IASC, 2012).

TABLE 1: TYPES OF COORDINATED ASSESSMENTS

Harmonized Assessments	Joint Assessments
▪ Sector partners independently collect, process, and analyze data. ▪ The data collected is comparable due to the use of common operational data sets (CODs). ▪ In the nutrition sector, this involves: ▪ Using common population figures. ▪ Using administrative and Livelihood or agroclimatic zones. ▪ Standard nutrition-specific and nutrition-sensitive indicators (refer to the Global Nutrition Cluster GNC Indicator registry). ▪ Ensuring the timing of needs assessments aligns with seasonality.	▪ Involve a collaborative process among partners and clusters/sectors throughout the planning and implementation. ▪ Data collection, processing, and analysis are conducted together within and between clusters/sectors, culminating in a single report. ▪ Sometimes referred to as a 'common assessment.' ▪ Joint assessments can be a collective effort within the nutrition sector or part of Multi-Sectoral Needs Assessments (MSNA) or the Multi-Cluster/Sector Initial Rapid Assessment (MIRA). MIRA is a joint needs assessment tool that can be used in sudden-onset emergencies that include nutrition modules.

2.3. Role and Responsibility of Cluster Coordination Team and Partners in Needs Assessment¹⁵

Cluster/Sector Coordination Team:

At the country level, cluster and sector coordination teams are responsible for coordinating sectoral assessments and analysis. Their key responsibilities include:

- Establishing internal mechanisms for planning, implementation, analysis, and coordination of sectoral assessments.
- Facilitating coordination for inter-cluster and sector assessments.

¹⁵ Inter-Agency Standing Committee (IASC). (2012). *Operational Guidance for Coordinated Assessments in Humanitarian Crises* (Provisional Version). March 2012.

Figure 1 : Key Issues To Consider In Coordinating Nutrition Needs Assessments



Ensure Geographical and Temporal Synchronization of Assessments:

The nutrition cluster or sector should coordinate the identification of assessment needs, specifying locations and timing to align efforts effectively.



Compile and Share Coordinated Assessment Plans:

The nutrition sector should periodically compile, update, and disseminate assessment plans. This ensures all partners are informed of planned assessments, preventing duplication and promoting complementary efforts.



Use a Consistent Set of Intersectoral Common Operational Datasets (CODs):

Utilizing CODs is essential for aggregating and comparing assessment information throughout the emergency cycle. This practice ensures agencies can accurately interpret and compare data across different information sources, such as clusters or agencies.



Use a Consistent Set of Agreed Sectoral Indicators:

Adopting a consistent and commonly agreed set of indicators, like those used for Humanitarian Nutrition Needs Assessment (HNNA), is crucial for harmonizing assessments. This consistency ensures that data collected is used effectively for needs analysis and strategic decision-making.



Ensure Use of Appropriate Methodology:

The methodology chosen should be examined for its methodological robustness (e.g., IPC AMN), feasibility, and affordability in the country context. It is important to follow national or global nutrition assessment methodologies to maintain standards.



Implement a Quality Assurance and Appraisal Mechanism:

All harmonized assessments should undergo quality assurance and appraisal by a Nutrition Information Systems Technical Working Group (NIS TWG) to ensure accuracy and reliability.

- Ensuring that cross-cutting issues, such as gender, HIV, age, and disability, are integrated into assessments conducted by their members.
- Promoting the dissemination and utilization of key findings from cluster and sector assessments within the nutrition community and intersectoral forums.

Individual Organizations/Cluster Partners:

Individual organizations and cluster/sector partners play a vital role in supporting joint assessments and harmonizing their own assessments. Their responsibilities include:

- Actively participating in cluster/sector coordination and engaging in joint assessments when appropriate.
- Adhering to agreed definitions, methodologies, and data-sharing protocols established by clusters and sectors.
- Ensuring temporal and geographical synchronization of their assessments.
- Sharing results and findings from individual assessments with the cluster/sector coordination team and the NIS Technical Working Group (TWG).

3. Joint and Intersectoral Needs Analysis – Humanitarian Needs Overview

The HNO is a vital element of the HPC process. It involves the synthesis and analysis of data related to the needs, vulnerabilities, and capacities of affected populations. This process draws on data from multi-sector and sector assessments, monitoring data, surveys, and insights provided. Moreover, the HNO outlines the country's humanitarian risk profile, offering

a comprehensive understanding of the context and challenges, ultimately laying the groundwork for the development of the Strategic Response Plan.¹⁶

The JIAF establishes global standards for the HNO process at the country level. It mandates that humanitarian actors consistently apply standardized processes and methods to evaluate the magnitude and severity of humanitarian needs, develop narratives regarding the interconnectedness of sectoral needs, and identify the characteristics of populations most impacted by crises.

As one of the IASC sectors, the nutrition humanitarian needs analysis is expected to align with JIAF's standards, methods, and timelines (JIAF Partnership, 2024). Active participation in the JIAF process at the country level is essential for nutrition sector coordination teams and partners. To support this, various resources are available, such as the [JIAF Learning Platform](#), [HPC Facilitation Package](#) and [GNC Learning](#). Additionally, the GNC conduits an annual HPC webinar series in French, English, and Spanish during the third quarter of every year. It is recommended that the Nutrition Information Systems (NIS) Technical Working Group, Sector Advisory Group (SAG) and sector partners receive orientation on the JIAF process to contribute effectively to both the nutrition sector and intersectoral needs analysis. To help users of this guidance gain a basic understanding of the essential elements of the JIAF, the section below provides an overview of JIAF outputs and sets the stage for the subsequent sections of the guidance. It covers the JIAF process workflow, the roles and responsibilities of the nutrition sector in the JIAF/HNO process, and the cross-cutting issues

¹⁶ IASC (Inter-Agency Standing Committee). 2015. IASC Reference Module for the Implementation of the Humanitarian Programme Cycle, Version 2.0.

that must be addressed in the needs assessment and analysis process.

3.1. Key Outputs of JIAF

The nutrition sector needs analysis at the country level contribute to the following JIAF outputs:

The nutrition sector's needs analysis at the country level contributes to the following outputs of the Joint Intersectoral Analysis Framework (JIAF):

- **Drivers of the Crisis:** Analyzing the underlying causes and context contributing to the crisis and associated humanitarian needs
- **Joint analysis of overall magnitude of needs:** Estimating the total number of individuals requiring

humanitarian assistance and protection, regardless of the source of their needs.

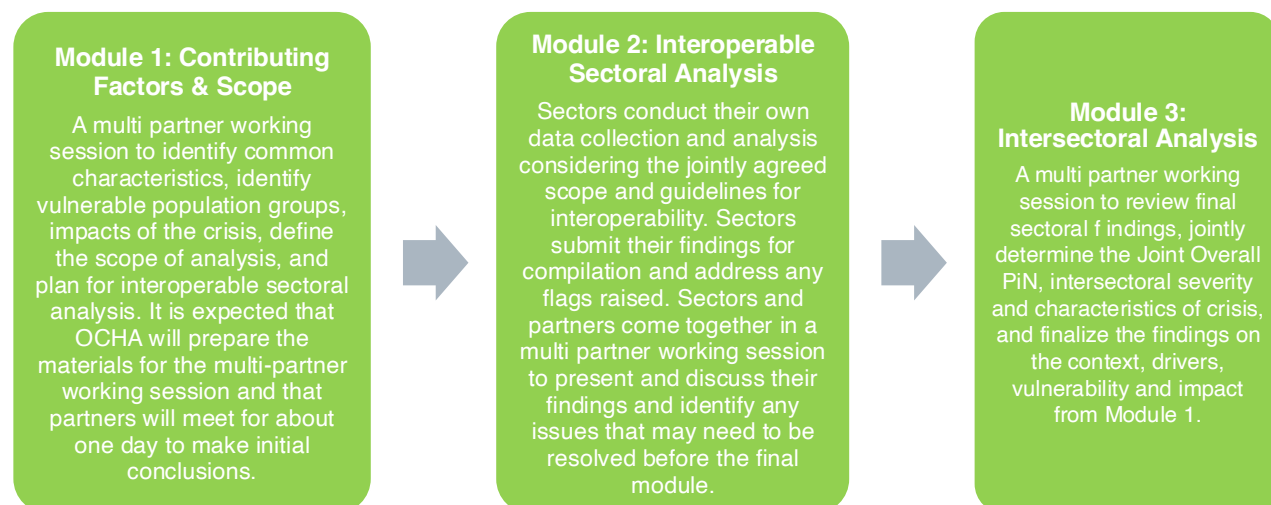
- **Intersectoral Severity:** Evaluating the severity of the humanitarian situation resulting from the combined impacts of overlapping needs across multiple sectors.
- **Sectoral Needs:** Determining the number of people with specific sectoral needs and assessing the severity of these needs using a standardized reference framework.
- **Identification of the Most Affected:** Highlighting the population groups and geographic areas most severely impacted by the crisis.
- **Linkages Between Sectoral Needs:** Examining how needs intersect, coexist, and interact across various sectors.



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3.2. The JIAF Process

Figure 2: The JIAF Analysis Framework modules



Adapted from: Joint and Inter-Sectoral Analysis Framework (JIAF 2.0) Technical Manual, JIAF Global Partnership, 2024

3.3. Role and Responsibility of Cluster Coordination Team and Partners in Need Analysis Process

The JIAF/HNO process is a collective responsibility of all humanitarian partners. The HCTs (or their equivalents) are responsible for engaging at strategic decision-making throughout the JIAF process to ensure transparent discussions and collective agreement on key findings. National clusters/sectors are tasked with conducting sectoral analysis in line with agreed interoperable standards, participating in joint and intersectoral working sessions to discuss sectoral findings, and contributing to the intersectoral analysis. OCHA is responsible for coordinating the JIAF/HNO process and organizing multi-partner working sessions. Operational partners and civil society organizations, including UN sector lead agencies, NGOs, and affected communities, should contribute their knowledge to support the analysis. Box A outlines the specific responsibilities of the nutrition sector/cluster coordination team at the country level (JIAF Partnership, 2024).

Box A. Role and Responsibility of Cluster/ Sector Coordination Team in the JIAF /HNO process¹⁷

- Follow global descriptions and methods for sectoral severity and PiN estimations and coordinate with the global clusters on any country-specific adaptations, which must be transparently documented and reported.
- Share with OCHA the description and methods for severity and PiN estimations and present them during the multi-partner working sessions.
- Ensure successful sectoral analysis at the agreed unit of analysis (area and/or population-based).
- Share preliminary and final results of sectoral analysis ahead of multi-partner working sessions, including sectoral PiN and severity.
- Participate in multi-partner working sessions:
- Agree on the JIAF scope and unit of analysis (areas and/or population group), including identifying common drivers and contributing factors that define the scope of the crisis and people affected.
- Share and discuss sectoral analysis, and, when relevant, take the opportunity to revise findings.
- Share and discuss the description and methods for sectoral severity and PiN estimations.
- Analyze how sectoral needs link, overlap, and have evolved over time, and how interactions vary between areas and population groups.

- Review Joint Overall PiN and discuss sectoral estimations, focusing on flagged areas.
- Review preliminary intersectoral severity analysis and conduct in-depth analysis for areas flagged.
- Collaborate to identify data needs and, to the extent possible, gather and analyze data in a coordinated, efficient, transparent, and accountable manner.
- Promote and support data collection in line with the agreed scope of analysis for the intersectoral outcome indicators detailed in the Intersectoral Reference Table.

4. Cross-Cutting Considerations in NHNAA¹⁸

In line with IASC commitments, the NHNAA process must integrate cross-cutting issues to ensure its effectiveness and inclusivity. Critical factors such as gender, age, disability, accountability to affected populations, and climate play a pivotal role in shaping both the process and its outcomes.

Gender Considerations: Addressing gender-specific needs and barriers is essential, recognizing the different roles and vulnerabilities of all genders in the community.

Age Sensitivity: Strategies should cater to the unique needs of various age groups, including children, adolescents, and the elderly.

Disability and Inclusion: Actively including individuals with disabilities is crucial for equity, requiring adaptations in tools and processes to assess their specific needs.

Accountability to Affected Populations: Building trust through transparent decision-making and community engagement is fundamental. This includes mechanisms for feedback and grievance redressal to ensure responsiveness to community needs.

Protection Mainstreaming: Ensuring safety and dignity directly impacts nutritional vulnerability. The NHNAA should focus on protection-related factors throughout the analysis process.

Box B : Cross-Cutting Issues guidelines

[Disability and Inclusion in HRP](#)

[Gender and Equity in HPC](#)

[PSEA IN HPC](#)

[IASC The Gender Handbook For Humanitarian Action](#)

[Resources | Global Nutrition Cluster](#)

[Additional HPC Cross-Cutting Issues Resources](#)

¹⁷ Joint and Inter Sectoral Analysis Framework (JIAF 2.0) Technical Manual, JIAF Global Partnership, 2024

¹⁸ Overview – Humanitarian Programme Cycle (hpc.tools)



PART 2: STEP FOR CONDUCTING NUTRITION HUMANITARIAN NEEDS ASSESSMENT AND ANALYSIS

1. Country Coordinated Assessment Planning and Implementation

Indicative timeline: Last quarter of the previous year

In order to inform appropriate response strategies, the development and regular maintenance of an annual nutrition assessment plan (see guidance provided in Annex 1) ensures up-to-date and quality data are used for nutrition situation (or trend) analysis, 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 HPC, accounting for seasonal considerations and inputs 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-AMN (Integrated Food Security Phase Classification – Acute Malnutrition) annual calendar may also be applicable given the humanitarian situation – see Box B for more details.

Box C. 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 or equivalent¹⁹, the following steps are recommended to support the contextualization of their nutrition assessment plan:

¹⁹ Further details on the roles and responsibilities of the NIS TWG can be found [here](#).

1. 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 on with other Clusters/Sectors 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.
2. 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**.
3. 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.
4. Develop and coordinate an annual (harmonized with other sectors as detailed in the IASC Operational Guidance for Coordinated Assessments²⁰) nutrition assessment plan (see *Annex 1*) to support the coordination of nutrition assessments and the analysis of the results, taking into account timelines for data analysis, key considerations (see Box D 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.
5. Ensure implementation of the plan and timely validation of the data collected.
6. Ensure results are being carefully analyzed and disseminated with KEY MESSAGES to relevant stakeholders and stored in a consolidated manner to facilitate any subsequent trend and/or Nutrition Situation Analyses.

Box D. Key considerations when reviewing data availability for decision-making and planning

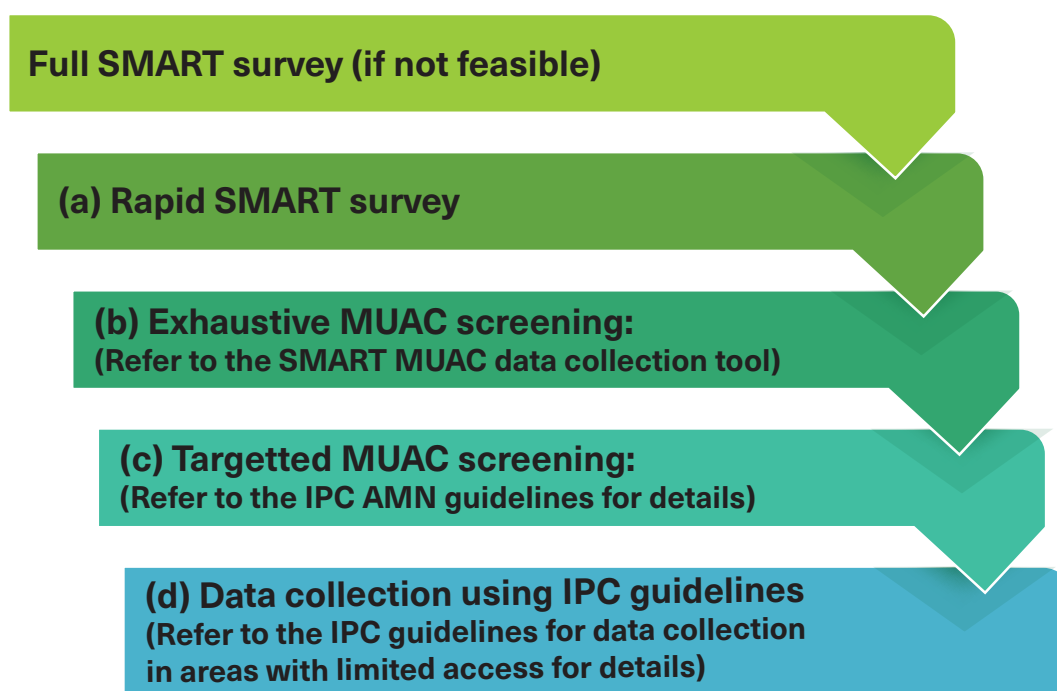
- **Accessibility:** In some instances, the nature of the humanitarian crisis (e.g. conflict) may limit the access of organizations to collect suitable evidence and affect the geographical coverage. Alternative considerations should be followed – see IPC’s summary guidance for data collection in areas 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 a subset (e.g. U5 SAM prevalence).
- **Level of disaggregation:** can be done by population group, by age category, by sex or by administrative level at which results from a survey can be representative at the unit of analysis.
- **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.

²⁰ Inter-Agency Standing Committee (IASC). (2012). *Operational Guidance for Coordinated Assessments in Humanitarian Crises* (Provisional Version). March 2012.

Figure 3. 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)	GAM based on WHZ from surveys representative at the unit of analysis with adequate precision and validated by an authority in the country.	
		- Cluster surveys with ≥ 25 clusters. - Simple or systematic surveys with ≥ 150 observations.	
	Limited(M_1)	GAM based on WHZ that partially meets representativeness and quality standards or GAM based on MUAC from minimally acceptable methods.	
		Surveys representative at the unit of analysis. - Estimates “validated with caution” (for GAM based on WHZ only). - Estimates of GAM based on MUAC from surveys rated good method. GAM based on WHZ from disaggregated surveys representative at a higher administrative unit. ≥ 5 clusters and ≥ 100 observations. GAM based on WHZ/MUAC from Sentinel sited. ≥ 5 sites per unit of analysis with ≥ 200 total observations (if the area is pastoral, ≥ 5 sited with 100 observations or acceptable). GAM based on MUAC from Screening. - Exhaustive screening (door to door) carried out at the unit of analysis (>80% coverage) or unit of analysis and ≥ 200 observations selected randomly or exhaustively (>80% coverage) from each site and with convergence of estimates from these sites. Surveys from similar areas. - GAM based on WHZ from a survey with Good Method from a similar area.	
Time relevance (T)	Good (M_2)	Evidence reflecting current conditions.	
		- Evidence collected during the same season of analysis, when there is seasonality. - Evidence collected anytime during the previous 12 months when there is no seasonality or significant shock to acute malnutrition contributing factor.	
	Limited(M_1)	Evidence inferred to reflect current conditions.	
		- Inferred estimates of evidence collected within the last 6 months but not from the same acute malnutrition season (12 months for areas with no seasonality). - Historical evidence collected during the same acute malnutrition season from at least 2 similar years in the last 5 years — only to be used in the absence of any unusual shocks.	

Figure 4: Decision-making tree for selecting assessment methods from alternative data sources,



Adapted from IPC RESOURCE 03 Guidance on evidence for IPC analysis of areas with limited or no access

2. Using Alternative Methodologies and Data Sources

When resources, capacity, and access to assessment areas allow, it is strongly recommended to use robust, population-representative methodologies like SMART surveys to assess nutritional status and its determinants among vulnerable groups such as children under five and Pregnant and Breast Feeding Women (PBW). SMART surveys are known for providing high-quality data on anthropometry and mortality; however, conducting SMART surveys may not always be feasible due to constraints like conflict and /or lack of accessibility due to multitudes of factors. In such cases, Rapid SMART surveys offer an alternative, though their implementation can also be limited by time and access challenges. Consequently, some geographic regions, including specific districts or provinces, may be entirely excluded from both SMART and Rapid SMART surveys during national-level assessments, leading to critical data gaps that hinder strategic and operational decision-making in the nutrition sector. When access is severely limited, and resources for SMART surveys are constrained, alternative methodologies and data sources become necessary to address gaps in nutritional assessment data. It is crucial to consider these alternative methods in the assessment planning to generate reliable estimates of acute malnutrition and mortality, ensuring informed decision-making (see Figure 4).

Decisions on selecting alternative data sources and methodologies should be made in close collaboration with nutrition cluster/sector partners and a designated

group of assessment experts to ensure consensus. It is strongly recommended that this consultation also involves representatives from nutrition-sensitive sectors, such as food security, health, and water and sanitation, whenever relevant and feasible.

Country cluster and sector coordination teams, along with their partners, can refer to the IPC Guidance Note on Access ([IPC_Guidance_Note_on_Access.pdf \(ipcinform.org\)](#)) for detailed guidance on exploring the most suitable alternative data collection methodologies and sources while planning assessments. The [IASC Operational Guidance For Coordinated Assessments in Humanitarian Crisis](#) also provides various considerations for deciding the most appropriate approach for selecting methodology /data sources (Box D) as well as the timeline for assessments. These considerations are particularly crucial during the initial phase of rapid-onset emergencies when timely information is needed for immediate decision-making. They remain important in subsequent phases, where a deeper understanding of sectoral needs becomes necessary for more comprehensive planning and response.

Box E. Considerations for selecting approaches to Coordinated Assessments

The IASC Operational Guidance For Coordinated Assessments in Humanitarian Crisis: Nutrition Humanitarian Needs Analysis Tool

The approach to coordinated assessments varies depending on the phase in which the assessment is conducted. This generally determines several key factors:

- **Timeliness of Assessment Results:** The success of an assessment partly hinges on the timeliness of its findings. It is crucial to strike an appropriate balance between data quality, the level of detail, and the timeliness of results. During the initial phase, gathering purposive data quickly is more critical than collecting statistically representative data.
- **Quantity and Type of Information Required:** Initial assessments primarily inform early strategic decisions and preliminary emergency funding allocations. In later phases, assessments inform programming, monitoring, and Flash Appeal revisions.
- **Resource Allocation:** The human and financial resources allocated to the assessment must be considered relative to those devoted to the delivery of relief assistance.

The IASC Assessment Framework distinguishes between different types of assessments based on their timing

- **Initial Assessments:** Conducted during Phase 1 (the first 72 hours).
- **Rapid Assessments:** Conducted during Phase 2 (the first and second weeks).
- **In-Depth Assessments:** Conducted during Phase 3 (the third and fourth weeks).
- **In-Depth Assessments:** Including Recovery Needs: Conducted during Phase 4 (fifth week onwards).

3. Conduct a Nutrition Humanitarian Needs 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 and October. The HPC Facilitation Package, published around mid-year, provides an indicative timeframe for the HNO process for each year.

Goal and Specific Objectives Humanitarian Nutrition Needs Analysis

The goal of the NHNAA is to conduct a timely, comprehensive, collaborative, consensus-driven, and



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methodologically sound analysis of malnutrition risk and its multisectoral determinants among children under five, pregnant and breastfeeding women, and other vulnerable groups. This analysis is aimed at guiding strategic decisions for emergency preparedness and response.

Specific Objectives:

- Identify the primary contextual drivers and contributing factors of malnutrition among children under five, pregnant and breastfeeding women and girls (PBWG), and other vulnerable groups, including but not limited to, people living with HIV (PLWHIV).
- Assess the severity of malnutrition risk across different population groups and administrative units.
- Estimate the need for emergency nutrition services among children under five, PBWG, and other vulnerable groups.
- Forecast the evolution of the severity and magnitude of nutrition needs based on the most likely scenarios over a specific period of time.

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 various 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?
- 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, morbidity, etc.)?
- Are certain livelihoods, socio-economic, age or gender groups more affected by malnutrition than others?
- Are there any trends, seasonal and/or long-term, in the prevalence of malnutrition to consider?

Step-by-Step Guidance for Nutrition Humanitarian Needs Analysis

The nutrition sector needs analysis process mirrors the JIAF process workflow, which starts with an analysis of contributing factors, followed by Sectoral PIN and Severity Analysis, intersectoral analysis of overall PIN and Severity, and linkages and patterns in the convergence of inter-sectoral needs. The specific steps involved in the analysis process are presented in Figure 5 below.

Use The **GNC Needs Analysis Tool** and **JIAF ANALYSIS PLATFORM**²¹ throughout out the analysis process.

Box F. What is the GNC Needs Analysis Tool?

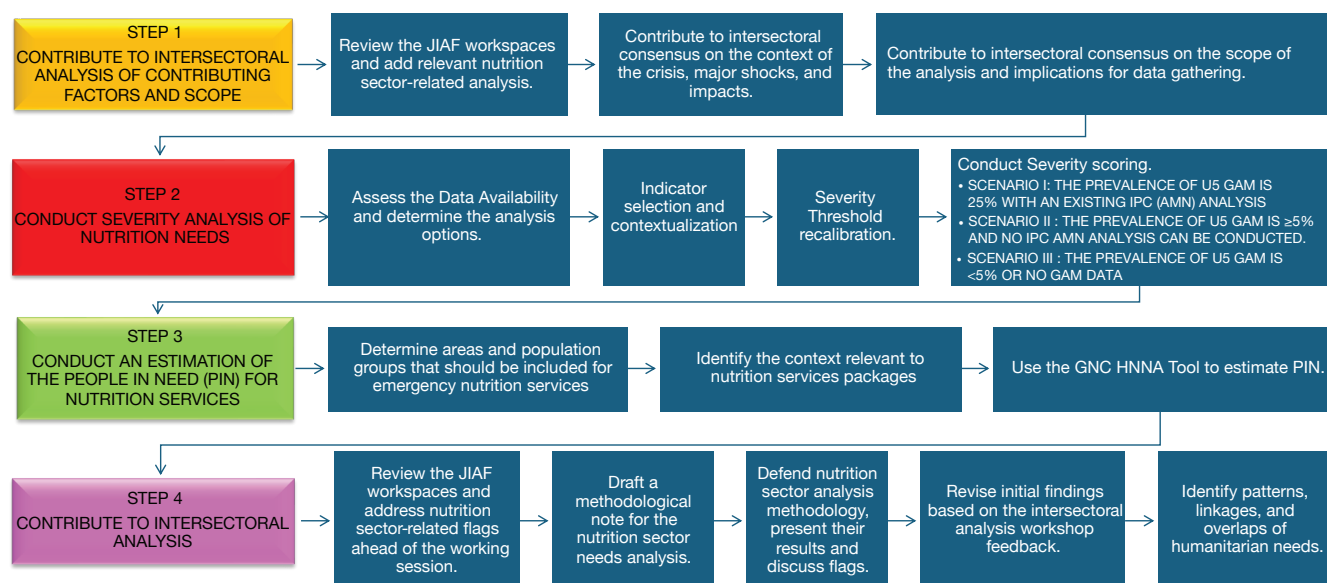
The GNC needs analysis tool is an Excel-based suite of tools for organising indicators and data sources, analysis of severity, and estimation of PiN.

- **Indicator Registry:** The list of all nutrition-related indicators adapted from the Nutrition Cluster's Indicators registry and framework, separating those deemed "core" to guide the Nutrition Situation Analysis.
- **Classification Thresholds:** The list of core nutrition-specific and nutrition-sensitive indicators and their corresponding thresholds (i.e. severity scale) to guide the situation analysis of nutritional needs for response planning.

- **Evidence Repository, Reliability:** Summary of the reliability scores for all evidence used for the Nutrition Situation Analysis based on IPC Acute Malnutrition's Reliability Scale.
- **Analysis Team Composition:** Summary of all members involved in the analysis, adapted from IPC Acute Malnutrition's Team Composition Matrix.
- **Scenario 2 – Nut. Analysis:** Humanitarian situations where an IPC Acute Malnutrition cannot be conducted and the prevalence of GAM for children U5 is $\geq 5\%$.
- **Scenario 2 – Contributing Fact:** Analysis of key contributing/contextual factors (often found in Living Standards pillar) to support the Nutrition Situation Analysis for Scenario 2 (U5 GAM $\geq 5\%$).
- **Scenario 3 – Nut. Analysis:** Humanitarian situations where the prevalence of GAM for children U5 is $< 5\%$.
- **Scenario 3 – Contributing Fact:** Analysis of key contributing/contextual factors to support the Nutrition Situation Analysis.
- **Population figures:** Key demographic information required for each of the "Affected" areas of interest in order to automatically calculate the subsequent number of "People in Need".
- **PiN Wasting & Treatment:** The numbers of "People in Need" (PiN) for malnutrition for U5 children/PBW/Older People/Adolescents are calculated automatically based on the insertion of a few parameters such as incident correction factors, proportion of different age groups for eventual program targeting. A preference for cGAM/cSAM prevalences is noted.
- **PiN IYCF:** The numbers of "People in Need" (PiN) for IYCF practices (and Stunting and Overweight for Scenario 2) are calculated automatically based on the insertion of a few parameters such as proportion of different age groups for eventual program targeting.
- **PiN Micronutrient Deficiency:** The numbers of "People in Need" (PiN) for Micronutrient Deficiencies are calculated automatically based on the insertion of a few parameters such as proportion of different age groups for eventual program targeting. These calculations also feed into Physical and Mental Well-being Pillar when relevant.
- **PiN Total:** The consolidation of numbers of "People in Need" per nutritional need are summarized per target group and disaggregated by disability to facilitate the HNO (Humanitarian Needs Overview) preparation and inter-sectoral analysis using the JIAF methodology. The % Targeted and % Reached are also included to support the HRP (Humanitarian Response Plan) preparation.

21 JIAF Analysis Platform, an online cloud-based system, is a one-stop place for analysts to conduct JIAF analysis. The analysis platform can be accessed at <https://analysis.jiaf.info/>. The test platform can be accessed with the username: student and password 123456.

Figure 5: Step for Conducting Nutrition Humanitarian Needs Analysis



Note: The Step 2 and Step 3 of the NHNA can be done concurrently.

Step 1: Contribute to Intersectoral Analysis of Contributing Factors and Scope

The first step of the NHNA involves collaboration with the inter-cluster team coordinated by OCHA. The main objectives include:

- Identifying key contextual information that relates to people's vulnerabilities to shocks, such as livelihoods, access to goods and services, etc. Unless there are major contextual shifts from one year to the next, this information can be obtained from the previous year's JIAF analyses.
- Defining the crisis by identifying major shocks and their impacts on the humanitarian situation. By pinpointing the relevant information about the shocks, such as location and intensity, analysts can better understand, map out and define the crisis. Assessing the impact of shocks on systems (e.g., infrastructure, service delivery, movement restrictions, etc.), and on people, including vulnerable population groups, is crucial to define the scope of analysis and establish a shared understanding and definition of the crisis.
- Determining the scope of the JIAF analysis to be conducted and relevant implications for data collection. This includes defining the geographic scope of analysis, the administrative level, and any specific population groups to be analyzed, which should be informed by the definition of the crisis.

While OCHA leads this step by organizing relevant indicators and preliminary context analysis, the nutrition sector/cluster coordination team plays a crucial role by reviewing the OCHA team's preliminary analysis, usually shared through the JIAF Analysis platform, and adding pertinent nutrition-related analysis. Specifically, the nutrition sector coordination team can contribute to the contributing factors and scope of analysis in the following ways:

- Reviewing the **JIAF workspaces (1A, 1B, and 1C)**²² and incorporating relevant nutrition sector-related analysis concerning the basic drivers of malnutrition applicable to the country context.
- Contributing to intersectoral consensus on the crisis context, major shocks, and their impacts. The intersectoral analysis group will develop a plausible narrative of the crisis context, highlighting significant shocks and their effects on people and systems. It is essential for the nutrition sector/cluster to provide all available evidence demonstrating how the underlying contextual factors impact nutritionally vulnerable groups, such as children and pregnant or breastfeeding women.
- Contributing to intersectoral consensus on the analysis scope and implications for data gathering. The final stage of the first step of JIAF and thus NHNA involves determining the analysis scope—defining which population groups and affected areas should be included for further sectoral and intersectoral severity and magnitude analysis. It is vital that the nutrition sector/cluster coordination team, in consultation with partners, provides

22 Refer to page 29-30, Joint and Inter Sectoral Analysis Framework (JIAF 2.0) Technical Manual, JIAF Global Partnership, 2024

supporting evidence to ensure all population groups and administrative areas with nutritional concerns are included in the needs analysis, regardless of whether the underlying drivers are recent or long-term deprivations.

Step 2 : Conduct Severity Analysis of Nutrition Needs

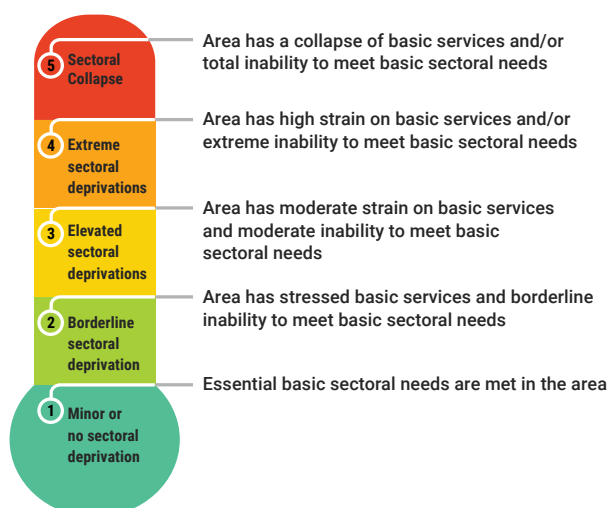
Step 2 focuses on the sector-specific analysis of humanitarian needs within the bounds of the agreed scope of inter-sectoral analysis. Each country's sector/cluster coordination mechanism has the liberty to use its sector-specific analysis methodology. This involves using standard indicators and severity thresholds for severity and magnitude analysis (See Indicator Registry Sheet of **The GNC Needs Analysis Tool and The GNC Severity Indicators Reference Table**). Additionally, they may use context-specific indicators and thresholds, recalibrating them to align with the JIAF 2.0 severity threshold definitions (see *Figure 6: JIAF's common five-scale severity levels*).

The country nutrition sector/cluster coordination team can follow these specific steps in the severity analysis:

1. Assess Data Availability and Determine Analysis

Options: Evaluate the availability of nutrition outcome data and determine the appropriate analysis options. There are three scenarios for severity analysis based on the level of acute malnutrition and the availability of outcome data, illustrated in Figure 6. This step helps categorize the country into one of the three scenarios and apply the corresponding severity analysis option or pathway.

Figure 6: JIAF's common five-scale severity levels



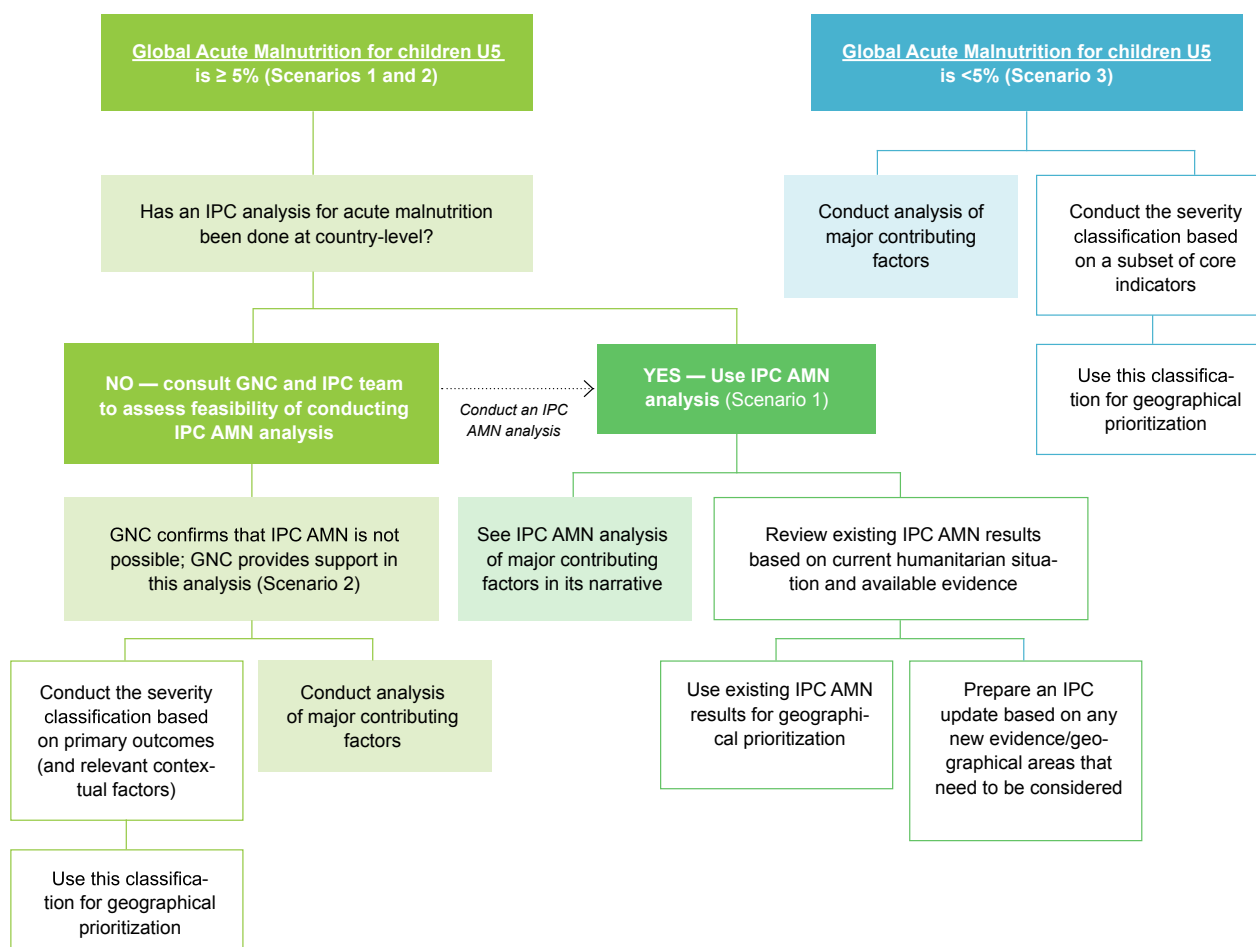
2. Indicator Selection and Contextualization:

Review the available data sources and indicators. Decide if there is a need to set country-specific severity thresholds for particular contextual or proxy indicators. In exceptional circumstances where data from household surveys such as SMART surveys is unavailable, country nutrition sector coordination teams may use proxy indicators from alternative data sources, such as other sector data or nutrition data from service delivery facilities or data from non-representative sources. These indicators should be comparable to the recommended nutrition sector standard indicators (see the Indicator Registry Sheet of the GNC Needs Analysis Tool). If the country sector/cluster is using proxy indicators, this should be indicated in Workspace 2B of the JIAF 2.0 analysis platform to ensure transparency and credibility in the sectoral analysis.

3. Recalibrate Severity Thresholds if Needed: Often, proxy indicators may not have standard severity cut-offs. In such cases, there is a need to recalibrate the severity thresholds by aligning them with the JIAF's common five-scale severity levels (Figure 7). Specify whether the nutrition sector indicator severity scale aligns with GNC severity standards. While alignment with global sectoral guidance is the goal, country clusters may adapt global guidance to their local context. Workspace 2B offers the options 'Aligned' and 'Adapted' to indicate alignment with global nutrition cluster guidance. If 'Adapted' is selected, analysts must describe the reasons for this adaptation. Additionally, the workspace requires sectors to share the list of indicators used for the analysis of severity, along with their definitions and applied thresholds.

The steps described above ensure the nutrition sector analysis meets the JIAF interoperability standards while at the same time providing the flexibility to use context-specific proxy indicators.

Figure 7 : Scenario-Based Options for Severity Analysis



Conduct Severity scoring²³.

- **SCENARIO I : The Prevalence Of U5 GAM Is ≥5% in most parts of the country With An Existing IPC AMN Analysis**
- **SCENARIO II : The Prevalence Of U5 GAM Is ≥5% in most parts of the country And No IPC AMN Analysis Can Be Conducted.**
- **SCENARIO III : The Prevalence Of U5 GAM Is <5% Or No GAM Data in most parts of the country**

These scenarios are based on available information in “most parts” of the country or areas included in the HNO scope of analysis. Since the designation of “most parts” is subjective, it is strongly recommended that the decision be made through a consultative and consensus-based approach by the nutrition sector coordination team and partners.

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 ≥5%, an IPC AMN analysis should be ideally used or planned for – see *Box G* below for more details.

²³ Refer to the GNC Webinar on the Nutrition Humanitarian Needs Analysis Guidelines for detail steps of the severity analysis https://youtu.be/ZFku1zB-2D3w?list=PLGaJD9KLkq2K5gKa_F_VBhYPqmOI41Pp6

Box G. 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).

Recommended “core” nutrition indicators for needs analysis

This recommended list of indicators was prepared by the GNC HNO Taskforce and NIS TWG 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**²⁴ – See **Indicator Registry worksheet** of the **Nutrition Cluster Nutrition Humanitarian Needs Analysis Tool**.

In alignment with the aforementioned IPC AMN Analytical Framework, *Table 3* (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 framework (Annex 2):** nutritional status indicators, mortality indicators, immediate and underlying causes, and other issues;
- **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)²⁵. However, for the purpose of this situation analysis, a preference for GAM based on WHZ²⁶ is applied; GAM based on MUAC must only be used in the absence of GAM based on WHZ, and always using convergence of evidence with contributing factors to arrive at a final conclusion.

²⁴ See the **Global Nutrition Cluster indicators registry** with needs assessment and performance monitoring indicators.

²⁵ 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.

²⁶ 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 2. List of Core Nutrition Indicators to guide the Nutrition Situation Analysis

			Severity Scale based on IPC/OCHA phases						
Category	Alignment with IPC AMN framework	Core Nutrition Indicators to guide response planning	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 <i>(if no data, use 6-59 months)</i>	<5%	5-9.9%	10-14.9%	15-29.9%	≥30%	IPC Global Partners (2019) Integrated Food Security Phase Classification Technical Manual Version 3.0.	
		Prevalence of GAM based on MUAC ²⁷ <125mm and/or bilateral pitting oedema among children 6-59 months	<5%					Preliminary thresholds suggested by IPC Global Partners (2019) Integrated Food Security Phase Classification Technical Manual Version 3.0.	
				5%-9.9%					
					10%-14.9%				
					≥15%				
		Prevalence of undernutrition based on MUAC<230mm among PBW	<20%		20-39.9%		≥40%	Women's nutrition humanitarian guidance-2024-FINAL-Sept2024.pdf.pdf	
Prevalence of stunting based on HAZ <-2 among children U5	<2.5%	2.5-9.9%	10-19.9%	20-29.9%	≥30%	De Onis et al (2018) Prevalence thresholds for wasting, overweight, and stunting in children under 5 years			
(Contextual factors)	Other causes	Prevalence of overweight based on WHZ>2 among children 0-59 months	<2.5%	2.5-4.9%	5-9.9%	10-14.9%	≥15%	De Onis et al (2018) Prevalence thresholds for wasting, overweight, and stunting in children under 5 years	
		Prevalence of GAM based MUAC<210mm among Older People(Age >=60 Years) ²⁸	<5%	5-9.9%	10-14.9% or 5-9.9% ²⁹	≥15% or 10%-14.9% ^{1bid}		HelpAge (2013) Nutrition Interventions for Older People in Emergencies	
	Micronutrient deficiencies	Prevalence of anemia (Hb <11g/dL) in pregnant women	<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	<5%	5-19.9%	20-39.9%	≥40%			
	Mortality indicators	Crude Death/Mortality Rate (deaths/ 10,000 persons/ day)	Under-five Death/Mortality Rate (deaths/ 10,000 children U5/ day)	<0.5		0.5-0.9	1-1.9	≥2	IPC Global Partners (2019) Integrated Food Security Phase Classification Technical Manual Version 3.0.
				<1		1-1.9	2-3.9	≥4	

²⁷ *Requires Minimum Meal Frequency in children 6-23 months to derive along with Minimum Dietary Diversity in children 6-23 months. See Box E above.

²⁸ The Old age group can vary according to the country's definition of "old". The HelpAge NiE Guideline recommends age 60 year or more to be considered nutritionally vulnerable group.

²⁹ 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.

			Severity Scale based on IPC/OCHA phases					
Category	Alignment with IPC AMN framework	Core Nutrition Indicators to guide response planning	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
Key contributing factors	Immediate causes (Food consumption)	Minimum Dietary Diversity in children 6 to 23 months	>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*	>70%	40-70%	20-39.9%	10-19.9%	<10%	Preliminary thresholds suggested by IFE Core Group
		Exclusive breastfeeding for infants 0-5 months	>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 IFE Operational Guidance's standards and recommendations	>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 IFE Operational Guidance's standards and recommendations	>60%	40-60%	20-39.9%	10-19.9%	<10%	Preliminary thresholds suggested by IFE Core Group
	Underlying causes (WASH)	% of HHs having access to an improved water source	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.	WASH Cluster HNO indicators for JIAF
		% of HHs having access to a sufficient quantity of water for drinking, cooking, bathing, washing or other domestic use	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	
		% of HHs having access to a functional and improved sanitation facility	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	
		% of HHs with access to functioning handwashing facilities, with water and soap available or % of HHs with access to soap	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	

Category	Alignment with IPC AMN framework	Core Nutrition Indicators to guide response planning	Severity Scale based on IPC/OCHA phases					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	
Key contributing factors	Underlying causes (Immunization)	Coverage of DTC3 (DPT3 / PENTA3) in <1 year old, by administrative unit	> 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 (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Routine polio vaccination coverage (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Routine Vitamin A supplementation coverage (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Campaign measles vaccination coverage (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Campaign polio vaccination coverage (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Campaign Vitamin A supplementation coverage (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Measles vaccination coverage from surveys (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Polio vaccination coverage from surveys (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Vitamin A supplementation coverage from surveys (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Coverage of all basic vaccinations from surveys (%)	> 90%	85% - 90%	75% - 85%	65% - 75%	< 65%	<i>Preliminary thresholds</i> , aligned with those for DTC3 suggested by the GNC Taskforce
		Percentage of children aged six months to 15 years who have received measles vaccination	>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

			Severity Scale based on IPC/OCHA phases					
Category	Alignment with IPC AMN framework	Core Nutrition Indicators to guide response planning	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
Key contributing factors	Immediate causes (Health status)	Number of cases for selected diseases relevant to the local context (e.g. cholera, measles, acute meningitis, COVID-19)	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
		Proportion of children U5 with diarrhea in the last two weeks	No thresholds proposed, use of consensus and expert judgement					Suggested by the GNC Taskforce
		Prevalence of HIV/AIDS	No thresholds proposed, use of consensus and expert judgement					Suggested by the GNC Taskforce
		Proportion of children U5 with fever in malaria-risk areas	No thresholds proposed, use of consensus and expert judgement					Suggested by the GNC Taskforce
		Proportion of children U5 who had Acute Respiratory Infections (ARI) in the last 2 weeks	No thresholds proposed, use of consensus and expert judgement					Suggested by the GNC Taskforce
		Number of reported cases of cholera or Acute Watery Diarrhea (AWD)	No thresholds proposed, use of consensus and expert judgement					Suggested by the GNC Taskforce

			Severity Scale based on IPC/OCHA phases					
Category	Alignment with IPC AMN framework	Core Nutrition Indicators to guide response planning	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
Key contributing factors	Underlying causes (Availability of and access to health services)	Percentage of population that can access primary healthcare within one hour's walk from dwellings	≥ 80%	75% - 80%	70% - 75%	65% - 70%	< 65%	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	4+	3 - 4	2 - 3	1 - 2	< 1	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	≥ 23	≥ 20	≥ 17	≥ 14	≥ 11	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)	PRIORITY: Food Security Cluster/Sector Analysis	1	2	3	4	5	To align with the final analysis in terms of phases provided by the in-country Food security colleagues
		Food Consumption Score	Acceptable and stable	Acceptable but deterioration from typical	Borderline	Poor	Poor	Subset suggested by <i>Food Security</i> colleagues for JIAF

Scenario 1: Humanitarian situations where the prevalence of U5 GAM is $\geq 5\%$ in most parts of the country and ³⁰with an existing IPC Acute Malnutrition (AMN) analysis

- 0.1 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;
- 0.2 Review the validity period of existing IPC AMN severity classification. If situation has significantly changed, use IPC guidance on updating the analysis;
- 0.3 Use the results of the IPC AMN analysis.

Scenario 2: Humanitarian situations where the prevalence of U5 GAM is $\geq 5\%$ most parts of the country and no IPC AMN analysis can be conducted

- 2.1 Contact the GNC-CT to discuss the feasibility of preparing an IPC AMN analysis – see Box F 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.
- 2.2 Use the IPC Acute Malnutrition Framework (see *Annex 1*) to guide the convergence of evidence for this analysis;
- 2.3 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**:

- 2.3.1 Conduct the **severity classification** of GAM based on the thresholds from Table 2 based on the following:

- ➔ 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 PBW 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.

- 2.3.2 Conduct an analysis of key contributing/contextual factors based on thresholds from *Table 2* using **Scenario 2: Contributing Fact worksheet** 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 *contributing factors* 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**.

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		

³⁰ This scenario is applicable if the GAM rate is $\geq 5\%$ in most parts of the country or areas included in the HNO scope of analysis and IPC AMN data is available.

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:

- 2.4 Prepare the report using the **consensus** of severity classification and its key contributing factors for geographical prioritization;
- 2.5 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 4*;
- 2.6 Present findings³¹ to decision-makers based on key points from *Annex 4* while highlighting any **population movements and accessibility issues** to take into consideration;
- 2.7 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.

Scenario 3: Humanitarian situations where the prevalence of U5 GAM is <5% most parts of the country³²

- 3.1 Use the IPC Acute Malnutrition Framework (see *Annex 1*) to guide the convergence of evidence for this analysis;
- 3.2 In the » **Scenario 3 Nut. Analysis** worksheet, conduct the severity classification using a **defined scoring system** in **columns P-U** that takes into account both vulnerability of the target groups and reliability of these 10 indicators (taking note of using *Minimum Acceptable Diet for children 6-23 months*, if available) deemed relevant for this scenario:

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
PRELIMINARY SCORING SYSTEM*	Acceptable/ Minimal	Alert/ Stress	Serious/ Severe	Critical/ Extreme	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
Minimum Dietary Diversity in children 6-23 months (if available, use Minimum Acceptable Diet in 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	
% 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	
GAM prevalence % for Adolescents (BMI-for-Age)	0.05	0.25	0.70	1.50	3.75
For country inputs (if relevant, column L)	0.05	0.25	0.70	1.50	3.75

31 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.

32 This scenarios is based on available information in "most parts" of the country or areas included in the HNO scope of analysis. Since the designation of "most parts" is subjective, it is strongly recommended that the decision be made through a consultative and consensus-based approach by the nutrition sector coordination team and partners..

3.2.1 → Insert the prevalence per geographical area for any of the readily available 10 indicators in **columns B-L**.

3.2.2 An automatic classification based on thresholds from *Table 2* will be done in these columns. Based on this classification, the associated number of points will be taken and added in **column M**.

3.2.3 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 cut-offs:

	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
TABLE OF INTERPRETATION	Acceptable/ Minimal	Alert/ Stress	Serious/ Severe	Critical/ Extreme	Extremely Critical/ Catastrophic
PRELIMINARY CUT-OFFS BASED ON SCORE	≤4	5-13	14-29	30-49	≥50

3.2.4 Conduct an analysis of key contributing/contextual factors based on thresholds from Table 1 using » **Scenario 3 - Contributing Fact** worksheet 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 IPCAMN 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		

- 3.3 Prepare the report using the **consensus** of severity classification based on **Scenario 3 Nut. Analysis** and its key contributing factors for geographical prioritization;
- 3.4 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*;
- 3.5 Present findings³³ to decision-makers based on key points from *Annex 4* while highlighting any **population movements and accessibility issues** to take into consideration;
- 3.6 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.

³³ 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.

Step 3: Estimation of People in Need (PiN) for Nutrition Services

The results of the Nutrition Situation analysis feed into the HNO and HRP population figures defined in *Annex 3*, 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.

A key output of nutrition humanitarian needs analysis is estimating the magnitude of need, referred to as the number of people in need (PiN) of emergency nutrition services. This estimation should encompass all contextually relevant essential nutrition services and be transparent, aligning with GNC and IASC/JIAF 2.0 definitions of needs. 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)³⁴ would affect the determinants of

optimum nutrition, growth and development through nutrition-specific and nutrition-sensitive interventions (*Figure 8*)

The first step in estimating the People in Need (PiN) within the nutrition sector/cluster is to identify nutritionally vulnerable population groups and administrative units. In most cases, these vulnerable groups and areas fall within the “affected areas and population groups” designated by the inter-sectoral scope of analysis and meet the inter-cluster PiN definition and inclusion criteria (see *Table 3*). However, there may be instances where the nutrition sector/cluster identifies additional nutritionally vulnerable populations and areas impacted by undernutrition that are outside those designated by the inter-cluster scope of analysis. The inclusion of PiN from these additional groups or areas must be justified by the nutrition sector, referring to GNC PiN definitions and inclusion criteria (refer to *Box G*).

The JIAF Analysis platform Workspace 2A enables country-level sectors to specify whether their PiN inclusion criteria or estimation methods align with the JIAF intersectoral PiN definition and inclusion criteria. While alignment with the intersectoral PiN is not mandatory for independent sectoral estimates, JIAF emphasizes the need for clarity and transparency regarding whether the sectoral PiN aligns with the JIAF/IASC criteria.

Workspace 2A provides a ‘Yes’ or ‘No’ option to indicate whether sectoral PiN methods and inclusion criteria align with the five key global operational guidance elements outlined in the reference table. If ‘No’ is selected, analysts (sector/cluster coordination team) must provide an explanation for the lack of alignment.

Table 3 : IASC/JIAF 2.0. Definition of Population in Need and Joint Overall PiN Operational Guidance

Part 1: IASC Definition of PiN	
People in Need (PiN) are a subset of the population affected and include those members whose physical security, basic rights, dignity, living conditions, or livelihoods are threatened or have been disrupted, AND 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. (IASC Humanitarian Population Figure, 2016)	
Part 2: Joint Overall PiN Operational Guidance	
JIAF 2.0 Joint Overall PiN refers to the people who are impacted by the crisis and who, as a result, experience or are threatened by disruptions and have elevated, extreme, or total deprivations of their basic needs and access to services in any of the sectors.	
1: Linked to agreed scope of analyses	Includes populations affected by the crisis as identified in the scope of analysis of the Humanitarian Needs Overview.
2: Identifies those with deprivations within affected populations	Includes people who are experiencing humanitarian deprivation or protection risk.
3: Is not masked by humanitarian assistance	Includes those who are already receiving assistance and require continued humanitarian assistance to meet their basic needs.
4: Includes all humanitarian needs independent of responding actor	Includes all people that are in need regardless if the response is or will be provided by the national governments, civil society, or any other actors.
5: Includes current and expected needs in the coming year	Reflects current and expected needs based on known trends and seasonal patterns.

³⁴ World Health Organization (2019) *Essential nutrition actions: mainstreaming nutrition through the life-course*

Box H: GNC Definition of People in Need

Children 0 to 59 months, Pregnant and Lactating Women, and other highly vulnerable groups* who are acutely malnourished or at heightened risk** of becoming acutely malnourished who are:

1. In areas affected by the crisis AND/OR
2. In areas where acute malnutrition rate is above emergency level*** outside areas affected by the crisis as defined by the scope of analysis.

* Highly vulnerable groups are exceptionally considered and can include: people in high HIV prevalence contexts or in contexts where there is extensive family where adults and elderly may also be affected.

** People at heightened risk of acute malnutrition include 1) all those in camps or camp-like settings, IDPs, vulnerable migrants and refugees 2) a subset of a population who experience poor Infant and Child Feeding Practices, micronutrient deficiency, high morbidity, who are not covered through regular nutrition programs (Bi-Annual Vitamin A supplementation, Growth Monitoring and Promotion, Community Based Nutrition programs).

*** Emergency level typically reflects GAM > 15% or GAM 10-14.99 % with aggravating factors.

Regardless of the nature of the humanitarian situation, diverse Essential Nutrition Actions (ENAs)³⁵ would affect the determinants of optimum nutrition, growth and

development through nutrition-specific and nutrition-sensitive interventions (Figure 8).

Figure 8. Subset of areas of focus drawn from WHO's ENAs

	Context (all settings vs targeted)	Essential Nutrition Actions	Others sectors Involved
1. Infants	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	
2. Children	All	A. Appropriate complementary feeding	Education, trade and industry
	All	B. Growth monitoring and assessment	Education
	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
3. Adolescents	Targeted	A. Iron-containing micronutrient supplementation	Education, trade and industry
4. Adults	All	A. Nutritional care of woman during pregnancy and postpartum	Education, trade and industry Labour (maternity protection and parental leave)
	Targeted	B. Iron-containing micronutrient supplementation	Education, trade and industry
	Targeted	C. Iodine supplementation	Education, trade and industry
5. Older persons	Targeted	A. Nutritional care for at-risk older persons	Education, trade and industry

35 World Health Organization (2019) *Essential nutrition actions: mainstreaming nutrition through the life-course*

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 the 4W (who, what, where, and when) mapping, along with other reporting and monitoring tools. Whenever applicable, information concerning refugees and their distinct context, needs, vulnerabilities, and situation should also be incorporated³⁶.

Tables 3A, 3B, 3C 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, nutritional supplementation of children with MAM and treatment of children with SAM³⁷, blanket or targeted approaches to provision of specially formulated foods (SFFs) for prevention of wasting/acute malnutrition in children and women, vitamin A supplementation) are also provided in these three tables.

Please note that the contents of Tables 5A, 5B, 5C 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:

1. Admin 2 for "Affected" areas of interest and population figures (from OCHA and/or government);
2. All available demographic information for U5 children, broken down by relevant age categories and **disaggregated by sex** if available:
 - If information is only available for 6-59 months, add **cell C9** to each of the calculations based on the difference with the % of children 0-5 months below. If no data is available, we can assume 6-59 months represent 98.2% of the total population;

- 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 data³⁸;
 - 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,
3. All available demographic information PBW, Older People and Adolescents as relevant and **disaggregated by sex** if available:
 - If no information is available for PBW, we can assume this group represents 5% of the total population, with 3% 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), PBWG, 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 cGAM³⁹ 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 Need Analysis Tools**, 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.

³⁶ This document and templates will not prejudice the Joint OCHA-UNHCR Note on Mixed Situations.

³⁷ 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.

³⁸ Taken from Annex 2 in WHO's Rapid health assessment protocols during emergencies.

³⁹ cGAM: aggregate indicator by combining GAM based on WHZ and GAM based on MUAC).

The process must be well documented to show where the numbers stop being representative and where the expert opinion beings to have equal influence.

- **Options for Estimating the Wasting PiN for Children Under Five:** The NIS GTWG has recommended three options for estimating the People in Need (PiN) for wasting among children under five. The details of each option, along with considerations for selecting the most appropriate one in a specific context, are outlined in Table 4 below.

Table 4 : Options for Estimating the Wasting PiN for children under five

Options	Description	Formula/Example
Option 1: Using Program Coverage <i>Applicable to both Severe and Moderate Wasting.</i>	Using reliable program coverage data.	Step 1: Estimate Expected Admission (Equation A): $\text{Expected Admission (T}_1\text{)} = \text{Admissions (T}_0\text{)} \times (\text{Population}^1 / \text{Population}^0) \times (\text{Prevalence}^1 / \text{Prevalence}^0) \times (\text{Coverage}^1 / \text{Coverage}^0)$ Step 2: Estimate Wasting PiN by using coverage (Equation B): $\text{Number of children in need} = \text{Number of expected admissions} \times (1 / \text{Coverage})$ Example for Step 1: $\text{Number of expected admissions (T}_1\text{)} = 6191$ Example for Step 2: $\text{Number of children in need} = 17,739$
Option 2: Context-Specific Incidence Factor (cK) <i>The cK reference is only available for severe wasting. - The global standard incidence factor of K = 1.6 is used for moderate wasting.</i>	PiN for SAM (0-59 months) = cSAM prevalence (by default) × population of children aged 0-59 months × (1 + cK)	Example: • Number of children in need = population (6-59 months) × [prevalence of severe wasting × (1 + cK)] • U5 Population = 10,000 • cSAM = 2% • K = cK • PiN Severe Wasting = $10,000 \times 2\% \times (1 + cK)$
Option 3: Using Global Incidence Factor (K = 1.6) <i>- The global standard incidence factor of K = 1.6 is applied.</i>	Using a Global Standard Incidence (K: 1.6) for calculating PiN for 0-59 months wasting treatment.	Example: • Number of children in need = population (6-59 months) × [prevalence of wasting × (1 + 1.6)] • U5 Population = 10,000 • cGAM = 20% • K = 1.6 • PiN Wasting = $10,000 \times 20\% \times 2.6$

Table 5A. 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
Acute Malnutrition (AMN) (Management of Wasting)	Nutrition Screening and referral	- All children U5 - PBWG - Adolescents - Older people⁴⁰	- Number of U5 children to be screened for malnutrition - Number of PBWG to be screened for malnutrition - Number of Adolescents to be screened for malnutrition - Number of Older People to be screened for malnutrition 100% of the estimated children should be targeted for screening. 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	Number of children to be screened for malnutrition (disaggregated by sex and disability when available) = Population figures from "Affected" areas x % of children U5 Number of PBWG to be screened for malnutrition = Population figures from "Affected" areas x % of PBWG Number of Adolescents to be screened for malnutrition (disaggregated by sex and disability when available) = Population figures from "Affected" areas x % of Adolescents Number of Older People to be screened for malnutrition (disaggregated by sex and disability when available) = Population figures from "Affected" areas x % of Older People
	Inpatient management of SAM (Stabilization centres -SC)	- 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 - PBWG with SAM and medical complications <i>If relevant:</i> - Older women and men with SAM - Adolescent girls and boys with SAM and medical complications <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>	- Prevalence of cSAM in U5 children (if not available, then use 6-59 months) - Prevalence of SAM in children 0-59 months based on WHZ and/or bilateral pitting oedema (if not available, then use 6-59 months) - Prevalence of SAM in children 6-59 months based on MUAC and/or bilateral pitting oedema - Prevalence of SAM in Older People based on MUAC - Prevalence of SAM in Adolescents based on BMI-for-Age If the GAM rate is known but the SAM prevalence is not known, consider using on average an estimate of 20% of GAM patients are suffering from SAM. 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.	Number of SAM U5 children in need⁴¹ (disaggregated by sex and disability when available) = cSAM prevalence x population of U5 x k (SAM incident factor) Number of SAM U5 in need of Inpatient Treatment^{41b} (disaggregated by sex and disability when available) = Number of SAM cases (based on cSAM by default) x Expected proportion of SAM cases for Inpatient treatment Number of Older People in nutritional need (disaggregated by sex and disability when available) = SAM prevalence based on MUAC x population of Older People Number of Adolescents in nutritional need (disaggregated by sex and disability when available) = SAM prevalence based on BMI-for-Age x population of Adolescents

⁴⁰ The UN definition for older people is people aged 60 years of age and above (≥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 (≥60).

⁴¹ 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.

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
	Outpatient Management (CMAM, Outpatient Therapeutic Program-OTP)	- Girls and boys between 6 and 59 months of age who have mild/moderate bilateral oedema (+, ++) or severe wasting without any medical complications - PBWG with SAM without any medical complications <i>If relevant:</i> Adolescent girls and boys with SAM without medical complications	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%.	Number of SAM children 6-59 months in need of Outpatient Treatment⁴² (disaggregated by sex and disability when available) = $cSAM\ prevalence \times population\ of\ children\ 6-59\ months \times k\ (SAM\ incident\ factor) \times Expected\ proportion\ of\ SAM\ cases\ for\ Outpatient\ treatment$ Same calculations details above for PBW and Adolescents.
	Nutritional Supplementation of MAM	- Moderately acutely malnourished girls and boys aged 6-59 months - Acutely malnourished (severe and moderate) PBWG with infants 0-5 months, - Severely, moderately and mildly acutely malnourished PLWHIV	- Prevalence of cMAM in U5 (if not available, then use 6-59 months) - Prevalence of MAM in U5 based on WHZ (if not available, then use 6-59 months) - Prevalence of MAM in children 6-59 months based on MUAC - Prevalence of acute malnutrition in PBWG based on MUAC - Prevalence of GAM in PLWHIV based on MUAC <210mm If MAM prevalence is not known, consider using on average an estimate of 80% of GAM patients are suffering from MAM.	Number of MAM children 6-59 months in need (disaggregated by sex and disability when available) = $cMAM\ prevalence\ (by\ default) \times population\ of\ children\ 6-59\ months \times k\ (MAM\ incident\ factor)$ Number of MAM children 6-59 months in need of programming (disaggregated by sex and disability when available) = $cMAM\ prevalence\ (by\ default) \times population\ of\ children\ 6-59\ months \times k\ (MAM\ incident\ factor) \times Expected\ proportion\ of\ MAM\ cases\ for\ programming$ Number of acutely malnourished PBWG in need = $MAM\ prevalence \times population\ of\ PBWG$
	Prevention of Wasting/ Acute malnutrition through the provision of specially formulated foods (SFFs)	- Girls and boys aged 6-23 months - PBWG. If resources allow, consider including U5 children and Older People.	- Proportion of children 6-23 months in need of SFF for prevention of wasting - Proportion of PBWG in need of SFF for prevention of underweight. 70-80% of U2 and PBWG estimated should be targeted for Prevention of Wasting through the provision of SFF.	Number of children 6-23 months in need of SFF for prevention of wasting (disaggregated by sex and disability when available) = $Population\ of\ children\ aged\ 0-23\ months \times Expected\ coverage\ for\ BSFP$ Number of MAM PBWG in need of SFF for prevention of acute malnutrition = $population\ of\ pPBWG \times Expected\ coverage\ for\ BSFP$
Chronic Malnutrition	Prevention of malnutrition	Girls and boys between 0 and 59 months	<i>Prevalence of Stunting in U5 children based on HAZ</i>	Number of Stunted children U5 in need (disaggregated by sex and disability when available) = $Stunting\ prevalence \times population\ of\ U5\ children$
Overweight	Prevention of malnutrition	Girls and boys between 0 and 59 months	<i>Prevalence of overweight in U5 children based on WHZ</i>	Number of Overweight children U5 in need (disaggregated by sex and disability when available) = $Overweight\ prevalence \times population\ of\ U5\ children$

⁴² 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.

Table 5B. 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
IYCF practices (Protection, promotion and support of optimum breastfeeding)	Establishment of IYCF safe spaces	- PBWG - Caregivers with U2 girls and boys (if feasible, access via community leaders and champions)	- Proportion of PBWG counselled on IYCF - Proportion of PBWG participating in group sessions on IYCF - Exclusive breastfeeding (EBF) for children 05 months - Infants (children 05 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 - Infants (children 611 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 - Proportion of nonbreastfed children 011 months (disaggregated by sex) - Continued breastfeeding at 1 year of age (Proportion of children 1215 months who are fed breastmilk)	Number of PBWG counselled (one-on-one) on IYCF = Population figures x % of PBWG x Proportion of PBWG individually counselled on IYCF
	Counselling (one-on-one) - Community - Nutrition and Health facilities - Other settings (e.g. food and cash distributions, womenfriendly spaces) as applicable			Number of PBWG participating in group sessions on IYCF = Population figures x % of PBWG x Proportion of PBWG participating in group sessions on IYCF
	Counselling (group sessions) - Community - Nutrition and Health facilities - Other settings (e.g. food and cash distributions, womenfriendly spaces) as applicable			Number of children 0-5 months in need of EBF support (disaggregated by sex and disability when available) = Population figures x % of children 0-5 months x (1- EBF proportion) Number of non-breastfed children aged 0-5 months in need of BMS supplies and support⁴³ (disaggregated by sex and disability when available) = Population figures x (# of non-breastfed children 0-5 months in need of BMS supplies and support surveyed / total children 0-5 months surveyed)
	Specialized support for non-breastfed/partially breastfed infants* (i.e. infant formula dependant children) *: may include provision and support with BMS and BMS kit	- PBWG - Caregivers of nonbreastfed girls and boys 05 months, 611 months, and nutritionally vulnerable infants	Where data is unavailable, assume: 05 months comprise 1.8% of population; 611 months comprise 1.8% of population; - PBWG combined comprise 5% of population.	Number of non-breastfed children aged 6-11 months in need of BMS supplies and support⁴³ (disaggregated by sex and disability when available) = Population figures x (# of non-breastfed children 6-11 months in need of BMS supplies and support surveyed / total children 6-11 months surveyed) Number of non-breastfed children aged 0-11 months (disaggregated by sex and disability when available) = Population figures x (# of non-breastfed children 0-11 months / total children 0-11 months surveyed) Number of children still breastfeeding at 1 year of age (disaggregated by sex and disability when available) = Population figures x (# of children 12-15 months who are fed breastmilk / total children 12-15 months surveyed)

⁴³ **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 breast-milk 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.

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
IYCF practices (Appropriate complementary feeding)	Promotion and support to appropriate, timely and safe complementary feeding	- Families with U2 girls and boys - PBWG Blanket coverage may be an option when it is too difficult to target specific group of beneficiaries	- Minimum dietary diversity in children 6-23 months - Minimum meal frequency in children 6-23 months - Minimum acceptable diet in children 6-23 months Where data is unavailable, assume: 6-23 months comprise 5.4% of population.	Number of children 6-23 months in need of Minimum Dietary Diversity support (disaggregated by sex and disability when available) = Population figures x % of children 6-23 months x (1- MDD proportion) Number of children 6-23 months in need of Minimum Meal Frequency support (disaggregated by sex and disability when available) = Population figures x % of children 6-23 months x (1- MFF proportion) Number of children 6-23 months in need of Minimum Acceptable diet support (disaggregated by sex and disability when available) = Population figures x % of children 6-23 months x (1- MAD proportion)
	Access to specialised nutrition commodities		Refer to either BSFP PiN in Table 3A above, or Micronutrient Supplementation PiN in Table 3C 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 (PBWG, U2)		
	Appropriate complementary feeding through food distributions (in kind)			

Table 5C. 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
Micronutrient deficiencies (Iron-containing micronutrient supplementation for children, adolescents, women during pregnancy and postpartum)	Iron or iron/folic acid supplementation	- Girls and boys 6-59 months of age (If resources allow, 6-59 months can be considered) - Pregnant Women - Women of reproductive age in populations where the prevalence of anaemia among nonpregnant women is 20% or higher - Women postpartum - Older women and men	- Prevalence of anemia Hb<11g/dl in children 6-59 months - Prevalence of anemia Hb<11g/dl in PW - Proportion of children 6-59 months of age receiving micronutrient supplements that contain adequate iron - Proportion of PW having received Iron-folic acid supplementation daily in previous 6 months/during pregnancy In areas with high GAM prevalence rate, do not forget to subtract children with GAM as they receive RUTF/ RUSF that already contain micronutrients	Number of anemic children 6-59 months (disaggregated by sex and disability when available) = Population figures x % of children 6-59 months x U5 anemia prevalence Number of anemic PW = Population figures x % of PW x PW anemia prevalence Number of children 6-59 months in need of iron supplementation (disaggregated by sex and disability when available) = Population figures x % of children 6-59 months x (1 - Proportion of children 6-59 months having received micronutrient supplements that contain adequate iron) Number of PW in need of iron supplementation = Population figures x % of PW x (1 - Proportion of PW having received micronutrient supplements that contain adequate iron)
	Calcium supplementation during pregnancy	PW	- Proportion of PW having received calcium supplementation during pregnancy - Proportion of PW having received multiple micronutrient supplementation during pregnancy	Number of PW in need of calcium supplementation = Population figures x % of PW x (1 - Proportion of PW having received calcium supplements during pregnancy)
	Multiple micronutrient supplementation in pregnancy		If no data exists assume PW comprise 2.4% of population (low income countries only)	Number of PW in need of multiple micronutrient supplementation = Population figures x % of PW x (1 - Proportion of PW having received multiple micronutrient supplements during pregnancy)
	Balanced energy protein supplementation during pregnancy and breastfeeding	PBWG	Proportion of PBWG having received balanced energy protein supplementation during pregnancy/ breastfeeding If no data exists assume 2.4% PW, 2.6% LW (low income countries only)	Number of PBWG in need of balanced energy protein supplementation = Population figures x % of PBWG x (1 - Proportion of PBWG having received balanced energy protein supplements during pregnancy and breastfeeding)
Micronutrient deficiencies (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 If relevant: - 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	- Prevalence of sub-clinical Vitamin A deficiency in children 6-59 months - Proportion of children 6-59 months having received vitamin A in previous 6 months 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	Number of VAD children 6-59 months in need (disaggregated by sex and disability when available) = Population figures x % of children 6-59 months x VAD prevalence for children 6-59 months Number of children 6-59 months in need of Vitamin A supplementation (disaggregated by sex and disability when available) = Population figures x % of children 6-59 months x (1 - Proportion of children 6-59 months having received vitamin A in previous 6 months)

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
Micronutrient deficiencies (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% - PBWG 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 If relevant: - All households for iodised salt distribution in countries with iodised salt consumption 20% or more.	- Prevalence of Iodine deficiency in children 6-23 months - Prevalence of Iodine deficiency in PBWG - Prevalence of Iodine deficiency in Older People	Number of iodine deficient children 6-23 months (disaggregated by sex and disability when available) = Population figures x % of children 6-23 months x iodine deficiency prevalence for children 6-23 months Number of iodine deficient PBWG = Population figures x % of PBWG x iodine deficiency prevalence for PBWG Number of iodine deficient Older People (disaggregated by sex and disability when available) = Population figures x % of Older People x iodine deficiency prevalence for Older People
Micronutrient deficiencies (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	Proportion of children 6-59 months having received Zinc in previous 6 months 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	Number of children 6-59 months in need of zinc supplementation (disaggregated by sex and disability when available) = Population figures x % of children 6-59 months x (1 - Proportion of children 6-59 months having received zinc supplementation)
Other micronutrient deficiencies (e.g. Pellagra)	Not applicable	Target group	Proportion of target group(s) being deficient in a given micronutrient	Number of target group(s) in need of a given micronutrient supplementation (disaggregated by sex and disability when available) = Population figures x target group(s) x prevalence of a given micronutrient deficiency
Disease prevention and management	Deworming (e.g. schistosomiasis, soil transmitted helminthes)	- Girls and boys 6-59 months - Schoolage girls and boys - Adolescent girls and boys - PW - Older women and men	Proportion of target population group having received deworming	Number of children 6-59 months in need of deworming (disaggregated by sex and disability when available) = Population figures x % of children 6-59 months x (1 - Proportion of children 6-59 months having received deworming) Same calculations per population groups.

Step 4: Contribute to Intersectoral Analysis

As part of the JIAF Intersectoral Analysis of Linkages and Patterns (Module 3) process, each sector is required to actively engage and contribute to the intersectoral analysis. This collaborative effort involves representatives from clusters, areas of responsibility, relevant sectoral coordination mechanisms at the country level, sector-leading agencies, OCHA, NGOs, civil society, and other key partners. The process functions as a peer review and quality assurance step within the humanitarian needs analysis, carried out during a multi-partner working session.

The objectives of the intersectoral analysis (Module 3 of JIAF 2.0) are to:

1. **Determine the Joint Overall PiN:** Establish the total estimated number of people in need (PiN) of humanitarian assistance across all administrative units and population groups within the scope of the analysis. The joint overall PiN includes individuals impacted by the crisis who face or are at risk of disruptions and deprivations of basic needs and services, requiring humanitarian assistance to protect lives, livelihoods, dignity, and restore normal living conditions.
2. **Determine the Intersectoral Severity:** Assess the intersectoral severity across all administrative units and population groups, evaluating the cumulative impact of sectoral needs, resulting in complex humanitarian conditions.
3. **Identify Characteristics of Humanitarian Needs:** Analyze spatial and population group patterns, sectoral overlaps, linkages, and trends in humanitarian needs.
4. **Finalize Preliminary Information from Module 1:** Review and update the information generated in Module 1 based on insights gathered throughout the JIAF process.

The nutrition sector/cluster at the country level is responsible for actively participating in this step of the JIAF analysis process by providing nutrition sector input and contributing to the inter-sectoral analysis. Responsibilities include reviewing the JIAF Analysis platform workspaces to address any nutrition sector-related issues before the working session. Additionally, the sector/cluster must draft a detailed methodological note outlining how the nutrition needs analysis was conducted. During the intersectoral analysis, the nutrition sector/cluster is expected to present and defend the methodology, ensuring the analysis and results are well justified while addressing any issues

that arise. Based on feedback from the intersectoral workshop, initial findings should be revised to incorporate new insights. The nutrition sector/cluster is also tasked with identifying patterns, linkages, and overlaps in humanitarian needs across sectors, contributing to the overall intersectoral analysis. The recommended required actions are outlined below.

Pre-workshop activities:

In preparation for the analysis working session, OCHA at the country level will develop Excel-based Workspaces 3A, 3B, and visuals in 3C, following the guidelines in Reference Tables 3A and 3B (accessible via the JIAF Analysis Platform). These workspaces will be made available on the platform or shared by OCHA before the multi-partner session(s). OCHA will ensure that all sectoral inputs, including PiNs and severity, are incorporated, and will integrate available outcome indicator data from the Intersectoral Severity table into Workspace 3B. Data will be aligned with their indicative severity phases to assess the consistency between preliminary intersectoral severity and outcome indicators.

Review of JIAF Workspaces and Addressing Nutrition Sector Flags Prior to the Working Session:

Before the joint working session, the nutrition sector/cluster team should review the workspaces, focusing on flagged units of analysis. It's important to note that flags indicate potential data issues, intended to facilitate joint analysis and evidence convergence, but do not necessarily imply that the data is incorrect. Therefore, nutrition sectors/clusters are not automatically required to revise PiN and Severity estimates solely because they have been flagged.

During and After the Analysis Workshop:

Correcting Flagged Data and Revising Initial Analysis Based on Inter-Cluster Feedback:

If issues are found in flagged sectoral PiN or severity data, corrections should be made by inter-cluster multi-partner working session participants. The inter-cluster group in each country will decide how revisions are documented—whether as a new column in Workspace 3A and 3B, replacing the existing column, or as a new file uploaded as individual sectoral inputs. However, if there are valid reasons to retain the flagged PiN or severity data as is, the nutrition sector/cluster should be prepared to provide a justification during the multi-partner working session. For further details on how to handle flags, refer to Annex 5 of the JIAF 2.0 Technical Manual.

Box I. Understanding Flags in JIAF 2

The flagging system is used to identify areas or population groups that need further review to ensure the data's validity. A flag does not necessarily mean the data is incorrect, but rather that it needs verification and, if necessary, revision. A discussion is required for all flagged areas, and sectors with flagged data are asked to explain and justify their results. If the explanation is not satisfactory to JIAF partners, the cluster or sector is asked to conduct further analysis and consider revising their findings. While clusters are strongly encouraged to adopt the adjustments recommended by inter-cluster analysts, they may choose not to change their analysis if their specific context requires estimates that differ from global operational guidance for joint PiN or Severity analysis. Detailed explanations of the application of flags are provided at relevant points in the [JIAF 2.0 Technical Manual page 34-35](#).

Developing a Methodological Note for Nutrition Sector Analysis:

To ensure a transparent, credible, and consensus-based analysis of nutrition needs, it is recommended to develop a methodological note. The sector/cluster coordination team can prepare the note prior to the analysis workshop. This note should provide a comprehensive overview of the methodology used for estimating PiN and Severity within the nutrition sector, as well as the decision-making and consultative processes. The note should outline the purpose, country or regional context, and the data sources utilized, such as surveys or sentinel surveillance data, with clear explanations for their selection and any limitations. It must describe how PiN and Severity were estimated, including the use of global standards like the GNC Severity Classification, PiN calculation methods, and IPC AMN analysis findings where applicable. It should also explain how disaggregation by age, gender, and diversity was handled. The note should address how flagged data was reviewed and managed, providing justifications for retaining flagged estimates when necessary, and explain how the analysis aligns with the intersectoral scope. Any challenges, such as data gaps or access issues, should be acknowledged, along with steps taken to address them. If the nutrition sector includes population groups or administrative units outside the agreed intersectoral scope, justifications may be required.

Contributing to Intersectoral Analysis on Identifying Patterns, Linkages, and Overlaps of Humanitarian Need:

The primary objective of this analysis is to create a common narrative that explains the humanitarian situation and key findings, based on joint analysis, to guide response planning and decision-making. By reviewing and discussing intersectoral patterns and

linkages, analysts can develop a shared understanding of the situation. Nutrition sectors/clusters at the country level should ensure that factors affecting the nutritional risk of vulnerable groups are well-represented in this narrative. This process also provides an opportunity for intersectoral collaboration to address nutrition outcomes collectively.

Guiding Questions for Nutrition Sector Analysis:

The following questions (adapted from JIAF 2.0 Inter-sectoral guiding questions) are intended to guide discussions in interpreting and identifying key findings for the nutrition sector within inter-sectoral analysis. These questions will help derive critical insights for strategic nutrition and intersectoral response planning. Nutrition sectors/clusters can adjust these questions based on their specific context, and it is recommended that the analysis team use these questions to guide discussions before the intersectoral analysis workshop:

1. Where is the highest concentration of the population in need of nutritional assistance in the country?
2. Where are the areas with the highest severity of nutrition needs?
3. Which areas have multiple sectoral needs converging with nutritional support?
4. Which sectors are likely contributing most significantly to the nutrition needs?
5. What is the PiN trend for nutrition compared to previous years?
6. How is the nutrition PiN disaggregated by age, gender, and other diversity characteristics?
7. Which areas have multiple sectors with overlapping high severity of nutrition-related needs?
8. Which sectors have the highest multisectoral severity, converging with high nutrition severity and driving nutrition needs in a given area?
9. Which areas and sectors show both high PiN and high severity for nutrition?
10. To what extent do nutrition sector PiNs correlate with other sectors' PiNs?

These questions are designed to help the nutrition sector identify areas of greatest need, understand the drivers of malnutrition, and ensure that response planning is aligned with the broader humanitarian context.

4. Nutrition Sector Needs Analysis Input to HNO

The JIAF/HNO process concludes with the production of a country-specific Humanitarian Needs Overview (HNO) document. The template for the HNO is published annually and made publicly available through the [HPC FACILITATION PACKAGE](#). The nutrition sector at the country level is expected to contribute narrative input towards the HNO (refer to **Annex 5 : Template for the nutrition sector narrative input to the HNO**). Typically, the nutrition needs analysis narrative input to the HNO constitutes a document that begins with an introduction providing a brief overview of the nutrition situation in the country, highlighting key humanitarian issues such as conflict, economic shocks, and displacement that affect nutrition. It defines the affected regions and population groups, including children under five and pregnant and breastfeeding women, while offering context on the broader humanitarian and development situation.

The analysis reports on the prevalence of Global Acute Malnutrition (GAM), Severe Acute Malnutrition (SAM), and Moderate Acute Malnutrition (MAM), focusing on high-risk areas and vulnerable populations. It also includes relevant data on nutrition indicators such as feeding practices and program coverage. Contributing factors, including conflict, food insecurity, health system breakdowns, public health crises, and inadequate feeding practices, are outlined to explain the drivers of malnutrition.

The narrative summarizes the current humanitarian response, identifying gaps in coverage, operational challenges, and partnerships. Projections for future needs are also provided, including estimates of malnutrition during seasonal peaks and the potential risks if these needs go unmet. The methodology and data sources used in the analysis are briefly explained, along with any limitations. The narrative concludes with key findings, actionable recommendations, and a call to action, emphasizing the need for timely and coordinated interventions to address malnutrition effectively.

REFERENCES

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

FANTA. (2018). [Training Guide for Community-Based Management of Acute Malnutrition \(CMAM\).](#)

Global Nutrition Cluster (2016) [TIPS ON NUTRITION INTERVENTIONS for the Humanitarian Response Plan](#)

Global Nutrition Cluster (2019) [PREPAREDNESS GUIDELINES FOR NUTRITION IN EMERGENCIES COORDINATION](#)

Guidance Coordinated Assessments in Humanitarian Crisis , IASC Task Force On Needs Assessment, March 2012

[HelpAge International, Nutrition Works, Global Nutrition Cluster \(2013\)](#)

[The Harmonised Training Package \(HTP\): Resource Material for Training on Nutrition in Emergencies, Module 23, Version 1 \(2013\) Nutrition of older people in emergencies](#)

[IASC \(2012\) Operational guidance on coordinated assessments in humanitarian crises](#)

[IASC \(2015\) Reference module for the implementation of the humanitarian programme cycle 2015 - Version 2](#)

[IASC \(2016\) Humanitarian Profile Support Guidance](#)

IASC (Inter-Agency Standing Committee). 2015. IASC Reference Module for the Implementation of the Humanitarian Programme Cycle, Version 2.0.

IASC (Inter-Agency Standing Committee). 2015. IASC Reference Module for the Implementation of the Humanitarian Programme Cycle, Version 2.0.

[IASC \(2009\) IASC Flash Appeals Guidelines \(2009\) IASC Flash Appeals Guidelines \(2009\)](#)

Inter-Agency Standing Committee (IASC). (2012). Operational Guidance for Coordinated Assessments in Humanitarian Crises (Provisional Version). March 2012.

[IPC Global Partners \(2019\) Integrated Food Security Phase Classification Technical Manual Version 3.0. Evidence and Standards for Better Food Security and Nutrition Decisions.](#)

[Joint and Inter Sectoral Analysis Framework \(JIAF 2.0\) Technical Manual, JIAF Global Partnership, 2024](#)

Marin-Ferrer, M., Vernaccini, L. and Poljansek, K., Index for Risk Management INFORM Concept and Methodology Report — Version 2017, EUR 28655 EN, doi:10.2760/094023

[OCHA \(2019\) Step-by-step Practical Guide for Humanitarian Needs Overviews, Humanitarian Response Plans and Updates](#)

OECD Risk Management: Strategic Crisis Management, OECD, 2013

[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.](#)

Risk analysis and risk-informed planning – Humanitarian Programme Cycle (hpc.tools)

[Sphere \(2019\) Sphere Glossary](#)

[Sphere Association \(2018\) The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response – Chapter 6: Food Security and Nutrition, fourth edition](#)

[The Lancet \(2013\) Executive Summary of The Lancet Maternal and Child Nutrition Series](#)

UNDRR (2023), Strengthening risk analysis for humanitarian planning Integrating disaster and climate risk in the Humanitarian Programme Cycle, United Nations Office for Disaster Risk Reduction (UNDRR)

[UNICEF\(2024\) Women's nutrition humanitarian guidance-2024-FINAL-Sept2024.pdf](#)

[UNICEF \(2013\) Global SAM Management Update -Summary of findings](#)

UNICEF Nutrition, New York; Guidance for Estimating the Number of Children in Need of Treatment for Wasting; July 2021

[World Health Organization \(1999\) Rapid health assessment protocols for emergencies](#)

[World Health Organization \(2000\) The management of nutrition in major emergencies – Annex 1: Energy requirements for emergency-affected populations](#)

[World Health Organization \(2016\) Obesity and Overweight. Fact Sheet](#)

[World Health Organization \(2019\) Essential nutrition actions: mainstreaming nutrition through the life-course](#)

ANNEX 1: 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 whenever collecting, analysing and publishing data and their results.

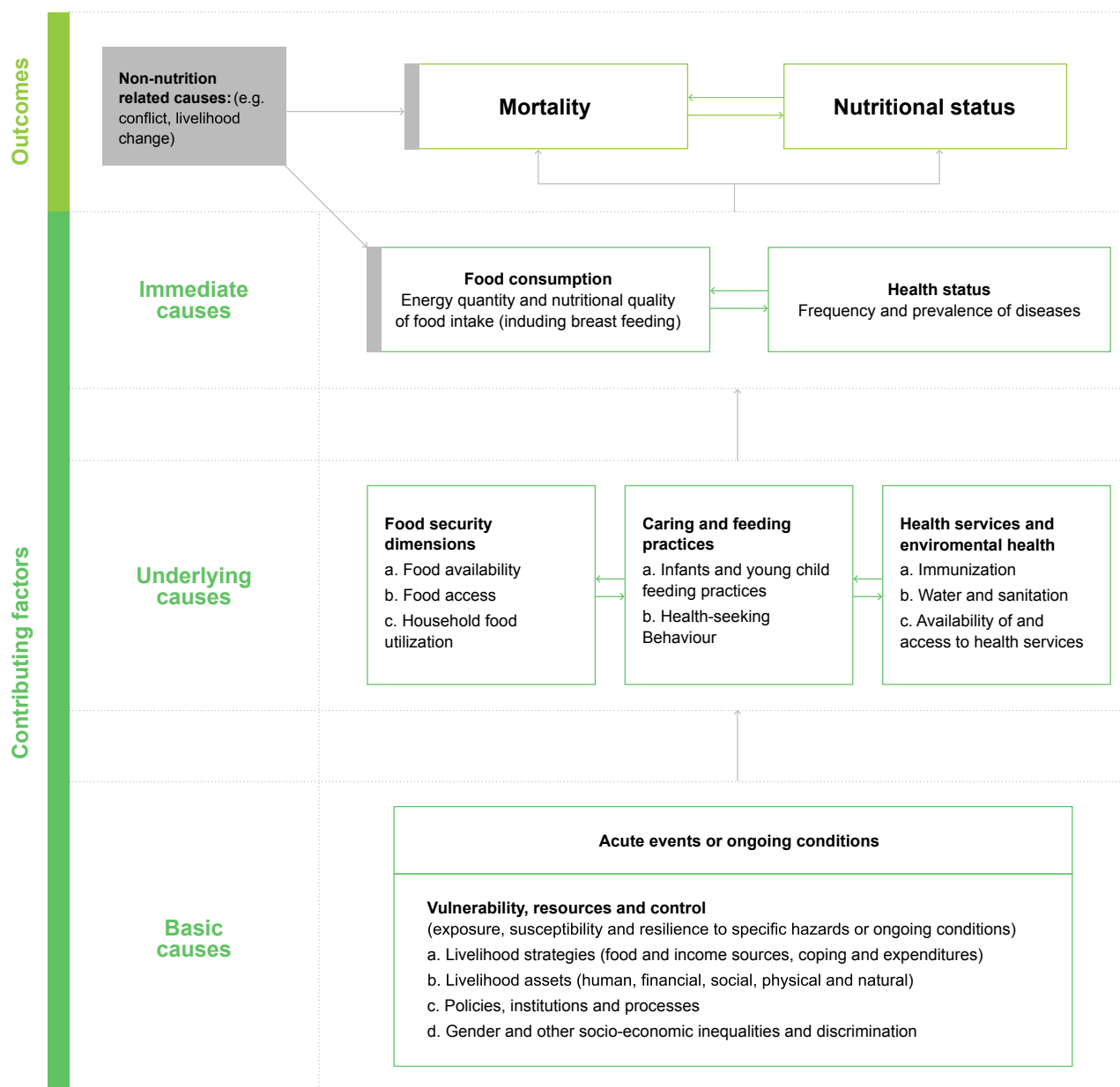
Starting with the Global Nutrition Cluster's *Surveys Database (Version 2 – April 2020)* in Excel, NIS TWG members can adapt and customize this database to meet the needs and demands of the country's context. It should include the following types of surveys: anthropometric, IYCF, and micronutrient as 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 2: KEY COMPONENTS OF THE IPC ACUTE MALNUTRITION ANALYTICAL FRAMEWORK

This 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

Nutritional status indicators

- Acute Malnutrition
- Chronic Malnutrition
- Micronutrient deficiencies

Mortality indicators

- Crude Death Rate
- Under-five Death Rate

Contributing factors

Immediate Causes⁴⁴

- **Food Consumption:** Minimum Dietary Diversity in women and children, Minimum Meal Frequency, Minimum Acceptable

⁴⁴ 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 weekend ability to engage in productive activities.

Diet, Exclusive Breastfeeding 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

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

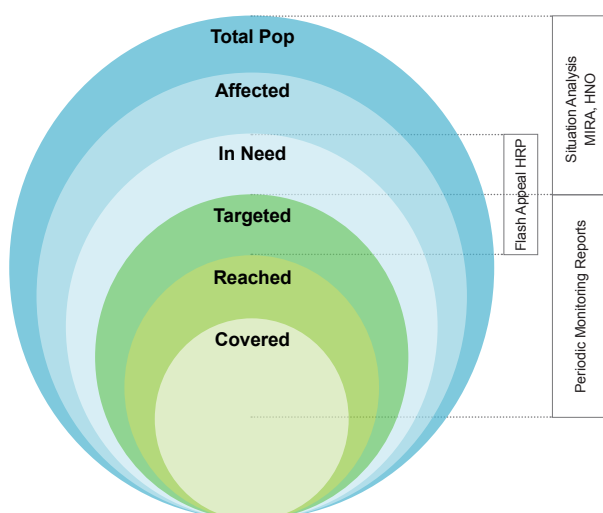
- **Acute events or ongoing conditions** (natural, socio-economic, conflict, disease and other)
- **Vulnerability, resources and control:** livelihood strategies (food and income sources, coping, and expenditures); livelihood assets (human, financial, social, physical and natural); policies, institutions and processes; gender and other socio-economic inequalities and discrimination.

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

ANNEX 3: 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 service⁴⁵ 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.

Figure: Representation of overall humanitarian population figures categories

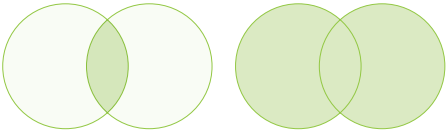


During the process of HNO development, it is important all sector and inter-sector figures are ALL based on the same conceptual approach to ensure comparability and consistency. For example, total population and population affected should be the same for all nutrition calculations and should be in line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

⁴⁵ Especially IYCF services need always to be specified: what are the services and who are the ones in need or who are the recipients: PBW, 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
Total Population	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)
Affected	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: • Being in close geographical proximity to a humanitarian situation; • Physically/emotionally impacted, including exposed to a human rights violation/protection incident; • Experiencing personal loss or loss of capital and assets as a direct result of the crisis (e.g. family member, livestock); • Being faced with an immediate threat from a humanitarian situation. 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. “Affected” = sum of displaced (IDPs, refugees, asylum seekers) and non-displaced (host and non-host) persons	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.)
In Need (PiN)	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: • Whose physical security, basic rights, dignity, living conditions or livelihoods are threatened or have been disrupted, AND • 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. 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.	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. 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.
	Number of people in need facing humanitarian access constraints (i.e. how many from the PiN are accessible).	All 89,250 in need of acute malnutrition treatment do not face humanitarian access constraints.
Targeted	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).
Reached	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.  Diagram 1. Difference between “Reached” and “Covered” ‘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).	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.
Covered	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.

ANNEX 4: 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.

ANNEX 5 : TEMPLATE FOR THE NUTRITION SECTOR NARRATIVE INPUT TO THE HNO

1. Introduction and Context

- Briefly describe the nutrition situation in the country and the broader humanitarian context.
- Define the geographic areas affected by malnutrition (e.g., regions, states, or administrative units).
- Identify key population groups impacted (e.g., children under five, pregnant and breastfeeding women).
- Mention any relevant crises or emergencies (e.g., conflict, displacement, economic collapse, health system breakdowns).

2. Current Nutrition Situation

- Report the prevalence of Global Acute Malnutrition (GAM), Severe Acute Malnutrition (SAM), and Moderate Acute Malnutrition (MAM).
- Include regional and localized malnutrition rates, and highlight hotspots.
- Describe the situation of key vulnerable groups (e.g., IDPs, returnees, and host communities).
- Provide data on key nutrition indicators (e.g., infant and young child feeding practices, minimum acceptable diet coverage).

3. Contributing Factors to Malnutrition

- Discuss how factors such as conflict, food insecurity, and public health crises contribute to malnutrition.
- Describe the impact of a collapsing health system, poor feeding practices, or other contributing elements.
- Include any relevant data on infectious disease outbreaks or economic shocks affecting nutrition.

4. Humanitarian Response and Gaps

- Summarize ongoing nutrition programs and interventions in place.
- Mention gaps in program coverage, challenges faced in reaching affected populations, and coordination efforts.
- Provide details on partnerships, such as those between humanitarian actors, governments, and local organizations.

5. Projections and Future Needs

- Highlight seasonal trends in malnutrition, such as peak periods during the lean season.
- Provide projections for children under five and pregnant and breastfeeding women expected to face acute malnutrition.
- Outline the potential consequences of unmet needs and the risks faced without sustained support.

6. Data Sources and Methodology

- List key data sources used for the analysis (e.g., nutrition surveys, health facility data).
- Briefly explain the methodology used for estimating People in Need (PiN) and severity.
- Acknowledge any limitations in data collection or analysis.

7. Conclusion and Recommendations

- Summarize the key findings from the analysis.
- Provide actionable recommendations for addressing the nutrition crisis.
- Include a call to action for timely interventions and coordinated efforts.

