Evidence for IPC Acute Food Insecurity classification in the context of COVID-19 pandemic - i.e. when normal field data collection is not possible

IPC should not be promoting large-scale face-to-face surveys for IPC classification at the time of the pandemic. Rather, other sources of evidence have been identified that can be used as per the IPC Technical Manual v3.0 guidance. Even without current household surveys, IPC acute food insecurity classifications can still be completed if one or more of the conditions below are met. Although only one of them is necessary to meet minimum evidence requirements, it is strongly recommended that at least two of them are available to increase the robustness of analysis.

A. **Collect outcome evidence on food consumption and livelihood change by Computer Assisted Telephone Interviewing** with at least 90 cases with more than 60% of households owning an operating phone (e.g. MVAM) (Method Scores M1). If CATI is used, existing systems should be scaled up and expanded to include randomly sampled households (current emphasis is often on beneficiary monitoring). At least 2 outcome indicators should be collected, if possible, in order to enable estimation of populations in different Phases.
B. **Use Household Economy Approach** - either based on a full LIAS or scenario building (scenario building does not allow population tables to be developed - overall national or aggregated number can nevertheless be developed). Up to date information is required on different indicators, e.g. production, shocks and food prices in order to run outcome analysis. Baseline can be older than 10 years where there have not been significant changes in livelihoods. → Ask FEWS NET and Save the Children to support HEA calculations.
C. **Inferred estimates of evidence collected within 6 months** (12 months for unimodal) - can be used in countries where data has been collected in past months, e.g. Zimbabwe. There are also countries that have collected data quite recently (prior to any potential movement restrictions) and have data from the same season that can be used for analyses. These countries include e.g. Afghanistan, Madagascar, Sudan, Burundi and El Salvador.
D. **Use historical evidence of outcomes** with M1 collected during the season of analysis from similar years in the last 5 years; only to be used in the absence of significant unusual shocks. This evidence can come from only one similar year, although evidence from more similar years is preferred. To be used among years that did not have significant different shocks, whereas continued typical shocks (e.g. usual level of conflict) does not prevent use of historical evidence.
E. **Utilize Protocols for Areas with Limited or No Humanitarian Access to collect data**. For example, in case of movement restrictions countries can proactively plan to use evidence with minimal field data collection. The vulnerability of populations to COVID-19 infections in countries in which IPC will be conducted calls for alternative methods of data collection further to face-to-face household interviews and anthropometric measurements.
    a. **Minimum evidence level includes at least two outcomes with R0 evidence** (need to add nutrition or mortality in addition to evidence on food consumption and/or livelihood change.)
        i. For food consumption (and/or livelihood change) can use CATI with lower sample size from at least 3 sites within an analysis area

ii. For nutrition can use historical evidence on GAM from at least 2 similar years in the last 5 years - only to be used in the absence of any unusual shocks, or to use inferred estimates of GAM by WHZ evidence collected within 6 months (12 months for unimodal) - can be used e.g. in Zimbabwe.

The guidance above on use of nutrition evidence applies to all classifications, also to those where protocols on areas with no or limited access are not applied.

For all the classifications, the following evidence use should be maximized:

b. **Maximize use of contributing factors:** Expand to on-line dashboards and other data sources, especially in terms of inference of outcomes.
c. **Maximize inputs during analyses/KII/feedback from local staff/officers** e.g. collecting data on market prices and market conditions, admissions to health clinics/treatment centres, crop conditions, and population and livestock movements.