



Food insecurity/drought

Last update: 2022-03-22

Key facts

- Persistent food and nutrition insecurity continues to be a chronic problem globally. Almost half of deaths (45 per cent) among children under the age of five years around the world are linked to undernutrition (wasting, stunting, underweight).
- Drought is the most common cause of food shortages. Other underlying factors include conflict, poverty, floods and lack of agricultural infrastructure. Drought is exacerbated by environmental degradation and climate change.
- One of the main concerns with food insecurity is insufficient nutrient intake and subsequent malnutrition. Children and adults who are malnourished have an increased risk of severe forms of infections, and higher rates of morbidity and mortality.
- Unlike rapid onset disasters, food insecurity has a gradual or slow onset. Response to food insecurity includes nutrition-specific interventions aimed at preventing or treating acute malnutrition, while including actions to address any existing drought and food insecurity.

Main health impacts

Health concern	Risk factors
Malnutrition including micronutrient deficiency	Insufficient nutrient intake, increased vulnerability to infection, morbidity and mortality. Vulnerable groups include children under five years, pregnant and lactating women (PLW), people with chronic illness such as HIV and tuberculosis and the elderly.
Diarrhoeal diseases	Limited access to water supplies, hygiene and sanitation services can lead to diarrhoeal diseases.
Respiratory illnesses and skin diseases	Significant population displacement following drought and overcrowded, communal emergency shelters, coupled with poor hygiene can lead to respiratory illnesses or skin diseases.

Priority actions for teams with community

and public health response capacity

<p>Immediate steps</p>	<ul style="list-style-type: none"> • Nutritional assessment (Note: This requires technical expertise in nutrition programming). • Identify key disease hazards and implement corresponding prevention and preparedness measures, in particular health hazards related to poor WASH services and to vaccine-preventable diseases.
<p>Surveillance</p>	<ul style="list-style-type: none"> • Assess existing surveillance mechanisms (if any). Determine, if there is a need, the extent to which the National Red Cross Red Crescent Society could feasibly support community-based surveillance efforts. If necessary, set up a community-based surveillance system. • If vector control is needed, consider household vector surveillance and community clean-up activities for vectors and breeding sites to reduce vector density.
<p>Community-based action and social mobilization</p>	<ul style="list-style-type: none"> • Screening for malnutrition (including corresponding community engagement and mobilization), to facilitate early case finding, referral to the community-based management programme, and effective follow-up measures at the community. Note: This is only appropriate if there is an existing Community Management of Acute Malnutrition (CMAM) programme that provides care for severe acute malnutrition (SAM) to which volunteers can refer cases. • Implement Risk Communication and Community Engagement (RCCE) for prevention of diarrhoeal disease, skin and eye infections. • Promotion of infant and young child feeding (IYCF) practices. • Ensure access to mental health and psychosocial support (MHPSS) services for community members and staff/volunteers which may include (but are not limited to): regularly assessing MHPSS needs; providing information on the situation regularly in cooperation with authorities; training volunteers for the provision of psychosocial support (PSS); using mobile teams providing a range of support; embedding PSS into evacuation centre/shelter facilities; providing special support to vulnerable groups; working closely with authorities in family tracing; coordinating points for further care. • Ensure procedures are in place to safely manage human and animal corpses. • Identification in the community of cases of high-risk diseases (see list of disease tools below) and referral to pre-identified health structures. This requires a prior elaboration of a referral pathway, that is, mapping of existing primary health facilities, and assessment of minimum quality care standards and accessibility (including geographic and cost-related barriers). • Social mobilization for emergency vaccination campaigns as needed.

For teams with additional clinical capacity

Please always refer to the appropriate local or international guidelines for clinical management.

Important primary health care interventions during droughts and food insecurity periods

- Specific primary care interventions for diarrhoeal diseases, respiratory tract infections, vector-borne diseases, noncommunicable diseases as well as other communicable diseases.
- Continuity of core service delivery at primary health care structures including maternal and child health.
- If disrupted, advocate and/or support authorities to ensure access to services and medication for patients with noncommunicable diseases and who require palliative care.
- CMAM which includes: community outreach and mobilization; inpatient management at a stabilization centre for SAM cases with complications; outpatient management for SAM cases without complications; and supplementary feeding programmes for moderate acute malnutrition (MAM) cases without complications. Implementation of the various components of CMAM can vary across geographic areas and implementers.
- Vaccination in children (as part of malnutrition prevention strategies).

Disease tools that may be relevant

- > [Hepatitis A](#)
- > [Measles](#)
- > [Malaria](#)
- > [Cholera](#)
- > [Acute respiratory infections \(ARI\): Influenza \(avian and seasonal\)](#)
- > [Diphtheria](#)
- > [Diarrhoeal diseases](#)
- > [Hepatitis E](#)
- > [Meningococcal meningitis](#)
- > [Pertussis \(whooping cough\)](#)
- > [Poliomyelitis \(polio\)](#)
- > [Rubella](#)
- > [Typhoid fever](#)