**Mading Nhial Wal**

**Assignments 1**

1. Discuss rationale for general food distribution

* **General food distribution (GFD) refers to the food rations given to populations affected by emergencies**. Food rations usually include dry items such as cereals, pulses, and oil, and are a response to populations needs. The design of the food basket is based on a comprehensive assessment of economic, nutritional, or livelihood interventions and needs to consider the population characteristics and availability of food items. Food distribution can be implemented as **take-­‐home rations** or through **large-­‐scale cooked food distribution**; each of these methods requires specific planning and monitoring to guarantee success.

* Monitoring of food distribution is important to assess whether the objectives are being achieved, and to make all the necessary modifications to the food basket.

* **General food distribution (GFD) is the term used for food rations that are given out to selected households affected by an emergency**. The food ration consists of a number of items: the minimum three are cereal, pulses and oil, but items such as salt, sugar, fresh vegetables, canned meat, or fish can be added. The general ration is normally delivered as a package of dry items.

* GFD is used to respond to an assessed food need based on livelihood, economic, or nutritional indicators or to vulnerable demographic groups identified as in need of food. The objectives of a general food distribution arise from the definition of need and could vary from **saving lives and protecting the nutritional status of a population to protecting and rehabilitating livelihoods**. Aside from the energy content of the diet, a well-­‐balanced ration should provide a combination of protein, fat, vitamins, and minerals. **Rations should be planned to make up for the differences between the nutritional requirement and what people can provide for themselves**. Where people have no access to food at all, the distributed ration should meet their total nutritional requirements. Water is not considered a food and is not distributed within a GFD ration. Figure 1 provides a quick overview of GFD in emergencies.
* A general food distribution, a standard food ration5 is provided to every beneficiary without distinction.

1. Explain different livelihood approaches in emergencies

Livelihoods *more broadly*, by referring to the comprehensive framework that comprises individuals’ spiritual and human, social, political, financial, natural and physical capital or assets,

A livelihood comprises the capabilities, assets (including both material and social resources) and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks, maintain or enhance its capabilities and assets, while not undermining the natural resource base A livelihood is sustainable when it can withstand and recover from a shock with the same or improved capabilities as before the shock, while maintaining the natural resource base.

The sustainable livelihoods framework underlines the fact that households rely on more than one type of capital, and vary the activities and their importance depending on the context and the livelihood outcomes pursued. Diversification of livelihood strategies is also key for sustainability.

Natural, conflict‑related or slow‑onset crises affect people’s livelihoods in various ways. Emergency response is guided by The Sphere Project’s two core beliefs: first, that those ‘affected by disaster or conflict have a right to receive protection and assistance to ensure the basic conditions for life with dignity’; and second, that ‘action should be taken to alleviate human suffering arising out of disaster or conflict.’3

Humanitarian programs should aim to restore all components of the livelihoods framework to achieve a sustainable recovery for affected households. However, often due to competing priorities and limited resources, humanitarian assistance prioritizes some components of the livelihoods framework over others. Thus, the remaining gaps hamper sustainable livelihood recovery.

This does not mean that a single humanitarian program should aim to cover all the needs; but such programs should have a comprehensive understanding of the existing capacities and needs of affected households to put in place programs that aim at sustainability.

1. What are the best ways of preventing communicable diseases? Explain five

* Effective prevention and control measures can interrupt faeco-oral transmission of infectious agents by targeting the different routes of transmission mentioned earlier and summarised in Figure 32.2. As you remember, the sources and modes of transmission to be targeted are: hands, food, water, utensils, soil and flies contaminated with faeces. Most of the prevention and control measures are relatively simple and easy to apply. You have an important role in educating your community by explaining what simple steps can be taken to reduce the risk of faeco-oral diseases. So, in addition to the effective treatment of cases, you need to help families put into effect the measures outlined below.
* Using the toilet and not washing the hands afterwards
* Cleaning a child’s bottom after defaecation
* Shaking hands with someone whose hand is already contaminated
* Diarrhoeal diseases are the second largest cause of death globally among children aged under five years – only pneumonia and other acute respiratory infections (ARIs, the subject of Study Session 35) account for more child deaths worldwide. The World Health Organization (WHO) estimates that 1.5 million children in this age group die from diarrhoeal diseases every year, almost half of them in Africa. The most vulnerable children are the youngest ones, particularly before their second birthday. In Ethiopia, 23% of deaths in children aged under five years is due to diarrhoeal diseases – around 73,000 such deaths every year. Diarrhoeal diseases kill more children than malaria, HIV/AIDS and measles combined.
* For patients with diarrhoea, especially children, the core measure in the treatment is rapid and adequate **rehydration** – fluid replacement – usually by drinking fluids. In the most severe cases the fluid has to be given intravenously (directly into a vein). Rehydration is the most important component of treatment for diarrhoea and it should be started as soon as possible and continued for as long as necessary. The best fluid to use to avoid the dangers of dehydration is a solution of **oral rehydration salts** (**ORS**) – a packet containing sugar and salts in the correct amounts, which the caregiver dissolves in clean drinking water. The sugar and salts

### Ways to prevent faecal contamination of hands

| A | Wash hands with soap and clean water: | |
| --- | --- | --- |
|  |  | |
|  | A1 | After defaecation, or cleaning the bottom of a child, or changing an infant’s nappy (diaper). |
|  | A2 | After working with soil, or after children have been playing on soil, where there has been open defaecation by people or animals. |
|  | A3 | Before preparing food or eating. |
| B | Cut fingernails and avoid putting fingers into the mouth. | |

1. Discuss thecommon emergencies common in the African content in the past twenty years.
2. **3 million flee conflict to find refuge in Uganda**

Sub-Saharan Africa hosts more than 26 percent of the world’s displaced population (UNHCR). The number has soared in recent years. Conflict is the main driver of displacement and movement of refugees in Africa.

Uganda is now one of the largest refugee-hosting countries in Africa, with an estimated 1.3 million people fleeing conflict from neighbouring South Sudan, DRC and Burundi.

In 2018, Uganda Red Cross has been responding to the immediate needs of many still crossing the borders, particularly from South Sudan and DRC, targeting 234,000 people affected.

1. **Zimbabwe fights typhoid and cholera outbreaks in a matter of months**

*Photo: Zimbabwe Red Cross*

More than 1,000 Red Cross volunteers fanned out through the densely populated suburbs of Zimbabwe’s capital, Harare, in a bid to contain a deadly cholera outbreak in September. The outbreak, which started on 6 September, killed 50 people and had 8,535  cumulative cases.

“Most of the areas affected have already been dealing with an outbreak of typhoid. So, this is a double punch for them, and it shows the weakness of water systems even here in the capital,” said Maxwell Phiri, Secretary General of the Zimbabwe Red Cross.

Since the outbreak began, Red Cross volunteers have been providing water treatment, tracking and referral services, and have been going door-to-door to provide families in high risk areas with information about cholera prevention. More than 500 volunteers in Midlands, Manicaland, Masvingo and Mashonaland Central provinces were also activated in an effort to halt the spread.

Cholera remains a major issue across Africa – yet, it is completely preventable. In the past two years, IFRC supported the response for seven major cholera outbreaks in the region.

1. **Droughts and conflict propel Sahel into deeper hunger crisis**

*an*[*emergency appeal of 1.6 million Swiss francs*](http://www.ifrc.org/fr/publications/FR-Appeals/?ac=&at=0&c=&co=SP165MR&dt=1&f=&re=&t=&ti=&zo=)*to support the Mauritanian Red Crescent Society to provide immediate assistance to 17,400 people.*

*IFRC/Moustapha Diallo*

Some 5.8 million people across Burkina Faso, Mali, Mauritania, Niger, Senegal and Chad are struggling daily to meet their food needs. This includes 1.6 million children suffering from severe acute malnutrition (UN Report, June 2018).

While food insecurity is largely due to poor rainfall and drought, climate change ushers in more extreme weather patterns – at not only an increasing number but also in scale. We will see an increased risk of crop failures and, consequently, the increase in the number of people requiring humanitarian aid.

IFRC is responding to food insecurity across the region, not only providing emergency relief, but also strengthening local communities so they are more resilient to future disasters. Despite our efforts, there are still many gaps that need to be addressed, including the lack of funding to support local actors, as well as crisis preparedness and prevention activities.

1. **Floods in Nigeria**

*Photo caption: Udeanyinya John speaks with a volunteer from Nigerian Red Cross in his submerged town. He has come back from a displacement camp to see what is left of his home and farmland. “You are the first to come here, we are only helping ourselves right now. We share the food, the little food we have left,” he said. Please do not forget about us.” IFRC/Corrie Butler*

In August and September, Nigeria’s two major rivers – Niger River and Benue River –overflowed, devastating communities nestled near its banks. Nearly 200 people have been killed, and damage to homes, farmland and livestock has been extensive. In all, an estimated 1.9 million people have been affected.

Since the flood hit, Nigerian Red Cross has been in affected communities, helping with evacuations, providing search and rescue, conducting first aid and psychosocial support, displacement camp management as well as sensitizing communities on good hygiene practices in the camps. With the support of the International Federation of the Red Cross and Red Crescent Societies (IFRC), Nigerian Red Cross is targeting 300,000 people affected by flooding this year.

1. **DRC tackling its biggest Ebola outbreak in history**

*Photo caption: Volunteers in North Kivu in a training on safe and dignified burials. ICRC*

The Democratic Republic of Congo (DRC) has been tackling its worst Ebola outbreak in history in the North Kivu. This is only months after tackling the ninth Ebola outbreak in western DRC.

This might be the most complex Ebola outbreak response in history, with the virus found in an area where there is complex and violent conflict. It is a deadly combination for responders on the ground for two reasons: first, the violence is making it difficult – at times even impossible – for humanitarians and health workers to reach remote and at-risk communities. Second, the legacy of violence means that even when humanitarians can reach communities, people are often scared and suspicious of the help being offered. It is a vicious cycle.

More than 180 Red Cross volunteers have reached nearly 160,000 people in communities across North Kivu Province to provide lifesaving information and dispel false rumours about Ebola. Specialist Red Cross teams have conducted over 235 safe and dignified burials which are crucial to reducing the spread of the disease.

1. Describe the roles of the UNITED NATIONS agencies that are involved in emergency response

* At its October 2002 session (CEB/2002/5, paras. 30-35)) HLCM noted that planning for Y2K and the events of 11 September 2001 had brought to light a number of concerns relating to organizations' preparedness to meet emergencies and to put business back on track after catastrophic events. Questions related to the perception of risk, threat scenarios, definition of mission critical elements, immediate response capacity and longer-term recovery strategies had to be resolved for all organizations. HLCM reviewed an initial report prepared by UNICEF based on their experience in formulating a Risk, Crisis and Disaster Management Plan, which raised policy issues for the Committee's consideration in relation to emergency management, including the phases of preparedness, response and recovery. The report underlined the strategic management imperative that senior executives be appointed and empowered to respond to any form of risk, crisis or disaster. The report concluded with an invitation to HLCM to consider four recommendations, as follows:
* that the HLCM, on behalf of CEB, endorse the principle that all UN organizations should develop a Risk, Crisis and Disaster Management Plan;
* (b)     that the Secretary-General and Heads of Agencies, thereafter, should consider mandating the development of their organizational 'Plan' in the shortest possible time frame, and should ensure that necessary financial, human and logistic resources were made available for the process;
* (c)     that the HLCM consider seeking the creation of an Inter-Agency Task Force in collaboration with the UN Department of Management (Task Team), in order to develop a definitive Framework with standardized terminology and format. Further, that this Task Force act as a reference point for organizations, providing technical advice and guidance and ensuring that all 'Plans' were as far as possible capable of being integrated and executed concurrently; and
* (d)     that the subject remain on the HLCM agenda with progress reports being presented by organizations to the Committee at its' next session.
* HLCM added a fifth recommendation: (e) that at all stages of the process, the highest priority had to be afforded to communication to staff in particular.
* (2)     Following UNICEF's presentation a number of organizations provided extensive commentary on their experiences in this regard. HLCM welcomed the comprehensive and thought-provoking presentations and noted that this was a sharp wake up call for all organizations and had already prompted many to review the status of their risk assessment and contingency planning. HLCM endorsed the recommendations (subject to a reservation by FAO on para. (2)(c) above) with the following comments with regard to future action:

common approaches needed to be developed at the global level and at each duty station;

* (b)     organizations would have to assess in detail the threats they faced including the risk of loss of key information;
* (c)     it was essential for organizations to work together to draw up a list of the collective assets of the organizations including aircraft, helicopters, global communications networks, field office support, etc., currently maintained by UN system organizations that could be drawn upon in the event of a disaster;
* (d)     organizations should determine exactly what were their mission critical activities and the means by which such activities could be continued in the event of a disaster resulting from any of the threats they had identified;
* (e)     within this framework, the responsibility of the host government, especially in assuming their costs for certain aspects of disaster preparedness, should also be assessed;
* (f)action plans had to be "living" mechanisms supported by regular review and testing and capable of being activated instantly;
* (g)     while contingency plans would contain an assessment of the minimum an organization would have to do to meet any threat, staff safety had always to remain a paramount consideration; it could not be subject to a "minimalist" approach; and
* (h)     experience showed that any structures created to meet disasters or crises should designate clearly the roles and responsibilities of a small team with a short chain of command who were empowered to take action and define how and where a command centre(s) would be established.
* (3)     In HLCM's view, the goal of the next stage of the consideration of the matter should be to determine how, in the broadest sense, organizations could help each other in the event of any disaster. Most immediately the need was to determine collective assets. To this end each Organization would need to determine what were its own key assets. The provision of financial resources was as always a concern especially in an era of zero nominal growth budgets but as UNICEF stated in the report "if we are to ensure that we can maintain our ability to operate no matter what befalls us, then there is no real alternative but to invest for the future in this manner." There was also evidence that the tragic events of 11 September 2001 had sensitized governing bodies to the need for action to avoid threats and that financial support for this stand alone item was not always as difficult as might be anticipated. HLCM decided to review the matter regularly and invited its secretariat, with input from agencies who had advanced furthest in terms of emergency preparedness, including UNICEF, UNDP, UN and IMF, to prepare a report for its next session incorporating the substance of a policy framework within a "road map" of future HLCM policy direction, which would lead towards the development of a common action plan.
* (4)     At its June 2003 session (CEB/2003/3, para. 26) HLCM, noting that Emergency Preparedeness and Business Continuity Planning (CEB/2003/HLCM/R.5)was a matter of work in progress, expressed appreciation for the information provided and congratulated those organizations that had taken action to develop emergency preparedness plans. It encouraged those who had not yet done so to move forward thereon and invited also those that had not yet done so to report to the secretariat on their common assets.
* (5)     At its 6th Session (October 2003: CEB/2003/5, para. 14) HLCM, after being provided with an oral report on the development of the UN contingency planning and comprehensive emergency preparedness plan,
* welcomed the UN’s offer to share the template of its plan and to help other organizations with the development of their plans,
* (b)     noting that most plans should be location-specific, underlined the urgent need to ensure that risk assessments were carried out for headquarters as well as for field duty stations and
* (c)     decided to review, in 2004, the status of the development of organizations’ plans.

In this context, the Committee requested its secretariat to undertake a survey for presentation to the Committee at its eighth session.

* (6)     At its 10th Session (October 2005: CEB/2005/5, paras. 30-34) HLCM reviewed WHO’s assessment of a pandemic risk with regard to the Avian Influenza. While the timing and degree of severity were still uncertain, the pandemic risk was considered to be great. At the time, alert phase 3 had been declared. Only 40 countries currently had a pandemic preparedness plan and WHO had issued guidelines and provided technical support to help countries develop national pandemic preparedness plans. In addition to preparedness plans, the stockpiling of antiviral medication and a global action plan to increase influenza vaccine production capacity in both developed and developing countries were of critical importance. A “United Nations Medical Services Staff Contingency Plan Guidelines for an Influenza Pandemic” had been prepared by the UN Medical Directors Group with technical input from WHO. The Plan set out measures and actions required of UN Medical Services, UN Resident Coordinators, UN Country Management Teams, Crisis Management Teams, UN Designated Officials, UN Security Management Teams, individual agencies and staff members. Measures were also needed for headquarters duty stations. A Task Force had been established by the Secretary-General, chaired by the Deputy Secretary-General, to monitor the situation and update the Guidelines as the situation evolved. With regard to the provision of antiviral and antibiotic medication and personal protective equipment, WHO emphasized that the guidelines made it clear that organizations should work with host countries’ health systems but should not rely on the host country for ensuring that measures were in place. In this regard, WHO’s contacts with the suppliers could be used by organizations (as had been done by the United Nations which had purchased 5,000 doses of Tamiflu) to obtain antiviral medication. The Committee expressed its strong support for the contingency plan and for the coordinating role of the Deputy Secretary-General and emphasized the importance of additional communication and coordination on the subject. It requested the Deputy Secretary-General to convene a video-conference with HLCM and the medical directors as soon as possible to discuss further the preparedness plans and measures.
* (7) At the eleventh meeting of the HLCM (CEB/2006/3, paras.39-41), the HR Network briefed the Committee on guidelines for dealing with an influenza pandemic, which would feed into the UN System Planning and Preparedness Guidelines.  Work was being undertaken on the determination of critical staff.  The Committee thanked the HR Network and requested that it finalise the administrative guidelines that would serve as a framework applicable to all UN Staff.
* (8) The UN and New York Working Group had produced thorough guidelines for Avian flu pandemic planning (CEB/HLCM/2006/11).  Harmonisation on issues such as determination of critical staff, modalities of absence for non critical staff, compensatory time off for critical staff, annual, home and sick leave, and health and life insurance was considered important.
* (9) At its meeting in Vienna, March 2006 (CEB/2006/HLCM/12), the HR Network requested that the CEB develop generic guidelines after the New York model and requested those organisations that had reserved its position to convey it quickly to the CEB Secretariat.
* (10) At its eighteenth session (CEB/2009/6, para.22), the Committee endorsed the formation of a Rapid Response Team to support country offices in the event of a crisis.   
  During its eighteenth session (CEB/2009/6, paras.83-84), HLCM requested the United Nations Humanitarian Air Service (UNHAS) to open a dialogue on UNHAS in the context of the Inter-Agency Standing Committee (IASC), and to revert back to the Committee at a later date. The Committee also requested UNHAS to consider the roles and responsibilities of ICAO with respect to UNHAS, with particular attention to international Aviation Standards (AVSTADS).
* (11) During the HR Network’s videoconference in October (CEB/2009/HLCM/HR/48, para.4), the CEB Secretariat agreed to develop the Action Plan on Rapid Response Administration Personnel as part of Immediate Crisis Response, in consultation with WFP and UNICEF by the end of 2009.
* (12) At the HR Network’s nineteenth session (CEB/2010/HLCM/HR/18, paras.71-74), the CEB secretariat prepared a proposal on the implementation aspects of a “Rapid Response Personnel” mechanism as a follow up to the document submitted to HLCM in September 2009. The ASG, OHRM proposed that the UN, the CEB Secretariat and the Field Group worked on the details of linking the Rapid response Personnel to the proposed Support Unit.  
  The Network agreed with the proposal made by the ASG, OHRM.
* (13) At its nineteenth session (CEB/2010/3, paras.32-39), the Committee requested UN/DFS and UN/DM, with the participation of all organizations/departments that may be interested in contributing their experiences, to prepare a report on ‘Lessons Learned on the UN system’s immediate response mechanisms in support of staff and their families’ for consideration and discussion at the HLCM fall 2010 session.
* (14) At its twentieth session (CEB/2010/HLCM/HR/35, paras.84-85), the HR Network agreed to focus on sharing practices between organisations so that RRT (Rapid Response Team) members would be informed about processes in all agencies; Further agreed to present a briefing note focusing on achievements to date to HLCM’s Fall 2010 session.
* (15) At the Committee’s twentieth session (CEB/2010/5, paras.131-134), the Under Secretary General for Management presented a briefing on the study undertaken by the Department of Management (DM) on lessons learned from the Haiti crisis response. She highlighted six issues related to the support to staff and their families in emergency situations.  These included:  
      1) Capacity building,   
      2) Accounting of staff,   
      3) Medical response,   
      4) Family focal points,   
      5) Peer support programme and   
      6) United Nations Memorial and Recognition Fund.  
  The Committee requested that the UN’s new Emergency Support Team and the HR Network Rapid Response Team, once established, should leverage each other’s capacities and avoid a duplication of efforts.
* (16) At its 21th session in Paris (CEB/2011/3, paras. 130-133), HLCM acknowledged with appreciation the work undertaken by the Medical Directors as a significant step towards an improved UN capacity to prepare for, respond to, and follow up after medical emergencies and mass casualty events.
* (17) At its twenty second session (CEB/2011/5, paras.30-47), the Committee:

•    Expressed appreciation to the United Nations Medical Emergency Response Team (UNMERT) for its prompt and effective action.  
•    Requested the Finance and Budget Network to examine available or new funding options for emergency needs.

1. Discuss factors that trigger nutrition emergencies

# Causes of food and nutrition emergencies

Access to food and adequate nutrition is critical to survival in an emergency situation. Malnutrition can be the most serious public health problem in an emergency. A food emergency exists if depleted food supplies are not replaced in the short term by food aid. A **famine** occurs in a population whose food consumption is reduced to the extent that the population becomes acutely malnourished and there is a rise in mortality. A **nutrition emergency** exists when there is the risk of or an actual rise in mortality due to acute malnutrition. A **complex emergency** is an internal crisis in the state where the capacity to sustain livelihood and life is threatened by primarily political factors and, in particular, high levels of violence. In complex emergencies, the focus is typically short term in response to changing circumstances such as movements of armies and bandits.

Food and nutrition insecurity result from the following:

* A natural disaster due to climatic or other environmental conditions such as drought, flooding, major storms or insect infestation such as locusts; global warming might

also contribute to an increase in droughts and floods;

* Armed conflict, war or political upheaval;
* Disruption or collapse of the food distribution network and/or the marketing system of a population. This might be the result of an environmental, political or economic crisis;
* Lack or disruption of the provision of emergency food distribution to a population experiencing a food shortage;
* HIV/AIDS;
* Extreme poverty of marginalised populations e.g. the elderly and urban slum populations who have poor access to water, sanitation, health care and livelihoods.

A **drought** is any unusual, prolonged dry period that reduces soil moisture and water supplies below the minimum level necessary for sustaining plant, animal and human life. Droughts occur because of low, sporadic or late rainfall and as a result of human activities such as deforestation, overgrazing by livestock, erosion, lack of soil conservation, reliance on the cultivation of single cash crops and traditional farming methods such as slash and burn.

The effects of drought are as follows:

* Overtaxing and drying up of water supplies resulting in the loss of crops, livestock and the lack of drinking water and water for washing and bathing;
* Crop failure, the depletion of food stocks and grazing for livestock causing temporary migration of families to areas with more pasture for remaining livestock or to cities for alternative sources of income. Livestock are susceptible to heat stress and drought.

Prolonged and repeated droughts may result in permanent changes in settlement, social and living patterns and major ecological changes, e.g., desertification, flash floods and soil erosion.

Most scientists agree that global warming because of increased emission of what are known as greenhouse gases is occurring. Greenhouse gases such as carbon dioxide from car exhaust and other gases from industrial plants and agricultural activities trap heat close to the earth's surface. The effect of global warming is an increase in extreme erratic weather and a rise in sea level leading to coastal erosion. Large-scale changes in rainfall and rainfall distribution will increase the risk in the subtropics of both droughts and floods because it will rain harder when it does rain.

*Investment in increasing agricultural productivity and reducing the vulnerability of livelihoods a vital part of the fight against hunger and poverty. Photo: Yoshi Shimizu / International*

*Federation*

Increasingly however, the main cause of food emergencies is armed conflict, not natural disaster.[[1]](#footnote-1)A Food emergencies due to violent conflict occur when civilian populations flee and/or are cut off from food markets and humanitarian aide or by the deliberate destruction of crops or livestock. Conflicts can create famine by leading to the following:

* Disruption of the agricultural cycle;
* Displacement of farmers from the land;
* Interference in the market;
* Destruction of food stocks and harvests;
* Creation of food shortages that drive prices up to levels that low-income households cannot afford;
* Reducing physical access to displaced populations.

Africa has been home to a disproportionate share of the world's emergencies and has suffered a disproportionate burden of the world's famine-related mortality. Major armed conflict occurred in seventeen countries in Africa during the period 1990 to 2003. Africa, where the prevalence of underweight among children under the age of five is the highest in the world, is especially vulnerable to nutrition emergencies.[[2]](#footnote-2) When a food emergency occurs, malnutrition, the resilience of livelihoods and household food insecurity to some extent predict the severity of the ensuing nutrition emergency and the ability of households to recover.

## HIV/AIDS and household food security

HIV/AIDS among otherwise productive adult members of the household puts a household at high risk of food insecurity. Like households exposed to other food security shocks, households affected by HIV/AIDS resort to coping strategies. When a household income earner becomes too sick to work, the household may be forced to develop knowledge, skills, assets and activities required for a new livelihood so that the household has access to food or income to buy food. Other family members-often grandparents or children- must compensate for the lost income and care for the sick family member. Savings and assets may be depleted while medical costs rise. Children may lose one or both parent and no longer attend school. Orphans might become dependent on other households for their food and survival. Local institutions and traditions are overburdened and break down e.g. food sharing, giving alms, lending money and adopting children-when so many households in one community are affected.

**Food security and**

**nutrition in emergencies**



Like high levels of chronic malnutrition, widespread HIV/AIDS is an underlying factor

that predicts the severity of an ensuing nutrition emergency for populations affected by HIV/AIDS as well as many households. When so many households in a community are affected, HIV/AIDS erodes institutions and traditions normally employed to mitigate food security shocks. Unlike other food security shocks, the effects of HIV/AIDS on the

household are permanent affecting long-term household food security, nutrition, health care and especially the support that is crucial for recovery.

|  |
| --- |
| Drought has been the cause of repeated food and nutrition emergencies in the Horn of Africa in 2000, 2002 to 2003 and 2005 to 2006.  In 2004, tropical storm Jeanne caused dangerous flooding and a food and nutrition [glo2] emergency in the Gonaives area of Haiti.  Flooding, civil strife and economic factors, as well as HIV/AIDS as an underlying factor caused the food and nutrition crisis that affected southern [glo3] Africa in 20012002. |

## Population displacement

Refugees and Internally Displaced Persons (IDPs) have a high risk of becoming malnourished because they are cut off from their land and are restricted from cultivating crops and producing food in the areas to which they flee nor can they find a means of livelihood in urban areas. Millions of people throughout the world are displaced (Table 91). Within the UN system, humanitarian assistance to refugees is the specific mandate of

UNHCR.

Humanitarian assistance and food aid distribution sometimes encourages population displacement and leads to large refugee settlements with high population densities, where the risk of disease epidemics with high levels of mortality is higher than in smaller camps. Whenever possible, assistance with strong referral networks should be provided to populations before they become displaced or to their camps if they are already displaced. Where people have been displaced, the food security of the host population must also be taken into account.

1. Natural disasters (mainly drought) were the main cause of 80% of food emergencies that occurred during the period 1986*–*1991 and the main cause of less than 60% during the period 1992*–*2003. Conflict and economic crises (mainly conflict) were the main cause of less than 20% of food emergencies during the period 1986*–*1991 and almost 40% of those that occurred during the period 1992*–*2003. [↑](#footnote-ref-1)
2. During the period 1990*–*2005 the number of underweight children decreased in all regions except Africa; the prevalence of underweight children under five years of age is 24% in Africa (30.6% in East Africa). [↑](#footnote-ref-2)