LESSON 11: ADDRESS HEALTH NEEDS DURING DROUGHT

Different and specific health needs should be addressed, and existing health infrastructure supported where possible given the extra demands on health services during drought.

Number of documents contributing to the lessons: 43

Average evidence scores of all documents contributing to the lessons: 3.9

Median evidence strength of documents contributing to the lessons: 80%

Health risks rise sharply during drought: from malnutrition and disease outbreaks to reduced access to essential services. This has a particular impact on children, pregnant and lactating women, persons living with disabilities and chronic illness, and older people. Maternal health is among the first areas to decline, with reduced antenatal and postnatal care visits, limited skilled birth attendance and rising risks of complications. A special need during drought is the rise in severe acute malnutrition (SAM) cases, which require immediate rehabilitation. Therapeutic feeding is rarely part of a conventional primary healthcare setup, and will need scaling up through investment in SAM-management programmes and facilities. Heat-related illness can also have an impact in periods of very high temperatures.[6]

While progress has been made in integrating the health needs of women and children, older people and persons with disabilities are consistently deprioritised. Programmes should target the specific health problems of older people, particularly access to drugs. Older adults also face a rising burden of non-communicable diseases (NCDs) such as hypertension, diabetes, arthritis and chronic respiratory diseases, which require consistent treatment that becomes harder to access during droughts. Too often, responses also treat persons with disabilities as a homogenous group, overlooking the wide variation in their health needs and resilience. Health interventions should therefore be designed using existing research and evidence about the particular needs of persons with disabilities and older people, supported by disaggregated data and tailored approaches, to ensure no one is left behind. Health access barriers, including long distances to health facilities, mobility challenges and lack of assistive devices, further exclude older adults and persons with disabilities from essential services. Frequent mobility of pastoralist households during drought also disrupts continuity of care, leading to missed immunisations, treatment interruptions and weak follow-up for chronic and childhood illnesses.

6 Delphi Panel members noted that establishing community cooling points can bring some relief.

Back to summary of lessons

Beyond physical impacts, drought creates significant mental burdens for caregivers, adolescents and displaced families; these are linked to livelihood loss, food insecurity and school disruption. Aid programmes can also unintentionally increase stress, if poorly designed. For example, because women frequently have both caregiving and farming roles, they simultaneously face pressure to farm in difficult conditions and to spend more time caring for sick family members; finding time to participate in a programme becomes yet another pressure. Tailored mental health and psychosocial support (MHPSS) interventions, embedded in community health and education systems, can reduce distress, strengthen family resilience and protect the wellbeing of young people, who are especially vulnerable to climate anxiety and trauma. Humanitarian programmes can unintentionally increase stress when aid is conditional, registration processes are complex or programme participants spend long hours waiting for assistance.

Drought places heavy pressure on fragile health systems, which undermines routine service delivery, including immunisation, antenatal care for pregnant women and routine nutrition screening, as health workers struggle to reach mobile or displaced households. These additional needs should be anticipated in areas prone to drought, including how to surge health capacity. Additionally, health budgets are often reduced or reallocated towards emergency drought response, limiting the resources available for the routine service delivery and strengthening of health facilities. Health-worker shortages worsen as some migrate, are reassigned to emergency duties or leave remote facilities due to poor working conditions. Evidence shows that building on existing government-run health centres is more efficient and sustainable than establishing temporary standalone systems. Strengthening continuity of essential services and securing reliable power, water and medical supplies reduces morbidity and prevents service collapse during prolonged crises.

Back to summary of lessons

RECOMMENDATIONS

- Humanitarian and development actors should integrate health considerations into drought assessments and response planning, recognising the direct and indirect impacts of drought on morbidity, mortality and wellbeing.
- Humanitarian and development actors should support the continuity of essential health services during drought, including primary healthcare, maternal and child health and management of chronic conditions.
- Humanitarian actors should strengthen the integration of health, nutrition and WASH interventions to address the interlinked drivers of poor health outcomes during drought.
- Humanitarian and development actors should invest in community-based and outreach health services to improve access for pastoralists, mobile populations and marginalised groups.
- Humanitarian actors and donors should support health-system strengthening in drought-prone areas, including supply chains, health workforce capacity and referral systems, to improve resilience to recurrent shocks.
- Humanitarian and development actors should strengthen health information systems and disease surveillance to enable early detection of drought-related health risks and timely response.
- Humanitarian actors should ensure that MHPSS needs are considered as part of drought health responses, alongside physical health priorities.

Back to summary of lessons