Health System Strengthening through DDR & CVR

(a) Brief description of the project

The current COVID pandemic has brought to the fore the linkages between peace and security, peacebuilding, social cohesion, and health. In many countries affected by the pandemic and affected by conflict, health systems and health care workers will be critical to the successful containment and management of the virus. However, it is precisely in these conflict-affected contexts that core state and local health functions are depleted and under resourced.

As part of the response to the COVID-19 pandemic, DDRS and the Health Emergencies Programme (WHE) of WHO have embarked on a nascent partnership to provide health guidance for DDR practitioners to ensure that critical DDR activities continue despite the pandemic. In addition, in contexts such as Mali and CAR, Community Violence Reduction (CVR) programming is being retooled to respond to the pandemic. As part of the initial engagement with WHO, it was noted that more could be done - *beyond* the pandemic – to strengthening the linkages between DPO and WHO, in line with the A4P commitments (sub-commitment 13 on protection of civilians; and sub-commitment 32 on greater coherence with UN actors) and Sustaining Peace Agenda:

1. On the one hand, UN DDR processes manage the risks posed by the presence of armed groups in volatile areas, thereby advancing peace and security and creating the conditions necessary for development and lasting health outcomes. DPO/DDRS capacities include expertise in peacekeeping operations (PKOs) and special political missions (SPM) settings; engaging with armed groups; experience in undertaking DDR and CVR programming; and standby capacity to provide specialized support.

2. On the other, under its Health and Peace Initiatives as part of its 13th Global Programme of Work (GPW 13), WHO maintains technical expertise, data, and guidance related to efforts on the promotion of the right to health in conflict settings; improvement of health care services in fragile contexts; community health systems strengthening; and social cohesion through Mental Health and Psychosocial Support (MHPSS). The Health and Peace Initiative is in line with the Sustaining Peace Agenda.

This partnership as well as its outcomes and outputs are therefore organized around leveraging these comparative advantages of both institutions focusing on areas of work where both health outcomes AND peace dividends can be achieved:

(b) Expected Outcomes, Outputs and Proposed Activities

Outcomes	Outputs	Proposed Activities
1. **Improving access to basic health care services in conflict settings:** mental health and psychosocial support to ex-combatants and affected communities through, and as part of, DDR and CVR programming is strengthened.	• Operational guidance on mental health and psychosocial support for ex-combatants as part of the sustaining peace approach. • Finalization of IDDRS module on Health and DDR, which includes section on Health and Sustaining Peace approach.	- Review MHPSS interventions as part of DDR, including the applicability of specialized interventions such as group-based sociotherapy for ex-combatants -focused review on evidence linking MHPSS interventions and recidivism.

	• 3 country profiles including lessons learned exercise where MHPSS has been used successfully (with a focus on approaches undertaken by national health institutions).	-mapping of tools and approaches to enable non-specialized personnel (such as DDR practitioners) to support in the identification, referral, and treatment of excombatants with mental health illnesses (only for low intensity MH interventions).
2. **Local health systems strengthening through contributions to health workforce:** develop new reintegration opportunities in local and community-based health systems for personnel from demobilized militias with health expertise and interest.	• Short report on DDR processes in "new contexts" with recommendations related to reintegration of health personnel; • adapted skillset and profiling tools to identify ex-combatants with health expertise. • Develop selection criteria of contexts affected by conflict settings and depleted health workforce needs, with the view of undertaking pilot CVR project where excombatants could become community health workers.	- Review emerging measures in DDR processes in health and other relevant processes -joint guidance between WHO and ILO on accreditation processes for ex-combatants as community health workers. -review past approaches to develop community-based health workers in conflict settings (Somalia, South Sudan, Sudan)
3. Health rights promotion as part of armed group engagement: the protection of health facilities is upheld through the engagement of armed groups to commit to the principles of SC Res. 2286 as part of DDR-related mediation, including in settings where no UN mission is present.	• A menu of programmatic options for several common types of armed groups (political resistance, violent extremists, economic opportunists etc.). • Demonstrating the impact on health in settings where attacks on health care facilities and workers are part of its MO, building on data contained in the WHO managed Surveillance System on Attacks on health care (SSA)	- Conduct broad typology analysis to identify arm groups characterized by consistent and intentional attacks on health care facilities (Libya, DRC); - Distil analysis methodology and best programmatic response into a practitioner toolkit. -convene technical meeting with partners such as Geneva Call and other civil society organizations that are engaged in the implementation of SC 2286

(c) Implementation Timeline

This project is designed to be implemented over a period of two years, but this proposal is budgeted for one year, with the option of extending to a second year if funding is made available.

(d) How does this project relate to internal and external United Nations partners?

The concept underpinning this proposal was born out of a nascent partnership between WHO/WHE and DDRS as part of its joint initiatives in response to COVID. As such the two entities will serve as the principal implementers, using either a) corporate capacities (standby capacity in Brindisi) or b) identifying external capacities to be managed jointly. The partnership is designed to bring the bear the comparative advantages in analysis, planning, and programming of DPO and WHO in conflict settings where peacekeeping and special political missions have been deployed AND where WHO has designated a health system and its capacities to be fragile, under its Fragility, Conflict-affected, and Vulnerable (FCV) strategy as part of its 13th Global Programme of Work (GPW 13) and Health and Peace Initiative.

(e) How gender aspects been included in the design and implementation of the project? How does it help the Department to implement their Women, Peace and Security and Gender Parity commitments?

By policy and design, gender mainstreaming is an integral part of DDR, included in all DDR Section projects and initiatives. Adjusting DDR to new environments has resulted in tools, such as CVR, that ensure increased balance among combatant and non-combatant men, women, boys and girls benefiting from DDR processes.

(f) Brief explanation of any risks that the implementation of the project may face and how to mitigate them, including with regards to the impact of COVID-19.

The phased approach to this proposal is an element of risk management. Each outcome-pillar is based on a research and/or review. Failing to identify concrete programmatic entry points through the research and reviews may prohibit the full implementation of subsequent activities. However, a viability study could provide recommendations related to the future direction of the project and projections about best implementation timelines. Initial phases, while the pandemic continues, will be focused on the outputs related to desk reviews, research, and analytical work. Country focused interventions and missions will be secondary, should travel and access allow as the pandemic-related restrictions begin to ease.

(g) Proposed Budget

Item[1]	Brief Description	Total Amount
Outcome 1		
Consultants	Focusing on mental health and psychosocial support for ex-combatants as part of the sustaining peace approach	73,000

[1] Post estimates need to include salary for the period together with standard costs, which include the following costs: (i) Rental Premises; (ii) Office Supplies; (iii) Telephone and Fax; and (iv) Computing Services. For the most recent scale of salaries and standard costs, please consult with the Executive Office. If you need a salary list, please contact ODCSS or the EO.

Publication	Graphic design, print preparations; printing and dissemination.	65,000
Outcome 2		
Consultants	One consultant focusing on health workforce in conflict settings to develop mapping, analysis and recommendations.	35,000
Travel	Research travel to one country	7,500
Workshop	Incl. travel and hosting costs	30,000
Outcome 3		
Consultants	One consultant to develop analysis and recommendations on arm group engagement and through SSA data	35,000
Travel	Research travel to one country	7,500
Workshop on Res.2286	Incl. travel and hosting costs	30,000
Support to Outcomes		
1 junior consultant for 12 months (P2)	Joint WHO-DPO associate support to programme management	77,369
Programme Support Costs (13%)[2]		46,848
Total		**$407,217**

[2] Mandatory Programme Support costs to be calculated against the subtotal of the programme support costs.