

5.70 Health and DDR

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5.70 Health and DDR

Summary

The links between conflict, health and peace are multifaceted. Armed conflicts have clear impacts on health. Conflict results directly in deaths and injuries of both combatants and civilians, but may also cause impacts on health beyond physical harm, such as increases in infectious diseases and non-communicable illness, including mental illness. When conflict impacts public infrastructure, both intentionally and unintentionally, health services are affected including vaccination distribution, child and maternal health, and sexual and reproductive health. Disrupted water and sanitation systems increase the risk of infectious waterborne diseases like cholera. Health-care may be deliberately attacked, including the destruction and looting of health facilities and violence against health workers and patients.

Conflicts cause the collapse of health systems and essential medical supply chains and the breakdown of social and economic systems as health-care workers flee, and starvation and epidemics spread. Rates of infant mortality, sexual violence and mental disorders such as depression, anxiety and post-traumatic stress increase significantly during and after armed conflicts. A depleted health workforce and ineffective health systems are not only the symptoms of conflict; in some cases, they can be a contributing factor to the outbreak of violence. The lack of access to basic social services such as health care for specific populations (e.g., ethnic, regional, religious or otherwise marginalized groups) can lead to perceptions of exclusion and unfair or unequal treatment. In many contexts, such inequities and lack of inclusion contribute to mounting grievances, which then boil over into protests and later violence.¹

This relationship between health and conflict is evident in the contexts in which DDR processes take place. After armed conflict, former members of armed forces and groups are left with injuries, physical and mental disabilities due to the trauma of being in active combat, and increased susceptibility to negative coping mechanisms, including substance abuse. The mental health of communities, victims, and former members of armed forces and groups is also a key factor in the success of reconciliation, transitional justice and other post-conflict peace processes. Lastly, health, especially that of children and women, is often viewed as a superordinate goal (shared value) for all sides in a conflict, which allows health initiatives to serve as a neutral starting point for bringing rival parties together as they work towards mutually beneficial objectives.

This module is intended to assist DDR practitioners to design DDR processes that contribute to better health outcomes for ex-combatants, persons formerly associated with armed forces and groups, and conflict-affected communities. The module is also intended for health actors, who may be unfamiliar with DDR, including generalists and non-specialized health actors who need to be aware of key health-related considerations, including infectious diseases like HIV/AIDS and emerging pandemics, throughout the DDR process. Therefore, this module provides policy orientation for

health practitioners who, when called upon to support DDR efforts, may require basic guidance on where their strategic, technical and operational expertise is required. While the primary objective of health action remains in all contexts to reduce avoidable illness, injuries and death, the role of health services as part of DDR will depend on conflict contexts and on what types of activities are implemented as part of DDR. Though this module focuses on guidance for DDR programmes in mission and non-mission settings alike, its proposed provisions are also applicable to health activities in support of DDR-related tools and reintegration support (see IDDRS 2.10 on The UN Approach to DDR).

Lastly, rather than treating health as a technical input to DDR, this module provides a framework to better understand the interlinkages between health, peace, social cohesion and reconciliation, and the impact that well-designed health interventions can have on the prospects for peace.

1. Module scope and objectives

As the objective of this module is to support the design and implementation of health programmes within a DDR framework, there are two intended audiences: DDR practitioners, who wish to design and implement DDR processes that contribute to better health outcomes, and health practitioners, who – when called upon to support the DDR process – may require basic guidance on the subject to contextualize their technical expertise. Previously, the IDDRS contained two separate modules, one on health and one on HIV/AIDS. Given the high risk of exposure to sexually transmitted infections (STIs), including HIV, in conflict and post-conflict settings, these modules have now been merged into one; although this module’s focus is on health in general, it retains a focus on HIV/AIDS and DDR.

This module consolidates the lessons learned by UN health actors and their partners in supporting DDR processes in a number of countries. It also draws from promising practice in humanitarian, development and peacebuilding contexts where health interventions have contributed to stability and recovery efforts. The scope and content of this module are therefore relevant for peacekeeping missions, special political missions and settings in which no UN mission has been established beyond the UN country team presence. In addition, the design principles that this module presents are applicable to all integrated DDR processes, namely, DDR programmes, DDR-related tools and reintegration support (see IDDRS 2.10 on The UN Approach to DDR). In order to address cross-cutting aspects of health, this module should be read in conjunction with other cross-cutting modules such as IDDRS 5.80 on Disability-Inclusive DDR.

2. Terms, definitions and abbreviations

This section contains a list of abbreviations used in this standard. A complete glossary of all the terms, definitions and abbreviations used in the IDDRS series is given in IDDRS 1.20. In the IDDRS series, the words ‘shall’, ‘should’, ‘may’, ‘can’ and ‘must’ are used to indicate the intended degree of compliance with the standards laid down. This

use is consistent with the language used in the International Organization for Standardization standards and guidelines:

- a. 'shall' is used to indicate requirements, methods or specifications that are to be applied in order to conform to the standard;
- b. 'should' is used to indicate the preferred requirements, methods or specifications;
- c. 'may' is used to indicate a possible method or course of action;
- d. 'can' is used to indicate a possibility and capability;
- e. 'must' is used to indicate an external constraint or obligation.

Acquired immunodeficiency syndrome (AIDS) describes the collection of symptoms and infections associated with acquired deficiency of the immune system. Infection with HIV has been established as the underlying cause of AIDS.

Determinants of health are the range of personal, social, economic and environmental factors that determine the healthy life expectancy of individuals and populations.

Gender-responsive health services aim to ensure that health services are affordable, accessible and acceptable to all. This entails taking into account that gender influences how people experience and access health care, and that health systems are not gender neutral; structures and processes of oppression and discrimination that exist in society are reproduced in health systems. Maintaining a gender perspective means awareness of gender norms, gender inequality and gender discrimination that may negatively affect people's health and well-being or present barriers to accessing health information and services.

Health is defined in the Constitution of the World Health Organization (1948) as a "state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity".

Health outcomes refer to changes in the health status of an individual, group or population that is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

Human immunodeficiency virus (HIV) is a retrovirus that infects cells of the human immune system.

Non-communicable disease, also known as chronic disease, tends to be of long duration and is the result of a combination of genetic, physiological, environmental and behavioural factors. The main types of non-communicable disease are cardiovascular diseases (such as heart attacks and strokes), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma) and diabetes.

Mental health and psychosocial support (MHPSS), following the Inter-Agency Standing Committee Guidelines for MHPSS in Emergency Settings, is understood as "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder".²

Opportunistic infections are diseases associated with severe immunodeficiency, including in people living with HIV.

Sexual and reproductive health (SRH) is often referred to as a "state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity".³ It should be noted that the achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights.

Universal health coverage (UHC) means that all people have access to the health services they need, at high quality, when and where they need them, without financial hardship across the life course. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care.

3. Introduction

Health cuts across every aspect of DDR, from the design and implementation of DDR processes to their success and sustainability. The exact nature of the role of health interventions may vary in different situations, ranging from standards setting to direct operational inputs in support of DDR. In the sections that follow, this module will outline a framework to guide practitioners on when certain health interventions may be considered throughout the DDR process, keeping in mind where health interventions may be explicitly designed to contribute to peace and social cohesion.

Conflict is a major determinant of health that can inhibit the services and behaviours required for positive health outcomes. Under international humanitarian law, health is protected, and parties to an armed conflict are required to ensure adequate medical care for the wounded and sick, including combatants. Health workers respond to emergencies created by armed conflict, and, more importantly, work to create the conditions that enable individuals, communities and societies to realize their aspirations without resorting to violence. This implies that the public health community can, and should, be involved in identifying and preventing circumstances that lead to armed conflict. This role also extends to supporting peace processes, such as DDR, at the national and community levels.

Health interventions in support of DDR represent a conscious decision to support national authorities to restore and/or deliver health services as part of structured, government-led programmes or in line with an agreed national health strategy. Health personnel working in support of a DDR process should understand that the health services they are providing can themselves be seen as a peace dividend. Health interventions, including basic curative and preventive services, as well as additional attention to mental health and psychosocial support and sexual and reproductive health, can help communities regain a sense of normality, support victims in their recovery, restore day-to-day functioning, promote social cohesion and facilitate relations between the state and communities, as well as within communities. In addition, where marginalization, stigmatization or discrimination may occur based on gender, race, ethnicity, or attitudes against people with physical, psychosocial, intellectual and cognitive disabilities or mental health conditions, the delivery of inclusive and equitable health interventions can contribute to peacebuilding by alleviating potential grievances that may arise from such inequities. Lastly, infectious disease hazard management, such as vaccination campaigns (for instance, in the context of child health and well-being) may also be used as neutral entry points, serving as confidence-building measures, for example, in mediation initiatives.

4. Guiding principles

IDDRS 2.10 on The UN Approach to DDR sets out the main principles that guide all aspects of DDR processes. This section outlines how these principles apply to health interventions for DDR.

4.1 In accordance with the standards and principles of humanitarian assistance

Health interventions in the context of DDR processes take place in diverse operational contexts. The Humanitarian Charter and Core Humanitarian Standards on Quality and Accountability provide a shared conviction governing humanitarian practice across all sectors underpinned by the principles of humanity, neutrality, impartiality, and independence.⁴ In line with the commitments of principled humanitarian action, health interventions address urgent needs in a non-discriminatory manner that leaves no one behind and are guided by an impartial and independent assessment of need. Carried out within a DDR process, the work of health practitioners is implemented as part of a political framework whose objectives are not specifically humanitarian. In such a situation, tensions can arise between humanitarian principles and the establishment of the overall political-strategic crisis management framework of integrated peacebuilding missions, which is the goal of the UN system.

Offering health services as part of the DDR process can cause a conflict between the ‘partiality’ involved in supporting a political transition and the ‘impartiality’ needed to protect the humanitarian aspects of the process and humanitarian space. These tensions gain more prominence where both health interventions and DDR are implemented in the absence of a comprehensive peace agreement. These are settings in which a widely accepted peace process endorsed by the United Nations is not yet in place, but where opportunities to support reconciliation or a sense of normality exist at the local level. In all scenarios, health interventions in areas still affected by conflict shall be underpinned by the notion of ‘do no harm’ and shall adhere to humanitarian principles. In line with global standards for health in emergencies, including the Sphere Minimum Standards for Healthcare, health care must be provided without discrimination and must be accessible, meaning that it is available, acceptable, affordable and of good quality. States are obliged to ensure this right during crises.

4.2 Gender transformative, responsive and inclusive

The design and implementation of health interventions in DDR contexts must be inclusive, equitable and gender responsive. As structures and processes of oppression and discrimination that exist in society are reproduced within health systems, they are intrinsically not gender neutral. Health interventions in DDR must therefore actively consider gender and other drivers of inequalities within health systems, focusing on reaching those living in the most vulnerable situations, such as marginalized, stigmatized and geographically isolated people of all ages. This entails determining who is left behind and why through the collection of disaggregated data and assessments of existing barriers to improve health outcomes; using evidence and community engagement to address these barriers and strengthen policies and programmes; monitoring progress through reviewing and reporting; building capacity among techni-

cal staff and dedicating adequate resources to promote gender equality and gender mainstreaming; and strengthening engagement with civil society and fostering their participation. Ultimately, a successful gender-responsive health policy will promote the empowerment of women and the involvement of men, and support gender equity/equality goals to enhance health outcomes for all.

It is important to note the value of intersectional approaches. This analytical lens examines how different social stratifiers (gender, class, race, education, ethnicity, age, geographic location, religion, migration status, ability, disability, sexuality, etc.) interact to create different experiences of privilege, vulnerability and/or marginalization. In the context of DDR programmes, this would entail considering how other elements of identity in addition to the social stratifiers described above – such as association and engagement with armed groups, disabilities, and experiences of sexual violence, – may intersect to affect an individual’s health status.

4.3 Conflict sensitive

As mentioned above, both DDR and health interventions shall ‘do no harm’. Interventions in conflict settings shall be provided in a manner that does not contribute to the root causes of the conflict or exacerbate adverse sentiments and promote and advocate for equitable access to essential health services. To achieve this goal, health interventions in the context of DDR programmes must be rooted in a thorough understanding of the context’s actors, dynamics and cultural specificities so as to avoid further entrenching conflict dynamics and grievances.

A potential risk for beneficiaries of health interventions or implementing partners, including health workers, could be tensions with local communities. The prevention of attacks against health facilities and workers is a key consideration of humanitarian actors. While health can be a potential influencer for peace, risk management processes are necessary during the programming of DDR and health interventions (informed by conflict analysis), in order to identify possible unintended negative impacts for stakeholders. Meaningful engagement with local and national partners shall be considered in the design and implementation stages to ensure sensitivity to local contexts and dynamics.

4.4 Nationally and locally owned

Concern for the health outcomes of former members of armed forces and groups, their family members and communities requires a consistent and coherent approach to the management of health risks. Continuity and quality of care is a critical principle when designing health interventions for chronic disease management, reproductive health and MHPSS. Wherever possible, health interventions as part of DDR processes shall be aligned with national and local health guidelines and embedded into the local health system. Health interventions shall, as much as possible, benefit former members of armed forces and groups as well as communities, avoiding inequities in health access.

To ensure that interventions are developed in response to local circumstances and needs, the planning, design and implementation of DDR and health programmes shall be built on engagement with both local and community-based implementing partners, as well as health practitioners within communities, such as traditional and customary

providers of health. Obstacles that might hinder meaningful participation and inclusion of local actors, such as language, jargon, disability or lack of transparent information, shall be identified and reduced (see IDDRS 4.60 on Public Information and Strategic Communication in Support of DDR). The integration of local and national actors should also be aligned with aid localization strategies already being implemented by other UN and international partners. A localization approach that is based in part on the principles of partnership, capacity strengthening, leadership, risk management/sharing and sustainable financing can ensure health and DDR interventions involve the perspectives of communities.

4.5 Integrated

In assessment, planning, design and implementation, all health interventions in DDR shall be coordinated with other UN health actors, international partners, and national and local partners and entities. Health interventions shall be developed and implemented in accordance with international and regional strategies for public health, including relevant Sustainable Development Goals.

5. Legal and normative framework

DDR processes are undertaken within the context of the international legal framework of rights and obligations (see IDDRS 2.11 on The Legal Framework for UN DDR). These are relevant to the implementation of health interventions in DDR. UN-supported health interventions in DDR shall be implemented to ensure that the relevant rights and obligations under that normative legal framework are respected. In addition to the norms guiding DDR, DDR practitioners shall be aware of the international instruments that the Member State(s) in which they operate has accepted or is a party to (including through treaty ratification) specifically related to health interventions in DDR, which may, or may not, include all of the instruments listed herein. What follows is a summary of the primary authorizing environment for approaching health interventions in a DDR context, as well as the primary relevant international agreements, standards and guidelines. The chronological overview below is not exhaustive but considers key laws, policy instruments and norms that have been established since 1946 that are specifically relevant to health and DDR, focusing on international norms. (Additional instruments, including at the regional level, may exist and be of relevance.) For a more extensive overview of human rights treaties and international humanitarian law that underpin the international legal framework of rights applicable to DDR processes, see IDDRS 2.11 on The Legal Framework for UN DDR.

5.1 International instruments

Constitution of the World Health Organization (1946)

The WHO Constitution was the first international instrument to enshrine the right to health, declaring that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”. The Constitution preamble defines

health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. In addition, the Constitution declares that health is fundamental to the attainment of peace and security.

Geneva Conventions (1949) and their Additional Protocols of 1977 and 2005

The Geneva Conventions and their Additional Protocols form the core of international humanitarian law, which regulates the conduct of armed conflict and seeks to limit its effects. They protect persons who are not, or no longer, participating in hostilities. They specifically protect people who are not taking part in the hostilities (civilians, health workers and aid workers) and those who are no longer participating in the hostilities, such as wounded, sick and shipwrecked soldiers and prisoners of war.

International Covenant on Economic, Social and Cultural Rights (1966)

Alongside the 1948 Universal Declaration of Human Rights, which recognizes health as a human right, the International Covenant on Economic, Social and Cultural Rights is the central international instrument to protect the right to health (“the highest attainable standard of physical and mental health”). States that are party to the Covenant commit to four steps to achieve the realization of this right to health, including the “creation of conditions which would assure to all medical service and medical attention in the event of sickness” and provisions to reduce infant mortality and for the healthy development of children. The covenant explicitly references not only physical but also mental health.

The Ottawa Charter for Health Promotion (1986)

This Charter remains a key reference for health promotion action towards achieving the ‘Health for All’ initiative. The charter focuses on health promotion but also defines the fundamental conditions and resources for health, among which are peace, social justice and equity. Included in its definition of health promotion is the declaration that health is “created by caring for oneself and others ... and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members”.

Convention on the Rights of the Child (1989)

The Convention on the Rights of the Child includes several provisions for health of children, including the recognition of the “right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.” States Parties “shall strive to ensure that no child is deprived of his or her right of access to such health care services.” The Convention emphasizes the need to protect children in times of conflict and the minimum age for recruitment to armed conflict and stipulates the measures to support physical and psychological recovery of children and social reintegration.

Security Council resolution 1308 (2000) and presidential statement 2005/33

Security Council resolution 1308 calls for HIV/AIDS training and prevention programmes for peacekeeping personnel. In addition, by recognizing the devastating impact that HIV/AIDS has on all sectors of society and by stressing that “the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security”, the resolution

points to a broader framework and obligation to integrate HIV/AIDS initiatives into post-conflict programmes, including DDR. Furthermore, the resolution stresses the importance of a coordinated approach among UN agencies, and essentially calls for the mainstreaming of HIV/AIDS into their respective mandates. Following discussions in 2005 on the implementation of Security Council resolution 1308, the Security Council issued a presidential statement (S/PRST/2005/33) supporting the efforts of peacekeeping missions to integrate HIV/AIDS awareness into their activities and outreach projects for vulnerable communities.

Security Council resolution 1325 (2000)

Security Council resolution 1325 on women, peace and security encourages “all involved in the planning for disarmament, demobilization and reintegration to consider the different needs of female and male ex-combatants and to take into account the needs of their dependants”. Consideration of HIV/AIDS interventions and requirements falls under this obligation. Furthermore, the resolution makes specific reference to the need to provide HIV/AIDS training for military, civilian police and civilian personnel deployed in peacekeeping operations. It also calls on all parties to armed conflict to take special measures to protect women and girls from gender-based violence, including rape.

Economic and Social Council resolution 2004/39 (2004)

This resolution expresses concern over reports of widespread abuse of drugs in countries emerging from conflict and war, among both the general population and soldiers, especially child soldiers, and highlights the need to ensure that effective measures for the protection, rehabilitation, physical and psychological recovery, and reintegration of women and children are systematically incorporated in all stages of the peace process, including peacekeeping and peacebuilding programmes.

International Health Regulations (2005)

The International Health Regulations (2005), adopted pursuant to Article 21 of the WHO Constitution, provide an overarching legal framework that defines countries’ rights and obligations in handling public health events and emergencies that have the potential to cross borders, including the requirement to report public health events. The IHR also outline the criteria to determine whether or not a particular event constitutes a “public health emergency of international concern”.

General Assembly Declaration of Commitment on HIV/AIDS (2001) and General Assembly resolutions S-26/2 and 60/262 (2006)

The General Assembly Special Session on HIV/AIDS Declaration of Commitment (June 2001), endorsed by resolution S-26/2 and reiterated in 2006 by resolution 60/262, established a common set of targets and agreed strategies to reduce the spread of HIV and mitigate its impact. It called for HIV/AIDS components to be included in international assistance programmes in crisis situations. More specifically, in addition to training for personnel involved in peacekeeping operations, the declaration called on Member States “by 2003 to have in place national strategies to address the spread of HIV among national uniformed services, where this is required, including armed forces and civ-

il defence forces". The obligation to include strategies to address HIV/AIDS in DDR programmes is clear for two reasons. First, national uniformed (government) forces, directly referred to in the declaration, and non-state combatants face HIV risks. Second, by extension, there is a need to consider HIV in broader security sector reform (SSR) initiatives and efforts to establish newly integrated national armed service and civil defence forces in post-conflict settings, as DDR is often closely linked to SSR. The declaration also points to national uniformed services as being a possible resource in themselves for HIV/AIDS initiatives, calling on Member States to "consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/AIDS awareness and prevention activities, including participation in emergency, humanitarian, disaster relief and rehabilitation assistance".

Convention on the Rights of Persons with Disabilities (2007)

This convention promotes and protects the human rights of persons with disabilities. The convention condemns the discrimination of persons with disabilities, including children, and reaffirms the need for equality and inclusion. In addition, the convention reaffirms the right of persons with disabilities to live independently, make their own choices, and play an active role in society. For further information, see IDDRS 5.80 on Disability-Inclusive DDR.

Security Council resolution 1983 (2011)

Security Council resolution 1983 on maintenance of international peace and security called for "the incorporation of HIV prevention, treatment, care and support to disarmament, demobilization and reintegration processes". This was the second time the Security Council discussed the global impact of HIV/AIDS on international peace and security. It urged for a comprehensive global response to curb the HIV epidemic as well as HIV prevention efforts to be aligned with efforts to end sexual violence among uniformed services in conflict and post-conflict situations. Furthermore, it acknowledged that violence and instability in conflict and post-conflict situations can worsen the HIV epidemic because of displacement, sexual violence and reduced access to HIV treatment and care. The resolution identified numerous stakeholders to contribute to this effort. It stressed the importance of strong support by UN peacekeeping operations, including through the incorporation of HIV prevention, testing, treatment and support services within the implementation of peacekeepers' mandated tasks, and the continuation of such support during and after transition to the other configurations of the UN presence.

General Assembly political declaration on HIV/AIDS (2011) and General Assembly resolutions 65/277 and 70/266 (2016)

The General Assembly political declaration entitled "Intensifying our efforts to eliminate HIV and AIDS" (July 2011), endorsed by resolution A/RES/65/277, established new commitment and bold targets in the effort to eliminate the HIV epidemic. Member States agreed to redouble efforts to achieve universal access to HIV prevention, treatment, care, and support and meet Millennium Development Goal 6 by 2015. Members gave their commitments to reduce sexual transmission

of HIV by 50 per cent, reduce transmission of HIV among people who inject drugs by 50 per cent, and eliminate mother-to-child transmission of HIV by 2015. They also pledged to eliminate gender inequalities and gender-based abuse and violence and to strengthen the capacity of adolescent girls and women to protect themselves from HIV infection.

The General Assembly political declaration entitled “On the fast track to accelerating the fight against HIV and to ending the AIDS epidemic by 2030” (June 2016), endorsed by resolution A/RES/70/266, set specific targets that must be reached by 2020 to end the AIDS epidemic by 2030. Member States pledged to leave no one behind and implement universal access to health-care services. The declaration recognized the importance of the 2030 Agenda for Sustainable Development and that, while significant progress has been made, continued effort is necessary for full implementation of the commitments, goals and targets in the 2001, 2006 and 2011 declarations. Member States drew attention to the importance of considering the national context in the global response, including humanitarian emergencies in conflict and post-conflict situations and the need for special attention to countries in situations of conflict. Members committed to ending all forms of violence and discrimination against women and girls, such as gender-based, sexual, domestic and intimate partner violence; forced marriages; female genital mutilation; trafficking; rape; abuse and harmful social norms that perpetuate the unequal status of women and girls, including in conflict and post-conflict and other humanitarian emergencies.

General Assembly resolution 67/81 (2012), political declaration of the high-level meeting on universal health coverage, and General Assembly resolution 74/2 (2019)

With resolution 67/81, the General Assembly endorsed a key resolution promoting universal health coverage (UHC), which has since been reaffirmed, including in resolutions 70/1 (2015) and 72/139 (2017). In 2019, the General Assembly adopted a political declaration entitled “Universal health coverage: moving together to build a healthier world”, approved by the high-level meeting and endorsed by resolution 74/2. It reaffirms the commitment of countries to achieving UHC and references the “increasing number of complex emergencies” hindering the achievement. The political declaration notes the importance of “coherent and inclusive approaches” to safeguard UHC in emergencies and promotes the provision of essential health services and public health functions in line with humanitarian principles.

Security Council resolution 2286 (2016)

This resolution “strongly condemns attacks and threats against the wounded and sick, medical personnel, and humanitarian personnel exclusively engaged in medical duties.” This includes their means of transport and equipment, as well as hospitals and other medical facilities. It demands all parties to armed conflict to fully comply with their obligations under international law, including international human rights law, as applicable, and international humanitarian law, in particular their obligations under the Geneva Conventions of 1949 and their Additional Protocols of 1977 and 2005. The resolution also demands the safe and unimpeded passage of medical and humanitarian personnel exclusively engaged in medical duties in armed conflict.

General Assembly political declaration on HIV and AIDS and resolution 75/284 (2021)

The General Assembly political declaration entitled “Ending inequalities and getting on track to end AIDS by 2030” (June 2021), endorsed by resolution 75/284, sets new specific targets that must be reached in order to deliver the 2030 Agenda for Sustainable Development Goals and end the AIDS epidemic by 2030. Member States pledged to end “all inequalities faced by people living with, at risk of and affected by HIV and by communities”. The declaration notes specifically that, depending on a country’s context, populations at elevated risk of HIV may include “men and women in uniform” as well as “people in humanitarian emergencies and conflict and post-conflict situations”. Member States commit to work with populations identified as at higher risk to design and deliver comprehensive HIV prevention services.

5.2 Key humanitarian guidance and standards

Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007)

These guidelines are meant to support humanitarian actors and communities in planning, establishing, and coordinating a set of minimum multi-sectoral responses to protect and improve people’s mental health and psychosocial well-being during an emergency. They focus on essential, high-priority responses that should be implemented as soon as possible in an emergency. These minimum responses are considered the first steps in addressing the mental health and psychosocial needs of affected individuals and communities. The guidelines also provide strategies for mental health and psychosocial support to be considered before and after the acute emergency phase.

Inter-Agency Standing Committee Guidelines for Addressing HIV/AIDS in Humanitarian Settings (revised 2009)

The Inter-Agency Standing Committee, which is the primary mechanism for facilitating inter-agency decision-making in response to complex emergencies and natural disasters, issued guidelines in 2004 for HIV/AIDS interventions in emergency settings. In 2009, the guidelines were revised to address humanitarian settings, reflecting improvements in the implementation of humanitarian coordination and evidence on the feasibility of antiretroviral therapy provision in low-resource settings. They are directed at programme planners and implementers from agencies involved in providing humanitarian assistance and focus on the integration of HIV into humanitarian crisis responses during the minimum initial response phase and the expanded response phase. Apart from recommended actions for vulnerable groups that are also valid for addressing HIV/AIDS among DDR participants and beneficiaries, ensuring access of uniformed personnel to HIV prevention information is included under the list of actions of a minimum initial response.

World Health Organization’s mhGAP Humanitarian Intervention Guide (2015)

The mhGAP Humanitarian Intervention Guide contains first-line management recommendations for mental, neurological and substance use conditions for non-specialist

health-care providers in humanitarian emergencies where access to specialists and treatment options is limited. It is a simple, practical tool that aims to support general health facilities in areas affected by humanitarian emergencies in assessing and managing acute stress, grief, depression, post-traumatic stress disorder, psychosis, epilepsy, intellectual disability, harmful substance use and risk of suicide.

The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, fourth edition (2018)

The Sphere humanitarian charter and minimum standards aim to provide a set of principles to guide all humanitarian action and a set of commitments to support accountability across all sectors. The Sphere Handbook provides guidance to practitioners in the planning, managing and implementation of humanitarian responses. Guided by the right to health care in humanitarian contexts, the Sphere Handbook provides technical support and minimum standards for the strengthening of health systems and the provision of essential health care. This includes, in particular, minimum standards on sexual and reproductive health, including key actions to ensure people's access to health care, thereby preventing transmission and reducing morbidity and mortality due to HIV.

Inter-Agency Standing Committee Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (2018)

These guidelines aim to assist humanitarian actors and communities affected by armed conflict, natural disasters and other humanitarian emergencies to coordinate, plan, implement, monitor and evaluate essential actions for the prevention and mitigation of gender-based violence (GBV) across all sectors of humanitarian response. They focus on (1) reducing risk of GBV by implementing GBV prevention and mitigation strategies from pre-emergency to recovery stages of humanitarian action; (2) promoting resilience by strengthening national and community-based systems that prevent and mitigate GBV, and by enabling survivors and those at risk of GBV to access specialized care and support; and (3) aiding recovery of communities and societies by supporting local and national capacity to create lasting solutions to the problem of GBV.

Inter-agency Field Manual on Reproductive Health in Humanitarian Settings (2018)

Based on guidelines issued by normative bodies, particularly those of the World Health Organization (WHO), the 2018 inter-agency field manual incorporates specific evidence from, or examples about, the application and adaptation of global sexual and reproductive health (SRH) or human rights standards in humanitarian settings. The 2018 manual reflects the wide application of its principles and technical content beyond refugee situations, to diverse crises that include conflict zones and natural disasters. The manual continues to be the authoritative source for SRH in crises; the Sphere Humanitarian Charter and Minimum Standards in Disaster Response incorporates the Minimum Initial Service Package for SRH – Chapter 3 in the 2018 manual – as a minimum standard of care in humanitarian response.

World Health Organization's Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings (2019, updated eLearning 2020)

Developed by WHO, the UN Population Fund, and the UN Refugee Agency, this guide is intended for use by qualified health-care providers (medical doctors, clinical officers, midwives and nurses) who are working in humanitarian emergencies or similar settings, and who wish to develop specific protocols for the medical care of survivors of sexual violence and intimate partner violence. This guidance will need to be adapted to each setting, taking into account available resources, materials, medications, and national policies and procedures. It can also be used to update existing protocols, help plan and provide services, and train health-care providers.

5.3 Multilateral standards and frameworks

RESPECT: A Framework for Prevention of Violence Against Women (2019) and Implementation Package (2020)

Aiming to end violence against women, the RESPECT framework was developed based on the 2015 UN framework for action to prevent violence against women and updated new evidence. The implementation package aims to support national- and subnational-level policy and programming to prevent violence against women and girls. It distils programming knowledge and guidance based on existing global evidence, expert recommendations and practitioner consensus. It is intended to support policymakers and practitioners to develop evidence-based, ethical and effective violence against women programming. It is divided into a series of standalone materials, which include guidance, promising practices, and links to resources and tools for the design, implementation, monitoring and evaluation of violence against women prevention programmes under each of the RESPECT strategies.

UNICEF Core Commitments for Children in Humanitarian Action (1998, revised in 2010 and 2020)

Based on global humanitarian standards, the core commitments for children complement the Sphere guidelines and Health Cluster Guide with specific benchmarks to achieve for women and children in humanitarian situations.

Global Health Cluster Guide (2020)

This guide provides advice for the Health Cluster lead agency, coordinator and partners on how to reduce avoidable mortality and morbidity during a humanitarian crisis. The guide also outlines key responsibilities for the Health Cluster Coordinator and lead agency regarding civil-military coordination.

Early Warning Alert and Response in Emergencies: An Operational Guide (2022)

Populations affected by emergencies are continually at risk of outbreaks of epidemic-prone diseases and other public health hazards. This operational guidance developed by WHO aims to guide decision-making on when and how to implement and strengthen early warning alert and response (EWAR) in preparation for and response to emergencies. Each module aims to provide updated operational guidance for EWAR practices, which may be more easily understood and applied during emergencies.

6. Planning health interventions as part of DDR

This section provides guidance on the objectives of health interventions in DDR. It then outlines the cross-cutting issues that are important to consider when planning health interventions as part of DDR, before discussing the specific role of the health sector in DDR planning.

6.1 Objectives

The primary objective of health action is to reduce avoidable illness, injuries and death. In the DDR context, this requires that the health interventions focus on providing:

- Basic, preventive, promotive, curative, specifically designed and good-quality health care that is easily accessible to everyone at every stage of the DDR process — in any transit stations, in demobilization/cantonment/assembly camps if they are used, in interim care centres (ICCs) for children, and in the communities in which former members of armed forces and groups live.
- Basic health care, including reproductive and sexual health care and mental health care, that addresses the different needs of men, women and people of diverse gender identities of all ages going through DDR. This service needs to be supported by effective referral systems and emergency backup systems, e.g., to control outbreaks of infectious diseases or deal with immediate, life-threatening illnesses or with acute and severe mental health conditions (e.g., psychotic disorders, suicidality). Health information and advice must be made available in language that can be understood by the different groups for which the health care is designed, including persons with disabilities (i.e., visually or hearing impaired), while appropriate feedback and complaints mechanisms are made available to ensure quality and accountability of health-care delivery.
- Training of camp managers on health-related matters, e.g., on the construction of appropriate areas for the registration and protection of vulnerable groups, the provision of food appropriate to different needs (e.g., the sick, nursing mothers, infants and small children), mental and substance use conditions (e.g., harmful use of drugs and alcohol), water, shelter, sanitation, supplies of items needed for hygiene (soap, buckets), and fuel.
- Specific assistance for women and girls to meet their hygiene needs, including menstrual supplies and clean birthing kits (ideally, referral to delivery care should be ensured).
- In settings where health resources and infrastructure are limited, health planning to meet the needs of those going through the DDR process starts from a minimum package of medical screening, onthespot treatment, provision of condoms and medical evacuation/referral, which should be developed to cover, at least:
 - Early detection of and response to epidemic outbreaks;
 - Routine immunization according to national schedule, including measles immunization + vitamin A for children ages 0–15 years and polio immunization for children under 5;
 - Treatment of severe, acute conditions and essential minimum health care (communicable diseases, child health, sexual and reproductive health, injury

and trauma care, mental health, non-communicable diseases and palliative care);

- Provision of long-lasting impregnated bed nets to prevent malaria; referral of serious cases to secondary/tertiary care facilities; voluntary testing and counselling for STIs, including HIV/AIDS;
- Assessment and management of priority mental, neurological and substance use conditions;
- Care and treatment for survivors of sexual violence, including testing and treatment for STIs.

Wherever possible, health-care provision should aim to contribute to social cohesion and address structural and access issues related to marginalization, discrimination and exclusion, as well as the access constraints due to lack of capacity for the provision of such services. Using health services and health service provision (such as treatments for harmful use of drugs and alcohol) can also contribute to reducing avoidable illnesses, injuries and deaths that result from the resurgence of armed conflict. Good public health practice requires identifying risk factors and determinants of collective violence and developing approaches to resolve conflicts without resorting to violence.

6.2 Cross-cutting issues

6.2.1 Gender considerations

In line with the principle of ensuring that DDR processes are gender responsive and inclusive (see section 4.2), planning needs to take into account specific gender-related health needs and vulnerabilities, as well as other intersecting forms of discrimination. People living in the most vulnerable situations usually include pregnant and lactating women and girls as well as survivors of sexual and gender-based violence (SGBV) and minority groups, such as lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) people. Gender-focused health planning needs to consider whether the existing health resources and workforce have the capacity to respond to gender-specific health needs of these groups in order to determine if special interventions are required (see the guiding questions in section 6.3.2).

Gender-responsive health interventions require equitable and meaningful participation of women, men and gender-diverse people as well as young people in their design and implementation (for example, through promoting the inclusion of women in health teams at DDR sites and ICCs for children). Specific measures are required to ensure protection for female combatants and women associated with fighting forces, abductees and dependants, including the adoption of evidence-based public health approaches to preventing interpersonal violence and SGBV. For specific considerations on HIV/AIDS and gender-based violence, see section 6.2.2. For more information on gender and DDR, see IDDRS 5.10 on Women, Gender and DDR.

6.2.2 HIV/AIDS and DDR

A number of factors make conflict and post-conflict settings high-risk environments for the spread of HIV. The age range, mobility and risk-taking ethos of armed forces and groups can put them at high risk of HIV infection — with some national militaries

reporting higher rates of HIV than their civilian counterparts — and they may act as ‘core transmitters’ to the wider population.⁵ Evidence indicates that children associated with armed forces and groups are at higher risk of exposure to STIs, including HIV. Female combatants, women associated with fighting forces, abductees and dependants are also at high risk as a result of conflict-related sexual violence and abuse and the breakdown of social protection systems that may increase the risk of transactional sex. Drug use has been shown to increase in some conflict settings, including intravenous drugs, which also increases the risk of HIV infection, as the virus can be transmitted through the sharing of infected needles.

Integrating HIV/AIDS prevention and response services into DDR processes is necessary to meet the immediate health and social needs of DDR participants and beneficiaries, for reintegration and post-conflict recovery efforts. The sustainability of DDR efforts requires that HIV/AIDS awareness and prevention strategies be directed at DDR participants, beneficiaries and stakeholders in order to prevent increases in HIV rates or more generalized epidemics developing in countries where HIV infection may be mainly limited to particular high-risk groups.

Negative community responses to returning former members of armed forces and groups and women and children associated with armed forces and groups, abductees and dependants may also arise and make HIV a community security issue. To assist reintegration into communities, it is necessary to counter discrimination against, and stigmatization of, those who are (or are perceived to be) HIV-positive. In some instances, communities have reacted with ostracization and threats of violence; such responses are largely based on fear because of misinformation about the disease.

In cases where SSR follows a DDR process, former combatants may enter reformed military, police or civil defence forces (see IDDRS 6.10 on DDR and SSR). In many developing countries, ministries of defence and of the interior report high HIV infection rates in the uniformed services. Increasingly, there are national policies of screening recruits and excluding those who are HIV-positive. Engaging in HIV/AIDS prevention at the outset of a DDR process will help to reduce new infections, thus — where national policies of HIV screening are in place — increasing the pool of potential candidates for recruitment, and will assist in planning for alternative occupational support and training for those found to be HIV-positive.⁶

DDR processes offer a unique opportunity to target high-risk groups for sensitization. In addition, with the right engagement and training, former combatants have the potential to become ‘change agents’, assisting in their communities with HIV/AIDS prevention activities, and so becoming part of the solution rather than being perceived as part of the problem.

HIV/AIDS and gender-based violence

As noted by the Inter-Agency Standing Committee, the very characteristics that define a complex emergency, such as conflict, social instability, poverty and powerlessness, are those that favour the spread of HIV and other STIs. Mass displacements can result in the movement of people between high and low HIV/AIDS prevalence areas, especially with migration towards urban settings. As aforementioned, women and girls in conflict settings are frequently at high risk of experiencing SGBV, including through forced marriages, rape as a weapon of war, and transactional sex. Women with disabilities, including female ex-combatants and women and girls associated with armed forc-



es and groups, are also at greater risk of sexual violence. Survivors of sexual violence (both male and female) are at risk of psychosocial disability, vulnerability to HIV and other STIs, and physical disability owing to violence. Some may require fistula surgery. In this context, health services must integrate clinical management of rape as well as frameworks for the prevention of violence against women. (See guidelines in section 5.2.) In consultation with local communities, including women's engagement, sexual and reproductive health and HIV/AIDS counselling and support should be provided, as well as other initiatives, such as provision of SRH and life skills training for demobilized boys and girls, including HIV and GBV prevention, family planning, gender and sexuality, negotiating relationships, and condom use.

HIV/AIDS and human rights

The promotion and protection of the human rights of DDR participants and beneficiaries is vital to prevent the spread of HIV and ensure that affected persons have an adequate standard of living. In upholding human rights, HIV responses in DDR can create an enabling environment that affirms the dignity of people who are living with, or are vulnerable to, HIV. Additionally, a rights-based response can ensure that persons affected by the disease are protected from discrimination and have access to treatment, care and support.

HIV/AIDS and key populations

Evidence shows that more than half of all new HIV infections in all operational environments are among key populations. There are five main key population groups that are considered particularly vulnerable to HIV and frequently lack adequate access to services: gay men and other men who have sex with men; sex workers; transgender people; people who inject drugs; and prisoners and other incarcerated people. In 2021, key populations and their sexual partners accounted for 70 per cent of HIV infections globally.⁷ Due to their specific vulnerabilities, special considerations for key populations are necessary for a comprehensive HIV response in DDR.

6.2.3 Mental health and psychosocial support

The term “mental health and psychosocial support” (MHPSS) is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental health conditions. The long-term exposure of former members of armed forces and groups to armed conflict and violence, separation from their families and communities, low standards of living, and possible social exclusion and community stigma directly affect their mental health. These individuals may continue to experience psychological stress or develop mental health and substance use conditions long after DDR. Priority mental health conditions for humanitarian emergencies that are also relevant to DDR participants and beneficiaries include acute stress, grief, depression, post-traumatic stress disorder, psychosis, epilepsy/seizures, intellectual disability, harmful use of alcohol and drugs, and suicide. Alcohol and drugs are often used to cope with difficult experiences and emotions during and after combat. Drug and alcohol use can also contribute to intimate partner violence and community violence. Integrating substance use prevention and treatment elements while providing needed health services, including MHPSS, should be considered.⁸

Persons with mental health conditions are often at a higher risk of experiencing violence and may need additional support and links to protection actors. Basic assessment and management of priority mental, neurological and substance use conditions should be integrated into non-specialized health care in DDR settings in line with mhGAP Humanitarian Intervention Guidelines (mhGAP-HIG).⁹ DDR practitioners should ensure that any health screening in support of DDR processes include the capacity to assess and manage people requiring mental health and psychosocial support, including establishing appropriate referral pathways to specialized care if needed. Community-level awareness-raising activities (e.g., radio programmes, campaigns, community discussions) and outreach are also important to improve access and use of mental health services and to reduce stigma and negative attitudes towards persons experiencing mental health conditions. Such efforts need to be especially tailored to the needs of specific populations, such as women, who may self-demobilize (due to stigma), may be 'hidden' and may not have access to information on available services. Recommended interventions provided by trained and supervised health and community workers include clinical management of priority mental health conditions (as described in the mhGAP-HIG), and psychological interventions (e.g., PM+).

Peer support and basic support by community workers (e.g., psychological first aid) should also be provided. It is important to consider the high comorbidity of mental health conditions and diseases such as HIV/AIDS and tuberculosis. Individual as well as community-level approaches are needed to comprehensively address MHPSS needs.¹⁰ Economic and social reintegration with communities (e.g., educational and livelihood opportunities, addressing community stigma) also play a central role in improving mental health and reducing harmful use of drugs and alcohol. All mental health conditions need to be addressed to enable full participation in educational, economic and social activities.

6.2.4 Persons with disabilities and/or life-threatening/incurable (non-)communicable diseases
DDR practitioners, health practitioners and national authorities should agree on a system to respond to physical, psychosocial, intellectual and cognitive disabilities in order for people to access services and support, gain entitlement to disability pensions, and/or join the social security system. An approach can be designed that measures an individual's impairment and how much the impairment limits his/her capacity to benefit from DDR. There are also special measures and considerations that health practitioners should keep in mind throughout the DDR process (see IDDRS 5.80 on Disability-Inclusive DDR).

Caring for people living with AIDS, especially in resource-poor settings, can present a number of challenges, particularly for the provision of even basic drugs and treatments. It also raises concerns about the extent to which families (some of whom may already be affected by the disease) and communities are able or willing to commit themselves to caring for former members of armed forces and groups who may have been away for some time. Overall, the burden of care tends to fall on women in communities. This will make the overall support and absorption of former members of armed forces and groups into civilian life more complicated. In addition, any differences in the types or levels of AIDS care and support provided to former members of armed forces and groups and communities is a sensitive issue. It is extremely important to provide a balance in services, so that communities do not think that those who



joined armed groups are being rewarded with preferential treatment. Wherever possible, support should be provided to existing medical and hospice facilities, linking up with national and local programmes, with targeted support and referrals for families caring for former members of armed forces and groups suffering from AIDS.

6.3 The role of the health sector in DDR planning

Keeping in mind the two-fold objective of health interventions in DDR and the above-mentioned cross-cutting issues, what follow are specific health considerations in relation to various elements of integrated DDR processes. DDR practitioners should seek the expertise of health practitioners in four main areas during the planning phase of DDR: (1) to assess the epidemiological profiles of former members of armed forces and groups, and community members, in the areas and populations of interest; (2) to assess existing health resources and workforce capacities; (3) to identify implementing partners; and (4) to advise on public health concerns related to DDR. Planning to meet health needs should start as early as possible and should be constantly updated as the DDR process develops.

6.3.1 Assessing epidemiological profiles

Epidemiological data, i.e., at least statistics on the most prevalent causes of illness and death, are usually available from national health authorities. This data may be out of date or may be poor quality in conflict-affected countries or those in transition to a post-conflict phase. Health data disaggregated by sex, age (e.g., for children) and disability may be lacking. In particular, there may be very little reliable data about HIV infection rates in conflict and post-conflict environments. In a ‘younger’ epidemic, HIV infections may not yet have translated into AIDS-related deaths, and the epidemic could still be relatively hidden, especially as AIDS deaths may be ascribed to an opportunistic infection and not the presence of the virus. Tuberculosis, for example, is both a common opportunistic infection and a common disease in many low-income countries.

However, even a broad overview can provide enough information to start planning. It is important to note that epidemiological surveys on mental health conditions are often costly, complex and not essential for programme planning. General estimates show that one person in five (22 per cent) living in an area affected by conflict is afflicted with depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia.

Qualitative data can be obtained through key informant interviews and focus group discussions that include health and community workers, religious leaders, women and youth groups, government officials, UN agencies, nongovernmental organizations (NGOs) and community-based organizations (CBOs), as well as ex-combatants and those associated with armed forces and groups. Detailed and updated information may also be available from NGOs working in the area or the health services of the armed forces or groups. In addition to a review of secondary data, health practitioners may also gather primary data on information gaps to the extent possible (for example, through field assessments or rapid surveys).

Sometimes data on knowledge, attitudes and practice regarding HIV/AIDS and other diseases are contained in demographic and health surveys that are regularly car-

ried out in many countries (although the administration of these may have been interrupted because of the conflict). It is important to identify the factors that may increase vulnerability to HIV and other diseases — such as levels of rape and gender-based violence and the extent of ‘survival sex’. In the planning process, the cultural sensitivities of DDR participants and beneficiaries shall be considered so that appropriate services can be designed. Within a given country, for example, the acceptability and trends of condom use or attitudes towards sexual relations outside of marriage can vary enormously; the country-specific context shall inform the design of programmes. Understanding local perceptions and misconceptions is also important to prevent problems during DDR processes, for example, in cases where communities may blame ex-combatants or women associated with fighting forces for the spread of disease and therefore stigmatize them.

The following information should be collected:

- What kinds of population movements are expected during the DDR process (not only movements of people associated with armed forces and groups, but also an idea of where populations of refugees and internally displaced persons might intersect/interact with them in some way)?
- What are the most prevalent health hazards (e.g., endemic diseases, history of epidemics, traumatic genital injury from sexual violence) in the areas of origin, transit and destination? Specific attention should be paid to the seasonality of certain diseases that may occur in the short and medium term.
- What is the national HIV/AIDS prevalence (usually based on sentinel surveillance of pregnant women)? What are the rates of STIs? Are there significant differences in different areas of the country? Is it a generalized epidemic or restricted to high-risk groups? What data are available from blood donors (are donors routinely tested)? What are the high-risk groups? What is driving the epidemic (for example, heterosexual sex; men who have sex with men; SGBV, including rape, sexual exploitation and abuse of women, girls and boys; poor medical procedures and blood transfusions; mother-to-child transmission; intravenous drug use; little or no knowledge of HIV; poor access to and knowledge of contraception; poor access to quality health services)? What is the regional status of the epidemic, especially in neighbouring countries that may have provided an external base for former members of armed forces and groups?
- What is the prevalence and scope of sexual violence, and who are the survivors (children, adolescent girls, women, men, etc.)? What referral pathways are available to survivors (note that even if sexual violence is not reported, it should be assumed that there is an SGBV risk and perpetration)? Are there linkages established between medical and psychological services, safety and security, social protection, child protection services, legal services and community care services?
- What is the size of groups (women combatants and supporters, children associated with armed forces and groups, child dependents, persons with disabilities, those with chronic illnesses, etc.) with specific health needs?
- Are there specific health concerns relating to military personnel, as opposed to the civilian population?

The geography of the country/region in which DDR takes place should also be taken into account when planning the health-related aspects of the operation, as this will help in the difficult task of identifying the stakeholders and possible partners that will be involved, and in planning the network of fixed structures and outreach circuits designed to cater to first health contact and/or referral, health logistics, etc., all of which have to be organized at local, district, national or even international (i.e., possibly cross-border) levels.

Health activities in support of DDR processes must take into account the movements of populations within countries and across borders. From an epidemiological point of view, the mass movements of people displaced by conflict may bring some communicable diseases into areas where they are not yet endemic, and also speed up the spread of outbreaks of diseases that can easily turn into epidemics or even pandemics.¹¹ In this regard, DDR processes should give specific attention to disease endemicity when combatants and associated persons are moving from rural areas (where human-animal interface is likely) into urban or densely populated areas, planning for early detection and containment of these population movements. Thus, health and DDR practitioners should develop appropriate strategies to prevent or minimize the risk that these diseases will propagate, and plan for the early detection and containment of any possible epidemic resulting from population movements. Those whom health actors will be dealing with include former combatants, supporters and dependants, as well as community members.

In cases where foreign combatants will be repatriated, cross-border health strategies should be devised in collaboration with the local health authorities and partner organizations in both the sending and receiving countries (see also IDDRS 5.40 on Cross-border Population Movements).

6.3.2 Assessing health resources and workforce capacities required for DDR

- *Health resources:* After the completion of an assessment of the health needs to be met in a crisis, the capacity of the system to meet these needs should be examined. It is necessary to identify the system's main weaknesses and to make improvements so that they do not endanger the success of the DDR process. Moreover, health-care workers are many times the first point of contact of people living in the most vulnerable situations, and as such are in a key position to respond to SGBV survivors – including women, girls, boys and LGBTQI+ – and can facilitate their access to additional services and support. Sexual and reproductive health providers may be particularly well positioned, given their expertise in addressing sensitive issues related to sex and sexual well-being. The following information is needed:
 - What is the location and state of existing health infrastructure? What can be done to upgrade it quickly, if necessary? A mapping of locations should include referral pathways.
 - Do adequate storage facilities for health supplies exist nearby?
 - Is there an adequate communications infrastructure/system with a good flow of information? Is there a health information management system in place at the national/subnational level?

- What human resources are there (numbers disaggregated by sex, qualification and experience levels, and geographical distribution)?
- Where is the closest humanitarian and/or health organization? Is it ready to participate or offer support? Who will coordinate efforts?
- What material resources, including supplies, equipment and finances, have been established?
- What is the state of support systems, including transport, energy, logistics/cold chains, testing, and administration?
- How are health costs financed, especially those associated with a complicated delivery or acute or chronic illness?
- Are efficient and non-stigmatizing screening measures in place to identify victims/survivors of sexual violence (male and female) and to provide, or refer them to, appropriate services in line with individual needs and choices?

Additionally, the following information specific to HIV/AIDS is needed:

- Does the country have a functioning national AIDS control strategy and programme?
- Are relevant ministries engaged in AIDS control strategies and programmes (this should go beyond the health ministry and include, for example, ministries of the interior, defence, education, gender, social welfare, etc.)?
- Are there prevention and awareness programmes in place? Are these directed at specific groups? Does the country have a social protection policy, strategies, mechanisms for support?
- Does any capacity for counselling and testing exist? Is there a strategy for the roll-out of antiretroviral drugs (ARVs)?
- Is there financial support available for HIV/AIDS? Do these assistance frameworks include DDR?
- What other actors (national and international) are present in the country? Are a UN theme group and technical working groups in place (the standard mechanisms to coordinate the HIV initiatives of UN agencies)?

After answering these questions and assessing the situation, it is possible for health practitioners to identify important gaps in the health system and to start taking steps to support the DDR process (e.g., rehabilitating a health centre in an area where combatants will be assembled), and to identify stakeholders – national and international – who can form partnerships with the health sector.

- *Health workforce:* Combatants and persons associated with armed forces and groups may have health or medical training. An analysis of their health expertise and skills is needed during the planning of the health programme, both to identify the areas in need of in-service training and to compare the medical knowledge and practices of different armed groups and forces. The following questions can guide this assessment process:

- What kinds of capacities are needed for each health service delivery point (tent/tent active case finding and/or specific health promotion messages, health posts within camps, referral health centre/hospital)?

- What mix and number of health workers are needed at each of these delivery points? (The recommended standard is 60 health workers for each 10,000 members of the target population.)

6.3.3 Identifying implementing partners

As part of health planning, it is crucial to understand which actors will lead the different aspects or phases of health-care delivery within DDR and whether potential coordination mechanisms exist. In line with a conflict-sensitive approach, the potential impact of the selection of suppliers and implementing partners in the conflict context should be considered. For instance, where there is a legitimate Government, the delivery of health interventions must not duplicate existing national health systems or undermine national capacities. Particular attention should be paid to possible unintended negative effects arising from the collaboration with partners who may be associated with a party in a conflict. Inclusive community engagement may strengthen trust with (and within) communities and reduce the risk of tensions. It may also help to understand localized and traditional approaches to health within communities and how these approaches can be reinforced and built upon, particularly those related to curbing stigmatization and reinforcing acceptance into a community. Wherever possible, particularly in health emergency operations, DDR and health programmes should be built on engagement with local and community-based implementing partners, considering that local actors are often more closely connected to the drivers for both conflict and peace within and between communities (and the state), and are therefore better positioned to help influence the delivery and outcome of DDR activities.

6.3.4 Assessing public health concerns related to DDR

When mass gathering events are planned in contexts where epidemic risk is high (such as assembly areas, cantonment sites established to carry out disarmament and demobilization, or large groups planned as part of community violence reduction or reintegration activities), health personnel should help with site selection and provide technical advice on site design. International humanitarian standards on camp design should apply, and gender-specific requirements should be taken into account, including for people of diverse gender identities,¹² with due consideration of security, SGBV prevention and risk mitigation, and the provision of essential health-care assistance (as outlined in the Sphere Handbook).¹³ In addition, site design should facilitate the efficient and safe movement of people through the site, including, where possible, measures for mitigating crowding, such as shortening waiting times and allowing ample space between sections in the site.

The design of DDR sites (including assembly areas, cantonment sites and reception centres) shall take into account the need for capacity to address HIV/AIDS. Possible options include a central dedicated (but mobile) unit to coordinate HIV issues; the establishment of focal points in each region; and the utilization of experts from relevant UN agencies, NGOs, the national ministry of health, and/or the national AIDS control programme. In many cases, DDR sites will be used as the locations where basic briefings to DDR participants and referrals to voluntary counselling and testing (VCT) are provided, so it is essential that all DDR personnel are trained in HIV awareness strategies and are fully knowledgeable about available facilities.

As a rule, the area around the DDR site must conform with the Sphere standards for water supply and sanitation, drainage, vector control, health, etc. (see section 5.2). Locations and routes for medical and obstetric emergency referral must be pre-identified, and there should be sufficient capacity for referral or medical evacuation to cater for any emergencies that may arise, e.g., postpartum bleeding (the distance to the nearest health facility and the time required to get there are important factors to consider).

When former members of armed forces and groups are housed in military barracks or public buildings are restored for this purpose, these should also be assessed in terms of public health needs, such as social distancing requirements. Issues to consider include basic sanitary facilities, the possibility of health referrals in the surrounding area, and so on. Other considerations include:

- Are there national standard case definitions used to classify a particular disease and case management protocols available, and is there any need to adapt these to the specific circumstances of DDR?
- Is there a need to define or agree to specific public health intervention(s) at the national level to respond to or prevent any public health threats?

The safety and protection of women, girls, boys and gender-diverse persons must be taken into account in the planning for all DDR sites and ICCs, to reduce the possibility of sexual exploitation and abuse (see also IDDRS 5.10 on Women, Gender and DDR, IDDRS 5.20 on Youth and DDR and IDDRS 5.30 on Children and DDR). Medical screening facilities should ensure privacy during physical check-ups and shall ensure that universal precautions are respected. An enclosed space is required for testing and counselling. This can be a tent, as long as the privacy of conversations can be maintained. Laboratory facilities are not required on site. For further information on the design of DDR sites, see IDDRS 4.20 on Demobilization.

7. Health interventions in support of a DDR programme

DDR programmes consist of a set of related measures, with a particular aim, falling under the operational categories of disarmament, demobilization and reintegration (see IDDRS 2.10 on The UN Approach to DDR). Disarmament and other DDR-related weapons control activities aim to reduce the number of illicit weapons, ammunition and explosives in circulation and are important elements in responding to and addressing the drivers of conflict. Demobilization, including the provision of tailored reinsertion packages, is crucial in discharging combatants and those in support roles from the structures of armed forces and groups. Furthermore, DDR programmes emphasize the developmental impact of sustainable and inclusive reintegration and its positive effect on the consolidation of long-lasting peace and security.

Several elements aim to ensure a sustaining peace approach to health interventions as part of DDR programmes. These elements include the fundamental components of the sustaining peace approach, such as conflict-sensitivity analysis, a 'do no harm' approach, and (wherever possible) a peace-responsive angle to health interventions that aims to promote social cohesion. A DDR programme provides a common results framework for the coordination, management and implementation of DDR by national

Governments with support from the UN system and regional and local stakeholders. A DDR programme establishes the outcomes, outputs, activities and inputs required; organizes costing requirements into a budget; and sets the monitoring and evaluation framework, including by identifying indicators, targets and milestones. During DDR programmes, health activities should do some or all of the following:

- Provide medical screening and counselling for combatants, persons associated with armed forces and groups, and dependants.
- Establish basic preventive and curative health services. Priority should go to acute and infectious conditions (typically malaria); however, as soon as possible, measures should also be set in place for chronic and noninfectious cases (e.g., tuberculosis, diabetes, epilepsy, mental and substance use conditions).
- Establish a confidential referral system that can cover medical, surgical, mental health and obstetric emergencies, as well as laboratory confirmation for, at the least, diseases that could cause epidemics.
- Adopt and adapt national standard protocols for the treatment of the most common diseases.
- Establish systems to monitor potential epidemiological/nutritional problems within assembly areas, barracks, camps for dependants, etc., with the capacity for early warning and outbreak response.
- Provide drugs and equipment, including a system for water quality control and biological sample management.
- Organize gender-transformative public health information campaigns on STIs (including HIV/AIDS), parenting, mental health promotion, women's maternal and reproductive health, waterborne disease, sanitation issues such as excreta disposal, food conservation and basic hygiene (especially for longer-term cantonment).
- Establish systems for coordination, communication and logistics to support the delivery of preventive and curative health care, including, preventing and responding to sexual and gender-based violence.
- Establish systems for coordination with other sectors, to ensure that all vital needs and support systems are in place and functioning.
- Ensure that health services have the capacity to assess and manage priority mental, neurological and substance use conditions, including acute stress, grief, depression, post-traumatic stress disorder, suicide, and harmful use of drugs and alcohol.
- Make medical screening and specialized health services available to all children (including children associated with armed forces and groups). This includes immunization, treatment of severe conditions (such as malaria and acute respiratory infections) as well as wounds and injuries, triage and referral of serious cases to secondary/tertiary facilities, mental health and psychosocial support, and access to referral provisions.

The delivery of such services requires the following personnel and equipment in each cantonment site or assembly area established as part of a DDR programme:

- Average team of one doctor or midlevel health technician, 4–5 public health care nurses and 3–4 ancillary workers per camp; one midwife where necessary;
- Essential medicines and equipment (for sterilization, stabilization, cold chain, etc.);

- Rapid tests and combined treatment for *P. Falciparum* malaria;
- Means of transport, easy procedures and prepositioned facilities for medical/obstetric evacuation;
- Options — either locally or by referral — for the treatment of chronic and severe conditions; at least tuberculosis, severe mental health conditions and epilepsy should be covered;
- Backup systems — teams on call, easy-access procedures, transport and buffer stocks (including protective equipment) — for early detection and treatment of outbreaks; availability and adoption of national standard case definitions and case management protocols;
- Emergency health kits and emergency reproductive health kits (including post-exposure prophylaxis kits and safe abortion care, when appropriate) should be provided to individuals, clinics and hospitals, along with training on their use as and when appropriate.

7.1 Specific HIV initiatives before and during demobilization

Where possible, gender-transformative HIV awareness training among members of armed forces and groups should be started before demobilization begins. For example, if combatants are being kept in their barracks in the interim period between the signing of a peace accord and the roll-out of the DDR programme, this provides an ideal captive (and restive) audience for awareness programmes and makes use of existing structures.¹⁴ In such cases, DDR planners should design joint projects with other actors working on HIV issues in the country. To avoid duplication or over-extending DDR HIV budgets, costs may be shared based on a proportional breakdown of the target group. For example, if it is anticipated that 40 per cent of armed personnel will be demobilized, the DDR programme could cover 40 per cent of the costs of awareness and prevention strategies at the pre-demobilization stage. Such an approach would be more comprehensive, easier to implement, and have longer-term benefits. It would also complement HIV/AIDS initiatives in broader SSR programmes.

Ultimately, most gender-transformative HIV initiatives will take place during the reinsertion phase of demobilization and the longer process of reintegration (see section 7.2.2). However, initial awareness training (distinct from peer education programmes) should be considered part of general demobilization orientation training, and the provision of voluntary HIV testing and counselling should be included alongside general medical screening and be available throughout the reinsertion and reintegration phases.

During cantonments of five days or more during demobilization, voluntary counselling and testing, and awareness sessions should be provided. If the time allowed for a specific phase is changed – for example, if an envisaged cantonment period is shortened – it should be understood that the HIV/AIDS minimum requirements are not dropped but are instead included in the next phase of the DDR programme. Condoms and awareness material/referral information should be available whatever the length of cantonment and should be included in transitional assistance (see IDDRS 4.20 on Demobilization).

HIV/AIDS awareness training

Initial gender-responsive HIV awareness training that covers the basic facts of HIV transmission and prevention methods, and debunks common myths should be provided to DDR participants (two-hour sessions). On the basis of the qualitative data gathered during the planning stages, information, education and communication materials should be developed that are sensitive to the local culture and customs. Written materials in local languages are useful, but alternative materials using pictures should also be provided to account for different literacy rates and to target children. Separate training for men and women should be available to encourage individuals to speak openly and ask questions. Attention should be given to formulating gender-responsive and -transformative messaging and the intersectionality between masculinities, socialization of violence, gender norms, and sexual health, including HIV. Children should receive special training in ICCs, in collaboration with child protection officers (see also IDDRS 5.10 on Women, Gender and DDR and IDDRS 5.30 on Children and DDR). Peer education programmes can be initiated during more extended cantonment periods of four weeks or more, and during reinsertion.

Peer education typically involves training and supporting a small group with the same background, experience and values to share knowledge and change behaviour patterns among their peers. Using peer education teams of men and women from different groups of the conflict can have a significant impact on both peacebuilding and shifting harmful gender norms. Peer education is often used to bring about changes in the knowledge, attitudes, beliefs and behaviours at the individual level. However, the approach can also be used as part of efforts to create change at the group level or in society as a whole by modifying norms and stimulating collective action, both of which contribute to changes in policies and programmes. Globally, peer education is one of the most widely used strategies to address the HIV/AIDS pandemic. It increases the capacity and sustainability of HIV/AIDS awareness and sensitization efforts. HIV/AIDS peer education kits for uniformed services and additional material for awareness sessions for women and children are available.

Syndromic management of STIs

Gender-responsive screening and treatment for STIs should be a standard component of health screening for DDR participants. STIs indicate risk behaviour, and their presence increases the chances of contracting or transmitting HIV. Syndromic management is a cost-effective approach that allows health workers to diagnose STIs based on a patient's history and symptoms, without the need for laboratory analysis. Treatment normally includes the use of broad-spectrum antibiotics. Individuals with an STI should be strongly encouraged to bring their partners in for STI screening so that both can receive treatment in order to prevent reinfection.

HIV counselling and testing

Counselling and testing as a way of allowing people to find out their HIV status is an integral element of prevention activities. Testing technologies have improved significantly, cutting the time required to get a result and reducing the reliance on laboratory facilities. It is therefore more feasible to include testing and counselling in DDR. In countries where ARVs are not yet easily available, disclosing an individual's HIV sta-

tus can create a quandary. It is therefore important that any test is based on informed consent and that providers are transparent about benefits and options (for example, additional nutritional support for HIV-positive people, and treatment for opportunistic infections). The confidentiality of results shall also be assured.

Even if treatment is not available, HIV-positive individuals can be provided with nutritional and other health advice to avoid opportunistic infections (see also IDDRS 5.50 on Food Assistance in DDR). Their HIV status may also influence their personal planning, including vocational choices. The majority of people living with HIV do not know that they are infected, underlining the importance of providing DDR participants with the option to find out their HIV status. Indeed, it may be that demand for VCT at the local level will have to be generated through awareness and advocacy campaigns, as people may either not understand the relevance of, or be reluctant to have, an HIV test.

It is particularly important for pregnant women to know their HIV status, as this may affect the health of their baby. During counselling, information on mother-to-child transmission, including short-course anti-retroviral therapy (to reduce the risk of transmission from an HIV-positive mother to the fetus), and guidance on breastfeeding can be provided. This approach is linked to the elimination strategy, which is lifelong ART for all pregnant and breastfeeding women living with HIV.

Testing and counselling for children associated with armed forces and groups should only be carried out in consultation with a child-protection officer with, where possible, the informed consent of the parent (see IDDRS 5.30 on Children and DDR). HIV counsellors should also be trained and funded. The provision of these counsellors should be based on an assessment of existing capacity, and these counsellors could include local medical personnel, religious leaders, NGOs and CBOs. Counselling capacity needs to be generated (where it does not already exist) and funded to ensure sufficient personnel to run VCT being offered as part of routine health checks, either in cantonment sites or during community-based demobilization, and continued during reinsertion and reintegration.

Counselling: Counselling is generally offered before and after an HIV test in order to help individuals make an informed decision about whether they want a test and to understand their risk behaviour and cope with a possible positive result (including information on how to stay as healthy as possible and how to minimize the risk of transmission to others) and provide referrals to options for treatment, care and support within the national system. Counselling also helps those who are not infected to stay HIV-negative. Counselling on an individual basis is ideal but it can also be offered in group settings with individual follow-up.

Individuals shall always be informed of their test result, and post-test counselling should be provided for both an HIV-positive and an HIV-negative result, especially given the ‘window period’ (period between infection with HIV and the appearance of detectable antibodies to the virus), the possibility for false negatives and the need to impact on behaviour. HIV-positive individuals should be strongly encouraged to bring their partner(s) for testing. In all instances, participants should be provided with referrals to further services in their communities. (For information on psychological, medical and legal support to rape victims, see IDDRS 5.10 on Women, Gender and DDR.)

Testing: In countries with an estimated HIV prevalence of 5 per cent or more, an (opt-in) HIV test with counselling and informed consent should be routinely offered as part of standard health checks for former members of armed forces and groups, but this must be linked to provisions for treatment and/or other benefits. In opt-in testing, individuals (in this case, DDR participants) are given counselling and are offered the option of having an HIV test. It must be explained that they have the right to decide whether they wish to undergo an HIV test, without any personal repercussions, regardless of what they decide. Routinely offering a test respects human rights guidelines, while also reaching a larger population. In general, such an approach results in greater numbers of people finding out their HIV status.

Routine opt-in testing is suggested because DDR participants are a distinct and potentially high-risk group. However, VCT services for participants and beneficiaries should also be provided alongside any offer of testing as part of medicals. Voluntary testing is a client-initiated process, whereby an individual chooses to go to a testing facility/provider to find out his/her HIV status.

Advances in testing technology mean that rapid tests can provide a result within approximately 30 minutes and do not require blood to be drawn or laboratory facilities. HIV-positive results need to be confirmed to rule out false positives. If local laboratory facilities do not exist, a combination of two further different rapid tests should be used to confirm an HIV-positive result. The mapping exercise will have identified national capacities. Planners also need to consult national legislation regarding which HIV tests are accepted, particularly with regard to rapid tests.

Providing condoms

Male and female condoms should be made freely available, and information regarding their correct use should be provided during demobilization and in transitional packs. A range of contraception measures also need to be considered as part of basic human-rights-based reproductive health services, including the prevention of unwanted pregnancies.

Programmes should consider how social norms, including harmful masculinities and gender norms, act as barriers to condom use, even where condoms are freely available. The promotion of their use should be accompanied by interventions that address these barriers, including teaching skills to negotiate safe sex, make women aware of their rights and risks related to HIV, and involve and support men and people of diverse gender identities to take responsibility for safer sex.

Post-conflict settings, particularly in communities where there is less knowledge about contraception options, have proved to be receptive environments for the introduction of female-controlled methods of HIV/STI prevention and contraception. It is important that any introduction of female condoms in DDR programmes be strongly linked to national/local initiatives. If female condoms are not available locally and there are no existing programmes, it may not be feasible or appropriate for DDR HIV/AIDS programmes to introduce and promote their use, which requires training and tailored information campaigns.

Voluntary medical male circumcision

Voluntary medical male circumcision (VMMC) is a medical procedure whereby a trained health-care professional removes all or part of the foreskin of the penis. This procedure reduces heterosexual male vulnerability to HIV infection by approximately 60 per cent for life. VMMC can also be an opportunity to provide a broader range of SRH/HIV services to men and adolescent boys. This is important given the limited engagement with health systems among men and adolescent boys, particularly in post-conflict settings. Therefore, VMMC should never be set up as a stand-alone intervention. VMMC should be complemented by HIV testing and counselling services, screening and treatment for STIs, the promotion of safer sex practices, and the provision of contraception, including male and female condoms. The provision of education on VMMC and appropriate referral mechanisms should be provided to DDR participants, beneficiaries and broader communities.

Provision of post-exposure prophylaxis kits

Post-exposure prophylaxis (PEP) kits are a short-term antiretroviral treatment that reduces the likelihood of HIV infection after potential exposure to infected body fluids, such as through a needle-stick injury or as a result of rape. The treatment should only be administered by a qualified health-care practitioner. It essentially consists of taking high doses of ARVs for 28 days. To be effective, the treatment must start within 2 to 72 hours of the possible exposure; the earlier the treatment is started, the more effective it is. The patient should be counselled extensively before starting treatment and advised to follow up with regular check-ups and HIV testing. PEP kits shall be available for all DDR staff and for victims of rape who present within the 72-hour period required (see also IDDRS 5.10 on Women, Gender and DDR).

Harm reduction

Despite declining global rates of HIV infection, the prevalence of HIV infections among people who inject drugs is rising. The transmission of diseases like viral hepatitis and tuberculosis, as well as deaths due to overdose, are preventable. Comprehensive harm reduction services reduce the incidence of blood-borne infections, problem drug use, overdose deaths and other harms. Harm reduction services include needle-syringe programmes, opioid agonist maintenance therapy, and overdose prevention with naloxone (in line with WHO's harm reduction package¹⁵). Testing and treatment for HIV, tuberculosis, and hepatitis B and C are also considered best practices.

7.2. Health initiatives during reintegration

7.2.1 The reintegration of demobilized health personnel into local and national health systems
To contribute to the sustainable reintegration of those leaving armed forces and groups, interventions can focus on the identification, training and reintegration of demobilized health personnel into local and national health systems. The health skill-set analysis will not only be important for standardizing care during the demobilization phase (as described above), but will give a basic understanding of the capacities of military

health workers, which will assist in their reintegration into civilian life, for example, as employees of the ministry of health or as community-level health service providers.

In line with underpinning principles of health interventions in support of DDR, reintegration interventions shall avoid raising tensions with local communities. The risk of unintended negative impacts may be reduced by adopting an inclusive community approach. Given the resource-poor environments in which DDR processes are often undertaken, DDR practitioners should explore whenever possible the potential to reintegrate demobilized health personnel into local health systems. This approach not only provides viable livelihood opportunities, but has the added benefit of strengthening the health system and augmenting a depleted health workforce. It may improve prospects for social reintegration and contribute to sustainable social cohesion.

It is essential that DDR and health practitioners involved in assessments seek out and record data on both men and women who have been involved in health work in armed forces and groups. This effort should encompass both formal and informal medical infrastructure, as well as the role of informal health-care providers. Women associated with armed forces and groups often work in nursing and/or medical capacities but can be easily overlooked during assessments if they are not considered official part of the armed force's or group's designated medical infrastructure.

The following questions can guide the process of designing a programme to support the reintegration of demobilized health personnel, using the skill-set analysis as a baseline to understand current capacities and health workforce needs. In order to apply a conflict-sensitive approach that strengthens the engagement of local actors, the skill-set analysis should be carried out in languages understood by all parties to a conflict:

- What are the minimum accreditation criteria for health workers? What is the accreditation process? And which national authority/board is in charge of this?¹⁶
- What are the theoretical and practical learning standards for health workers (on-the-job training, classroom hours, etc.)? With what competencies and what type and level of education?
- Which type of workers (clinicians, primary health-care providers, educators, social mobilizers) will be needed/demanded? How many?¹⁷

7.2.2 Mental health and group therapy in support of reintegration

Targeted MHPSS interventions can improve the effectiveness of community-based reintegration programmes by addressing some of the dynamics hampering successful reintegration (such as stigmatization) and aiming to prevent future recruitment and sustain peace. Lingering collective trauma linked to war-related atrocities can lead to further marginalization, grievances and violent behaviour, and impair efforts for reconciliation and rebuilding the social fabric after violent conflict. Giving former members of armed forces and groups, as well as their victims and communities, opportunities to talk about the physical and mental challenges of conflict in a safe and constructive manner can open a pathway to strengthening community resilience to violent conflict and participation in the reconciliation process, and reduce rates of re-recruitment. MHPSS programmes can be designed in support of reconciliation efforts, reintegration programmes, and transitional justice activities between former members of armed forces and groups and communities, through the use of group-focused inter-

ventions such as interpersonal group therapy or community healing dialogues. These types of interventions require specialized personnel and/or community health workers familiar with group-based, age-appropriate MHPSS programmes.

7.2.3 Specific HIV initiatives during reintegration

HIV/AIDS initiatives should be started in receiving communities before demobilization to support or create local capacity for sustainable reintegration. HIV/AIDS activities are a vital part of, but not limited to, DDR initiatives. Whenever possible, planners should work with stakeholders and implementing partners to link these activities with the broader recovery and humanitarian assistance being provided at the community level and the strategy of the national AIDS control programme. People living with HIV/AIDS in the community should be consulted and involved in planning from the outset.

The DDR programme should plan and budget for the following initiatives:

- *Community capacity-enhancement and public information programmes:* These involve providing training for local Government, NGOs/CBOs and faith-based organizations to support forums for communities to talk openly about HIV/AIDS and related issues of stigma, discrimination, gender and power relations, and masculinities; men having sex with men; taboos and fears. This enables communities to better define their needs and address concerns about real or perceived HIV rates among returning former members of armed forces and groups. Public information campaigns should raise awareness among communities, but it is important that communication strategies not inadvertently increase stigma and discrimination. HIV/AIDS should be approached as an issue of concern for the entire community and not something that only affects those being demobilized.
- *Maintain counsellor and peer educator capacity:* Training and funding is needed to maintain VCT and peer education programmes.

Peer education

Peer education training (including behaviour-change communication strategies) should be initiated during the reinsertion and reintegration phases or, if started during cantonment, continued during the subsequent phases. Based on the feedback from the programmes to improve community capacity, training sessions should be extended to include both DDR participants and communities, in particular local NGOs.

During peer education programmes, it may be possible to identify among DDR participants those who have the necessary skills and personal profile to provide ongoing HIV/AIDS programmes in the communities and become change agents. Planning and funding for vocational training should contemplate including such HIV/AIDS educators in broader initiatives within national HIV/AIDS strategies and the public health sector. It cannot be assumed, however, that all those trained will be sufficiently equipped to become peer educators. Trainees should be individually evaluated and supported with refresher courses to maintain levels of knowledge and tackle any problems that may arise.

During the selection of participants for peer education training, it is important to consider the different profiles of DDR participants and the different phases of the programme. For example, peer education programmes should target women associ-

ated with armed forces and groups and NGOs working with women specifically. In addition, before using DDR participants as community HIV/AIDS workers, it is essential to identify whether they may be feared within the community because of the nature of the conflict in which they participated. If former members of armed forces and groups are highly respected in their communities, this can strengthen reintegration and acceptance of HIV sensitization activities. Conversely, if involving them in HIV/AIDS training could increase stigma, and therefore undermine reintegration efforts, they should not be involved in peer education at the community level. Focus group discussions and local capacity-enhancement programmes that are started before reintegration begins should include an assessment of the community's receptiveness. An understanding of the community's views will help in the selection of people to train as peer educators. Gender-transformative messaging and opportunities to leverage gender equity in selection and pairing peer educators must be well utilized.

Voluntary counselling and testing

Voluntary counselling and testing (VCT) should be available during the reinsertion and reintegration phases in the communities to which former members of armed forces and groups are returning. This is distinct from any routine offer of testing as part of medical checks. VCT can be provided through a variety of mechanisms, including through free-standing sites, integrated with other health services, provided within already established non-health locations and facilities, and via mobile/outreach VCT services.

Condoms and PEP kits

Male and female condoms should continue to be provided during the reinsertion and reintegration phases to the DDR target groups. It is imperative, though, that such access to condoms is linked to — and ultimately handed over to — local HIV initiatives, as it would be unmanageable for the DDR programme to maintain the provision of condoms to former combatants, associated groups and their families. Similarly, DDR planners should link with local initiatives for providing PEP kits, especially in instances of rape (see also IDDRS 5.10 on Women, Gender and DDR).

Livelihood creation

One of the major factors increasing vulnerability to HIV in post-conflict settings is the increased levels of commercial/survival sex in communities where unemployment rates are high. Poverty-reduction initiatives, including income-generation and vocational training programmes, should be seen as vital parts of overall community reconstruction, and also contribute to reducing the social risk factors for HIV transmission.

For all DDR participants, the creation of livelihoods is a vital aspect of HIV prevention. For those who may be HIV-positive but otherwise healthy (i.e., have functioning immune systems and show no symptoms), vocational counselling may need to consider health and risk issues, but shall not deny each individual's ability or right to be trained and have a livelihood. The long incubation period of the virus means that it can be many years before an HIV-positive individual develops AIDS, even if he/she is not on treatment.

Social and behaviour change

Gender-transformative social and behaviour change programmes aim to reinforce protective sexual behaviours by addressing knowledge, attitudes, skills and social norms using a combination of strategic approaches and methods. These approaches and methods are essential to preventing sexual and gender-based violence, and to increasing the uptake of HIV prevention tools, including condoms, VMMC, HIV testing and counselling for early treatment, and ARV-based approaches to prevention. Social and behaviour change programmes must be context specific, gender responsive, planned and designed considering local practices and methods, and inclusive of affected populations. They should leverage opportunities for gender-transformative messaging and promote dialogue and engagement in community discussions. Essential components of these programmes may include sociocultural and market research, advocacy for social change, interpersonal communication and mass communication.

7.2.4 Identifying existing capacities

National AIDS control programmes, where they exist, must be the first point of reference for, and key actors in, designing and running HIV/AIDS initiatives as part of DDR programmes. The UN Resident Coordinator/Humanitarian Coordinator can give essential guidance and will have established networks with relevant NGOs/CBOs. The UN theme group is the main mechanism to coordinate HIV/AIDS initiatives among UN agencies and other partners.

Implementing partners

In many settings, key HIV/AIDS implementing partners may already be working in the country, but not necessarily in all the areas where demobilization and reinsertion/reintegration will take place. To initiate programmes, DDR practitioners should consider providing seed money to kick-start projects, for example, covering the costs of establishing a basic VCT centre and training counsellors in a particular area, on the understanding that the implementing partner would assume the costs of running the facility for an agreed period of time. This is because it is often easier for NGOs to raise donor funds to maintain a project that has been shown to work than to set one up. Such an approach has the additional benefit of extending HIV facilities to local communities beyond the time frame of DDR, and can provide a buffer for HIV-related services at the reinsertion stage, for example, if there are delays in the demobilization process, such as time lags between the demobilization of special groups and ex-combatants.

HIV-related support for peacekeeping missions

HIV/AIDS adviser: Peacekeeping missions routinely have HIV/AIDS advisers, assisted by UN volunteers and international/national professionals, as a support function of the mission to provide awareness and prevention programmes for peacekeeping personnel and to integrate HIV/AIDS into mission-mandated activities. HIV/AIDS advisers can facilitate the initial training of peer educators, provide guidance on setting up VCT, and assist with the design of information, education and communication materials, including on preventing SGBV. They should be involved in the planning of DDR from the outset.

Peacekeepers: Peacekeepers are increasingly being trained as HIV/AIDS peer educators, and therefore might be used to help support training. This role would, however, be beyond their agreed duties as defined in troop-contributing country memorandums of understanding, and would require the agreement of their contingent commander and the force commander. In addition, abilities vary enormously: the mission HIV/AIDS adviser should be consulted to identify those who could take part.

Many battalion medical facilities offer basic treatment to host populations, often treating cases of STIs, as part of ‘hearts and minds’ initiatives. Battalion doctors may be able to assist in training local medical personnel in the syndromic management of STIs, or directly provide treatment to communities. Again, any such assistance provided is not included in memorandums of understanding or self-sustainment agreements, and so would require the authorization of contingent commanders and the force commander, and the capability and expertise of any troop-contributing country doctor would have to be assessed in advance (see IDDRS 4.40 on UN Military Roles and Responsibilities).

8. Health interventions in support of DDR-related tools

In addition to DDR programmes, the UN has developed a set of DDR-related tools aiming to provide immediate and targeted responses (see IDDRS 2.10 on The UN Approach to DDR). These include pre-DDR, transitional weapons and ammunition management (WAM), community violence reduction (CVR), initiatives to prevent individuals from joining armed groups designated as terrorist organizations, DDR support to mediation, and DDR support to transitional security arrangements. In addition, support to programmes for those leaving armed groups labelled and/or designated as terrorist organizations may also be provided by DDR practitioners using DDR-related tools in compliance with international standards.

The specific aims of DDR-related tools vary according to the context and can contribute to broader political and peacebuilding efforts in line with United Nations Security Council and General Assembly mandates and broader strategic frameworks, such as the United Nations Sustainable Development Cooperation Framework, the Humanitarian Response Plan and/or the Integrated Strategic Framework. A gender- and child-sensitive approach should be applied to the planning, implementation and monitoring of DDR-related tools.

DDR-related tools may be applied before, during and after DDR programmes as complementary measures. However, they may also be used when the preconditions for DDR programmes are not in place. In these cases, it is particularly important to delimit the boundaries of an integrated DDR process. Integrated DDR processes without DDR programmes do not include all ongoing stabilization and recovery measures, but only those DDR-related tools (CVR, transitional WAM and so forth) and reintegration efforts that directly respond to the presence of active and/or former members of armed groups. Clear DDR mandates and specific requests for DDR assistance also define the parameters and scope of integrated DDR processes.

During the implementation of DDR-related tools, health activities should include some or all of those relevant to DDR programmes (see section 7). In addition, the feasibility of the following activities should be explored:

- *Community violence reduction:* CVR is a bottom-up approach that targets youth at risk of recruitment, community members and armed groups (see IDDRS 2.30 on Community Violence Reduction). CVR encompasses a range of activities – including labour-intensive projects, business incubation and community dialogue forums – directly engaging with former members of armed forces and groups and children and youth at risk to prevent further recruitment. Lastly, CVR helps to eliminate the main drivers of violence and build social cohesion, including by addressing inequities in access to basic services such as health. Examples of using CVR in support of health outcomes may include:
 - *Increasing production of and access to personal protective equipment:* In resource-poor environments with a fragile health system, CVR may be used in support of national and local health efforts. This may include the production of PPE, such as gloves, gowns, face masks, hand sanitizers, bed nets (to prevent the spread of mosquito-borne diseases such as malaria and yellow fever) and portable hand-washing stations. The determination of which items should be the focus of production by CVR participants should be (a) made in collaboration with health partners; (b) based on a health needs assessment; and (c) in cases where the CVR project is meant to be income generating, mindful of market dynamics so as to avoid saturation and price fluctuations.
 - *Building health infrastructure:* Depending on the needs of communities or in response to an ongoing outbreak, CVR may be considered with the view of directly supporting local health systems. This can include building or rehabilitating health facilities such as community health centres or isolation wards in support of infectious disease mitigation measures, as well as digging wells and bore holes to improve access to water, sanitation and hygiene. If nearby health facilities are to be rehabilitated or new facilities established, the work should fit in with medium to long-term plans as outlined in the national health strategy. Even though health care will be provided to former members of armed forces and groups and their dependants during the DDR process only for a short time, facilities should be rehabilitated or established that meet the requirements of the national strategy for rehabilitating the health system and provide the maximum long-term benefit possible to the general population. Resources allocated towards health facilities and training of staff can also contribute to building stronger health systems in the longer term, including better mental health care and comprehensive reproductive and maternal health services, for former members of armed forces and groups, their families and the rest of the population.

- *Pre-DDR:* Pre-DDR involves local-level transitional stabilization measures designed for those who are eligible for a national DDR programme (see IDDRS 2.10 on The UN Approach to DDR). It includes (but is not limited to) WAM, gender-responsive and age-appropriate vocational training, setting up small businesses and cash for work, and can be conducted with male and female ex-combatants who are in camps or who are already in communities.
 - *Identifying and training health personnel in support of the DDR programme:* When relevant and possible, the level of health expertise within armed groups and

forces should be assessed to identify people who can be trained (this is also applicable during the demobilization phase of a DDR programme). Health expertise should be understood in a wide sense to include, when this is relevant and appropriate, traditional practitioners, and combatants and associates who have experience of health work, even without formal education and training, provided that appropriate supervision is guaranteed. Training of local health personnel is vital in order to implement the complex health response needed during DDR processes. In many cases, the warring parties will have their own military medical staff who have had different training, roles, experiences and expectations. However, these personnel can all play a vital role in the DDR process. Their skills and knowledge will need to be updated and refreshed, since the health priorities likely to emerge in assembly areas or cantonment sites — or neighbouring villages — are different from those of the battlefield.

- *DDR mediation support:* As members of mediation support teams or mission staff in an advisory role to the Special Representative of the Secretary-General or Deputy Special Representative of the Secretary-General, DDR practitioners can provide insights into the interests and positions of armed forces and groups related to DDR. This support also includes DDR practitioners' provision of advice on how to engage with armed forces and groups on DDR issues and contribute to the attainment of agreements. In some cases, health and health emergencies such as outbreaks can be used as neutral entry points to engage with armed groups.
 - *Engaging with armed groups on health issues:* Where engagement with armed groups continues, DDR practitioners may consider advising mediators to incorporate key messages related to the respect and protection of health-care facilities, health workers and medical transports in accordance with international humanitarian law.
 - *Promoting the cessation of hostilities during outbreaks:* Where applicable, DDR practitioners may explore where DDR processes may benefit from or contribute to calls for a ceasefire as well as national and regional initiatives related to humanitarian pauses in conflict.

9. Health interventions and reintegration support during active conflict

As outlined in IDDRS 2.10 on the UN Approach to DDR, DDR practitioners can provide support to reintegration as part of a DDR programme, but also when no DDR programme is in place (see IDDRS 2.40 on Reintegration as Part of Sustaining Peace and IDDRS 4.30 on Reintegration). DDR practitioners should consider the specific health initiatives outlined above, in section 7.2 on reintegration, even when reintegration support is provided in contexts where there is no peace agreement and no DDR programme. In these contexts, particular attention to the principle of conflict sensitivity is required.

Annex A: Abbreviations

ART	anti-retroviral therapy
ARV	anti-retroviral
CBO	community-based organization
EWAR	early warning alert and response
GBV	gender-based violence
IASC	Inter-Agency Standing Committee
ICC	interim care centre
MHPSS	mental health and psychosocial support
NCD	non-communicable disease
NGO	nongovernmental organization
OI	opportunistic infection
PEP	post-exposure prophylaxis
SGBV	sexual and gender-based violence
SRH	sexual and reproductive health
SSR	security sector reform
STI	sexually transmitted infections
VCT	voluntary counselling and testing
VMMC	voluntary medical male circumcision
WHO	World Health Organization

Endnotes

- 1 United Nations and World Bank, *Pathways for Peace: Inclusive Approaches to Preventing Violent Conflict* (Washington, DC, 2018).
- 2 Inter-Agency Standing Committee (IASC), *IASC Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings* (Geneva, 2007).
- 3 United Nations Population Fund, “Sexual and reproductive health and rights: an essential element of universal health coverage” (Nairobi, 2019).
- 4 Sphere Association, *The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response*, 4th ed. (2018).
- 5 HIV risk in militaries is related to specific contexts, with a number of influencing factors, including the context in which troops are deployed. Many AIDS interventions by ministries of defence have been effective and have reduced HIV infection rates in the uniformed services.
- 6 In many cases, ex-combatants who are set to join a uniformed service do not go through the DDR process. There would still be a potential benefit, however, in instances where HIV/AIDS awareness has started in the barracks/camps.
- 7 UNAIDS, “Fact sheet 2022.” Available at https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf (accessed on 31 January 2023).
- 8 For general guidance on prevention, treatment and recovery from drugs, see also United Nations Office on Drugs and Crime (UNODC) and World Health Organization (WHO), *International Standards on Drug Use Prevention*, 2nd ed. (Vienna, 2018). See also UNODC and WHO, *International Standards for the Treatment of Drug Use Disorders*, revised ed. (Switzerland, 2020).
- 9 A useful framework for programming is outlined in the IASC, *Guidelines on Mental Health and Psychological Support in Emergency Settings*, 2007. Useful programme intervention tools include (1) WHO, *mhGAP Humanitarian Intervention Guide: Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies*, 2015 (mhGAP-HIG); (2) WHO, *Psychological First Aid: Guide for Field Workers*, 2011; (3) WHO, *Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity* (2011).
- 10 mhGAP-HIG.
- 11 WHO, *Early Warning Alert and Response in Emergencies: An Operational Guide* (Geneva, 2022).
- 12 On health-specific needs of LGBTIQ+ populations, see Women’s Refugee Commission, *Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector* (New York, 2021).
- 13 *Sphere Handbook*.
- 14 At the same time, planners cannot assume that all fighting forces will have an organized structure in barracks with the associated logistical support. In some cases, combatants may be mixed with the general population and hard to distinguish.
- 15 WHO, *Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations* (Geneva, 2022).
- 16 WHO, *Quality and Accreditation in Health Care Services: A Global Review* (Malta, 2003).
- 17 Gilles Dussault et al., “Assessing future health workforce needs”, Policy Summary 2, European Observatory on Health Systems and Policies (WHO, 2010).