SECRETARY-GENERAL'S PEACEBUILDING FUND
PROJECT DOCUMENT TEMPLATE

United Nations Peacebuilding

PBF PROJECT DOCUMENT

Country: Guinea-Bissau	
Project Title: Strengthening social cohesion through promoting inclusive and effective public health sector governance, management, and administration. **Project Number from MPTF-O Gateway (if existing project):**	
PBF project modality: ☐ IRF ☒ PRF	**If funding is disbursed into a national or regional trust fund (instead of into individual recipient agency accounts):** ☐ Country Trust Fund ☐ Regional Trust Fund **Name of Recipient Fund:**
List all direct project recipient organizations (starting with Convening Agency), followed by type of organization (UN, CSO etc.): The World Health Organization, UN (WHO) United Nations Children's Fund, UN (UNICEF) **List additional implementing partners, and specify the type of organization (Government, INGO, local CSO):** Interpeace, CSO Voz di Paz, CSO	
Project duration in months[1]: 24 months **Geographic zones (within the country) for project implementation:** Across all the 11 health regions in the country (Bafata, Bijagos, Biombo, Bissau, Bolama, Cacheu, Farim, Gabu, Oio, Quinara and Tombali). (*Outcome 1 is focused on the national level while Outcome 2 will be focused in some specific regions based on the results of the Outcome 1 study. See II (d) Project Targeting for further details on specific activities and geographic implementation*).	
Does the project fall under one or more of the specific PBF priority windows below: ☐ Gender promotion initiative[2] ☐ Youth promotion initiative[3] ☐ Transition from UN or regional peacekeeping or special political missions ☐ Cross-border or regional project	
Total PBF approved project budget* (by recipient organization): **WHO:** $1,018,500 **UNICEF**: $481,500 Total budget: $1,500,000 *The overall approved budget and the release of the second and any subsequent tranche are conditional and subject to PBSO's approval and subject to the availability of funds in the PBF	

[1] The official project start date will be the date of the first project budget transfer by MPTFO to the recipient organization(s), as per the MPTFO Gateway page.

[2] Check this box only if the project was approved under PBF's special call for proposals, the Gender Promotion Initiative

[3] Check this box only if the project was approved under PBF's special call for proposals, the Youth Promotion Initiative

account. For payment of second and subsequent tranches the Coordinating agency needs to demonstrate expenditure/commitment of at least 75% of the previous tranche and provision of any PBF reports due in the period elapsed.
Any other existing funding for the project (amount and source): UNICEF funds for strengthening the social service workforce will complement and support the project interventions to enhance the health social services to provide MHPSS. (UNICEF Thematic Funds, USD 35, 000)

PBF 1st tranche (60%) **WHO: $ 611,100** **UNICEF: $ 288,900** **Total: $ 900,000**	**PBF 2nd tranche* (40%)** **WHO: $ 407,400** **UNICEF: $ 192,600** **Total: $ 600,000**	

Provide a brief project description (describe the main project goal; do not list outcomes and outputs):

The broader goal of the proposed project is to contribute to the strengthening of social cohesion through promoting inclusive and effective public health sector governance. The project thus focuses on addressing conflict triggers as discussed in the context analysis by strengthening the capacities of both the Government and HCWs, including citizens as elaborated below.

Towards strengthening Government's capacity to understand and respond to citizens' and HCWs' demands, the project will aim to contribute to the development of policy frameworks and mechanisms such as Human Resources for Health Policy, Annual Planning and Monitoring tools, and Standard Operating Procedure(SOPs), through an inclusive and participatory manner. Equally the project will support actions of currently established health structures such as the health committees (at the Parliament and Ministry of Public Health), associations, workers union, and the professional council to advocate for the rights of the health workforce and promote dialogue with the government as well as to promote health security and efficient and effective health service delivery. By creating the space for citizens, the health workforce, development partners, and the Government to work together across dividing lines to develop policies and find a consensus on key health sector priorities, the implementation of policies and health programmes will be made effective, coherent, and targeted. Considering the willingness of relevant stakeholders and institutions who were consulted during the project design phase to support the proposed actions, the project will lay the groundwork for continued broader reforms especially by strengthening the capacities of the different departments at the Ministry of Health and specifically the Directorate of General Administration and Health Systems(DGASS) and the Directorate of Studies, Planning and Partnerships Services (DSEPP).

Towards strengthening the capacity of the health workforce in negotiations and dialogue with the government to foster the resolution of grievances, and towards the delivery of quality health service provision, the project aims to strengthen the capacity of HCWs and the workers union in key areas such as conflict resolution and mediation, advocacy and lobbying and strategic engagement. Accordingly, by strengthening the capacities of healthcare workers on medical ethics and protocols, the project will promote a culture of accountability, transparency, and citizen trust and equally the delivery of quality health services. Finally, by working with CSOs, health structures, and HCWs to advocate and raise awareness of their rights and duties, and likewise to promote the

monitoring of the implementation of health policies and programmes, the project aims to foster citizen participation in health governance.

Summarize the in-country project consultation process prior to submission to PBSO, including with the PBF Steering Committee, civil society (including any women and youth organizations), and stakeholder communities (including women, youth and marginalized groups):

NGOs: Interpeace and its local partner **Voz di Paz were consulted and** were actively involved in the drafting of the proposal.

United Nations Agencies: UNDP was consulted to explore complementarity and synergistic collaboration in peacebuilding programming. Inputs were also widely sought from UNDPs Health Programme team.

The Resident Coordinators Office (RCO): Efforts were also made to solicit input from the RCO's office, and their feedback was incorporated into the PRODOC.

Government and CSOs: During the development of the concept note, WHO, UNICEF, and Interpeace organized meetings with senior staff in the different line ministries. A meeting was held with the General Director of Health Care Establishment from the **Ministry of Public Health** and her feedback was incorporated in the document accordingly. Additionally, the **Ministry of Women, Family, and Social Solidarity** (through the Woman and Child Institute) was also consulted in the development of the fully-fledged proposal. A consultation with representatives from the **Ministry of Health**, **CSOs,** and the HCW's **professional association** was also carried out[4] to validate the Concept Note and solicit new perspectives which were fully incorporated in the PRODOC.

Project Gender Marker score[5]: 2
Specify % and $ of total project budget allocated to activities in pursuit of gender equality and women's empowerment:
51.34 % of the budget, which is approximately **USD 770,165** has been allocated to activities in pursuit of gender equality. **Note**: Gender equality and women empowerment are cross-cutting in all planned activities.

***Briefly* explain through which major intervention(s) the project will contribute to gender equality and women's empowerment [6]:**

The proposed interventions are gender-responsive by design and have strategically been developed to contribute to Gender Equality and Women's Empowerment (GEWE). In fostering dialogue among relevant stakeholders at the local and regional level, women and girls and other disadvantaged and vulnerable groups will be invited to actively participate in discussions on health governance and health rights. Under Outcome 2, the capacity of women's groups at the local and

[4] Consultation was held on the 15th /06/2022

[5] **Score 3** for projects that have gender equality as a principal objective and allocate at least 80% of the total project budget to Gender Equality and Women's Empowerment (GEWE)
Score 2 for projects that have gender equality as a significant objective and allocate between 30 and 79% of the total project budget to GEWE
Score 1 for projects that contribute in some way to gender equality, but not significantly (less than 30% of the total budget for GEWE)

[6] Please consult the **PBF Guidance Note on Gender Marker Calculations and Gender-responsive Peacebuilding**

regional levels will also be strengthened on gender, equity, and human rights to support efforts towards advocacy and awareness-raising about health rights and to enable them to actively participate in decision-making in the health sector.

Furthermore, the development of gender-responsive health policies, which are informed by comprehensive gender analysis and barriers assessment embedded in the work done under output 1.1, will be a focus of the project, and a part of health governance, management, and administrative reforms that the project envisions. The development of gender-sensitive human resources for health policy, for instance, is envisioned to promote equity in the hiring of the health sector workforce. Furthermore, a gender analysis of Human Resources for Health practices will be conducted, and efforts will be dedicated under (Outcome 1) to promote and support education and training, recruitment, deployment, and retention of HCW and to optimize health worker motivation, satisfaction, retention, equitable distribution, and performance. In engagement with the Parliament, efforts will be made to support the Parliamentary Health Committee to advocate for Gender-Responsive Budgeting to contribute to improved health outcomes, and with women at their center.

Project Risk Marker score[7]: 1

Select PBF Focus Areas which best summarizes the focus of the project *(select ONLY one)* [8]:

(3.2) Equitable access to social services

If applicable, SDCF/**UNDAF outcome(s)** to which the project contributes:
The project seeks to contribute to priority area 1 of the UNSDCF: Transformational and inclusive governance encompassing respect for the rule of law and sustaining peace: More specifically it will contribute to the following outcome: By 2026, people in Guinea-Bissau will enjoy improved democratic governance, peace and rule of law and their needs are met.
Sustainable Development Goal(s) and Target(s) to which the project contributes:

- **SDG 3:** Good health and well-being: ensure healthy lives and promote well-being for all at all ages.
- **SDG 5:** Gender equality: achieve gender equality and empower all women and girls.
- **SDG 8:** Decent work and economic growth: promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all.
- **SDG 10:** Reduce inequalities: reduce inequalities within and among countries.
- **SDG 16:** Peace, justice, and strong institutions: Promote peaceful inclusive societies for sustainable development: provide access to justice for all, and build effective, accountable, and inclusive institutions at all levels.
- **SDG 17:** Partnership for the goals: strengthen the means of implementation and revitalize the global partnership for sustainable development.

Type of submission:	**If it is a project amendment, select all changes that apply and provide a brief justification: N/A**
☒ **New project**	

[7] **Risk marker 0** = low risk to achieving outcomes
Risk marker 1 = medium risk to achieving outcomes
Risk marker 2 = high risk to achieving outcomes

[8] **PBF Focus Areas** are:
(1.1) SSR, (1.2) Rule of Law; (1.3) DDR; (1.4) Political Dialogue;
(2.1) National reconciliation; (2.2) Democratic Governance; (2.3) Conflict prevention/management;
(3.1) Employment; (3.2) Equitable access to social services
(4.1) Strengthening of essential national state capacity; (4.2) extension of state authority/local administration; (4.3) Governance of peacebuilding resources (including PBF Secretariats)

☐ **Project amendment**	**Extension of duration:** ☐ Additional duration in months (number of months and new end date): **Change of project outcome/ scope:** ☐ **Change of budget allocation between outcomes or budget categories of more than 15%:** ☐ **Additional PBF budget:** ☐ Additional amount by recipient organization: None **Brief justification for amendment:** *Note: If this is an amendment, show any changes to the project document in RED color or in TRACKED CHANGES, ensuring a new result framework and budget tables are included with clearly visible changes. Any parts of the document which are not affected should remain the same. New project signatures are required.*

PROJECT SIGNATURES:

Recipient Organization(s)[9]	**Representative of National Authorities**
Name of Representative *Dr. Jean-Marie Kipela,* [redacted] *Signature* *Name of Agency: WHO* *Date & Seal:* 28/11/2022	*Name of Government Counterpart* *Dr. Dionisio Cumbà* [redacted] *Signature* *Title: Minister of Public Health* *Date & Seal:* 19/12/22
Recipient Organization(s)[10] *Name of Representative* *Etona Ekole* [redacted] *Signature* *Name of Agency: UNICEF* *Date & Seal*	
Head of UN Country Team	**Peacebuilding Support Office (PBSO)**
Name of Representative *Anthony Ohemeng-Boamah* *Signature* [redacted] *Title: Resident Coordinator* *Date & Seal* 20/XII/2022	Elizabeth Spehar [redacted] *Signature* Assistant Secretary-General for Peacebuilding Support *Date & Seal* 21/12/2022

[9] Please include a separate signature block for each direct recipient organization under this project.

[10] Please include a separate signature block for each direct recipient organization under this project.

I. Peacebuilding Context and Rationale for PBF support (4 pages max)

a. A brief summary of **conflict analysis findings** as they relate to this project.

Guinea-Bissau gained independence in 1973 aiming to bring about rapid economic, political, and social transformation. However, post-independence efforts failed to translate into a meaningful state-building agenda. The country remains mired in a political crisis that is rooted in a history of power struggles as evidenced by the Coup d'états of-1980, 2003, and 2012. Weak and poorly governed institutions are the result of the failure of successive Governments to establish functional democratic and inclusive state institutions, and despite the recent conclusion of the mandate of the United Nations Integrated Peacebuilding Office in Guinea-Bissau (UNIOGBIS) in December 2020, conflict drivers persist which are evidently visible in the public health sector. The poor governance of the health sector coupled with the tense and unpredictable political environment have resulted in protracted industrial action, strikes, and boycotts, which have consequently impacted citizens' access to healthcare services. Given the central importance of the health sector in promoting social cohesion, and minimizing social conflict drivers, the deterioration of health services due to poor health governance risks undoing the gains made in peacebuilding in Guinea-Bissau.

From **a political standpoint**, the public health sector has been fundamentally impacted by unpredictable political decisions and choices. Erratic Government cabinet reshuffles, unpredictable changes in Government policy towards the health sector, and political impasses, compounded with poor administrative and management capacities have inevitably created institutional gaps. Categorically, there is a lack of accountability mechanisms, regulatory frameworks, and mechanisms which has also resulted in corrupt tendencies[2]. Cases of mismanagement, informal payments,[13], and inaction by the government have thus heightened tensions between the health workforce, government, and citizens.

In terms of public health sector financing, the health sector is neglected and poorly financed. A study of the National Health Accounts conducted between 2015-2017 showed that Government spending on health accounted for only 7% of the State budget, which is far from the 15% target that countries in the African Region committed to achieving in the Abuja Declaration on Health in 2015, and hence reflects poorly on social outcomes. In terms of budgetary governance at the sectoral level, there are loopholes particularly in budgetary practices and control mechanisms. Although the health budget is directly controlled by the Ministry of Finance(MoF), requisitions, disbursements, and budget execution are directly managed by the Ministry of Health(MoH),whose financial control and regulatory mechanisms are flawed. Budget formulation, monitoring, and oversight are equally deficient, and despite ongoing efforts to reform budgetary practices at the MoH through the WHO-EU partnership on health financing, such an intervention is mainly focused on improving operational efficiency and capacity strengthening, and thus through the proposed action on health governance, the latter will be reinvigorated by the policy frameworks that the proposed action will put in place and thus establish the basis for sustained budgetary governance practices. The development of the human resources for health policy will for instance strengthen the mandate of the Directorate of Planning, Studies, Partnerships and Services to provide stringent oversight on all budgetary and financial transactions which will promote transparency, and accountability in budgetary governance at the MoH.

Similarly, the World Bank's Public Expenditure Review (2020) showed that public spending in Guinea-Bissau is low and volatile. The associated social conflict drivers of a weak healthcare system are often overlooked which also negatively impacts **service delivery and the welfare of the health workforce.** Consequently, such conditions have generated a sense of exclusion and fostered a culture of institutional violence, civil disobedience, and public strikes. The citizens' trust in the Government's ability to provide health services, as envisioned in the National Health Development Plan (2018-2022) as well as the National Development Plan (2020-2023) has been diminished substantially. Efforts to manage communication, dialogue, and mediation among aggrieved parties have equally been curtailed.

Thus, access to health services remains constrained and ineffective. The fragility of the public health sector, therefore, implies a substantial emotional component, which has triggered desperation among ordinary Bissau Guineans and hence risks spiraling into violent action in the quest for a change of the status quo. Whilst the consequences of weak institutional governance in other sectors are equally visible, in the health sector specifically, they are immediately and tragically evident and impactful to citizens and even though private health services can be accessed as an alternative to public health services, only a handful of citizens can afford such services. In turn, Bissau Guineans find themselves in intolerably precarious conditions and predisposed to hold the government to account through violent means and civil disobedience.

Categorically, due to poor health governance and mismanagement, women and girls have disproportionately been affected the most. Approximately 70% of the HCW are women, and a majority of whom are in the nursing workforce. Men on the other hand make up a majority of the senior and managerial roles. Thus, in instances where there are HCW strikes, women find themselves at risk of losing their jobs. Women in Guinea-Bissau also find themselves burdened by Communicable Diseases (i.e HIV, Malaria, and TB,) and more recently COVID-19 and although these diseases affect both women and men,[11] women and girls are largely affected due to their weak economic status. Women also do have specific health needs which are either overlooked or neglected. For instance, access to Maternal and Child Health Services (MCH) has not fully received government attention. The national average rate of maternal mortality is estimated at 746 per 100,000 live births which is among the highest in West Africa. Furthermore, women do not have access to, sexual and reproductive health services and they do suffer from, health issues related to Gender Based Violent (GBV) including Mental Health and Psychosocial problems and are equally subjected to Female Genital Mutation (FGM)12. As primary caregivers, women also bear the burden of the children's disease, health provision, and hospitalization and thus in a situation where the public health sector is poorly governed and mismanaged, the provision of quality and timely health services is impacted which consequently affects women and other marginalized groups.

In this context, the UNCT believes that this kind of intervention in the health sector is strategically valuable as it could catalyze a change of attitude, with a more positive perspective towards the government. Thus, two conflict dimensions exist within the public health sector in Guinea-Bissau that present potential conflict triggers as follows:

[11] (MICs 2016),
[12] 52% of women and girls in Guinea-Bissau have undergone FGM

1. **Existence of deep-rooted grievances between HCWs and the Government**

i. **The failure of the Government to provide a conducive work environment and welfare for the health workforce has deepened grievances between the health workforce and the government**. The health workforce in Guinea-Bissau is comprised of approximately 70% female and 30% male of whom 1,884 are nurses, 450 doctors, 213 midwives, 206 laboratory technicians, 73 pharmacists, 48 radiologists, and 19 specialists. The lack of a clear human resource for health policy, defined procedures for human resources recruitment, as well as career development and division of competencies for the latter, have constrained efforts to effectively and efficiently manage the public health sector resulting in delayed payments of HCW salaries. The lack of a performance monitoring mechanism and the unequal treatment of health professionals have equally created a less productive environment which consequently has fueled public anger and resentment towards the Government as evidenced by the protracted strikes by the health workforce and the workers union. Due to a lack of a fully established inter-ministerial coordination mechanism between the Ministry of Public Health (MoH) and the Ministry of Finance (MoF) to coordinate and streamline budgeting vis-à-vis recruitment of HCW, medium-term and long-term budgetary estimates are difficult to forecast and hence has impacted health sector spending and financial allocations. Consequently, the health workforce is deprived of welfare which has resulted in corrupt tendencies in the form of informal payments, a burden of which is born by ordinary citizens.

ii. Second**, there is a lack of a fully functional structure within the HCWs union and the health professional board**. Both the workers union and the health professional board have failed to represent the HCWs' interests due to their weak structure and leadership and their lack of capacities. New representatives have not been elected in the past years and the institutions do not have the capacity to function efficiently, and monitor the HCWs conditions and needs, neither participate in the active search for solutions to problems affecting HCWs nor negotiate with government and other key institutions. Due to the limited capacities of the workers unions, HCWs mainly organize themselves through informal groups to organize unregulated strikes and boycotts which consequently disrupt the provision of health services. A glaring example is the general boycott of September 2021. On this occasion, for one entire week, across the country, no HCW reported on duty . This boycott was organized by the independent HCWs groups using WhatsApp as a platform in which both the workers union and the professional association were not in control of the situation. Strengthening the representative role of workers union and the health professional board and building their capacity in negotiations and dialogue is thus key to ensure that HCWs have formal, effective and a reliable channel to lodge their grievances and complaints, and equally to express their voices when faced with adversity without fear of retribution by the opposing forces in government.

iii. Third, **there is absence of constructive negotiations and dialogue between HCWs and the Government.** Despite the existence of space and openness to negotiation and dialogue between HCWs representatives and the government, efforts to engage in meaningful negotiations and dialogue in the past years have yielded no substantial outcomes. In September 2022, after the Government made a decision to dismiss 1000 HCW due in part to irregularities

in the hiring of public health workers, the possibility of another boycott was announced by HCW who threatened to leave patients unattended. This situation has unequivocally shed light on the need for dialogue between the government, workers union, and the professional association who were not consulted nor informed of this decision. Efforts to negotiate following the latter were inconclusive and futile: the government (represented by the First Vice Prime Minister) issued a circular to discontinue a certain cohort of HCWs and accordingly, HCWs union called for a general strike. Due to the failure of formal negotiations, informal negotiations took place at the individual level (for example between the hospital director and the HCW employed in respective health centers and hospitals) and through informal channels not representative of the collective health workforce or workers union. Arguably the complete boycott of HCWs in 2021 demonstrated the difficulties encountered by the Government in finding a workable solution to HCW grievances. Despite the existing structural constraints that Government is faced with to meaningfully commit to public health sector reforms, structured negotiations however between the Government and HCW representatives could contribute to honest and transparent dialogue to guard against practices of civil disobedience and potentially violent strikes, and boycotts, which disrupt provision of health services.

Consequences of the above-mentioned factors include:

Unregulated strikes and a boycott disrupt the provision of health services which risk triggering violent protests and demonstrations. These unregulated strikes, which are either spontaneously organized by HCWs through WhatsApp groups, or by the workers union, disrupt the provision of essential health services to an unbearable extent. The current strike[14] has been on and off since October 2020, and hence has disrupted normal working schedules: public health services are only operational 2 or 3 days per week. The protracted strike has inevitably created social tension due to the constant threat of escalation into a level of a complete boycott, similar to the events of September 2021. The complete boycott organized by the HCW led to incidences of civil disobedience, moreover the strikes affected the provision of health services as well as the COVID-19 vaccine campaign throughout 2021 and 2022. Consequently, it resulted in increased mortality rates, especially among vulnerable groups such as women and children. Clinical data obtained from Simao Mendes National Hospital in Bissau showed that deaths tripled during the strike of September 2022. There is increasingly growing evidence that suggests a possibility of yet another boycott .The pediatric and neonatal department has raised the possibility that HCWs would leave patients unattended if no corresponding actions are taken by the duty bearers.

- **A loss of confidence and credibility in Government.** Failure of the government to address the demands of the HCW despite the increasingly unregulated strikes and boycotts have resulted in weakened government credibility and equally a loss of confidence in the government's ability to provide and sustain the welfare of public servants which in turn has weakened the existing social contract between government and citizens. Similarly, it has eroded confidence in other political dialogue processes which may now be treated with a high degree of skepticism. In this context, the lack of coordination and dialogue among relevant

stakeholders in the health sector, sets a bad precedent for future dialogues on peaceful resolution of conflicts and grievances.

2. **Inadequate access to healthcare services resulting in erosion of social bonds and trust between citizens, the health workforce, and health institutions**.

i. Due to **poor health service delivery and a fragile health system,** access to essential health care services is limited. The health system in Guinea-Bissau is characterized by a weak health workforce(insufficient and underqualified human resources), poor health governance, dysfunctional health information system, a lack of health financing mechanism as well as a lack of access to essential medicines, and technologies, all of which are a result of political instability, poor institutional governance, and high dependence on donor support as described above. In this context, access to health care for certain groups is heavily compromised. Women, young women, children, and people with disabilities bear the heaviest burden of the shortcomings of the health system and hence has deepened vulnerability and created a sense of neglect by the duty bearers. Particularly, women and young women's access to reproductive health services, prenatal and maternity service is jeopardized moreover these are highly supported by development partners. Social service providers on the other hand have a weak capacity to deliver health services such as Mental Health and Psychosocial Support Services (MHPSS) to the population in general and, especially, to women, children, and those at risk of GB. Between 2019 and 2021, 185 cases of GBV cases were reported, mainly in rural areas, where MHPSS services continue to be overlooked. The lack of such services in the health centres, coupled with high rates of GBV cases and equally a weak response mechanism to all social and health challenges has created a sense of further exclusion among marginalized groups and thus deepened poverty and inequality in the different pockets of the country. The consequences posed by the latter therefore threaten peace and stability which risks undoing gains and investments made in peacebuilding in Guinea Bissau over the decades.

ii. A **lack of awareness by citizens of their health rights and duties;** and the **lack of accountability mechanisms or channels** contribute to misunderstandings and fraudulent acts. Examples are informal payments, and the blackmailing of patients by medical staff. On the one hand, citizens and CSOs lack information and tools to better monitor the provision of health services and implementation of policies to hold government to account. Likewise, HCWs, as duty bearers, are not aware of their obligations. Despite the promises to guarantee health rights as articulated in the Guinea-Bissau National Health Development Plan (2018-2022) as well as article 12 of the International Covenant on Economic, Social and Cultural Rights (ratified by Guinea-Bissau ratified in 1992), the lack of corresponding state obligations and support from duty bearers constitutes a denial of health rights for citizens in Guinea Bissau.[13] This denial has created a sense of neglect and exclusion in the public domain, especially amongst the most vulnerable and marginalized groups such as women and children, Persons with Disabilities (PWDs), and people living with HIV, and hence has resulted in a loss of confidence in the government to provide accountability for investments made in the public health sector. Malaria

[13] United Nations Economic and Social Council; the Committee on Economic Social and Cultural Rights. E/C.12/2000/4, August 2000

treatment provides an example of this context. As defined by the Guinea Bissau policy on malaria, treatment should be provided for free in public hospitals and health centers after medical diagnosis and prescription. However, citizens are often asked to pay for the treatment, and, in other cases, the treatment is not available in public hospitals and clinics despite being provided by development partners. The limited awareness of citizens about their rights, the mismanagement of medical resources, and the endemic corrupt practices, consequently, affect the implementation of key health policies and procedures, limit citizens' access to health services and jeopardizes government efforts to increase access to health services more effectively and efficiently. Thus, the lack of institutional mechanisms for citizens to express disapproval, criticize or demand accountability has eroded citizens trust and confidence in health institutions that should instead guard against health insecurity and individual precarity. Given such systemic obstacles, strengthening awareness of HCW's on their duties and responsibilities as well as citizens on their rights, and developing capacity of CSOs such as the Youth Association and the National Association of Social Assistants to monitor implementation of health policies as well as provision of health services would provide the necessary checks required to hold government to account.

b) A brief description of how the project aligns with/ supports existing Governmental and UN strategic frameworks[14] and how it ensures national ownership. If this project is designed in a PRF country, describe how the main objective advances a relevant strategic objective identified through the Eligibility Process

The development of this proposal fully aligns with the 2022-2023 Programme Workplan that was endorsed by the Minister of Health in February 2022. The proposed actions also received support from different directorates at the MOH and particularly, the Directorate of Health Systems Administration(DGASS) and the Directorate of Planning, Studies, Partnerships, and Services(DSEPP). Additionally, the General Director of Health Care Establishment from the Ministry of Health and the Chief of Cabinet of the Minister, as well as other public servants who were consulted at the outset expressed full support for the proposed action. More broadly, the project is aligned with the **Government's Plan for Guinea-Bissau – 10th Legislature (2020-2023)**. Specifically, it will directly contribute to strategic objective 1: "*Consolidate the democratic rule of law, reform and modernize public institutions'* and to strategic objective 4: "*Valorize human capital and improve living conditions of the population*". The intervention responds to the **national development and peacebuilding priorities,** validated by the Government in November 2020, and is also aligned with the Political and Social Stability Pact (2019) which aims "*to strengthen social cohesion mechanisms and strengthen dialogue between political and social actors around major national issues, such as the implementation of structural reforms and the conclusion of the labor stability agreement*". The project also contributes to the priorities outlined in the **African Union** continental framework and its **Agenda 2063** defining the practical and measurable actions for the structural, social, economic, and environmental transformation of Africa.

[14] Including national gender and youth strategies and commitments, such as a National Action Plan 1325, a National Youth Policy etc.

The project will further contribute to the newly adopted **United Nations Sustainable Development Framework** (2022-2026) and particularly to Output 1.1: "*The institutional framework and the human and operational capacities of the State and non-State actors, including agents of change, are enhanced to support a transformational change and societal shift in favor of consolidating peace and democratic governance and to respond to all citizens' needs*" and Priority 3: Human Capital Development including support to the health sector. With a focus on the **PBF's political engagement in the country, the project will contributes to** priority 2, as identified in the 2020 Conflict Analysis document " Support the Government of Guinea-Bissau in strengthening democratic accountable institutions and enhancing the capacity of state organs to function effectively, in accordance with the Constitution, including through a progressively decentralized and inclusive governing system, and a National Parliament which fully assumes its oversight role. The project is complementary to the ongoing PBF portfolio, thus it will contribute to the ongoing political dialogue project (delivered by UNDP, UNFPA, and UNESCO) that focuses dialogue on social issues that are at the center of citizens. By fostering citizens' active participation in monitoring policy implementation in the health sector (outcome 2) the project also complements the efforts of UNICEF and UNDP in strengthening human rights institutions project and aligns with the national strategy to fight corruption developed under the CDTOC intervention (UNDP, UNODC). Finally, with a specific focus on health sector governance, this intervention will contribute to other ongoing interventions in the health sector, for instance, the action on Health Financing Mechanism: towards Universal Health Coverage (PIMI III), which is funded by the EU and implemented by the WHO's with a view to promoting access to primary health care.

Furthermore, through the implementation of the proposed project, a baseline for benchmarking future peacebuilding interventions and investments around the health-peace nexus will also be established which will serve to either inform, underpin, or build on such interventions. Additionally, it will contribute to the implementation of the Global Health for Peace Initiative (GHPI), which was recently endorsed by all Member States during the 75th World Health Assembly in May 2022. The Global Health for Peace Initiative[15] is WHO's contribution to putting the "peace" in the Humanitarian-Development-Peace Nexus, under its commitment to the United Nations Sustaining Peace Resolutions (A/RES/70/262 and S/RES/2282).

a) A brief explanation of how the project fills any strategic gaps and complements any other relevant interventions, PBF funded or otherwise. Also, provide a brief **summary of existing interventions** in the proposal's sector by filling out the table below.

Project name (duration)	Donor and budget	Project focus	Difference from/ complementarity to current proposal
PIMI III Strengthening health financing mechanisms through support to maternal and Child health- (towards	European Union EUR 1,653,431	The project envisions strengthening government health financing and management capacity for primary health care	Whilst the current project proposal focuses on health governance, the PIMI III project focus is on health financing and, particularly on

[15] https://www.who.int/initiatives/who-health-and-peace-initiative

Universal Health Coverage, **SHEFiM-UHC-PIMI III** Duration: 3 years (2022-2024) To be implemented by: WHO		to contribute to increased and equitable access and use of essential quality health services, especially for the most vulnerable groups, adolescent girls, women of reproductive age, and children under 5 years of age.	strengthening the capacity of relevant stakeholders on program-based budgeting and management and developing tools for improved financial risk protection as well as improve the health information, procurement and supply chain systems for maternal and child health. By developing ad hoc policies, governance structures, and institutional mechanisms, the proposed action will lay the groundwork for implementation of the capacity-building activities foreseen by the PIMI III project due to strengthened, administrative and managerial competencies that are developed under the current proposed action.
Support to COVID-19 crisis response. (COVID-19) - (PALPC) Duration: 2.5 years Dec 2020- May 2023 WHO	African Development Bank USD 8,280,299	Focuses on supporting COVID-19 response efforts in Guinea Bissau and specifically supporting efforts of the Ministry of Public Health and relevant stakeholders to prepare and manage COVID-19 management and response efforts.	The proposed project will build on the capacities already strengthened and equally leverage the networks already created.
Strengthening Maternal and Child Services in Guinea Bissau Duration: 3 years UNICEF	World Bank USD6,802,739	3 main objectives: (1) Strengthen the promotion of 18 essential family practices, the retention of CHWs and the implementation of iCCM (Integrated	By strengthening the role of Community Health workers; promoting community responses to EEFs, prevention, and quality of treatment for cases at the community level, the project will

		Community Case Management) in the 11 health regions; (2) Strengthen the coordination, planning, monitoring-evaluation, and support of community activities in the 11 health regions; (3) Establish a mechanism for motivating and retaining CHWs and supply and management chain for essential drugs, materials, and equipment necessary for the promotion of EEFs, prevention, and quality treatment of cases at the community level.	complement open dialogues between communities and healthcare workers to monitor decision-making processes and raise awareness on respective rights and duties.
Community Health Programme Feb 2021 to Dec. 2023 UNICEF	GF/UNDP USD 2,025,981	Support to Community Health Programme to Improve access to quality health care for pregnant women and children.	By working with families and communities, identification of vulnerable groups at the community level will be made easy and by promoting dialogue between families and health services, the project will build social bonds.
Health System Strengthening 3 years UNICEF	GAVI USD 2,100,071	To strengthen the Health System with a focus on immunization as a proxy.	By strengthening central and peripheral coordination, service delivery and health service providers will equally benefit from interventions in the proposed project.

COVID-19 Emergency Response Project (COVID-19 ERP June 2020- Dec 2022 Duration: 2.5 years WHO	Islamic Development Bank(IsDB) USD, 11,831,789	Project objectives focus on (1) strengthening surveillance at Points of Entry, health structures, and laboratories for early detection of COVID-19, (2) Dissemination of messages for prevention and control of COVID-19, and ensure community participation in all activities related to prevention and response preparation and (3) Ensure adequate treatment of detected cases.	By supporting efforts of the Ministry of Public Health to prepare and manage COVID-19 cases and by supporting CSOs to develop capacity of communities, the proposed project will build on the capacities already strengthened and equally leverage the networks already created.
Political Dialogue Duration:30 months Implemented by UNDP	PBF USD 2,400,000	The project has two main components. The first one is working with political parties in ANP while the second is working with CSOs to create the conditions for national dialogue to foster Peace, Security, and Justice. UNDP intervention also supports the Leadership Academy in partnership with the National School of Administration (ENA) to build CSOs and other key stakeholders' capacity.	By bringing together the population and the government to develop a common understanding of key challenges and viable solutions in the governance of the health sector (outcome 1) and by providing peacebuilding tools to key actors in the government and health institutions to facilitate constructive and peaceful dialogue (outcome 3), the project will develop synergies with the Leadership Academy thus contribute to the consolidation of peace.
Human Rights Protection Duration: 3 years Implemented by UNICEF, UNDP, OHCHR	PBF USD 3,300,000	The project aims to enhance the individual and institutional capacity of both duty-bearers and rights-holders. It seeks to do so with full respect for	By fostering citizens' active participation in monitoring policy implementation in the health sector (outcome 2), the project will also contribute to the efforts

		national ownership, working closely with both state and non-state actors to facilitate dialogue and trust.	of UNICEF and UNDP to promote human rights, which includes the right to health.
Strengthening social protection. Implemented by UNFPA, WFP, and UNICEF	SDG Funds	Tackling the lack of social protection.	By working to promote social security – this SDG Fund project will provide the basis for building synergies in promoting social security.
Promotion of Health rights Implemented by Gabinete do Utente	AIDA	The project aims to promote the right to health, support citizens, and raise awareness of policies, procedures, and rights in the health space.	The proposed project will build on the latter aims, which focus on raising awareness of the rights of citizens around the health space.

II. Project content, strategic justification and implementation strategy (4 pages max Plus Results Framework Annex)

a) A brief **description of the project** focus and approach.

The project aims to contribute to the strengthening of social cohesion by promoting inclusive and effective public health sector governance through activities that include participatory action research, participatory policy making, capacity building, dialogue between social groups and institutions, advocacy, and stakeholder engagement. Additionally, the project aims to create spaces for joint action on the resolution of grievances and social tension in the health sector and will equally aim to mobilize political will to support such action.

At the institutional level, the project will strengthen capacity of relevant government stakeholders to deepen their understanding of the demands of citizens' and HCWs' through a participatory approach. Strengthening capacity of established health structures such as the health committees in the Parliament and the Ministry of Public Health to support actions of the health workforce and particularly to advocate for the promotion of health rights and health security will go a long way towards reaching a consensus on varying views. Participatory development of key health policies, procedures and establishment of regulatory frameworks would institute a culture of ownership of actions and results which is currently a missing element in the ongoing reform programmes. Additionally, a participatory approach towards the proposed action would foster collaboration and dialogue among relevant stakeholders and hence facilitate the resolution of existing grievances and conflicts[16], and thus strengthen confidence in the governance of the health sector.

[16] Aligned to the willingness from not only the HCW, government and international national organizations to improve the situation

On the other hand, the project will work with CSOs on capacity building activities aimed at improving the relationship between HCWs and government institutions on one side, and HCWs and citizens on the other. Particularly, the project aims to foster dialogue spaces and strengthen capacities of HCWs on negotiations, as well as raise awareness of citizens and CSOs of their rights and duties to monitor health sector governance and service provision for enhanced transparency and accountability.

b) Provide a **project-level 'theory of change'**.

The project *Peaceful Governance of the Health Sector* is based on the assumption that

- If HCWs, and the population at large are consulted on their perception of health governance and on the relationships/conflict dynamics existing in this sector , and they actively participate in the development of policy recommendations; and
- If capacities and spaces for participatory budgeting and policy development are created for CSOs, governmental, political, and international stakeholders working in the health sector; and
- If HCWs 'workers union and professional board roles in mediation processes are fostered and governmental and institutional actors', are trained in formal negotiation skills and engage in an open dialogue/negotiation for the first time; and

- If HCWs tools to identify and respond to GBV and to provide MHPSS to people from marginalized and excluded groups are strengthened and innovative tools to facilitate the collection of feedback from users and the dialogue between users and HCWs are developed and introduced; and
- If citizens and CSOs are trained in advocacy and human rights (the right to health), CSOs platforms to access information and file complaints are strengthened and spaces for constructive dialogue between citizens and HCWs are opened.

Then,

- Policies, programmes and budget of international and governmental key stakeholders working in the health sector will be informed by the population and HCWs perception, perspective and needs with higher potential in terms of effectiveness and relevance, and returns to investment
- HCWs will be actors of change and will play a key role in peacefully resolving their grievances with the government, to deliver impartial and inclusive health services, and to contribute to citizens' efforts to improve accountability in health sector governance and service provision.

Because:

- Governmental and international institutions will be more aware of the population and HCWs' perception of the national and local governance of the health sector in Guinea Bissau and they will have the opportunity to work together to influence and develop informed policies, budgets and actions plan.
- HCWs will have the tools to facilitate constructive and peaceful dialogue with governmental institutions to resolve their grievances without resorting to unregulated strikes or boycotts.
- In some key regions, HCWs (including community health workers and social workers) capacities to provide prioritized health care service, including Mental Health and Psychosocial Support (MHPSS), will be strengthened, with a specific focus on excluded and marginalized groups and their action will be informed by citizens perspective.

- Citizens, CSOs and relevant institutions at the local level will have the capacities and spaces to effectively monitor decision-making processes in the health sector and the provision of health services at the level of local authorities and health centers.

Assuming that:

- CSOs, citizens, HCWs and institutions, and health structures are agents of change and will actively participate in project activities due to their potential in making health governance more transparent, inclusive, and efficient.
- HCWs and governmental institutions are open to negotiations and working together because they recognize that their interests are embedded in the proposed action (as expressed in the consultations held during the proposal development process, and notably by HCWs Associations and Government as a whole).
- The MoH is fully engaged in the implementation of project activities due to its timeliness and the collective benefits it will yield in terms of reforms that aim at not only contributing to the efficient management of the Ministry of Public Health but also at pacifying the public health sector as a whole.

c) **Provide a narrative description of key project components** (outcomes and outputs).

Outcome 1: The government's capacity to understand and respond to citizens' and HCWs' demands is strengthened, and health institutions are better prepared to identify and develop inclusive and realistic policy solutions to challenges faced in health sector governance.

To achieve this outcome, the project aims to deepen the understanding of the key challenges faced in public health sector governance taking all the different perspectives into consideration, and, to develop policy tools and knowledge products that can contribute to creating an enabling environment for the improvement of health sector governance. Through a participatory and inclusive Health and Peace Resilience Barometer, the project will capture the views and perceptions of citizens, healthcare workers, and CSOs on the governance of the public health sector, to inform decision-making in ways that promote health security[i] and social cohesion, and equally maximize the impact of investments in the public health sector.

Output 1.1: Qualitative and quantitative data on citizens' and HCWs' perceptions are gathered and used to inform policies, programmes, and decision-making on health sector governance, management, and administration.

A1.1.1 Create a steering committee for the study to engage with key stakeholders in the health sector; deepen understanding of the dynamics pertaining to the health sector and increase the ownership of the project's products and results. Particularly, the project will engage with the Health Sector Development Partners Group (HSDPG) led by WHO and includes the WB, the EU, UN agencies, and some key development partners including major donors in Guinea Bissau, to maximize synergies with other ongoing interventions in the health sector. The steering committee will involve members from the HSDPG and from key national institutions to increase sustainability and ownership of the action. The project will consult the other relevant development partners on the survey with a view to considering further support to this kind of mechanism in the future.

A1.1.2 Develop and validate a data collection tool in a participatory way through a series of public consultation sessions across regions to capture citizens' and HCWs' perspectives on health governance.The proposed methodology will allow the development of a data collection tool tailored to the needs of the population and with higher relevance to the context. Specific attention will be paid to ensure that the questionnaire captures children, youth, women, and young women's perception and needs in the health sector. The tool will be designed to allow the collection of both quantitative and qualitative data. In all the phases of developing the questionnaire, technical people from relevant departments of the Ministry of Health will be involved as part of the capacity building process on how to develop data collection tools.

A1.1.3 Collect data on perceptions and experience of health governance and related issues in all the regions whilst ensuring statistical relevance of the results at the national level. Data collected will be consolidated in an online platform which will be used to carry out a series of participatory data analysis sessions with key actors at the regional and national levels. The participatory analysis will provide a qualitative interpretation of the data collected whilst ensuring realistic interpretations of quantitative data. Specific analysis sessions will be dedicated to women, youth, and vulnerable groups to ensure their perspective and needs are embedded in the final product. Technical people from relevant departments of the Ministry of Health will be involved to accompany the whole data collection and analysis process as part of the capacity-building processs.

A1.1.4 Develop policy recommendations to support effective public health governance for strengthened social cohesion. Policy recommendations will be developed in a participatory manner and will be used as a basis for the activities under output 1.2. Both the recommendations developed, and the methodology adopted will be produced and disseminated to relevant stakeholders for informed programming.

Output 1.2: Based on the results of Output 1.1, public health sector policies, action plans, and budgets are better informed and developed in a participatory manner with relevant government entities, CSOs, and development partners and are age and gender sensitive.

A1.2.1 Host a workshop to develop the capacity of existing public health stakeholders, including key departments in the Ministry of Health, health committees, workers union, CSOs, and the professional council on the policy cycle to enable them to participate in policy development.

A1.2.2 Organize a health policy workshop (clinic) with relevant government entities, CSOs, and development partners to review and validate findings from output 1.1 and other research and reports, and produce shared and specific recommendations for policy development, budget allocation, and future programming around health governance to make health policies and budgeting much more coordinated and coherent and gender sensitive. The workshop will allow national and international stakeholders to define shared policy priorities through a pilot study on participatory health sector budgeting, with a view to proposing changes in budgetary allocation for the health sector.

A1.2.3 Based on recommendations developed under A1.2.2, support the Government to develop key policy and procedures taking in consideration the specific gender and age dimensions (I.e. Terms of Reference clearly defining functions and competencies of each individual, a procedure to regulate the interaction between central and regional health structures, a human resources policy, as well as a career advancement and a health workforce rotational policy and a policy on incentives). In parallel, a specific

exercise on budget allocation for peace-responsive health sector budgeting with the available resources will be carried out with governmental and international stakeholders.

A1.2.4. Strengthen the capacity of the Parliamentary Health Committee on health security and advocacy to promote reform efforts on health budget allocations. Capacity building will focus on members of the Parliamentary Health Committees and the MOH with a view to advancing efforts towards the achievement of universal coverage as articulated in the National Health Development Plan 2018-2022.

Outcome 2: The Health workforce is better equipped to peacefully resolve conflicts; deliver impartial and inclusive health services; and improve accountability of health sector governance and service provision.

Based on the information collected under output 1.1 and the policy work done under output 1.2, the project aims to pilot viable solutions focusing on the health workforce. Considering the existing constraints in the provision of health services and the limited resources available, the project will target key regions based on the results of the study conducted under outcome 1. Furthermore, the project will carry out monitoring to capture learnings and best practices to inform future interventions. In the target areas, the project aims to strengthen the capacities of the health workforce, specifically social service workforce and psychologists, to enable them to better provide specific health services to meet the needs of citizens including prevention of GBV and provision of MHPSS. The project will further strengthen the capacities of CSOs' and associations to monitor the provision of healthcare services against the existing policies and the decision-making processes and practices in the health sector at the local level. This would guard against fraudulent practices, thus creating more awareness among users of their health rights, and equally strengthen solidarity between HCW and citizens. For the peaceful resolution of grievances, the project will focus on promoting institutional dialogue at the national level by building the capacities of relevant stakeholders within the health workforce on negotiations and mediation.

Output 2.1 Capacity of HCWs (including community health workers and social workers) to provide impartial and inclusive health care services identified as a priority under outcome 1 is strengthened, including Mental Health and Psychosocial Support (MHPSS).

A 2.1.1 Based on findings under output 1.1 and other studies and reports, identify key regions and potential areas of intervention where capacity building is urgently needed.

A 2.1.2 Strengthen the case management and referral of violence against children and women, including Gender-Based Violence (GBV) and community-based MHPSS within the health sector, through the development of clear SOPs and tools, and equally develop the capacity of the health sector's social service workforce.

A 2.1.3: Support HCW to provide MHPSS to children and women at risk and survivors of GBV within the public health sector, including community health workers.

A 2.1.4: Put in place and test an innovative tool to facilitate the collection of feedback from beneficiary communities on UN-led interventions in the health sector as part of the AAP (Accountability to Affected Populations) framework. Focus will be placed on 3 of the 7 pillars of AAP (Participation, Feedback, and Complaints, Information and Communication), particularly on youth engagement and participation as co-creators of community-based health/communication interventions, feedback

collectors, disseminators of lifesaving/key health information amongst peers (Peer-to-Peer Information Sharing) and advocates for social & behavior change

Output 2.2 CSOs and relevant institutions have the mechanisms and capacities needed to monitor decision-making and the provision of health services at the level of local authorities and health centers, advocate for effective healthcare provision, and improve accountability of healthcare governance and service provision at the local and regional levels.

A2.2.1 In the target areas identified under outcome 1, develop the capacity of relevant stakeholders and CSOs on human rights and advocacy to promote their participation in monitoring health provision at the regional and local levels. This activity will make CSOs active at the local level to be better informed and equipped enabling them to monitor health service provision in the health centers and regional hospitals and to advocate with local authorities for better local health provision.

A 2.2.2 Strengthen CSOs and institutional platforms and channels at the regional level, through which citizens can access information related to health rights (by leveraging learnings from partners) and lodge complaints about malpractices.

A 2.2.3 Organize periodical dialogues at the regional level between the communities and healthcare workers which will contribute to the creation of spaces where citizens and CSO representatives can express their opinions. This will contribute to making citizens and CSOs more active in monitoring decision-making processes at the local level and raise awareness of citizens' health rights and duties.

Output 2.3 The health workforce is equipped with the skills and structures needed to facilitate constructive and peaceful dialogue with governmental institutions to address grievances and resolve conflicts peacefully.

A 2.3.1 Organize a workshop to undertake a participatory conflict analysis with all the relevant stakeholders (representatives from both the Ministry of Public Health and Ministry of Finance, professional association, workers union, and relevant CSOs) to analyze the dynamics of grievances between HCWs and the Government. This specific activity will facilitate the creation of a shared understanding of the root causes of conflict, allowing for better-tailored training contents based on the Guinea Bissau context.

A 2.3.2 Based on the analysis done, with the support of the ILO Training Centre, develop the capacity of relevant stakeholders (Ministry of Health and Ministry of Finance, workers union, and professional association) on peaceful negotiations and of HCWs on the role of workers union and professional associations.

A 2.3.3 Organize negotiations with the support of development partners by creating a negotiation commission/or Task Group/ at the Ministry to support meaningful negotiation processes with the HCW. Based on this experience develop knowledge products to inform future learnings relevant to other sectors in Guinea Bissau (for example other social-economic rights).

Use Annex C to list all outcomes, outputs, and indicators.

d) **Project targeting.**

The project will be implemented in all the 11 regions of the country, and these include Bafata, Biombo, Bijagos Bissau, Bolama, Cacheu, Gabu, Oio, Farim, Quinara and Tombali. Public health institutions both at the national and sub-national levels are weak, dysfunctional, and poorly governed, in some cases resulting in a denial of health rights. **This has contributed to a breakdown of social bonds which has consequently impacted solidarity and social cohesion between the health sector, communities, and citizens.** Thus, the project will transversally include all these different groups. Particularly, activities under output 1.1 will be implemented in all regions to support government responsiveness to public health sector needs. The data collection will be conducted by Interpeace and Voz di Paz in collaboration with local authorities and based on a randomly selected and statistically significant sample to mirror the **different social groups in Guinea Bissau.** Based on the result of output 1.1, the project will work with **key institutional and CSO actors at the national level** to implement activities under output 1.2. The project will involve representatives and decision-makers from relevant directorates within the Ministry of Public Health and the Ministry of Finance as well as representatives from CSOs working in the health sector, HCWs' professional associations, the workers union, international organizations, and UN Agencies working in the health sector.

Activities under outputs 2.1 and 2.2 will be piloted in the regions identified based on the results of the study carried out under output 1.1. **HCWs from public and private structures** existing in these regions will be involved in the delivery of capacity-building activities and **CSOs and associations** active in these regions will be mobilized to represent citizens' interests. Specific efforts will also be made to engage youth and women groups and associations as well as HCWs.

In all activities under outputs 2.1 and 2.2, the project will engage **local authorities and government representatives in the regions** to ensure greater national ownership and sustainability. Under output 1.2, key institutional actors from output 2.3 will be involved, to foster institutional dialogue among HCWs and the government around HCWs' needs and priorities.

III. Project management and coordination (4 pages max)

a) **Recipient organizations and implementing partners.**

Agency	Total budget in previous calendar year	Key sources of budget (which donors etc.)	Location of in-country offices	No. of existing staff, of which in project zones	Highlight any existing expert staff of relevance to project
Convening Organization: World Health Organization	The total financial portfolio in the previous calendar year	WHO's model of financing is two pronged in nature:(1) Through Assessed Contributions (AC)	Across all regions	12 staff (5 internationals & 7	The Project will benefit from the expertise and support
Implementing partners:					

Interpeace/Voz di Paz	amounted to approximately USD 25,000,000	which are contributions from Member States. (2) Voluntary contributions, which are contributions from development partners, i.e., Trust Funds, International Financial Institutions, (IFIs), bilaterals, multilaterals and Intergovernmental Organizations		nationals), and 21 field consultants (19 nationals and 2 internationals.	of the External Relations and Partnerships Officer, particularly in conflict-sensitive programming, resilience building, and strategic oversight.
Recipient Organization: United Nations Children's Fund Implementing partners: Government: Ministry of Health -Social Service department-, Community Health services; Woman and Child Institute (MWFSS); Civil society organizations: AGAS (National Association of social Assistants); Children's Friends Association/AMIC (local	USD 9,723,861 at the country level	●UNICEF National Committees (France, Portugal, Italy). ●Thematic Funds. ●Global Fund. ●European Union ●(Multi-country funds) FGM JP ●Italian gov. funds	Bissau, Guinea-Bissau	45 staff in Guinea-Bissau	The Country Office Child protection and Child survivor and Development programmes will manage the UNICEF component of the project. A National UNV will be responsible for ensuring closer implementation and monitoring of the planned activities.

CSO), Federation of people with disabilities (local					

b) **Project management and coordination**

Project team: The project team will be composed of staff from WHO, UNICEF and Interpeace who will lead the implementation of the project and monitor progress and discuss any other potential risks. They will be responsible for work plan development and engagement with key partners with whom the project will interact. The WHO as the lead agency will particularly be responsible for reporting, convening meetings, and informing the PBF Secretariat on updates to the project. The project team will further collaborate with PBF-funded projects in the country to share knowledge and exchange best practices where necessary.

Project Steering Committee: During the inception phase, a Project Steering Committee **(PSC)** will be created and will provide strategic oversight, and guidance on matters related to the management of the project. The committee will also coordinate efforts at the highest level of government to promote project buy-in. The overall objective of the PSC will be to facilitate effective and efficient collaboration between the participating organizations and to provide overall guidance and direction to the work of the Project Manager to ensure successful implementation of the project. The committee will be comprised of representatives from the WHO, UNICEF, the Ministry of Health, the European Union, the PBF Secretariat, and Interpeace. More specifically the role of the PSC will encompass (1) Providing strategic direction and advice on the strategy for implementation. 2) Discussing emerging issues and challenges related to peaceful health governance. 3) Monitoring progress towards results of the project 4) Review, discuss and comment on the key activities in the annual work plans and annual report(s), including the informal inception report, 5) Address any project management concerns. The detailed TORs of the PSC will be finalized during the inception phase. The first PSC meeting will be conducted at the end of the inception phase (6 months after the start of the project). Thereafter, the Committee will meet once a year preferably.

Project Board: The board will be composed of all signatories of the Project Document. These include the Ministry of Public Health, the Head of the UN Country Team, Representatives of both WHO &UNICEF and, the PBSO. They will meet to approve major changes in the project and provide strategic guidance if needed. Board members will also be tasked with clearing reports internally prior to compilation and submission to the PBSO.

Project Management: Managerial and administrative responsibilities will be led by the WHO and supported by UNICEF and Interpeace. The WHO will hire a Project Manager at the level of an International UNV (who will be supported by a Monitoring Officer at the WHO Regional Office for Africa) to fully support the implementation of the project. The manager will be responsible for coordinating and managing project activities including the development of quarterly and annual work plans, leading correspondence with project partners (UNICEF and Interpeace), reporting and monitoring project implementation and progress including dissemination of information to all relevant

stakeholders. UNICEF will hire a Programme Officer (national UNV) to ensure quality implementation of the community health and AAP component, including the work with the social service workforce from the health sector, and will further be tasked with planning, implementation, and monitoring of project activities. The in-house Child Protection Manager and Health Specialist, along with the Social and Behavior Change Officer, will contribute to the implementation of the project and will work 50% of the time. Interpeace Programme Manager in Guinea Bissau will also provide technical guidance and support the implementation of the project.

Additionally, the Project Manager will coordinate efforts jointly with UNICEF and Interpeace to closely work with the government (MoH and Parliament), and national CSOs to facilitate project delivery. Internally the WHO will create a Project Management Board that will be composed of the WHO Representative, the WHO Health Policy Advisor, and the External Relations and Partnerships Officer. The role of the Board will be to provide technical guidance and strategic-level support to the project manager including in reporting, communication, and correspondence with the PBF as well as managing technical experts and consultants.

Fiduciary safeguards and Quality Assurance: Guarding against fiduciary risks and ensuring quality assurance are key to successful implementation of the project. The project management board will be involved in making financial and procedural approvals as well as budget revisions and clearance. The Board will coordinate efforts with the WHO Regional Office for Africa on agreements management matters, as well as on potential partnerships under the WHO Framework for Engagement with Non-State Actors (FENSA). Reporting will follow WHO's standard procedures on reporting and publication and as per precedent established with the organization. Efforts will also be made to work with the WHO sub-regional offices to provide oversight in accordance with established terms.

c) **Risk management.**

Project specific risk	**Risk level (low, medium, high)**	**Mitigation strategy (including Do No Harm considerations)**
Political instability: Change in government may disrupt project implementation.	Medium	Intensify efforts to work with the parliamentary health committee to advocate, mobilize and secure political will and support for the project.
Competing interests vis-à-vis political party affiliations: This may impede or reduce space for dialogue considering the upcoming legislative elections slated for December 2022.	Medium	Collaboration with neutral partners, stakeholders and brokers such as CSOs and established structures such as the workers union and committees will be sought.

Abuse /or non-compliance with regulatory frameworks and tools developed such as human resources for health policy as well as other established protocols/ or mechanisms.	Medium	Implement control measures such as spot checks, monitoring visits, training, and sanctions etc.
Poor infrastructure may limit access to project sites and field visits to the regions. Note: Due to heavy rains, there is a risk of flash floods which risk making the roads impassable, resulting in a challenge to reach certain communities and regions.	Medium	Intensify efforts towards advance planning and monitoring; use of online meetings and trainings.
Weak capacities of potential beneficiaries may threaten full ownership of knowledge developed around conflict resolution, medical ethics and related protocols.	Medium	Provision of regular technical support and mentoring by WHO, UNICEF, and Interpeace.
Resistance to change and acceptance of ad hoc reforms may impede efforts to institutionalize accountability mechanisms	Medium	Intensify collaboration with the monitoring unit at the MOH to ensure oversight in the implementation of accountability mechanisms/processes and frameworks.

d) **Monitoring and evaluation.**

Monitoring & Evaluation strategies (M&E) are embedded in the project design to measure its effectiveness, determine progress towards outcomes and inform decisions during project implementation. A project manager will be responsible for the development of M&E tools. The manager will be supported by the technical staff from WHO, UNICEF, and implementing partners. During the inception phase of the project, a comprehensive M&E plan will be developed to ensure the tracking of project indicators. Both quantitative and qualitative data will be collected against both output and outcome indicators using surveys. Key Informant Interviews (KII), Focus Group Discussions(FGDs), and Open Space Discussions methods will be used to collect data. Furthermore, quantitative, and qualitative data collected under output 1.1(outcome 1) through a survey at the outset of the project will be used to establish baseline data against which to track progress towards output indicators and will feed into the overall M&E plan described below.

Specific M&E Activity	Purpose	Frequency	Expected Action
Tracking progress towards results	Progress data against output indicators will be collected and analyzed to assess the progress of the project towards achieving the agreed outputs. This will be collected through surveys, questionnaires/ KIIs and FGD's.	Quarterly	Project Manager alongside the implementing partners with lead these efforts
Monitoring and Managing the Risk	Identifying project specific risks that may threaten the achievement of intended results will be prioritized. Risks identified will be managed using the Risk Mitigation Strategy identified in Section C above.	Quarterly	Risks are identified by project management and actions are taken to manage the risk. The risk matrix will actively be tracked to identify risks and corrective actions.
Lessons and Learnings	Knowledge, good practices, and lessons will be captured regularly, as well as actively sourced from other projects and partners and integrated back into the project.	At least annually	Relevant lessons are captured by the project team and used to inform management decisions.
Midterm Project Review	A midterm review of the project will be conducted to identify project strengths and weaknesses and to inform management decision-making to improve the project. A SWOT analysis will be utilized for this purpose.	Semesterly	Areas of strength and weakness will be reviewed by project management and used to inform decisions to improve project performance.
Data and quality assurance	Review of survey reports will be done to ensure data and evidence from all monitoring actions are accurate to inform decision-making processes.	Semesterly	Performance data, risks, lessons, and quality will be discussed by the project board and used to make decisions.
Progress Report	A progress report will be presented, consisting of progress data showing the results achieved against pre-defined indicators at the output level, and any evaluation or review reports prepared over the period.	As per the financing agreement	

e) **Project exit strategy/ sustainability**.

Sustainability is a key component of the proposed intervention which has been developed to ensure a catalytic effect both within the public health sector and beyond. The project aims to foster vertical and horizontal trust and, since its development, it has adopted an **integrated and participatory approach** that brings together local communities, civil society, government, and development partners. Project stakeholders both at the national and regional levels will be involved in consultations aimed at developing mechanisms, policies, and tools to regulate the management and administration of the public health sector. Particularly, the work developed under outcome 1 and, specifically, activities included under output 1.2 will focus on the joint development of context-specific policies to allow national institutions and, namely, the Ministry of Public Health, to be more effective in responding to the population's needs. Furthermore, the project will seek to leverage existing forums such as the Health Sector Development Partners Group to ensure greater alignment with public health sector needs, and by leveraging expert knowledge, guidance, and best practices, sustainability will be ensured beyond the duration of the project. Additionally, for sustained results, WHO, UNICEF & Interpeace will leverage existing partnerships, contextual knowledge, and expertise to intensify collaboration with relevant government agencies, departments, and established structures, with whom the project will interact, particularly the Ministry of Public Health (MOH), Ministry of Finance, and Ministry of Economy, Planning & Regional Integration, mainly for purposes of national ownership. By promoting dialogue among relevant stakeholders, the project will foster trust between citizens, the government, and HCW thus promoting social cohesion at the community and national levels. By investing in the relationship between HCW and the government, the project aims to create suitable conditions for a lasting solution within the public health sector. By building the relationship between HCW and users, the intervention aims to create the conditions for greater dialogue among different social groups. And by strengthening the relationship between citizens and their institutions, the project aims to make institutions more accountable and citizens more capable of monitoring their performance which will contribute to a renewed social contract between government and citizens.

III. Project budget

Provide brief additional information on project costs, highlighting any specific choices that have underpinned the budget preparation, especially for personnel, travel or other indirect project support, to demonstrate value for money for the project. The proposed budget for all projects must include sufficient funds for an independent evaluation. The proposed budget for projects involving non-UN direct recipients must include funds for independent audit. Fill out **Annex A.2** on project value for money.

WHO as the lead agency will hire an International UNV with relevant expertise on project management and public health. He/she will manage and coordinate all aspects of the project including implementation, monitoring, and reporting. The total amount allocated for this position is USD 200.000(as per the budget) for a period of 2 years. UNICEF on the other hand will hire a programme officer, national UNV, to coordinate and oversee activities delivered at the community level. UNICEF together with the WHO, will coordinate efforts for timely, effective, and efficient implementation of activities. The total amount allocated by UNICEF for the National UNV position is: USD 65.000.

Please note that in nearly all cases, the Peacebuilding Fund transfers project funds in a series of performance-based tranches. PBF's standard approach is to transfer project funds in two tranches for UN recipients and three tranches for non-UN recipients, releasing second and third tranches upon demonstration that performance benchmarks have been met. All projects include the following two standard performance benchmarks: 1) at least 75% of funds from the first tranche have been committed, and 2) all project reporting obligations have been met. In addition to these standard benchmarks and depending on the risk rating or other context-specific factors, additional benchmarks may be indicated for the release of second and third tranches.

Please specify below any context-specific factors that may be relevant for the release of second and third tranches. These may include the successful conduct of elections, passage of key legislation, the standing up of key counterpart units or offices, or other performance indicators that are necessary before project implementation may advance. Within your response, please reflect how performance-based tranches affect project sequencing considerations.

Due to greater involvement of development partners in peacebuilding efforts, this may result in successful legislative elections planned for December 2022 and hence will facilitate the release of subsequent tranches.

Fill out two tables in the Excel budget **Annex D**.

In the first Excel budget table in Annex D, please include the percentage towards Gender Equality and Women's Empowerment (GEWE) for every activity. Also provide a clear justification for every GEWE allocation (e.g., training will have a session on gender equality, specific efforts will be made to ensure equal representation of women etc.).

Annex A.1: Checklist of project implementation readiness

estion	Yes	No	Comment
Planning			
Have all implementing partners been identified? If not, what steps remain and proposed timeline	X		Yes, Interpeace, ENDA-Sante
Have TORs for key project staff been finalized and ready to advertise? Please attach to the submission	x		
Have project sites been identified? If not, what will be the process and timeline			
Have local communities and government offices been consulted/ sensitized on the existence of the project Please state when this was done or when it will be done.	X		Yes, a consultation meeting was held with the Ministry of Health; DGASS
Has any preliminary analysis/ identification of lessons learned/ existing activities been done? If not, what analysis remains to be done to enable implementation and the proposed timeline?	x		
Have beneficiary criteria been identified? If not, what will be the process and timeline.	x		
Have any agreements been made with the relevant Government counterparts relating to project implementation sites, approaches, Government contribution?		x	Work in Progress
Have clear arrangements been made on project implementing approach between project recipient organizations?	x		
What other preparatory activities need to be undertaken before actual project implementation can begin and how long will this take?	N/A		
Gender			
Did UN gender expertise inform the design of the project (e.g. has a gender adviser/expert/focal point or U men colleague provided input)?	X		
Did consultations with women and/or youth organizations inform the design of the project?	x		
Are the indicators and targets in the results framework disaggregated by sex and age?	x		
Does the budget annex include allocations towards GEWE for all activities and clear justifications for WE allocations?	x		Budget is designed to also benefit women although not directly

Annex A.2: Checklist for project value for money

estion	Yes	No	Project Comment
Does the project have a budget narrative justification, which provides additional project specific information on any major budget choices or higher than usual staffing, operational or travel costs, so as to explain how the project ensures value for money?		x	
Are unit costs (e.g. for travel, consultancies, procurement of materials etc.) comparable with those used in similar interventions (either in similar country contexts, within regions, or in past interventions in the same country context)? If not, this needs to be explained in the budget narrative section.	x		
Is the proposed budget proportionate to the expected project outcomes and to the scope of the project (e.g., number, size and remoteness of geographic zones and number of proposed direct and indirect beneficiaries)? Provide any comments.	x		
Is the percentage of staffing and operational costs by the Receiving UN Agency and by any implementing partners clearly visible and reasonable for the context (i.e. no more than 20% for staffing, reasonable operational costs, including travel and direct operational costs) unless well justified in narrative section?	x		
Are staff costs proportionate to the amount of work required for the activity? And is the project using local rather than international staff/expertise wherever possible? What is the justification for use of international staff, if applicable?	x		Project aims to use both local and international staff
Does the project propose purchase of materials, equipment and infrastructure for more than 15% of the budget? If yes, please state what measures are being taken to ensure value for money in the procurement process and their maintenance/ sustainable use for peacebuilding after the project end.		x	
Does the project propose purchase of a vehicle(s) for the project? If yes, please provide justification as to why existing vehicles/ hire vehicles cannot be used.		x	
Do the implementing agencies or the UN Mission bring any additional non-PBF source of funding/ in-kind support to the project? Please explain what is provided. And if not, why not.	x		Office space and support provided by other human resources.

Annex B.1: Project Administrative arrangements for UN Recipient Organizations

(This section uses standard wording – please do not remove)

The UNDP MPTF Office serves as the Administrative Agent (AA) of the PBF and is responsible for the receipt of donor contributions, the transfer of funds to Recipient UN Organizations, the consolidation of narrative and financial reports and the submission of these to the PBSO and the PBF donors. As the Administrative Agent of the PBF, MPTF Office transfers funds to RUNOS on the basis of the signed Memorandum of Understanding between each RUNO and the MPTF Office.

AA Functions

On behalf of the Recipient Organizations, and in accordance with the UNDG-approved "Protocol on the Administrative Agent for Multi Donor Trust Funds and Joint Programmes, and One UN funds" (2008), the MPTF Office as the AA of the PBF will:

- Disburse funds to each of the RUNO in accordance with instructions from the PBSO. The AA will normally make each disbursement within three (3) to five (5) business days after having received instructions from the PBSO along with the relevant Submission form and Project document signed by all participants concerned;
- Consolidate the financial statements (Annual and Final), based on submissions provided to the AA by RUNOS and provide the PBF annual consolidated progress reports to the donors and the PBSO.
- Proceed with the operational and financial closure of the project in the MPTF Office system once the completion is completed by the RUNO. A project will be considered as operationally closed upon submission of a joint final narrative report. In order for the MPTF Office to financially closed a project, each RUNO must refund unspent balance of over 250 USD, indirect cost (GMS) should not exceed 7% and submission of a certified final financial statement by the recipient organizations' headquarters);
- Disburse funds to any RUNO for any cost extension that the PBSO may decide in accordance with the PBF rules & regulations.

Accountability, transparency and reporting of the Recipient United Nations Organizations

Recipient United Nations Organizations will assume full programmatic and financial accountability for the funds disbursed to them by the Administrative Agent. Such funds will be administered by each RUNO in accordance with its own regulations, rules, directives and procedures.

Each RUNO shall establish a separate ledger account for the receipt and administration of the funds disbursed to it by the Administrative Agent from the PBF account. This separate ledger account shall be administered by each RUNO in accordance with its own regulations, rules, directives and procedures, including those relating to interest. The separate ledger account shall be subject exclusively to the internal and external auditing procedures laid down in the financial regulations, rules, directives and procedures applicable to the RUNO.

Each RUNO will provide the Administrative Agent and the PBSO (for narrative reports only) with:

Type of report	Due when	Submitted by
Semi-annual project progress report	15 June	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
Annual project progress report	15 November	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
End of project report covering the entire project duration	Within three months from the operational project closure (it can be submitted instead of an annual report if timing coincides)	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
Annual strategic peacebuilding and PBF progress report (for PRF allocations only), which may contain a request for additional PBF allocation if the context requires it	1 December	PBF Secretariat on behalf of the PBF Steering Committee, where it exists or Head of UN Country Team where it does not.

Financial reporting and timeline

Timeline	**Event**
30 April	Annual reporting – Report **Q4 expenses** (Jan. to Dec. of previous year)
Certified final financial report to be provided by 30 June of the calendar year after project closure	

UNEX also opens for voluntary financial reporting for UN recipient organizations the following dates

31 July	Voluntary Q2 expenses (January to June)
31 October	Voluntary Q3 expenses (January to September)

Unspent Balance exceeding USD 250, at the closure of the project would have to be refunded and a notification sent to the MPTF Office, no later than six months (30 June) of the year following the completion of the activities.

Ownership of Equipment, Supplies and Other Property

Ownership of equipment, supplies and other property financed from the PBF shall vest in the RUNO undertaking the activities. Matters relating to the transfer of ownership by the RUNO shall be determined in accordance with its own applicable policies and procedures.

Public Disclosure

The PBSO and Administrative Agent will ensure that operations of the PBF are publicly disclosed on the PBF website (www.un.org/peacebuilding/fund) and the Administrative Agent's website (www.mptf.undp.org).

Annex B.2: Project Administrative arrangements for Non-UN Recipient Organizations

(This section uses standard wording – please do not remove)

Accountability, transparency, and reporting of the Recipient Non-United Nations Organization:

The Recipient Non-United Nations Organization will assume full programmatic and financial accountability for the funds disbursed to them by the Administrative Agent. Such funds will be administered by each recipient in accordance with its own regulations, rules, directives and procedures.

The Recipient Non-United Nations Organization will have full responsibility for ensuring that the Activity is implemented in accordance with the signed Project Document.

In the event of a financial review, audit or evaluation recommended by PBSO, the cost of such activity should be included in the project budget.

Ensure professional management of the Activity, including performance monitoring and reporting activities in accordance with PBSO guidelines.

Ensure compliance with the Financing Agreement and relevant applicable clauses in the Fund MOU.

Reporting:

Each Recipient will provide the Administrative Agent and the PBSO (for narrative reports only) with:

Type of report	Due when	Submitted by
Bi-annual project progress report	15 June	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
Annual project progress report	15 November	Convening Agency on behalf of all implementing organizations and in consultation with/ quality assurance by PBF Secretariats, where they exist
End of project report covering entire project duration	Within three months from the operational project closure (it can be submitted instead of an	Convening Agency on behalf of all implementing organizations and in

	annual report if timing coincides)	consultation with/ quality assurance by PBF Secretariats, where they exist
Annual strategic peacebuilding and PBF progress report (for PRF allocations only), which may contain a request for additional PBF allocation if the context requires it	1 December	PBF Secretariat on behalf of the PBF Steering Committee, where it exists or Head of UN Country Team where it does not.

Financial reports and timeline

Timeline	Event
28 February	Annual reporting – Report **Q4 expenses** (Jan. to Dec. of previous year)
30 April	Report **Q1 expenses** (January to March)
31 July	Report **Q2 expenses** (January to June)
31 October	Report **Q3 expenses** (January to September)
Certified final financial report to be provided at the quarter following the project financial closure	

Unspent Balance exceeding USD 250 at the closure of the project would have to been refunded and a notification sent to the Administrative Agent, no later than three months (31 March) of the year following the completion of the activities.

Ownership of Equipment, Supplies and Other Property

Matters relating to the transfer of ownership by the Recipient Non-UN Recipient Organization will be determined in accordance with applicable policies and procedures defined by the PBSO.

Public Disclosure

The PBSO and Administrative Agent will ensure that operations of the PBF are publicly disclosed on the PBF website (www.un.org/peacebuilding/fund) and the Administrative Agent website (www.mptf.undp.org).

Final Project Audit for non-UN recipient organization projects

An independent project audit will be requested by the end of the project. The audit report needs to be attached to the final narrative project report. The cost of such activity must be included in the project budget.

Special Provisions regarding Financing of Terrorism

Consistent with UN Security Council Resolutions relating to terrorism, including UN Security Council Resolution 1373 (2001) and 1267 (1999) and related resolutions, the Participants are firmly committed to the international fight against terrorism, and in particular, against the financing of terrorism. Similarly, all Recipient Organizations recognize their obligation to comply with any applicable sanctions imposed by the UN Security Council. Each of the Recipient Organizations will use all reasonable efforts to ensure that the funds transferred to it in accordance with this agreement

are not used to provide support or assistance to individuals or entities associated with terrorism as designated by any UN Security Council sanctions regime. If, during the term of this agreement, a Recipient Organization determines that there are credible allegations that funds transferred to it in accordance with this agreement have been used to provide support or assistance to individuals or entities associated with terrorism as designated by any UN Security Council sanctions regime it will as soon as it becomes aware of it inform the head of PBSO, the Administrative Agent and the donor(s) and, in consultation with the donors as appropriate, determine an appropriate response.

Non-UN recipient organization (NUNO) eligibility:

In order to be declared eligible to receipt of PBF funds directly, NUNOs must be assessed as technically, financially and legally sound by the PBF and its agent, the Multi Partner Trust Fund Office (MPTFO). Prior to submitting a finalized project document, it is the responsibility of each NUNO to liaise with PBSO and MPTFO and provide all the necessary documents (see below) to demonstrate that all the criteria have been fulfilled and to be declared as eligible for direct PBF funds.

The NUNO must provide (in a timely fashion, ensuring PBSO and MPTFO have sufficient time to review the package) the documentation demonstrating that the NUNO:

- Has previously received funding from the UN, the PBF, or any of the contributors to the PBF, in the country of project implementation.
- Has a current valid registration as a non-profit, tax-exempt organization with a social based mission in both the country where headquarters is located and in country of project implementation for the duration of the proposed grant. (**NOTE**: If registration is done on an annual basis in the country, the organization must have the current registration and obtain renewals for the duration of the project, in order to receive subsequent funding tranches).
- Produces an annual report that includes the proposed country for the grant.
- Commissions audited financial statements, available for the last two years, including the auditor opinion letter. The financial statements should include the legal organization that will sign the agreement (and oversee the country of implementation, if applicable) as well as the activities of the country of implementation. (**NOTE**: If these are not available for the country of proposed project implementation, the CSO will also need to provide the latest two audit reports for a program or project-based audit in country.) The letter from the auditor should also state whether the auditor firm is part of the nationally qualified audit firms.
- Demonstrates an annual budget in the country of proposed project implementation for the previous two calendar years, which is at least twice the annualized budget sought from PBF for the project.[17]
- Demonstrates at least 3 years of experience in the country where grant is sought.
- Provides a clear explanation of the CSO's legal structure, including the specific entity which will enter into the legal agreement with the MPTF-O for the PBF grant.

[17] The annualized PBF project budget is obtained by dividing the PBF project budget by the number of project duration months and multiplying by 12.

Annex C: Project Results Framework (MUST include sex- and age disaggregated targets)

Outcomes	Outputs	Indicators	Means of Verification/ frequency of collection	Indicator milestones
Outcome 1: The government's capacity to understand and respond to citizens' and HCWs' needs is strengthened, and health institutions are better prepared to identify and develop inclusive and realistic policy solutions to challenges faced in health sector governance. **(Any SDG Target that this Outcome contributes to)** **(Any Universal Periodic Review of Human Rights (UPR) recommendation that this Outcome helps to implement and if so, year of UPR)**		Outcome Indicator 1a Number of strategic documents(policies/ or budgets and procedures developed or revised based on the results of the study Baseline: 0 Target: 3 documents, all including elements addressing gender and youth specific needs.	-Monitoring reports - Media Reports -Policy documents	-At least 3 health policies, budgets or procedures, that integrate project's recommendations, are developed by the end of the project.
		1b Percentage of people who perceive that documents (policies, procedures and budgets) developed or modified in accordance with the project's recommendations are relevant to both the context and needs of the population, HCWs, and institutions disaggregated by sex, age, and occupation. Baseline: 0 Target: 70% of the interviewed people,	Final External Evaluation	
	Output 1.1 Qualitative and quantitative data on citizens' and HCWs' perceptions are gathered and used to inform policies, programmes, and decision-making on health sector governance, management, and administration.	Output Indicator 1.1.1 Number of people disaggregated by institutions, gender, age, and region who are consulted and participate in the development of the study. Baseline: 0 Target: At least 3000 nationwide, among those at least 40% women and 40% youth under the age of 35, with at least 30% of HCWs.	Gender-sensitive policies/action plans etc. Attendances sheets Activities report	-Agreed upon action plan by 2024
		Output Indicator 1.1.2 Number of international and government decision-makers who are aware and recognize the importance of	- Perception survey - Interview records -Advocacy Meeting	-At least 20 decision-makers and advocacy

		recommendations developed by citizens and HCWs Baseline: 0 Target: At least 10 governmental actors, and 10 national and international organizations.	-Activity Report -Meetings Report and Minutes -Public Declarations	stakeholders will be aware by the end of the project.
	Output 1.2: Based on the results of Output 1.1, public health sector policies, action plans, and budgets are better informed and developed in a participatory manner with relevant government entities, CSOs, and development partners.	Output Indicator 1.2.1 Number of stakeholders (disaggregated by type of actor, gender, and age) engaged in policy, action plan and budget drafting processes and revision exercises Baseline: 0 Target: At least 50 people from different key institutions of those 40% women and 20% youth	-Assessment report	-At least 2 (policies/ or action plans/or budget) Leveraging the efforts of the parliamentary committee(based on recommendations may result in incremental budgetary allocations.
Outcome 2: The Health workforce is better equipped to peacefully resolve conflicts; deliver impartial and inclusive health services; and improve accountability of health sector governance and service provision		Outcome Indicator 2a Percentage of institutional stakeholders who think mediation channels/skills created with the project contribute to the relationship between HCWs and the government. Baseline:0 Target: 20%	-Assessment report	-At least one report

(Any SDG Target that this Outcome contributes to) **(Any Universal Periodic Review of Human Rights (UPR) recommendation that this Outcome helps to implement and if so, year of UPR)**		Outcome Indicator 2b % of participants who use monitoring mechanisms to flag limitations, issues and irregularities with procedures and policies in the health sector (disaggregated by gender and age) Target: At least 60% of participants (of which 40% are women, 40% youth)	- Minutes of meetings - Monitoring reports - Interview records	By the end of the project in 2024
	Output 2.1: Capacity of HCWs (including community health workers and social workers) to provide impartial and inclusive health care services identified as a priority under outcome 1 is strengthened, including on GBV and Mental Health and Psychosocial Support (MHPSS).	Output Indicator 2.1.1 % Of the health sector's workforce with strengthened capacity on GBV and MHPSS. Baseline: 0 Target: 50% of social workers in the health sector	- Assessment report - Survey - Standard operating procedures and tools that are developed. - Attendance records	The capacities in GBV and MHPSS of at least 50% of the health sector social workers are strengthened by the end of the project in 2024
		Output Indicator 2.1.2 Number of HCW and social service providers trained to provide MHPSS to children and women at risk and survivors of GBV within the public health sector, including community health workers. Baseline:30 social assistants Target: 100 (60 females and 40 males)	-Reports on advocacy and human rights promotion	-At least 100 HCW and social service providers are trained by the end of the project.
		Output Indicator 2.1.3 Number of periodical dialogues organized at the regional level between the communities and HCW, including health authorities. Baseline: 0 Target: 3 new dialogues at the regional level	-Reports of the dialogues	-At least 3 dialogues are organized at the regional level by the end of the project.

	Output 2.2: CSOs and relevant institutions have the mechanisms and capacities needed to monitor decision-making in the health sector, advocate for effective healthcare provision, and improve accountability of healthcare governance and service provision at local and regional level.	Output Indicator 2.2.1 Number of institutional stakeholders and CSOs (NGOs, Media, and Professional associations) advocating for citizen participation in decision-making and monitoring health governance at the regional level, disaggregated by category. Baseline: 0 Target: 5	- Minutes of meetings and/or dialogue reports -Public statements -Interviews records	At least 5 institutional and CSOs stakeholders are advocating for citizen participation in regional-level health governance in the second year of the project implementation
		Output Indicator 2.2.2 Number of platforms and mechanisms that are developed and used by CSOs and relevant institutions at the regional level to monitor decision-making processes. Baseline: 0 Target: 3	- Minutes of meetings - Interview records	-At least 3 platforms or mechanisms established and functioning at the regional level by the end of the project in 2024
		Output Indicator 2.2.3 Percentage of people who say are satisfied with the monitoring mechanism created by the project. Baseline: 0 Target: 70%	Final External Evaluation	
		Output Indicator 2.2.4 Number of participants(community leaders, community health workers, and CSO representatives) disaggregated by age and sex trained to use, and access information	- List of trained participants.	-At least 50 participants trained by the end of the project in 2024.

		related to health rights (by leveraging learnings from partners), and lodge complaints about malpractices. Baseline: 0 Target: 50		
	Output 2.3 **The health workforce is equipped with the skills and resources needed to facilitate constructive and peaceful dialogue with governmental institutions to address grievances and resolve conflict peacefully.**	Output Indicator 2.3.1: Number of HCWs and government representatives (disaggregated by age and sex) with increased capacity to carry out dialogues and negotiation processes with the government. Baseline: 0 Target: 40	- A report of activities carried out. - Interview questionnaire	40 key actors from the MoH and from HCWs professional association and workers union have strengthened capacity by the end of the project.
		Output Indicator 2.3.2 Number of HCWs unregulated strikes and their duration before and after the project. Baseline: to be collected at the beginning of the project Target: reduction of 70% after the project end	Final External Evaluation	
		Output Indicator 2.3.3 Number of key stakeholders (MoH, the HCW union, government representatives, and professional board) who actively participate in the negotiation rounds organized by the project Baseline:0 Target: 4	-Activities and project reports	4 key stakeholders being the MoH the government, HCWs union and the professional board who participate in negotiations by the end of the project.

Summary of Project budget

Annex 1: **Performance-Based Tranche Breakdown**

Performance-Based Tranche Breakdown					
	Recipient Organization 1: WHO	**Recipient Organization 2: UNICEF**	**0**	**Total**	**Tranche %**
First Tranche:	**$ 611,100**	**$ 288,900**	**$ -**	**$ 900,000**	**60%**
Second Tranche:	**$ 407,400**	**$ 192,600**	**$ -**	**$ 600,000**	**40%**
Third Tranche	**$ -**	**$ -**	**$ -**	**$ -**	**0%**
Total:	**$ 1,018,500**	**$ 481,500**	**$ -**	**$ 1,500,000**	**100%**

Annex 2: Totals

	Recipient Organization 1: WHO	Recipient Organization 2: UNICEF	0	Totals
1. Staff and other personnel	$ -	$ 65,000.00	$ -	**$65,000.00**
2. Supplies, Commodities, Materials	$ 5,000.00	$ 48,000.00	$ -	**$53,000.00**
3. Equipment, Vehicles, and Furniture (including Depreciation)	$ -	$ 52,000.00	$ -	**$52,000.00**
4. Contractual services	$ 325,000.00	$ 70,000.00	$ -	**$395,000.00**
5. Travel	$ 35,000.00	$ 8,000.00	$ -	**$43,000.00**
6. Transfers and Grants to Counterparts	$ 515,567.50	$ 185,000.00	$ -	**$700,567.50**
7. General Operating and other Costs	$ 71,302.00	$ 22,000.00	$ -	**$93,302.00**
Subtotal	$ 951,869.50	$ 450,000.00	$ -	$1,401,869.50
7% Indirect Costs	$ 66,630.87	$ 31,500.00	$ -	$98,131
TOTAL	**$ 1,018,500**	**$ 481,500.00**	$ -	**$1,500,000**