SECRETARY-GENERAL'S PEACEBUILDING FUND
PROJECT DOCUMENT TEMPLATE

United Nations Peacebuilding

PBF PROJECT DOCUMENT

Country(ies): Cameroon, Far-North	
Project Title: Peace through Health: peacebuilding and violence reduction in communities in the Far-North, through inclusive health and social interventions **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.): WHO (UN), IOM (UN) **List additional implementing partners, specify the type of organization (Government, INGO, local CSO):** UN DPO (UN), some CSOs: International Medical Corps (IMC) and Demtou Humanitaire	
Project duration in months[1] [2]: 18 months **Geographic zones (within the country) for project implementation:** Far-North Region (with some activities in Yaoundé).	
Does the project fall under one or more of the specific PBF priority windows below: ☐ Gender promotion initiative[3] ☐ Youth promotion initiative[4] ☐ Transition from UN or regional peacekeeping or special political missions ☐ Cross-border or regional project	
Total PBF approved project budget* (by recipient organization): **WHO**: $ 1,273,300 **IOM**: $ 1,288,743.40 TOTAL: $ 2,562,043.40	

[1] Maximum project duration for IRF projects is 18 months, for PRF projects – 36 months.
[2] 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.
[3] Check this box only if the project was approved under PBF's special call for proposals, the Gender Promotion Initiative
[4] Check this box only if the project was approved under PBF's special call for proposals, the Youth Promotion Initiative

**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 availability of funds in the PBF 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):

PBF 1st tranche (40%):	**PBF 2nd tranche* (30%):**	**PBF 3rd tranche* (30%):**
WHO: $ 509,320.00	WHO: $ 381,990.00	WHO: $ 381,990.00
IOM: $ 515,497.36	IOM: $ 386,623.02	IOM: $ 386,623.02
Total: $ 1,024,817.36	Total: $ 768,613.02	Total: $ 768,613.02

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

The project aims to contribute to strengthening the socio-political and institutional conditions for effective and sustainable peace in Cameroon, by using health interventions as an entry point to supporting national entities and local communities towards promoting social cohesion, dialogue on security issues, and trust between communities, and towards national authorities in the Far-North region, specifically addressing the negative impacts of armed groups in the Far North. The project aims to help deliver shared healthcare and health services that have deteriorated due to the ongoing crisis in a manner that is effective, equitable and inclusive through community-based mechanisms (outcome 1) and thus serves as a confidence-building measure based on a common good to be shared (*vivre ensemble*) and/or a starting point for wider engagement on the common concerns between stakeholders in the Far North of Cameroon. Through its conflict-sensitive and peace-responsive health interventions, the project will contribute to addressing the conflict drivers that lead to exploitation of youth by armed groups designated as terrorist organisations (AGDTOs) (outcome 3), in the Far-North at community level, while laying the groundwork for an improved Disarmament, Demobilization, and Reintegration (DDR) process through capacity-building of relevant state security institutions (outcome 2).

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): Various stakeholders have been consulted during the development of this proposal.

The Department of Peace Operations (DPO)/Office of Rule of Law and Security Institutions (OROLSI)/DDR Section (DDRS) received a formal request to provide multidimensional assistance to national authorities on the implementation of current DDR efforts. The DDRS has since been engaged with national authorities in shaping the scope and parameters of such assistance. This engagement was initiated in March 2021 through a strategic discussion between DPO, IOM, and the national coordinator of the NDDRC. Since then, these discussions have continued at the technical level through hold bi-monthly meetings between DPO, IOM, and the NDDRC technical officers.

The project will provide capacity-building support that will be complementary with support provided by DDRS.

The project was also discussed with the National Disarmament, Demobilization and Reintegration Coordinator, the Regional Delegation of Public Health of the Far-North as well as the heads of health districts of the departments affected by the crisis, in order to ensure the existence of various health committees that will be called upon as part of the implementation of the project.

Communities in the Far-North have also been consulted. Between 12-16 July 2021, consultations were conducted by IOM staff with traditional chiefs of villages and community members in the Diamare, Mayo-Sava and Mayo-Tsanaga departments, in order to collect their views on existing CVR and economic reinsertion programming, as well as on some of the underlying factors contributing towards Boko Haram recruitment. This strengthened the overall context analysis and design of the project by confirming communities' satisfaction in participatory grant mechanisms following dialogue processes and reconfirmed the proposed theory of change for reducing factors contributing to the exploitation and recruitment of youth in the Far-North. The Meri transitional centre was also visited.

At the local level, the project was also discussed with the Regional Delegation of Public Health of the Far-North as well as the heads of health districts of the departments affected by the crisis, in order to ensure the existence of various health committees that will be called upon as part of the implementation of the project. Three health districts were consulted (2 in Mayo-Sava, 1 in Mayo-Tsanaga) through a joint WHO-IOM mission (3-4 August 2021), discussing the approach of using health forums as entry points for wider dialogue and engagement on peacebuilding and social cohesion.

Finally, WHO, IOM and DPO jointly presented the project and approach to DPPA and UNOCA for their feedback and comments (on 3 August 2021), with the project's concept understood and accepted with specific feedback to ensure engagement of local government stakeholders, the Ministry of Health, Ministry of Women's Affairs and alignment with the National DDR Framework. The three organisations, through the Resident Coordinator's Office, also contacted to the Lake Chad Basin Commission (LCBC) to engage with them on the project and create further synergies at the regional level.

Project Gender Marker score[5]: 2
Specify % and $ of total project budget allocated to activities in pursuit of gender equality and women's empowerment: **34.62% corresponding to 886,869.69 USD**

[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)

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

Gender-specific needs of men and women, girls and boys, have been analysed as part of the project development process, and will be taken into account throughout the project's implementation, monitoring and evaluation. The profiling of beneficiaries will be carefully done with disaggregation by gender and age.

More specifically, under Outcome 1, when organizing and operating community health dialogue fora (*comités de santé*, COSA), equitable representation of different population groups within communities, including youth and women, will be ensured in order to capture specific needs which may vary by gender, age, and other socio-economic status. Based on the needs identified at the COSA, as well as the demographic profiles in different communities, a wide range of health and other social services will be provided, including sexual and reproductive health, assistance to survivors of gender-based violence (GBV), maternal and new-born health to child and adolescent health, based on the (high) needs for this in the region.

Under Outcome 2, the lack of inclusion and participation of female ex-associates in the reintegration process will be tackled by building the capacities of state institutions towards increased gender-sensitive approaches to assistance, as well as the mainstreaming of gender considerations into the development processes of national DDR framework.

Under Outcome 3, the project plans to provide training and capacity building programmes for vulnerable groups, especially youth at risk of exploitation by armed groups including girls and young women, to be equipped with skillsets and competencies for viable alternatives to violence. If necessary, specific training sessions can be tailored for women only, given the existing socio-cultural obstacles to women's participation in activities with men, in some cases. In order to support /facilitate the capacity-building process with women, communities will also need to be sensitized on gender dynamics and stereotypes that lead to women's exclusion and stigmatization, particularly amongst female ex-associates.

Project Risk Marker score[7]: 2

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

If applicable, SDCF/**UNDAF outcome(s)** to which the project contributes:

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

[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)

Sustainable Development Goal(s) and Target(s) to which the project contributes: Goal 16: Peace, Justice and Strong Institutions (Targets 16.1, 16.3, 16.A), Goal 17: Partnerships for the Goals, Goal 5: Gender Equality	
Type of submission: ☒ **New project** ☐ **Project amendment**	**If it is a project amendment, select all changes that apply and provide a brief justification:** **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: USD XXXXX **Brief justification for amendment:** *Note: If this is an amendment, show any changes to the project document in RED colour 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 Phanuel Habimana *Signature* [redacted] *Name of Agency: World Health Organization (Cameroon)* *Date & Seal* 19/10/2021 *Name of Representative: Patrich Dinnall* *Signature* [redacted] *Name of Agency: International Organization for Migration (Cameroon)* *Date & Seal* 19/10/2021	*Name of Government Counterpart* *Signature* [redacted] *Title* Alamine Ousmane Mey *Date & Seal* 15 NOV 2021
Head of UN Country Team	**Peacebuilding Support Office (PBSO)**
Name of Representative ~~Oscar Fernandez-Taranco~~ Matthias Z. NAAB *Signature* [redacted] *Title* Coordonnateur Résident *Date & Seal* 20/10/2021	*Name of Representative* Awa Dabo *Signature* [redacted] *Title* Deputy Director and Officer in Charge, Peacebuilding Support Office *Date & Seal* 29 November 2021

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

Peacebuilding Context and Rationale for PBF support

a) Analysis findings

Cameroon is beset with violent conflicts and faces rising tensions as regional dynamics risk further escalation if left unaddressed. The four riparian countries around Lake Chad – Cameroon, Chad, Niger and Nigeria, are experiencing unprecedented levels of crises, exacerbated by repeated incidences of violence from armed groups designated as terrorist organisations (AGDTOs). These crises have deepened instability and slowed economic growth in a sub-region that has historically been characterized by environmental and developmental challenges prior to the activities of Boko Haram and the resultant humanitarian crisis[10]. In the Far-North of Cameroon specifically, armed group dynamics continue to trigger lower magnitude displacements and community shocks exacerbating already significant humanitarian needs and vulnerabilities particularly in the health sector. Since 2013, sporadic attacks and activities by these AGDTOs have resulted in the continuation of violence with more than 341,535 IDPs, 48,902 Nigerian out-of-camp refugees and 124,310 returnees uprooted as of March 2021,[11] placing a severe strain on surrounding communities in terms of access to shared resources and livelihoods; testing host communities' abilities to absorb new populations, and further contributing to a deterioration of social cohesion. Although commonly acknowledged that GBV cases are under-reported, this includes a substantial rise in the number of cases of gender-based violence (GBV) including rape, child marriage, intimate partner violence and sexual exploitation (the majority who report GBV cases being women and girls), with incidence increasing during periods of conflict and the subsequent breakdown of social and state structures.[12] The Far-North region and the wider Lake Chad Basin and septentrional area are also home to large transhumance communities, and while relations between transhumance populations and village farmers were already under strain due to climate change, armed violence has meant that a large amount of transhumance populations are no longer able to roam in areas controlled by or are perceived to be threatened by Boko Haram, who regularly steal cattle. As a result, cross-border transhumance migratory patterns are pushed into smaller and smaller geographic areas, (mostly on the Cameroonian side), which further adds to the difficulties in host communities' abilities to absorb mobile populations and provide resources such as water to all in need.

AGDTOs such as Jamā'at Ahl as-Sunnah lid-Da'wah wa'l-Jihād (JAS) and the Islamic State West Africa Province (ISWAP - hereinafter jointly referred to as Boko Haram) in the Far-North Region [continue to] undertake sporadic attacks primarily in border areas, using the more isolated parts of Cameroon's Far-North region such as the Mandara mountains or islands of Lake Chad as bases for coordination. Attacks are not only limited to clashes with Government security forces, but are carried out on nearby communities in order to amass wealth and resources such as money and cattle, as well as a means of kidnapping both men and

[10] Regional Strategy for the Stabilization, Recovery and Resilience of the Boko Haram affected Areas of the Lake Chad Basin Region
[11] IOM Displacement Tracking Matrix (DTM) Mobility Tracking Round, March 2021
[12] Cameroon Humanitarian Response Plan, 7th April 2021, OCHA

women as a mode of forced recruitment. In a recent survey conducted by UN Women in the localities of Kolofata and Kerawa, Boko Haram was identified as the principal perpetrator of acts of GBV, followed by family members and the military.[13] In response, since 2014, multiple self-defence forces and small groups of village defenders mostly consisting of young men (numbering some 14'000) emerged in order to provide protection to vulnerable communities, further contributing to instability and conflict. Ineffective governance, corruption, lack of, or inadequate basic services, mistrust of security forces and a sense of isolation from the central government are all results of the under-development that the Far-North region has seen, and these factors have contributed to creating fertile ground for the manipulation, recruitment and exploitation of vulnerable persons by and into these armed groups. The Far-North region of Cameroon is the country's poorest, with 74 per cent of the population living below the poverty line compared to an average of 37.5 per cent in the country as a whole.[14] Compounding this are high levels of illiteracy and unemployment, and low levels of education and direction (or '*manque d'encadrement*') for youth - resulting in a gap between the youth's ambitions for work and access to livelihoods in diverse areas such as agriculture, cattle herding, tailoring, micro-businesses, and working for the state, and their lack of financial starter capital and resources to begin any activities or further training.

In addition to these socio-economic drivers is the pre-existing trust deficit between distinctly different identity groups across heterogenous parts of the country. More broadly, these divides are ethnically and socially pronounced between the predominantly Muslim/Fulani groups in the Far-North, and the economically and politically more influential Beti and Bulu/Christian groups in Yaoundé. In this environment of strained inter-communal relations, poor access to basic social services such as health and education, and perceptions of poor governance and corruption only act to fuel frustrations in the ability of the state to equitably provide to all, irrespective of group identity.

These various factors cultivate a viewpoint among some, especially youth, that armed groups and local defence forces offer an alternative pathway to access to livelihoods and well-being. In addition to social pressures and expectations placed on youth (e.g., to aspire to favorable community status, to marry and provide for their family), rumors, disinformation and misinformation add to the list of variables rendering youth vulnerable towards Boko Haram.

Factors contributing to AGDTO Exploitation and Recruitment

Both men and women can be found within armed groups such as Boko Haram. Men and boys may be targeted more for their physical strength in the hope of recruitment that leads to their active participation in the group's military operations. Women and girls may be targeted for

---

[13] Evaluation des normes genres et violences basees sur le genre (VBG) incluant les hommes et les garçons, les autorites traditionnelles et religieuses a kolofata et a kerawa dans le departement du mayo sava a l' Extreme-Nord du Cameroun, UNWomen, November 2020

[14] *Trends, characteristics and determinants of poverty in Cameroon between 2001 and 2014*, Report of the fourth Cameroonian household survey, National Institute of Statistics, December 2015 Issa Saibou," Economic and social effects of the Boko Haram attacks in the Extreme -Nord du Cameroun ", Kaliao, special edition November 2014, p. 156; Machikou Nadine, Claude Mbowou, "Political Economy of Violence in the Far-North", Cameroon National Report, United Nations Development Program (UNDP), October 2015.

services such as cooking or nursing. Amongst both boys/men and girls/women, some consciously join Boko Haram for a variety of reasons, including in the hope for social gains, based on the promises that are made by the existing "recruiting" narratives or rumours. Those include the prospect of (easier) access to marriage for men; and for women, access to more freedom and education, and the prospect of marriage to a high-ranking officer - that would see their social status increase.[15]

In the absence of job opportunities, these youths (as described above), are also pressured into considering Boko Haram and other AGDTOs as an alternative source of livelihood. A recent study by UNWomen found that for women, poverty was the principle reason for Boko Haram recruitment into their most dangerous combat activities, including a perceived 'feminization' of suicide bombing activities as a tactic of Boko Haram.[16] Cameroon is experiencing a "youth bulge", with the country's average age being 19 years and a population growth of about 2.5 percent per year.[17] According to a 2020 Labour Market Survey carried out by IOM in the three most heavily impacted departments of the Far-North region by the Boko Haram crisis,[18] unemployment was listed as the number one push factor to joining Boko Haram (and this was followed by lack of education and the influence of friendship). According to interviews conducted with defecting Boko Haram fighters, Boko Haram are reported to have *promised* to pay youths a "recruitment bonus" ranging between US$600 – US$800 each month, including a motorbike (while the minimum wage for a job within society is about US$72 per month). Against this backdrop, the prospect of economic gains is a major pull factor for youth enrolment in AGDTOs – although not the only one.

Dissatisfaction with the government as the principal provider of public goods also features as a key recruitment driver. Perceptions of the state only ensuring the welfare of select, privileged

---

[15] For men with low incomes, opportunities to marry may not be present due to the lack of financial resources to pay a dowry, and membership of Boko Haram gives them direct access to women in the form of a wife who is 'assigned' to them – and/or access to money or personal goods they cannot afford otherwise. For women, recruitment factors include opportunities for greater freedoms, education opportunities and social status - that are inaccessible to them outside of Boko Haram structures. See Matfess, J. 2018 Women and the War on Boko Haram: Wives, Weapons, Witnesses. Zed Books, London. Women rejecting paternalistic and ideological factors within their own communities, aspire to take an active role within the group and perceive opportunities for greater freedoms, education opportunities and social status that are inaccessible to them outside of Boko Haram structures. See International Crisis Group and International Organization for Migration (IOM), 2021. Gendered Dimensions of Disengagement, Disassociation, Reintegration and Reconciliation in the Lake Chad Basin Region. IOM, Geneva. Available at: https://publications.iom.int/books/gendered-dimensions-and-lake-chad-basin-region-disengagement-disassociation-reintegration.

[16] Evaluation des normes genres et violences basees sur le genre (VBG) incluant les hommes et les garçons, les autorites traditionnelles et religieuses a kolofata et a kerawa dans le departement du mayo sava a l' Extreme-Nord du Cameroun, UNWomen, November 2020

[17] Recovery and Peace Consolidation Strategy for Northern and East Cameroon 2018–2022, at https://documents1.worldbank.org/curated/en/245081527486919288/pdf/126613-WP-P160779-PUBLIC-cameroon-RPC-english-web-DISCLAIMER.pdf

[18] The study aimed to create a greater understanding of the ambitions of youth in the region, the reasons that act as push factors to joining Boko Haram, what kind of available job sectors there are for employment, and which sectors would hold the greatest potential absorption capacity for facilitating a durable socio-economic reintegration of ex-associates in the region. See IOM Study Report: Mapping-out Growth Sectors Likely to Generate Concrete Job Opportunities and Assistance Program for a Sustainable Socioeconomic Reintegration of Ex-Boko Haram Associates in the Far-North Region of Cameroon (forthcoming).

groups fuel a moral and social legitimacy crisis among disenchanted youths, which can be exploited by trans-national groups such as Boko Haram to recruit the aggrieved youth.[19] According to UNDP, around 71% of Boko Haram recruits surveyed identified "government action", including "killing or arrest of a family member or friend" as the "tipping point" which convinced them to join Boko Haram.[20] In the Far-North of Cameroon, resource and water-based conflicts between herder populations and fishing communities have further contributed to widening the distrustful relationship among communities and between communities and the state.[21]

According to IOM's 2020 Labour Market Survey, explicitly religiously or ideologically motivated reasons where only registered among 1-3% of respondents across the three departments studied in the Far-North.

Diminished healthcare systems and COVID-19: a compounding factor

The existing perception, amongst parts of the populations in the Far-North, of being overlooked or under-served by the State concerns various sectors, including the health sector. According to the data of the Government's Sectoral health strategy, Cameroon faces poor financial and geographic accessibility to health services in general, and the situation has been deteriorating since 2011. The regions of the Far-North and the North are the most affected. It is estimated that 1.2 million people will need assistance to meet their basic health needs in 2021 in the Far-North Region. Before the crisis in the Far-North, the health situation was already dire, with children and women[22] being particularly affected by the lack of health services. According to data from the 2014 Multiple Indicator Cluster Survey (MICS), infant mortality and mortality among children under one year of age in the Far-North Region were the highest in the country.

As a result of the crisis, these indicators have collapsed even further.[23] Inadequate health, hygiene and sanitation facilities further contribute to the emergence of epidemics, as well as the ability to quell their propagation such as with COVID-19. Health centres that are still functional are under increasing pressure due to the large number of displaced people, new refugees from Nigeria and the influx of seriously injured people resulting from the conflict.

---

[19] Armed groups have been able to use Cameroonian student recruits (particularly of the Kanuri, Choa Arab and Mandara ethnic groups) in Nigeria to further fan discontent and promote the group's radical religious ideology inside Cameroon proper.

[20] UNDP (2017), *Journey to Extremism in Africa: Drivers, Incentives and the Tipping Point for Recruitment*

[21] UNDSS Far-North, Flash-Report, 'Conflict Between the Arabs and the Musgum in Logone Birni in the Logone Birni Subdivision, August 2021

[22] According to data from the 2014 Multiple Indicator Cluster Survey (MICS), the prevalence of diarrhea in children under five was 36% in the Far-North compared to 20% nationally. In addition, 42% of children in the Far-North were likely to be stunted while 31% were underweight. Further, 38% of pregnant women do not benefit from any prenatal visit compared to 17%. Only 25 per cent of deliveries take place in health facilities in the Far-North, and only 29 per cent of them receive qualified assistance. Finally, only 34% of mothers in the Far-North and their newborns benefit from a health check after the baby is born.

[23] For example, according to the survey on the availability of services conducted by the WHO in 2017, emergency obstetric care and the management of spontaneous abortions constitute a real challenge and are not available in some health facilities in the area impacted by the crisis.

Several health centres have also closed[24] due to the conflict and reduced access to water and sanitation further aggravates the situation. Among displaced populations, pregnant women, persons with disabilities and women and girls find it the most difficult to access health services in the Far-North region. The permanent attacks by AGDTOs, which sometimes specifically target health structures, push health personnel to desert their health facilities.[25] This further reduces the availability of health services and increases the feeling of marginalization of communities in the Far-North. In a recent survey of 319 persons in some of the most impacted areas of the current crisis, only 39.5 per cent revealed knowing of services available for survivors of GBV.[26]

Against this backdrop, the existence of trusted community health structures across Cameroon is an opportunity that is worth highlighting, from both a health and a peacebuilding perspective. In the Far-North region, there is a network of approximately 289 health committees or "COSA" (*comités de santé*) spread through the region. They report directly to their respective health districts in order to coordinate health needs. These COSA are already a well-developed and engaged network of community health structures that are trusted by their communities partly due to being composed of individuals representing various groups from the area, but currently lack the financial resources to fully provide health services to all that need them currently. In a recent series of consultations with the COSA (*comités de santé*) and COSADI (*comités de santé de district*) in the Far-North, health officials stated that these committees do show a great potential to act as a neutral entry point for the building of wider peace initiatives more directed at some of the underlying factors contributing to the conflict. They also expressed the view that COSA are the best available health structure to engage with for local health issues and wider community grievances that form the background of exploitation and recruitment into AGDTOs, with the COSADI (*comite de sante de district)* suitable for initiatives at the larger district levels. Furthermore, local officials listed other community-based groups and structures that are already present in the communities and which could also be engaged in coordination with COSA, including women's associations, youth groups, IDP representatives, development committees, and women's networks for development. The project will engage and strengthen the COSA as part of its objectives to improve the inclusive, equitable delivery of health care, while opening dialogue between the various communities and the authorities.

Defection factors and the Reintegration process – Challenges, Needs and Opportunities

[24] It is the case of the health centres in Zehlevet, Assigasha, Goldavi, Gousdavreket, Nguetchewe, Ouzal and Toufou in the department of Mayo Tsanaga, the integrated health centres of Limani and Kouyape in Mayo Sava, the health centres of Tchika, Naga and Bargaram in Logone and Chari, for example.

[25] In the Koza Health District alone (Mayo-Tsanaga), health centers that have either been destroyed or deserted include for the localities of Zehlevet, Assigasha, Goldavi, Gousda-Vreket, Nguetchewe and Ouzal. Multiple health centres in the departements of Mayo-Sava and Logone-et-Chari have also been either destroyed, partially destroyed or abandoned due to insecurity.

[26] The areas of the survey being Kolofata and Kerawa See: Evaluation des normes genres et violences basees sur le genre (VBG) incluant les hommes et les garçons, les autorites traditionnelles et religieuses a kolofata et a kerawa dans le departement du mayo sava a l' Extreme-Nord du Cameroun, UNWomen, November 2020

The backdrop (as described above) of social, political, economic, and security pull and push factors driving recruitment of youth into armed groups requires an integrated approach which must offer both social and economic alternatives for those members who are considering leaving these armed groups, or for youth at risk of exploitation by them. Recruitment prevention and reintegration processes with ex-associates must build upon the identified factors influencing recruitment and defection amongst youth. For those that decide to defect from Boko Haram, a sudden awareness (*prise de conscience*) of their situation was listed as number one in a 2020 IOM labour market survey that covered the three most affected departments of the Far-North region, either due to a rejection of the living conditions with the group or if the expectations they had before they joined were not met.[27] It is important to note that this reason was followed by the perceived threat of being killed in combat, and a need to return back to their families and community of origin. This highlights the importance of considering security and social factors, in addition to economic ones, in reintegration strategies.

Family groups may decide to defect all together, or women may defect on their own due to their male counterparts having been killed. In fact, women and young children make up the vast majority of the potential caseload of former associates eligible for reintegration pathways in the Far-North.[28] Beyond women themselves taking an active role in combat, some may have been previously inserted into family structures within Boko Haram groups.

At present, a comprehensive framework or process that clarifies the status of various AGDTOs and their members in the region and that provides for their reintegration into the communities remains to be developed. So does a clear programmatic strategy to address the impact of Boko Haram in communities. State institutions, such as the National DDR Committee (NDDRC), mandated to implement reintegration measures and other relevant line ministries (such as those of justice, education and health) are under-resourced, under-capacitated, and in some areas of the country, not trusted by communities. This is having an impact on the government's - and supporting technical and financial partners' - ability to provide viable and sustainable alternatives to those who have recently left or are considering leaving armed groups, and would be in need of possible mental health and psychosocial support, social services, training and economic reinsertion in order to restart their lives outside of armed group structures.

The recent fallout of in-fighting between Boko Haram factions in Nigeria and the death of JAS leader Abubakar Shekau in May 2021 has substantially changed the political and operational dynamics of AGDTOs in the Far-North region and presents a timely opportunity to further support disengagement and reintegration processes. The Meri transition centre now holds approximately 800 ex-associates, with the recent arrival of an additional 200 ex-associates in

[27] The socio-economic promises made by armed groups to the enrolled youth are not often met; and once recruited, the pathways to exiting the group progressively narrow: new fighters are re-indoctrinated and drugged with Tramol, with successive payments being withheld/conditioned on the completion of missions.

[28] Voice of America, 'Cameroon Says Hundreds Boko Haram Fighters Surrendering After Abubakar Shekau's Death', 3 August 2021 https://www.voanews.com/africa/cameroon-says-hundreds-boko-haram-fighters-surrendering-after-abubakar-shekaus-death

August 2021[29] confirming a trend of increased Boko Haram defections, with a temporary reduction in cross border attacks[30] attributed to confusion in Boko Haram command structures. As this recent trend continues, having an effective process to accommodate these surrenders would further incentive other who are considering doing the same.

In the particular context in Cameroon, community chiefs[31] play a crucial role in the processing of Boko Haram defections, with ex-associates mostly turning themselves in to local leadership structures who then in turn notify the security authorities to refer individuals to the regional DDR centre in Mora, as well as the regional transition centre in Meri. Local leadership under this context receives training and sensitization on what the correct course of action is when notifying of an ex-associate in their area, and how to best facilitate the protection and oversight of individuals before they are handed over to more formalised processes.

Currently, women and children do not have the same access to rehabilitation and reintegration processes and assistance as their male counterparts. Due to the perception that women are playing secondary support roles within Boko Haram,[32] until now, the NDDRC and other reintegration efforts have focused primarily on men.[33] Women and children are excluded from formal assistance and find themselves in a situation of increased vulnerability, GBV risks, marginalization and with an important risk of recidivism.[34] In some rare cases, female ex-associates are viewed as more dangerous than men by communities, because of fears that they may continue to operate under male influence to conduct violent acts - an entrenched gender stereotype that inhibits their reintegration.[35]

---

[29] Actu Cameroun 'Extrême-Nord- Plus de 200 ex-combattants nigérians de Boko Haram accueillis au centre de transit de Meri', 23 August 2021, https://actucameroun.com/2021/08/23/extreme-nord-plus-de-200-ex-combattants-nigerians-de-boko-haram-accueillis-au-centre-de-transit-de-meri/

[30] UNDSS, Central Africa: Monthly Situational Analysis and Forecast, June 2021

[31] The region of the Far-North of Cameroon is home to an incredibly rich and deep set of cultural networks of local leadership, both through ethnic, community and local government networks and links. Local village leadership in the typical form of a *chef du village* can act as the main entry point of all administrative and practical engagement with the community itself.

[32] In recent research conducted by IOM, the majority of community respondents to a survey stated that they thought the reintegration of men was of higher priority than that of women (55 per cent), as respondents perceived women's 'passivity' with the attacks likely to stop only once men's needs are addressed. Women's reintegration is also viewed as 'less difficult' than of men, as their exit from Boko Haram is understood as a 'rescue' and that their reintegration will follow naturally once the reintegration of men is completed. See International Organization for Migration (IOM), 2021. Gendered Dimensions of Disengagement, Disassociation, Reintegration and Reconciliation in the Lake Chad Basin Region. IOM. Geneva.

[33] Currently as of mid-2021, the NDDRC's interventions are based on the Presidential Decree No. 2018/719 of 30 November 2018 that established and mandated the NDDRC for 'organizing, supervising and managing the disarmament, demobilization and reintegration of ex-fighters of Boko Haram [...] willing to respond favorably to the Head of State's peace appeal by laying down their arms '. So far the NDDRC's reintegration efforts in the Far-North include limited access to basic social services to ex-Boko Haram associates, who are present at the Meri transitional center as well as a temporary center in Mora.

[34] Hudson, V., B. Ballif-Spanvill, M. Caprioli and C.F. Emmett 2012 Sex and World Peace. Columbia University Press, New York.

[35] International Organization for Migration (IOM), 2021. Gendered Dimensions of Disengagement, Disassociation, Reintegration and Reconciliation in the Lake Chad Basin Region. IOM. Geneva. Available at: https://publications.iom.int/books/gendered-dimensions-and-lake-chad-basin-region-disengagement-disassociation-reintegration

Addressing these issues of inclusion and participation at community level will involve strengthening the capacities of state, regional and local institutions towards increased understanding of the importance of tailored and gender sensitive approaches to reintegration assistance. It will also involve the sensitizing of communities themselves on the specific gender dynamics and stereotypes that lead to women's exclusion and stigmatization, which are counterproductive to the laying of foundations for a sustainable and resilient peace which includes all relevant parties. Any post-disengagement processes in a working DDR framework should take into consideration the needs of both women and men, who both face risks of potential recidivism and the continuation of the Boko Haram conflict. The good practices and lessons learnt of this pilot project – including from a gender-sensitive perspective – will contribute to the development of the national DDR framework in Cameroon.

b) Complementarity with existing Government and UN strategic frameworks; strategic objectives under PBF national eligibility framework

The proposed project aims to simultaneously complement and fill gaps in current programming (outlined in the summary of existing interventions below) through a new partnership between WHO, IOM and DPO. The project aligns with national and regional, conflict prevention and peacebuilding strategies and frameworks, including the national development strategy 2020-2030, the Presidential Decree No. 2018/719 that established the NDDRC, and the Regional Strategy for the Stabilization, Recovery, and Resilience of the Boko Haram-affected areas of the Lake Chad Basin Region (objectives 7, 11 and 12). The project builds towards Sustainable Development Goal (SDG) 16 for Peace, Justice and Strong Institutions, SDG Goal 17 for Partnerships, and Goal 5 for Gender Equality. This project is also designed to respond to the government of Cameroon's recent formal request for the DPO to provide multidimensional assistance to national authorities on the implementation of current DDR efforts. Finally, the proposed project responds directly to one of the government's three identified thematic priorities for the Peacebuilding Fund in Cameroon agreed between the United Nations and the Government of Cameroon, and articulated in all engagements between the United Nations Resident Coordinators Office for UN PBF initiatives: the implementation of national Disarmament, Demobilization and Reintegration programs of ex-combatants from non-state armed groups.

c) Summary of existing interventions

The proposed project complements existing stabilization and peacebuilding programming in the Far-North region that seeks to address the underlying factors leading towards continued capacity of Boko Haram to exploit and recruit vulnerable community members. IOM's current Disengagement, Disassociation, Reintegration and Reconciliation (DDRR) programme in the Lake Chad Basin funded by the US State Department and the Government of Japan in part focuses on preparing communities in the Far-North for receiving ex-associates for reintegration, and works to build both regional and national capacities with strong national

legal frameworks.[36] It will also build from the best practices and progress of IOM's current PBF-financed project, '*Stabilisation et Relèvement des Communautés Affectées par la Crise Sécuritaire à l'Extrême-Nord du Cameroun*', which focuses on community-based approaches including innovative community violence reduction (CVR) processes to provide a holistic approach to reducing community vulnerabilities to exploitation.

The project also seeks to build on IOM progress implementing Information, Counselling and Referral Services (ICRS) to the authorities supporting the rehabilitation and reintegration of former associates with components specific to providing economic reinsertion assistance through health and non-health sectors. This project will also build on the emergency interventions carried out by WHO in the Far-North region from 2016 to 2019.

Project name (duration)	**Donor and budget**	**Project focus**	**Difference from/ complementarity to current proposal**
Disengagement, Disassociation, Reintegration and Reconciliation: Conflict Dissolution and Peacebuilding in the Lake Chad Region (IOM)	US Department of State Bureau of African Affairs (10,982,499 USD for the Region)	Supporting the governments of the Lake Chad Basin Region in developing legal and operational frameworks for DDRR, capacity building of local actors and authorities, community-based reintegration and reconciliation, roll out of ICRS to facilitate individual case management and reintegration.	Complementarity with capacity building and strategic document development.
Stabilisation et Relèvement des Communautés Affectées par la Crise Sécuritaire à	UN PBF (933,018.60 USD)	Community Violence Reduction, Economic Reinsertion, Psychosocial Support	Pilot Community Violence Reduction approaches may be built upon/ less emphasis on as well

[36] IOM's regional DDRR programme for the Lake Chad Basin has been running since 2017 and is divided into four pillars of action: (1) Assessment, Context Analysis and National Planning, (2) Upstream Government Support, (3) Individual Case Management and (4) Community-Based Reintegration and Reconciliation.

l'Extrême-Nord du Cameroun (IOM (lead, UNFPA, FAO)			as capacity building initiatives
Strengthening Community Resilience and Recovery in Cameroon for the Humanitarian Development Peace Nexus (IOM)	Japan (1,498,000 USD)	Information, Counselling and Referral Services, Community Based Impact Projects	Complements capacity building, Information Counselling and Referral Services
Displacement Tracking Matrix components of the "Emergency Assistance to Displaced Populations in the Lake Chad Region" & "Supporting conflict-affected populations in Cameroon through the implementation of the Displacement Tracking Matrix (DTM)" projects (IOM)	Germany & ECHO (617,941 EUR)	Displacement Tracking and Data Collection for Stability Indicators in Far-North region	Data Collection may help in the targeting of areas under this project
Strengthening of epidemic preparedness and response capacities in health districts impacted by the crisis in the Far-North (WHO)	ECHO (600,000 EUR)	- Community epidemiological surveillance - Pre-positioning of inputs for epidemic response - Training of staff in the detection of cases with epidemic potential	Reinforcement of the gains obtained by the previous project

		- Coordination for the preparation and response to epidemics	
Emergency health assistance to vulnerable populations in 23 health areas in the department of Logone and Chari (WHO)	CERF (1,000,183 USD)	- Curative care through mobile clinics - Support for psychological and physical trauma of conflict victims - Minor rehabilitation and equipment of health facilities - Response to ongoing epidemics	- Improve the reduction of the gap in terms of access to health care - Strengthen inter-community dialogue through the engagement of health committees
Health support to vulnerable populations for the improvement of primary and promotional health care in the departments of Mayo Sava and Mayo Tsanaga (WHO)	CERF (900,000 USD)	- Curative care through mobile clinics - Support for psychological and physical trauma of conflict victims	- Improve the reduction of the gap in terms of access to health care - Strengthen inter-community dialogue through the engagement of health committees
Auto visual AFP (Acute Flaccid Paralysis) detection and reporting project (WHO)	Bill & Melinda Gates Foundation (1,260,000)	- Training of community health workers - Enrollment of community health workers in the surveillance of AFP cases - Recruitment of members of vigilance committees for the active search of AFP cases	- Reinforcement of the gains obtained by the previous project - Strengthen inter-community dialogue through the engagement of health committees

		- Provision of smartphones for the transmission of information - Investigation of AFP cases	
Youth and Stabilization for Peace and Security in the Far-North Region (UNDP, UNFPA, UNICEF)	European Union (2,200,000 EUR)	- Prevention of new recruitments and rejoining of youth to the terrorist group through life skills promotion. - Accompaniment of ex-associates and hostages for better social reintegration and economic opportunities promotion.	- Creation of livelihood opportunities in health-related areas - Strengthen inter-community dialogue to build social cohesion. - Capacity building for government partners in charge of DDR process
Supporting household resilience of Lake Chad Basin communities affected by the Boko Haram insurgency (FAO)	Ireland (57,000 USD)	- Development of the cropping area, vegetable production and aquaculture	- Creation of livelihood opportunities in health-related areas
Integrated Regional Stabilisation of the Lake Chad Basin/Community Stabilisation (UNDP)	Germany (12,000,000 EUR)	Phase 2 of Integrated Regional Stabilisation of the Lake Chad Basin/Community Stabilization covering Far-North/Logone and Chari, Mayo Sava and Mayo Tsanaga	- Strengthen inter-community dialogue to build social cohesion - Creation of livelihood opportunities in health-related areas
Supporting community-level peacebuilding mechanisms and the inclusion of young people in border areas	PBF (1,499,962 USD)	- Employment and equitable access to social services - Re-establishment of essential administrative services	Improve peace and stability in the target border areas by addressing the factors that are sources of conflict and violent extremism.

between Chad and Cameroon. (UNDP)		- Strengthening national capacity in essential services - Extension of state authority / local administration - Governance of peacebuilding resources	
Lake Chad Region Recovery and Development Project; PROLAC (Lake Chad Basin Commission)	World Bank (170,000,000 USD for Cameroon, Chad, Niger)	- Support national and regional coordination platforms - Restore sustainable rural mobility and connectivity - Strengthen the recovery of agricultural livelihoods in selected provinces - Knowledge sharing and regional dialogue with a data platform hosted at the Lake Chad Basin Commission - Strengthen community empowerment through labour-intensive public works	- Focus on Far-North region in Cameroon - Capacity building for national authorities (including NDDRC) - Creation of livelihood opportunities in health-related areas - Restore health infrastructures - Reinforcement of the gains obtained from regional projects

I. Project content, strategic justification and implementation strategy

a) Brief description of the project focus and approach

The ultimate goal of the project is to contribute to enabling the conditions for effective and sustainable peace in Cameroon, focusing on the Far-North, through the implementation of a "pilot project" using health interventions as an entry point to supporting national entities and local communities towards promoting social cohesion, dialogue and trust between and within communities, and towards national authorities. The project will specifically address key factors of exploitation and recruitment of youth by AGDTOs and contribute to laying the groundwork for a comprehensive framework for a DDR process in the Far-North.

The approach of this pilot project in the Cameroon context is based on the principle that healthcare and health services, when and if provided in an effective, conflict-sensitive, equitable and inclusive manner, can serve as a confidence-building measure for wider engagement on common concerns between community members within a conflict context such as the Far-North. As identified by conflict and contextual analyses, the Far-North region is

under a concerning situation of limited access to health and other basic social services. While conflicts are a major obstacle to health, a lack of access to health services and other social services can equally lead or contribute to feelings of exclusion and the development of grievances, which hinder cohesion between communities (including mobile populations - which include ex-associates and IDPs) and further reduce trust in the State. While preventing further deterioration of health system in the region and promoting health as well as other social services as a common good to be shared /the '*vivre ensemble*'. All three project outcomes and activities are designed to use health-related interventions as an entry point for engagement on wider peacebuilding processes at both the local and national level to contribute to building confidence, strengthening cohesion, preventing or reducing levels of community violence, supporting economic empowerment, while laying the groundwork for an effective DDR process in the Far-North. Lessons shall be drawn from the project through the Monitoring and Evaluation process, and the possibility to replicate or adapt the approach for conflict reduction in other parts of Cameroon will be assessed.

b) A project-level 'theory of change'

The project pursues the following theory of change:

<u>At impact level</u>

- **If** healthcare and health services are provided to communities in the Far-North in a way that is inclusive, equitable and effective, then their perception of exclusion by the State and their mistrust of state institutions will diminish;
- **If** community health fora in the Far-North effectively enable members of the community to engage in inclusive dialogue about grievances and to jointly address common health priorities;
- **If** confidence is built between the NDDRC, former ADGTOs' associates and host communities at local level in the Far North through the provision of health care and the strengthening of the competence and capacities in managing DDR processes in compliance with international norms and standards;
  If youth enrolment and recidivism in AGDTOs is reduced through the creation of health-related socio-economic and training opportunities, as alternatives to violence for youth at-risk of recruitment (including girls and young women) in the Far-North;

THEN violence will be reduced and socio-political and institutional conditions for sustainable peace[building] will be reinforced in the Far-North.

<u>At Outcome level</u>

Outcome 1

IF the establishment or reinforcement of community health dialogue fora (COSA) for the inclusive and participatory identification of health and other social needs, involving communities and the local authorities, allows for constructive engagement by these stakeholders on local-level grievances, recruitment drivers and greater conflict-reduction capacity (output 1.1),

And IF the provision of healthcare and other social services by Public services is enhanced in an equitable manner across communities, using referral mechanisms of Information and Counselling and Referral Services (ICRS) and based on the needs identified by the different community health for a (output 1.2),

THEN trust between communities as well as trust in the authorities will increase, through using improved and equitable access to health and other social services as an entry point for inclusive community engagement in the targeted areas of the Far-North region.

Outcome 2

IF the NDDRC has the capacities to provide health and psychosocial assistance for ex-associates and their families and communities in the Far-North region (output 2.1),
And IF the NDDRC has the capacities to develop interventions that are in line with national and international standards, including the Integrated DDR Standards (IDDRS) and International Humanitarian Law (IHL) (output 2.2),

THEN confidence will be built between the NDDRC, former ADGTOs' associates and host communities at local level (in the Far North region).

Outcome 3

IF youth at risk of enrolment within AGDTOs (including girls and young women) from different communities undertake short-term labour-intensive projects to rehabilitate and/or construct local health facilities or other infrastructure essential for improving community cohesion, as identified in earlier dialogue activities [under output 1.1] (output 3.1),
And IF ex-associates and youth at risk of recruitment (including girls and young women) from different communities participate in socioeconomic opportunities in both health and non-health related areas (including as community health workers and as part of the COVID-19 response), then they will be reinserted into community life (output 3.2),

THEN Youth enrolment and recidivism in AGDTOs will be better prevented through the creation of socioeconomic alternatives to violence for youth at-risk of recruitment (including girls and young women) and through the mitigation of grievances thanks to improved and equitable access to health care in the Far-North.

The theory of change is based on evidence and assumptions drawing upon field observations within current programming, situational and conflict analysis. In the Far-North region, those voluntarily leaving armed groups who have returned to their communities of origin are more likely to be excluded and marginalized given that livelihood opportunities and equitable access to social services cannot be assured for them and their communities due to the deteriorated socio-economic situation.

In this context, the project plans to enhance community-level dialogue mechanisms, in which members of different communities, including ex-associates, can share openly their grievances and needs with others, including local authorities – starting with the health sector. The existing - and trusted – 289 community health committees or "COSA" (*comités de santé* – which all report to their respect Health Districts) in the region will play a key role in this dialogue process, that should also contribute to building trust between communities, and between them and the authorities. Based on the discussions within the COSA, relevant health and other social interventions can be undertaken by the project, by local communities as well as by national and local government actors to satisfy those needs identified. This will strengthen the social accountability of government authorities to deliver basic social services in the eyes of communities. Ultimately this contributes to fostering the preconditions for an effective DDR process and thus for peacebuilding.

Recognising the importance of providing positive, socio-economic opportunities to vulnerable populations, towards weakening the "alternative path" offered by AGDTOs such as Boko Haram and prevent further recruitment, the project plans to provide training and capacity building programmes for vulnerable groups, especially youth at risk of recruitment including girls and young women, to be equipped with skillsets and competencies for valued and viable alternatives to violence - such as the implementation of health-related activities at community level.

Finally, the project plans to enhance relevant capacities and technical expertise of the existing state institutions effectively practicing DDR in line with international standards and International Humanitarian Law (IHL). With an enhanced capacity, the NDDRC and relevant government partners are expected to set up a comprehensive framework for a DDR process in the Far-North to deal with various categories of former associates as well as the subsequent impact of Boko Haram in the Far-North Region. The development of a comprehensive framework first requires an understanding of the political, legal, coordination, operational, financial and communications aspects of DDR for which the NDDRC has requested support through a recent request to the United Nations. At the same time, some of the activities under the project are planned in a manner that will provide visibility for the strengthened interventions of the NDDRC, which in turn will contribute to improving trust between communities and the Committee - and potentially other, related state security institutions. The framework will be a groundwork for an effective reintegration that supports lowering risk of recidivism and contributes to long lasting and sustainable peace in the Far-North region.

c) A narrative description of key project components

The project will aim to achieve the following **three outcomes**:

1. **Trust between communities as well as trust in the authorities are increased, through using health as an entry point for community engagement and participatory and inclusive dialogue that leads also to more equitable and improved access to health and other social services in the targeted communities of the Far-North region.**

Traditional leaders will be the gateway for the implementation of all community interventions that will be carried out under the project. Traditional power has a great influence and a good reputation in the Far-North. Administrative authorities will also be invited and involved to COSA dialogue sessions, as they are a key player in providing sustainable responses to community grievances – and thus in restoring vertical trust. Two outputs are expected to contribute to this outcome: (1) the reinforcement of community health dialogue fora (COSA) for the inclusive and participatory identification of equitable health (and other social) needs, involving the various communities and the local authorities, allowing for wider engagement on local-level grievances, recruitment drivers and greater conflict-reduction capacity ; and (2) the provision of health and other social services is enhanced in an equitable manner across communities, using referral mechanisms of Information and Counselling and Referral Services (ICRS) and based on the needs identified by the different community health fora. When organizing and operating the COSA, equitable representation of different population groups within communities, including youth and women will be ensured in order to capture specific needs which vary by gender, age, and other socio-economic status. Video participation activities and video-screening events within health dialogue structures are also envisaged to make advocacy tools on community issues available for a wider population group. On the basis of the balanced representation of community members at COSA, the ICRS socio-economic profiling of beneficiaries will be carefully done with disaggregation by gender and age. Based on the needs identified at COSA as well as demographic profiles in different communities, a wide range of health services, from sexual and reproductive health, maternal and newborn health, assistance to survivors of GBV, to child and adolescent health and Mental Health Psychosocial Support (MHPSS) will be provided, including the provision of MHPSS kits.[37]

2. **The ability of the NDDRC and other relevant State institutions to design and implement more sustainable and effective DDR interventions - which also allow for confidence-building between the NDDRC, former ADGTOs' associates and host communities at local level (in the Far North region) through the provision of health care, respect of IHL and implementation of IDDRS – is improved.** This will involve two outputs. Firstly, the provision of health-related support to the NDDRC will aim to improve the capacities of DDR practitioners to address health and MHPSS needs for ex-associates and their families and communities in the Far-North region, including at the NDDRC Mora infirmary and the Meri district hospital, where needs are high. This responds to the identified high need from ex-associates related to psychosocial support as they may have experienced traumatic events rendering them unable to proceed with further assistance until health-related aspects are met. In addition, the project interventions will alleviate grievances accumulated by ex-associates due to the poor conditions in the Meri transition center, which triggered a series of localized protests in early 2020.

[37] The composition of MHPSS kits will be done in consultation between community members and COSA representatives, and can include items such as personal hygiene items (soap), clothing, sports equipment, whistles, rechargeable torches, children's toys, COVID-19 information booklet. Kits will be distributed during COSA community dialogue activities.

Secondly, capacity-building and implementation-support shall help the NDDRC and other relevant state institutions in developing interventions that are in line with national and international standards, including the Integrated DDR Standards (IDDRS) and IHL. The training will especially include specific gender components to be considered in the regional context. Given that the current processes provide markedly more limited support for women and children, the project activities will aim to improve the gender sensitivity and responsiveness of DDR policies and processes.

3. **Youth enrolment and recidivism in AGDTOs is better prevented through the creation of socio-economic alternatives to violence for youth at-risk of recruitment (including girls and young women) in the Far-North, while contributing to health preparedness and equitable access to health care at community level.** This will be done through two outputs: (1) offer youth at risk of enrolment within AGDTOs (including girls and young women), from different communities, short-term labour-intensive employment opportunities to rehabilitate and/or construct local health facilities or other infrastructure essential for improving community cohesion, as identified through community dialogues (see Output 1.1); and (2) provide capacity-building and socio-economic opportunities for ex-associates and youth at risk of recruitment (including girls and young women) from different communities, in both health and non-health related areas (including as community health workers and in contribution to the COVID-19 prevention efforts), thus contributing to positively reinserting youth in community life. Through a Community Violence Reduction (CVR) approach, these activities will offer immediate and mid-term alternatives to enrolment and recidivism into AGDTOs. Specific training sessions will be tailored for girls and women only, given the existing socio-cultural obstacles to women's participation to activities with men in some cases, in public spaces. In order to support /facilitate the capacity-building process with women, communities will also need to be sensitized on gender dynamics and stereotypes that lead to women's exclusion and stigmatization, particularly amongst female ex-associates.

   The multiple trainings of young people (165 in total) within the framework of the implementation of the project will allow them to be recognized and taken into account by their communities as Community Health Workers; that is, integrating them as part of the health system. A further 160 individuals (130 community members and 30 ex-associates) will be trained on non-health related socio-economic opportunities. Thus, based on other WHO experiences in Cameroon, at the end of the project, these young people will be well placed to be recruited by the health districts for the implementation of other community activities such as mass vaccination campaigns, mass distribution of antimalarial drugs through seasonal malaria chemoprophylaxis campaigns, active search for cases of diseases under permanent surveillance[38], etc. These young people will also have the opportunity to

[38] To strengthen epidemiological surveillance efforts, the project will engage with the vigilance committees set up by the authorities at local level. They are made up of young people who are appreciated by the communities; they have very good command of what happens in their locality and constitute a link on which we the project should rely, on a context basis.

collaborate with many NGOs present in the Far-North, which are constantly looking for young people trained for the implementation of their community activities.

d) Project targeting

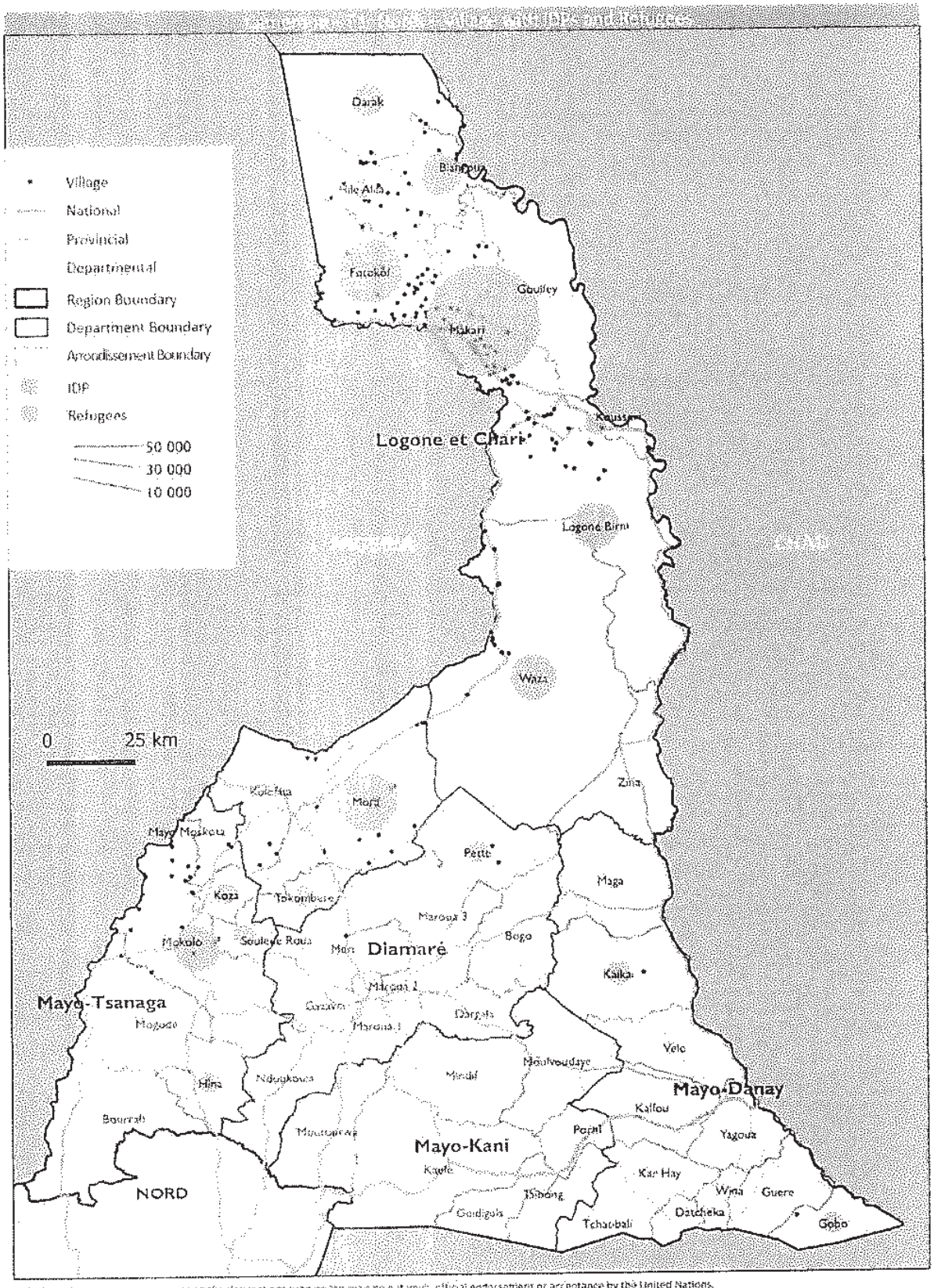
The Far-North region will be the geographic area of focus of the project. At the beginning of the project, a scoping and geographic targeting exercise will be conducted with relevant authorities including the NDDRC, Ministry of Health and territorial authorities, and recipient organizations, which will also involve a process to identify community members who will benefit from income generating activities. This exercise will take into consideration the areas identified by the NDDRC and other relevant partners as high priority for the strengthening of peace and social cohesion. It will also take into consideration information from local and traditional authorities on which specific localities contain higher numbers of ex-associates within communities, and relevant data collected by IOM to identify the areas where tensions over access to resources may be exacerbated by displacements into safe hosting areas as well as the areas that present the greatest potential for stabilization and transitional programming (levels of stability). Based on this information, outcome 1 and outcome 3 activities will take place in the three most affected *départements* of the Far-North region (Mayo-Sava, Mayo-Tsanaga and Logone-et-Chari), using the IOM Stability Index dataset in accordance with the accompanying programming recommendations.[39] Geographic targeting for activities under outcomes 1 and 3 will also take into consideration on-going discussions between Government authorities and the UN Humanitarian Development Peace Nexus (HDPN) task force on the identification of 'zones of convergence' as areas on which to direct collective agency efforts in stabilization and HDP Nexus programming.

The main beneficiaries will be a) vetted ex-associates, b) individuals at risk of recruitment, especially youth, c) vulnerable host community members, d) community representatives including traditional leaders and local health structure representatives, e) local authorities and government officials including those of the NDDRC and f) mobile populations, including returnees and IDPs, who equally require access to livelihoods and durable solutions to displacement. Both men and women, boys and girls will be targeted across these various groups, on the basis of needs and risks factors and through a gender-sensitive approach. Gender-disaggregated indicators will help monitoring the effective inclusion of both men and women in different, key activities.

[39] IOM's Stability Index for Cameroon's Far-North region (available at https://dtm.iom.int/reports/stability-index-%E2%80%93-cameroon-%E2%80%93-country-overview-%E2%80%93-marchapril-2021) comes with specific stabilization programming recommendations including to (1) Focus intervention(s) on fields with the most impact on stability and (2) Rely on geographical and contextual proximity to develop positive spillover effects.

Target Population:

Outcome 1: 225 direct beneficiaries (15 COSA targeted with an average of 15 health and non-health representatives), 261,720 indirect beneficiaries (average of 17,448 persons living in each area covered by COSA)
Outcome 2: (215) direct beneficiaries, 1953 indirect beneficiaries (total number of ex-associates currently based at the Meri transitional centre or Mora DDR centre)
Outcome 3: 1025 direct beneficiaries (directly benefiting from all socio-economic opportunities), 261,720 indirect beneficiaries (persons living in areas of targeted COSA who benefit from increased economic activity in their area)



The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
Note: In some cases, the boundaries of the Arrondissements can include an important margin of error. Source: IOM-DTM Round 22

II. Project management and coordination

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
Lead Recipient Organization: WHO	5,869,000	ECHO, CERF, BMGF	Yaoundé, Douala, Maroua, Bertoua, Buea,	92 (10 in project zone)	Epidemiological surveillance Experts
Implementing partners: AHA; CARITAS; Demtou Humanitaire, International Medical Corps (IMC)					
Recipient Organization: IOM	5 442 953 USD (2020)	EU, USA, PBF, Japan, ECHO, France, CERF	Yaoundé, Maroua, Buea, Douala, Bertoua	96 (72 in project zones of Yaounde and Maroua)	DDRR Programme Managers
Implementing partners: CAPROD ACDC, JAPSSO, RESAEC, APA APDC, EFA, SADEC, AAEDC COHEB, APESS, Codas Caritas Caritas, Shumas					

The World Health Organization's Health and Peace Initiative aims at making WHO a Sustaining peace actor, in collaboration with its partners. In order to respond to the crisis in the Far-North Region, WHO Cameroon has opened a field office, whose staff is dedicated to coordinating partners in the health sector, detecting and responding to any public health incident and humanitarian response. WHO had already had to deploy surgeons and clinical psychologists in 2018 and 2019 in the Far-North, who helped taking care of victims of the conflict with various trauma. WHO has experience engaging with youth and providing them opportunities in the health sector, with positive impact both at health and social cohesion levels in that region.

IOM has been present in Cameroon since 2007 with over 90 staff in five offices. In the Far-North, IOM has been running its Disengagement, Disassociation, Reintegration and Reconciliation (DDRR) programme since 2017. In support of the Cameroonian government, the programme supports former associates of Boko Haram and other AGDTOs that have disengaged to start a new life with support for rehabilitation, reintegration and livelihoods.

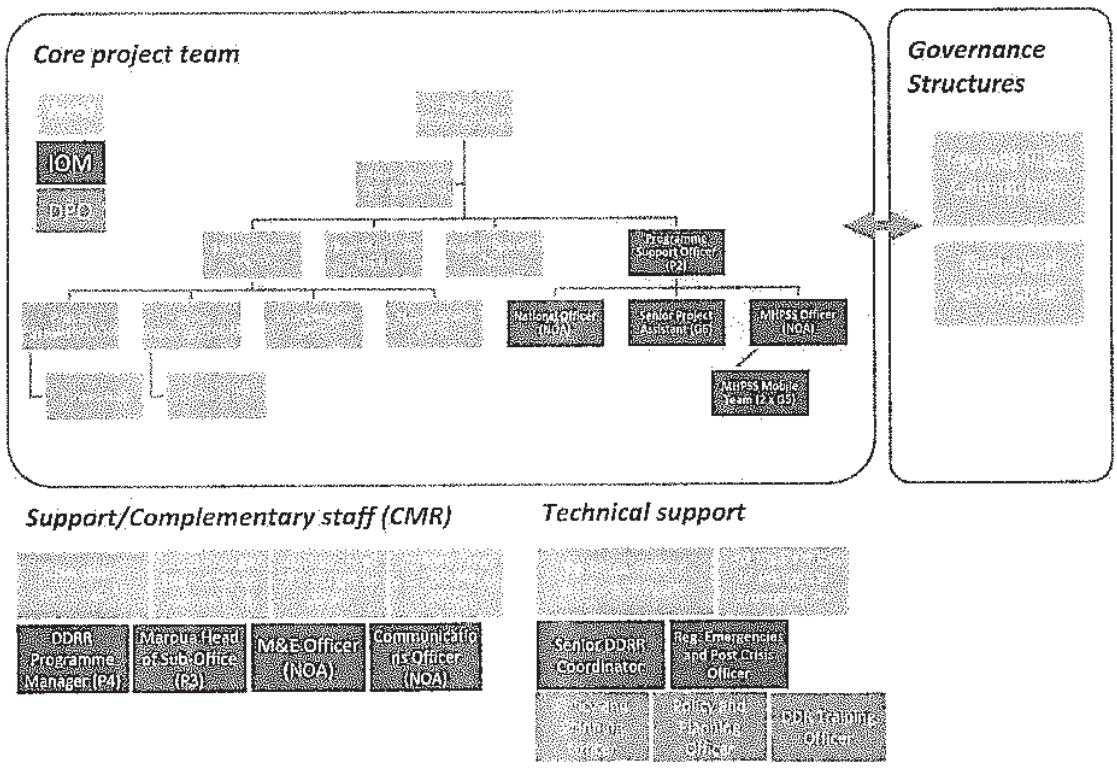
IOM also has on-going community stabilization and peacebuilding initiatives in the Far-North that will also be leveraged through existing expertise, context analysis and data collection. IOM is co-lead of the Humanitarian, Development and Peace Nexus working group in Cameroon and co-leads the DDR inter-agency working group with UNDP, leads the Sub Technical Committee for the Regional DDR Centre with the NDDRC, as well as co-lead of the MHPSS working group in Maroua, Far-North region.

b) **Project management and coordination:**

The implementation will be ensured by a core project team mostly based in Maroua and placed under the overall coordination of WHO as a Lead Agency. This team will oversee the day-to-day implementation and conducting of all activities and be led by a Project Coordinator (WHO, NOC,100%) with proven experience in the management, monitoring and evaluation of public health projects. For WHO other core project team members include two Epidemiologists (NOB, 50%), two Clinical Psychologists (NOA, 60%), one Surgeon (NOB, 60%), one Data Manager (NOA, 60%), one Monitoring &Evaluation Specialist (NOA, 100%) and one Communication Specialist (NOA, 60%). WHO will focus their attention in national staff with high level of skills. For IOM it includes a Programme Support Officer (P2, 30%), National Officer (NOA, 100%), Senior Project Assistant (G6, 100%) and MHPSS Officer (NOA, 83%). In addition, the core project team will benefit from technical support and synergies from complementary projects and programmes, including from WHO an Operations Officer (P3), an Epidemiological Surveillance Officer (P3), a Disease Prevention and Control Officer (NOC) and Maroua Head of Field Office (NOC), and from IOM a DDRR Programme Manager (P4, 5%), the Maroua Head of Sub-Office (P3, 5%), a National M&E Officer (NOA) and a National Communications Officer (NOA). The implementation of the project will be done with the support of partners which may be NGOs or other entities present in the region and having a good knowledge of the project intervention areas. WHO as Agency-Lead will be responsible for consolidating all reports (coordination meetings, supervision missions, monitoring & evaluation, and the final independent evaluation etc).

The core project implementation team will also receive technical support from headquarters/regional office levels of WHO (Mathilde Boddaert, Technical Officer (Health and Peace), and Aiman Zarul, Technical Officer (Inter-Agency Policy for Emergencies)), IOM (Marise Habib, Regional Emergency and Post-Crisis Officer and Nathalie Gendre, Senior DDRR Coordinator for the Lake Chad Basin) and the UN Department of Peace Operations (Sergiusz Sidorowicz, Policy and Planning Officer, Kwame Poku, Policy and Planning Officer, and Marc Schibli, DDR Training Officer), who has also been involved in the design of the project with WHO and IOM.

Project Organigram



c) Risk management

Project specific risk	Risk level (low, medium, high)	Mitigation strategy (including Do No Harm considerations)
Increased insecurity in the project intervention area with restricted access to the project areas, reprisals against former partners	High	Solicitation of support from the security forces (protection of former associates who run the risk of reprisals from armed groups, armed escorts for those working in difficult to access areas) Periodic assessments of the security situation by UNDSS and local administrative authorities
Dissatisfaction of host communities with the help that ex-associates receive perceived as being unfair in wider DDR initiatives (risk of exacerbating	High	Inclusive approach in the conduct of activities (incl. the delivery of healthcare services), including host communities.

inequalities between population groups, disruption of relations between them, stigmatization etc.)		Sensitization of the populations on the objectives and expected results of the project.
Low level of, or absence of ownership of interventions by state / national actors and local authorities including health district and COSA representatives	High	Solicit and maintain the commitment of state partners through regular communication on the importance of the project and the sustainability of results. Continued engagement through other programming in Cameroon on increasing ownership and appropriation by the state and national actors. Regular sensitization with local government officials on the approach and added value.
Mistrust / doubt about the positions of WHO and IOM, who could be badly perceived by communities as supporting the NDDRC (which is mistrusted in some parts of the country, amongst sections of the population)	Medium	Promote the project's objectives related to the improvement of equitable access to health services as a confidence-building message to the population. Communicate on WHO and IOM's impartiality and their role in supporting Member States in providing effective and responsive services to vulnerable communities. Work in close collaboration with local authorities. Monitoring of socio-political conditions in the project area. Closely monitoring the conditions and perceptions of staff and implementing agencies at both regional and national levels.
Mistrust / doubt about the positions of WHO and IOM which could be perceived as collaborating with armed groups and makes agencies ability to assist government more difficult.	Low	The project will only engage with ex-associates who have undergone the government-led vetting and rehabilitation process, in support of community-based reintegration. Communicate clearly to the populations by presenting the evidence and data that demonstrate health needs, WHO and IOM's neutrality Work in close collaboration with national and local authorities. Monitoring of socio-political conditions in the project area.
Insufficient coordination between stakeholders	High	Hold regular coordination meetings at all levels including regular contact on day-to-day activities between the core- project team, regular updates and liaising with technical support colleagues, and regular meetings as planned with the steering and monitoring committees)

d) **Monitoring and evaluation**

The monitoring and evaluation of the project will be carried out jointly by WHO and IOM based on the project's results framework and a detailed joint Monitoring and Evaluation plan. The plan will include regular monitoring visits (every three months) to the areas of intervention. The plan will ensure the collection of baseline data, include perception surveys and effective data collection through implementation, in line with qualitative and quantitative indicators and means of verification identified in the project's results framework. Following mid-term monitoring visits, a mid-term project report will be prepared and shared, with the results allowing for any necessary reformulations in the implementation strategy to ensure that the higher level outcome results are achieved. All bi-annual and annual reporting requirements and the and the final report of the project will be approved initially by the steering committee before their transmission. WHO and IOM will ensure that it has the necessary monitoring capacity throughout the project, through M&E functions of project and complementary staff as well as through the usage of locally rooted monitoring committees for the project's interventions that will help in the transfer of information and the setting up of feedback and complaint mechanisms to implementing partners. Such locally rooted monitoring Committee will be responsible for monitoring the implementation of activities at each COSA level, and be made up of local actors implicated in the project such as local health representatives, community leaders and female representatives. At the end of the project, WHO as lead agency will coordinate an independent evaluation that will look at the overall results of the project and the efficacy of the health-centered approach for peacebuilding.

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

The proposed project and its methodology are designed to reinforce existing community health structures, local authorities' capacities to respond to community grievances, and the NDDRC's and other relevant state entities' capacity to effectively govern DDR processes, all of which will ensure durability of the project's accomplishments.

Each participating organization will also contribute to the sustainability of this project through its own ongoing resource mobilization and programmatic strategies to continue similar interventions beyond the 18-month timeframe. IOM and WHO will engage with donors that have a presence in Cameroon to consider providing further funding for a replication or scaling up of the project's approach, including the USA, UK, Germany, France, the European Union, the World Bank, and the African Development Bank.

Agencies will also engage with the Lake Chad Basin Commission (LCBC) and the accompanying Regional Stabilization Strategy and the Regional Stabilization Fund, in order to continue the approach and intervention under closer partnership with the LCBC.

IOM will further explore how the project's innovative approach that uses a specific sector as a neutral entry point for peacebuilding and community engagement can further be used in stabilization programming, including IOM's regional DDRR programme for the Lake Chad

Basin, in which IOM since 2017 has been supporting governments of the region to take steps to develop legal and operational frameworks, manage individual cases of ex-associates of Boko Haram, and increase community resilience to violent extremism and acceptance of returning ex-associates for durable solutions to conflict.

This project also represents a pilot project for the implementation of Community Violence Reduction activities by the UN Department of Peace Operations, in a setting where no Special Political Mission (SPM) or Peacekeeping Operation (PKO) are present. As part of its working in these non-mission settings DPO, working closely with the Resident Coordinator's office, will strengthen its partnerships with key donors, including the World Bank (WB), to support future implementation of DDR and CVR activities, including in Cameroon. On the latter, the UN-WB partnership on DDR which consists of collaborative efforts through the a) African Union DDR Capacity Programme (AUDDRCP); and b) the WB's Global Program for Reintegration Support (GPRS), represent opportunities to attract further and more sustainable, resources, capacities, and technical support to Cameroon should this project show concrete results and demonstrate measurable peace dividends as well as tangible health outcomes. In this regard, the World Bank will be kept abreast of the projects progress and milestones, through these partnership structures.

III. Project budget

The project budget has been prepared to ensure that the project benefits from existing health and peacebuilding capacities present both in Yaoundé and Maroua. WHO will in part be supporting existing staff with strong public health expertise in addition to the recruitment of a project coordinator, while IOM will retain existing staff while benefiting from the technical support and advice from its DDRR programme.

Under Outcome 1, WHO and IOM plan to dedicate a large proportion of costs to local implementing partners for community engagement and implementation of project activities. IOM will also allocate costs within this outcome to fund mobile teams that will provide Mental Health and Psychosocial Support (MHPSS) to project beneficiaries.

Under Outcome 2, capacity building of the NDDRC and other relevant state institutions has taken into consideration the required costs for venue reservation, logistics, contractual services of facilitators, and travel costs to cover the movement of trainers and trainees for the purposes of peer-to-peer learning.

Under Outcome 3, WHO and IOM will use local partners to implement cash-for-work activities and socio-economic assistance. WHO will make use of implementing partner contracts for the implementation of health-related socio-economic opportunities.

The budget includes sufficient allocations for travel (280,000 USD) which coupled with the transportation of beneficiaries (the majority of which sits under capacity building initiatives under Outcome 2) and the running of activities will also be used for the monitoring of activities. At all times the project will be in compliance with the UNCT in Cameroon's policy on daily subsistence allowance (DSA) for government and non-government partners, as outlined by the

Resident Coordinator's Office in Cameroon and most recently updated July 2020.[40] In addition, WHO has allocated 45,000 USD for the launching of an independent evaluation at the end of the project period.

[40] Memorandum Inter-Agences, 9 July 2020, 'Révision de la prise en charge des partenaires gouvernementaux and non gouvernementaux par les Agences du Système des Nations Unies au Cameroun'

Annex A.1: Checklist of project implementation readiness (To read during contributions for framing guidance)

Question	Yes	No	Comment
Planning			
1. Have all implementing partners been identified? If not, what steps remain and proposed timeline		X	Some key IPs have already been identified with possibility of both implementing agencies making use of existing relationships
2. Have TORs for key project staff been finalized and ready to advertise? Please attach to the submission		X	For WHO, several positions plan to be recruited following the confirmation of the project, such as the project coordinator and M&E Specialist. ToRs have not yet been finalised, but WHO will make efforts to advance recruitme process between time of projects confirmation and projec launching to ensure quick operationalization of project team. For IOM, all project staff have been fully recruited prior to project.
3. Have project sites been identified? If not, what will be the process and timeline		X	A targeting workshop is outlined to take place at the very beginning of the project for governments inclusion, although IOM data on displacements and stability already indicate certain areas to be prioritized
4. 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		Local communities and government officials consulted months of July and August 2021
5. Has any preliminary analysis/ identification of lessons learned/ existing activitie been done? If not, what analysis remains to be done to enable implementation and proposed timeline?	X		Proposed projects builds from the best practices and lessons learned of previous projects and complementary programmes
6. Have beneficiary criteria been identified? If not, what will be the process and timeline.	X		Beneficiary criteria outlined, including specific gender targets

7. Have any agreements been made with the relevant Government counterparts relating to project implementation sites, approaches, Government contribution?	X		Consultations made between DPO and NDDRC that have influenced project development, as well as agreement in principle by the MoH
8. Have clear arrangements been made on project implementing approach between project recipient organizations?	X		Coordination structure and core project team organigram developed
9. What other preparatory activities need to be undertaken before actual project implementation can begin and how long will this take?	N/A		
Gender			
10. Did UN gender expertise inform the design of the project (e.g. has a gender adviser/expert/focal point or UN Women colleague provided input)?	X		Took place during multiple extensive reviews by both implementing agencies and the Resident Coordinator's Office
11. Did consultations with women and/or youth organizations inform the design of t project?		X	No specific organisational groups were spoken to, althoug consultations were made with specific local community members including youth, community leaders and female ex-associates
12. Are the indicators and targets in the results framework disaggregated by sex ar age?	X		Including specific targets by sex and age
13. Does the budget annex include allocations towards GEWE for all activities and clear justifications for GEWE allocations?	X		

Annex A.2: Checklist for project value for money (To read during contributions for framing guidance)

Question	Yes	No	Project Comment
1. 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		
2. 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		
3. 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		The project actually delivers outcomes beyon the normal expectations of the proposed budg thanks to complementary programmes and co sharing
4. 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		
5. 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		International staff are only used where justifie and project contains roles of responsibility an decision making for national staff
6. 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	Nine per cent
7. 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	Project will benefit from existing vehicles and u rentals when necessary
8. 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	No additional non-PBF source of funding exist per se, however the project benefits greatly fro the existence of complementary funding for co

			sharing of technical staff. Both implementing agencies will be looking for additional donor engagements to ensure the continuity of the project and approach.

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 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 been 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 Receipt 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 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 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 receive 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 headquarter 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.[41]
- 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.

[41] 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: Trust between communities as well as trust in the authorities is increased, through using health as an entry point for community engagement and participatory and inclusive dialogue that leads to more equitable and improved access to health and other social services in the targeted communities of the Far-North region (Any SDG Target that this Outcome contributes to)	[redacted]	Outcome indicator 1a Improved perception during interventions among community members participating in health dialogue forums (COSA) in the ability of local authorities to respond to their needs (disaggregated by gender and age) Baseline: TBC (first survey) Target: 70% improvement	Survey conducted approximately every 3 months using consistent methodology (questionnaire including self-evaluation of trust-level) among a significant, gender and youth-balanced sample (through monitoring missions during COSA engagement activities)	-completion of survey methodology and identification of consistent sample size and profile. -mid-term review of evolution in perception levels.
		Outcome indicator 1b Improved perception during interventions among community members participating in health dialogue forums (COSA) in the ability of multiple villages within the same *aire de santé* to create solutions to shared issues of concern (disaggregated by gender and age) Baseline: TBC (first survey) Target: 70% improvement	Survey conducted approximately every 3 months (through monitoring missions during COSA engagement activities)	Completion of initial geographic targeting and preliminary COSA engagements plus commencement of community dialogue activities
(Any Universal Periodic Review of Human Rights (UPR) recommendation that this Outcome helps to implement and if so, year of UPR)	Output 1.1 Community health dialogue fora (COSA) are reinforced for the inclusive and participatory identification of equitable health (and other social) needs, involving the communities and the local authorities with a view to addressing grievances collectively and reducing violence.	Output indicator 1.1.1: Number of existing COSA receiving support during project (disaggregated by gender and age for COSA participants) Baseline: 0 Target: 15	• Project reporting • Implementing partner reports	Commencement of wider dialogue forums through COSA and other community representatives/ groups. Finalization of joint consultations with relevant partners for selection of localities to be targeted under project.
		Output Indicator 1.1.2:	• Implementing partner reports • COSA meeting agendas, reports	Commencement of wider dialogue forums through COSA and other community representatives/ groups

List of activities under this Output: Activity 1: Organize consultations between government entities, health authorities, civil society and community representatives to jointly select the localities and health fora that will be prioritized under the project. Activity 2: Support the organization of community health dialogue fora (COSA) between heads of health facilities, members of health dialogue structures and representatives from different communities on a regular basis (every three months), in order to inform communities about health issues and services, to sensitize on the use of dialogue for addressing health problems (and other non-health issues) and train/facilitate COSA representatives to lead regular dialogue events with communities. Activity 3: Identify advocacy points through COSA representatives and community members for regular feedback to local authorities such as health districts, regional health authorities and other relevant authorities on dialogue findings and the presenting of community concerns (every 3 months) Activity 4: Support 15 COSA with the resources to respond to one of	Number of COSA who now facilitate inclusive and participatory dialogue within or between the communities that they cover community health needs as well as on other community concerns during project (disaggregated by gender and age for COSA participants) Baseline: Target: 15		
	Output Indicator 1.1.3 Improved perception during interventions among community members participating in dialogue that COSA and other local health structures are a good entry point for dialogue (disaggregated by gender and age) Baseline: TBC (first survey) Target: 70% improvement	• Implementing partner reports • COSA meeting agendas, reports	Completion of initial geographic targeting and preliminary COSA engagements plus commencement of community dialogue activities
	Output Indicator 1.1.4: Proportion of community members that effectively use COSA to address health-related grievances and communicate other priority community needs (disaggregated by gender and age) Baseline: N/A Target: 60%	• Training report • Pictures •Perception surveys •Reporting mechanisms through COSAs and local authorities	Identification of COSA involved in the project
	Output Indicator 1.1.5: Number of priority health problems resulting from community diagnoses that are brought to the attention of local authorities (disaggregated by gender and age). Baseline: N/A Target: 45	• Implementing partner reports • Pictures • Community based monitoring committees	Commencement of wider dialogue forums through COSA and other community representatives/ groups

	the key issues of concern identified through participatory dialogue events with communities, either through the usage of small grant mechanisms, health infrastructure rehabilitation or construction, and cultural events. Activity 5: Support COSA and health districts in the planning and implementing of 5 local cultural events and festivities for community members, including an innovative video participation activity and video-screening events hat improve social cohesion and create an additional form of advocacy with authorities on community issues linked to health and other social services.	Output Indicator 1.1.6 Percentage of COSA engaged with for wider social cohesion and dialogue processes that contain at least 50% women representation Baseline: N/A Target: 100%	Implementing partner reports and weekly contact during the conducting of activities, field monitoring missions to oversee activities	Commencement of wider dialogue forums through COSA and other community representatives/ groups
		Output Indicator 1.1.7 Number of COSA that complete a participative process in coordination with other community members including women and youth through dialogue on the selection of a quick impact project (health or other social services) that responds to collective needs. Baseline: N/A Target: 10	Implementing partner reports and weekly contact during the conducting of activities, field monitoring missions to oversee activities. Launching of procurement processes with supporting documents.	Commencement of wider dialogue forums through COSA and other community representatives/ groups for the selection of quick impact projects
		Output Indicator 1.1.8 Number of public events related to health promotion, cultural days, sports days and video participation screenings involving relevant ministries or local government officials / authorities with women's participation. Baseline: N/A Target: 5	Activity reports and photos	Completion of earlier dialogue activities and COSA sensitizations
		Output Indicator 1.1.9 On a scale of 1 to 10, degree to which governmental counterparts from relevant line ministries or local authorities engaged in public events linked to advocacy, cultural days, sports days and video participation believe these have made them more informed on the needs of communities (health or otherwise,disaggregated by gender and age)	Post activity data collection tools, meetings with local authority counterparts	Completion of earlier dialogue activities and COSA sensitizations

		Baseline: N/A Target: 7/10		
	Output 1.2 The provision of health and other social services by Public services is enhanced in an equitable manner across communities, using referral mechanisms of Information and Counselling and Referral Services (ICRS) and, based on the needs identified by the different community health fora List of activities under this Output: Activity 1: Mapping of health sector service providers for referrals and entering into the ICRS database Activity 2: Conduct ICRS socio-economic profiling of selected beneficiaries and data entry of profiled beneficiaries. Activity 3: Provide mental health and psychosocial support (MHPSS) via group consultations and direct assistance through the usage of a mobile clinic Activity 4: Strengthen the capacities of health personnel within the geographic coverage of 15 COSA for the provision of certain health services including GBV clinical management that respond to the needs identified through COSA dialogue processes as well as consultations with health districts	Output Indicator 1.2.1 Increased number of health service providers registered into ICRS database for future referrals (disaggregated by gender and age specific health services) Baseline: 0 Target: 150	Report on the mapping for health service providers in the Far-North region for entry into ICRC database	To be updated following mapping of health services exercise
		Output Indicator 1.2.2 Number of ex-associates living with host communities in Far-North that are screened and profiled using the ICRS screening methodology for data entry into the ICRS data system (disaggregated by gender and age) Baseline: 0 Target: 800	Regular reports drawn from the ICRC database	To be launched in the first third of the project period, following the finalisation of the ICRS screening survey
		Output Indicator 1.2.3 Number of community members who say that they are satisfied with the assistance of a MHPSS mobile clinic in target areas, disaggregated by gender and age (disaggregated by gender and age) Baseline: N/A Target: 600	Daily contact with mobile team (staff) on organization of missions, usage of monitoring tools for beneficiary information	Establishment of the MHPSS mobile clinic and creation of a beneficiary targeting strategy
		Output Indicator 1.2.4 Number of ex-associates who say that they are satisfied with the assistance of a MHPSS mobile clinic in target areas, disaggregated by gender and age (disaggregated by gender and age)	Daily contact with mobile team (staff) on organization of missions, usage of monitoring tools for beneficiary information with regular contact with community leaders who may make referrals to ex-associates	Establishment of the MHPSS mobile clinic and creation of a beneficiary targeting strategy in coordination with community leaders for ex-associates

	Activity 5: Provision of health services (such as maternal and child health, curative care, GBV clinical management) using an implementing partner and respond to the needs identified through COSA dialogue processes as well as consultations with health districts Activity 6: Distribution of MHPSS individual or household kits following consultations with beneficiaries and COSA Activity 7: Procure and provide basic health equipment to targeted health facilities that have lost equipment due to general degradation, attacks and destruction of health facilities Activity 8: Deploy trauma surgeons to provide services to victims with physical trauma and other emergencies	Baseline: N/A Target: 400		
		Output Indicator 1.2.5 Proportion of target population benefiting from provision of other health services (such as maternal and child health, curative care, GBV clinical management, disaggregated by gender and age) Baseline: N/A Target: 60%	• Consultation records • Quick satisfaction survey	Establishment of operational team and creation of a beneficiary targeting strategy
		Output Indicator 1.2.6 Number of health personnel within the geographic coverage of 15 COSA that receive a training on the provision of certain health services identified through COSA dialogue processes including on GBV referral mechanisms and services (disaggregated by gender and age) Baseline: 0 Target: 75	• Training reports • Quick satisfaction survey	Progress made on the launching of initial dialogue processes through COSA and the identification of health needs
		Output Indicator 1.2.7 Number of individuals within the geographic coverage of 15 COSA that receive medical service from an implementing partner in response to needs identified through COSA dialogue processes. (disaggregated by gender, age, type of medical service) Baseline: 0 Target: 26600	• Implementing partner reports	Progress made on the launching of initial dialogue processes through COSA and the identification of health needs
		Output Indicator 1.2.8 Number of ex-associates within the geographic coverage of 15 COSA that receive medical service from an implementing partner in response to needs identified through COSA dialogue	• Implementing partner reports	Progress made on the launching of initial dialogue processes through COSA and the identification of health needs

		processes. (disaggregated by gender, age, type of medical service) Baseline: 0 Target: 400		
		Output Indicator 1.2.9 Number of individual or family MHPSS kits distributed (disaggregated by gender and age for recipients) Baseline: N/A Target: 200	• Logistics report • Individual discharge sheet	Establishment of operational team and creation of a beneficiary targeting strategy
		Output Indicator 1.2.10 Number of health facilities provided with basic health equipment. Baseline: 0 Target: 15	• Delivery slip • Discharge sheet	Equipment availability is effective in the first quarter of the project
		Output Indicator 1.2.11 Number of trauma surgery interventions delivered to community members (disaggregated by gender and age) Baseline: 0 Target: 170	- Final project report - Community satisfaction survey	Specific management of trauma cases due to armed violence
		Output Indicator 1.2.12 Number of trauma surgery interventions delivered to ex-associates (disaggregated by gender and age) Baseline: 0 Target: 30	- Final project report - Community satisfaction survey	Specific management of trauma cases due to armed violence
Outcome 2:		Outcome Indicator 2a	Pre and post training surveys, on a rolling basis depending on identified needs	Throughout the project period

Confidence between the NDDRC, former ADGTOs' associates and host communities at local level (in the Far North region) is improved through greater capacities and resources to meet the health needs of former associates and develop a comprehensive and inclusive DDR framework in respect of IHL IDDRS (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)		Increased understanding by officials from the NDDRC or other relevant state institutions of IDDRS modules (disaggregated by gender and age) Baseline: Target: 7/10		Strengthening of the capacities of actors involved in NDDRC.
		Outcome Indicator 2b Increased understanding of officials from the NDDRC or other relevant state institutions of the specific gender components of DDR for consideration in the Far-North context (disaggregated by gender and age) Baseline: Target: 7/10	Pre and post training surveys, on a rolling basis depending on identified needs	Strengthening of the capacities of actors involved in NDDR.
		Outcome Indicator 2c Number of strategic documents (new legislation, government strategies, workplans or frameworks) aiming to facilitate DDR processes that are worked upon and are demonstrated to be in line with national and international standards, including the Integrated DDR Standards (IDDRS) and international humanitarian law Baseline: Target: 3	Status updates on key documents, updated versions of documents and ratification of documents on a rolling basis whenever key progress made. Independent reviews of strategic documents by external partners including technical support from other UN agencies and DDR international partners	Following the commencement of capacity building activities Identification of those law projects, strategies, workplans or frameworks that can benefit from the project's capacity-building efforts
		Outcome Indicator 2c Number of strategic documents (new legislation, government strategies, workplans or frameworks) aiming to facilitate DDR processes that are worked upon and demonstrate progress towards further incorporating gender components and considerations into National DDR processes Baseline: Target: 1	Status updates on key documents, updated versions of documents and ratification of documents on a rolling basis whenever key progress made Independent reviews of strategic documents by external partners including technical support from other UN agencies and DDR international partners	Following the commencement of capacity building activities

	[redacted]	Outcome Indicator 2d Number of ex-associates, members of their families and communities who have benefited from health and psychosocial assistance who express increased satisfaction and/or trust in the NDDRC/the reintegration process, in the Far-North region (disaggregated by gender and age) Baseline: N/A Target: 70%	- Activity report of the implementation partner - DDR centre infirmary consultation report - Satisfaction survey report	Delivery of health and psychosocial assistance to ex-associates, members of their families and communities.
	Output 2.1 Technical and health-related support is provided to the NDDRC to improve its health and psychosocial assistance to ex-associates and their families and communities in the Far-North region. List of activities under this Output: Activity 1: Supply of equipment, materials and drugs to the NDDRC infirmary in Mora as well as the Meri District Hospital where they are often referred to ensure the adequate care of ex-associates and surrounding community members in accordance with consultations and a needs assessment Activity 2: One capacity building training to the government officials who will be in charge of referrals through ICRS tool Activity 3: One capacity building training to the government officials who will be in charge of medical	Output Indicator 2.1.1 Number of input (equipment, materials and drugs) batches/packages provided Baseline: N/A Target: 3	• Delivery slip • Donation form	Needs assessment of the availability of health services (with regards to equipment, materials and drugs)
		Output Indicator 2.1.2 Number of ex-associates in Mora and Meri who are provided with medical services at infirmary and district hospital following the supply of equipment, materials and drugs (disaggregated by gender and age) Baseline: N/A Target: 500	• Local health authority reports	Following donations of equipment, materials and drugs to the Mora DDR centre infirmary and Meri district hospital
		Output Indicator 2.1.3 Increased confidence by government training participants in conducting independently medical screenings and psychosocial referrals of ex-associates through the ICRS tool (disaggregated by gender and age) Baseline: 0 Target: 8/10	Post training reports	Capacity-building needs assessed; and Training sessions designed
		Output Indicator 2.1.4	• Attendance record • Training report	Capacity-building needs assessed; and Training sessions designed

	and psychosocial screening of ex-combatants/ex-associates	Number officials based at Mora regional DDR centre who are trained on ICRS referrals and the medical and psychosocial screening of ex-combatants/ex-associates (disaggregated by gender and age) Baseline: N/A Target: 7	• Pictures	
	Output 2.2 Capacity-building and implementation-support to the NDDRC to develop interventions that are in line with national and international standards, including the Integrated DDR Standards (IDDRS) and international humanitarian law.	Output Indicator 2.2.1 Number of workshops and consultations with selected mid-level and senior level government officials on specific issues of DDR and program activities, including on IDDRS implementation (participation disaggregated by gender and age) Baseline: 3 Target: 8	Post workshop reports, on a rolling basis depending on identified needs	First workshop being held
	List of activities under this Output: Activity 1: Workshops and other trainings on the latest international standards on DDR as outlined in the Integrated DDR Standards Activity 2: Specific support in building NDDRC's capacities in understanding, developing, and implementing DDR processes and operations	Output Indicator 2.2.2 Number of NDDRC and other relevant government officials trained through workshops and consultations and showing a strong understanding of IDDRS (disaggregated by gender and age) Baseline: 0 Target: 215	Workshop and consultation participants lists. Questionnaires. Usage of independently developed training and testing materials.	Commencement of capacity building activities
	Activity 3: Training on IHR (2005) requirements Activity 4: Training on International Humanitarian Law in collaboration with the ICRC	Output Indicator 2.2.3 The NDDRC, Ministry of Justice, Ministry of Health, Office of the Prime Minister and other relevant government bodies complete a stakeholder mapping and identification of priorities and action points, as well as the formulation of a roadmap. Baseline: 0 Target: 1	-Mapping exercise completed -Roadmap document produced/approved -Priority and action point document produced/approved by NDDRC	Commencement of initial capacity building activities First workshop being held -Draft roadmap document produced -Draft priority and action plan document produced

		Output Indicator 2.2.4 Basic/advanced knowledge that government counterparts participating in relevant trainings state on International Health Regulations and International Humanitarian Law (disaggregated by gender and age) Baseline: 0 Target: 8/10	Post training reports	Capacity-building needs assessed; and Training sessions designed
Outcome 3: Youth enrolment and recidivism in AGDTOs is reduced through the creation of socio-economic alternatives to violence – for youth at-risk of recruitment (including girls and young women) in the Far-North, while contributing to health preparedness and equitable access to health care at community level (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 3a Percentage of local authority representatives who believe that socio-economic and training opportunities for youth have decreased the risk of recruitment in the Far-North by the provision of alternatives (disaggregated by gender and age) Baseline: Target: 70%	Monitoring missions pre, during and post cash for work and economic (re)insertion activities using data collection tools/ surveys with regular liaising with local authority representatives (after 12 months and at the end of the project)	Following launching of cash-for-work and economic (re)insertion activities, following dialogue activities
		Outcome Indicator 3b Percentage of youth benefiting from socio-economic and training opportunities that say they feel that their economic position has been improved (disaggregated by gender and age) Baseline: Target: 90%	Monitoring missions pre, during and post cash for work and economic (re)insertion activities using data collection tools/ surveys with regular liaising with local authority representatives, (after 12 months and at the end of the project)	Following launching of cash-for-work and economic (re)insertion activities, following dialogue activities
		Outcome Indicator 3c Percentage of the targeted 325 youth integrated into health-related disease surveillance mechanisms and other socio-economic activities who feel that they now hold positive roles within their communities (disaggregated by gender and age) Baseline: 0 Target: 70%	Monitoring missions pre, during and post cash for work and economic (re)insertion activities using data collection tools/ surveys with regular liaising with local authority representatives, every 2-3 months	Following launching of COSA engagement activities where a stronger understanding is made on the community health needs

	Output 3.1 Youth at risk of enrolment within AGDTOs (including girls and young women), from different communities, are engaged in short-term labour-intensive projects to rehabilitate and/or construct local health facilities or other infrastructure essential for improving community cohesion, as identified through community dialogues (see Output 1.1) List of activities under this Output: Activity 1: Targeted communities identify the key needs in terms of health infrastructure, and jointly identify through a participatory process the persons to potentially benefit from cash-for-work activities in their construction, the vulnerable groups, such as at-risk youth Activity 2: Build, reconstruct, rehabilitate and improve local health facilities and other infrastructures identified through dialogue that are essential for improving community health, using local labour and a diverse range of community members Activity 3: Conduct monitoring missions post construction to make needs assessments for health equipment and further rehabilitations	Output Indicator 3.1.1 Number of participatory processes with communities (and the NDDRC for ex-associates) for the selection of youth to benefit from cash-for-work activities where communities and the NDDRC collectively agree on who is prioritized and who benefits, taking into consideration specific gender and age-related vulnerabilities (participation disaggregated by gender and age) Baseline: 0 Target: 2	Post consultation reports, during and post consultations	Likely following initial COSA engagement activities
		Output Indicator 3.1.2 Number of persons in targeted communities who benefit from cash for work activities in the construction or rehabilitation of health infrastructure identified through COSA led dialogue discussions (disaggregated by gender and age) Baseline: 0 Target: 700	Monitoring missions during cash for work and economic (re)insertion activities using data collection tools/ surveys	Following initial COSA engagement activities that identify infrastructure projects
		Output Indicator 3.1.3 Enhanced perception by women of ability to safely access adapted and gender sensitive health care services (e.g. child and maternal care) within areas covered by the 15 targeted COSA (disaggregated by age) Baseline: TBC (first assessment) Target: 80%	Monitoring missions following health interventions. Community based monitoring mechanisms.	Following health infrastructure building/ rehabilitation and equipment donations
		Output Indicator 3.1.4 Number of monitoring missions carried out aimed at assessing the needs for additional health equipment and further rehabilitations Baseline: 0 Target: 6	• Missions report • Pictures	Permanent monitoring of the implementation of activities is necessary for reframing interventions when necessary

	Activity 4: Donate small emergency equipment of first necessity to rehabilitated structures based on previous needs assessments	Output Indicator 3.1.5 Percentage of COSA members where small emergency equipment of first necessity has been distributed who say that the equipment responds well to the needs that they identified (disaggregated by gender and age) Baseline: N/A Target: 90%	Monitoring missions post cash for work and distribution activities using data collection tools/ surveys	Following initial COSA engagement activities that identify infrastructure projects as well as equipment distributions
	Output 3.2 Provide capacity-building and socio-economic opportunities for ex-associates and youth at risk of recruitment (including girls and young women) from different communities in both health and non-health related areas (including as community health workers), to support the humanitarian response at community level (including the COVID-19 response), in order to positively reinsert youth in community life. List of activities under this Output: Activity 1: Identify jointly with community structures a way of selecting young beneficiaries for additional health and non-health related socioeconomic activities Activity 2: Recruit and train youth at risk of recruitment into armed groups (including girls and young women) on community-based surveillance to strengthen epidemiological surveillance of	Output Indicator 3.2.1 Number of youths identified through participatory selection processes with communities to benefit from health and non-health related socio-economic and training opportunities (disaggregated by gender and age) Baseline: 290 Target: 615	Post consultation reports and monitoring missions with implementing partners	Following earlier dialogue activities
		Output Indicator 3.2.2 Number of youths trained in epidemiological surveillance activities (at least 30 per cent of which will be young women) (disaggregated by gender and age) Baseline: 0 Target: 100	• Attendance record • Training report • Pictures •Activities reports	Gender-sensitive selection process of the young trainees, with gender-based disaggregated data.
		Output Indicator 3.2.3 Number of young people recruited, trained and enrolled in continuous assessments such as the Health resources and services availability monitoring system (HeRAMS) (disaggregated by gender and age) Baseline: 0 Target: 40	• Attendance record • Training report • Picture •Activities reports	The project must first provide information on the availability of resources within health facilities as well as their level of functionality.

	common diseases including cases of COVID-19 including mobilization and sensitization against diseases of epidemic potential (active case finding) Activity 3: Engage and train youths at risk of recruitment (including girls and young women) in carrying out continuous assessments such as the Health resources and services availability monitoring system (HeRAMS) Activity 4: Engage, train and support youths at risk of recruitment (including girls and young women) on first response/referral of cases in need of MHPSS. Activity 5: Provide economic insertion and reinsertion assistance to community members and ex-associates in non-health related sectors through trainings and socio-economic opportunities	Output Indicator 3.2.4 Number of young people (including girls and young women) recruited and trained on first response/referral of cases in need of MHPSS. (disaggregated by gender and age) Baseline: 0 Target: 25	• Attendance record • Training report • Pictures •Activities reports	Participatory targeting of youth beneficiaries at the beginning of the project.
		Output Indicator 3.2.5 Number of youth benefiting from economic insertion and reinsertion assistance in non-health related sectors through training and socio-economic opportunities (disaggregated by gender and age) Baseline: 290 Target: 420 individuals	Implementing partner reports and weekly contact during the conducting of activities, field monitoring missions to oversee activities. Launching of procurement processes in the case of direct assistance with supporting documents	Following earlier dialogue activities
		Output Indicator 3.2.6 Number of ex-associates benefiting from economic insertion and reinsertion assistance in non-health related sectors through training and socio-economic opportunities (disaggregated by gender and age) Baseline: 0 Target: 30 individuals	Implementing partner reports and weekly contact during the conducting of activities, field monitoring missions to oversee activities. Launching of procurement processes in the case of direct assistance with supporting documents	Following earlier dialogue activities
		Output Indicator 3.2.7 Number of youth benefiting from economic insertion and reinsertion assistance in non-health related sectors through training and socio-economic opportunities that are continuing their chosen activity independently 6 months after initial support (disaggregated by gender, age and beneficiary type)	Implementing partner reports and weekly contact during the conducting of activities, field monitoring missions to oversee activities and to meet beneficiaries with the usage of data collection tools.	Following economic assistance activities

	Baseline: Target: 60% of beneficiaries.		

For MPTFO Use

Totals				
	Recipient Organization 1 (budget in USD) WHO	Recipient Organization 2 (budget in USD) IOM	Recipient Organization 3	Totals
1. Staff and other personnel	$ 165,000.00	$ 387,286.37	$ -	**$ 552,286.37**
2. Supplies, Commodities, Materials	$ 120,000.00	$ 97,000.00	$ -	**$ 217,000.00**
3. Equipment, Vehicles, and Furniture (including Depreciation)	$ 135,000.00	$ 68,260.00	$ -	**$ 203,260.00**
4. Contractual services	$ 70,000.00	$ 53,000.00	$ -	**$ 123,000.00**
5. Travel	$ 60,000.00	$ 220,000.00	$ -	**$ 280,000.00**
6. Transfers and Grants to Counterparts	$ 595,000.00	$ 327,226.71	$ -	**$ 922,226.71**
7. General Operating and other Costs	$ 45,000.00	$ 51,660.00	$ -	**$ 96,660.00**
Sub-Total	**$ 1,190,000.00**	**$ 1,204,433.08**	**$ -**	**$ 2,394,433.08**
7% Indirect Costs	**$ 83,300.00**	**$ 84,310.32**	**$ -**	**$ 167,610.32**
Total	**$ 1,273,300.00**	**$ 1,288,743.40**	**$ -**	**$ 2,562,043.40**

Performance-Based Tranche Breakdown					
	Recipient Organization 1 (budget in USD) WHO	Recipient Organization 2 (budget in USD) IOM	Recipient Organization 3	TOTAL	Tranche %
First Tranche:	$ 509,320.00	$ 515,497.36	$ -	**$ 1,024,817.36**	**40%**
Second Tranche:	$ 381,990.00	$ 386,623.02	$ -	**$ 768,613.02**	**30%**
Third Tranche:	$ 381,990.00	$ 386,623.02	$ -	**$ 768,613.02**	**30%**
TOTAL	**$ 1,273,300.00**	**$ 1,288,743.40**	**$ -**	**$ 2,562,043.40**	