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UNFPA – Country programmes and related matters

United Nations Population Fund

Country programme document for Nicaragua

Proposed indicative UNFPA assistance:	\$8.8 million: \$3.8 million from regular resources and \$5.0 million through co-financing modalities or other resources
Programme period:	5 years (2024-2028)
Cycle of assistance:	Tenth
Category:	Tier II
Alignment with the UNSDCF Cycle	--

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I. Programme rationale

1. Nicaragua is a diverse, multicultural and multiethnic country. In 2022, its population is estimated at 6.7 million inhabitants, 41 per cent of them living in rural areas.¹ With adolescents aged 10-19 years accounting for 19.5 per cent of the total population, the country has a unique opportunity to reap the benefits of the demographic dividend, prioritizing appropriate investments for this age group. According to the last census (2005), 8.6 per cent of the population recognizes itself as of Indigenous or Afro-descendant identity. Of these, 57.1 per cent live on the Caribbean Coast, one of the regions with the highest vulnerabilities to climate-related emergencies, with rurally dispersed settlement patterns, lower educational levels, and higher poverty rates (39 per cent below the poverty line in 2014). People with disabilities account for 10.3 per cent of the country's population, 56.5 per cent of which are women.²

2. Poverty rates decreased, from 48.3 per cent in 2005 to 29.6 per cent in 2014. However, there are significant gaps between urban (14.8 per cent) and rural areas (50.1 per cent),³ where most indigenous and Afro-descendant populations are concentrated. Climate change is a threat to poverty reduction and development strategies. Hurricanes Eta, Iota and Julia and storm Bonnie recently impacted the country. Between 1998 and 2017, Nicaragua ranked fourth among countries most affected by meteorological phenomena.⁴ The combined impact of climate change and the COVID-19 pandemic led to three years of economic decline. However, the country's gross domestic product (GDP) experienced a recovery in 2021 growing at an annual rate of 10.3 per cent, while the per capita GDP reached \$2,327.3 in 2022.⁵ Nicaragua is a country of origin and transit of migration, with remittances accounting for 22 per cent of its GDP.⁶

3. Nicaragua supports the Programme of Action of the International Conference on Population and Development (ICPD) and the Montevideo Consensus. At national level, the Constitution⁷ and ordinary laws recognize sexual and reproductive health and rights (SRHR), the right to comprehensive sexuality education (CSE), gender equity and equality, protection, prevention and care from gender-based violence (GBV) and other harmful practices, particularly early unions (Family Code).⁸ Adolescents and women's rights, including reproductive rights, are integrated and protected in these legal frameworks, while the National Plan for Poverty Reduction and Promotion of Human Development, 2022-2026 (PNDL-DH, after its acronym in Spanish) integrates strategies to operationalize them. The country is committed to universal access and coverage of sexual and reproductive health (SRH) and recognizes the right to free public education and health care without discrimination, bearing the cost of the purchase of contraceptive methods.

4. Over the last decade, Nicaragua has made important progress in policy, normative and services provision related to SRH, GBV and CSE. However, progress has been uneven, with significant access gaps among population groups, especially women and adolescents in rural areas, indigenous and Afro-descendant communities, and people with disabilities. These gaps are particularly manifested in the high number of adolescent pregnancies, with opportunity costs of 0.4 per cent of GDP. Despite the low unmet need for family planning (5.8 per cent) and high contraceptive prevalence rates among women aged 15-49 years (77.3 per cent),⁹ Nicaragua records high adolescent fertility rates (82 per 1,000 adolescents aged 15-19 years and 4.37 per 1,000 among girls under age 15).¹⁰ Adolescent pregnancy is a multicausal phenomenon, determined by various factors, particularly early unions, sexual violence, limited comprehensive sexuality education and limited access to contraceptives, particularly long-acting reversible contraceptives (LARCs). Early unions are a major determinant of adolescent pregnancy in Nicaragua, as 35 per cent of girls enter in unions before 18 years old and 9.7 per cent before 15 years old.¹¹

5. Unmet need shows significant gaps by age, level of education, and geographic location. Adolescents aged 15-19 years have an unmet need of 10.8 per cent, double that of women aged 15-49 years. Women with lower levels

¹ National Institute of Statistics (INIDE), 2021.

² Encuesta Nacional de Discapacidad (ENDIS), 2003.

³ Living Standard Measurement Survey (EMNV, 2014).

⁴ Climate Risk Index, 2019.

⁵ Central Bank of Nicaragua-Main Macroeconomic Indicators, 2022.

⁶ World Bank (2023).

⁷ National Assembly, 2015, Art. 27.

⁸ This equalized the minimum age of marriage for both males and females at 16 years, and established 18 years as the legal age of marriage.

⁹ Encuesta Nacional de Demografía y Salud (ENDESA), 2011.

¹⁰ Calculated based on INIDE 2021.

¹¹ Encuesta Nacional de Demografía y Salud (ENDESA), 2011.

of schooling have a higher unmet need than those with higher education (8.6 per cent versus 3.3 per cent)¹² The Caribbean Coast – North (11.8 per cent) and South (8.0 per cent) and the northern regions (7.3 per cent) have the highest percentages of unmet need. Four local health districts (SILAIS, for its initials in Spanish), located in the country's north, west and along the Caribbean Coast,¹³ record a higher unmet need for family planning. The SILAIS in the Caribbean coast represent 10 out of 19 local health districts categorized at high HIV risk. An estimated 25.5 per cent of new HIV infections are among adolescents and young people aged 10-24 years.¹⁴ The impact of the COVID-19 pandemic increased the unmet need for family planning, from 5.8 per cent in 2019 to 10.1 per cent in 2021, equivalent to a 14-year setback (UNFPA, 2021).

6. The Government of Nicaragua prioritized maternal mortality reduction in national planning and policy documents (including the PNDL-DH, the Family and Community Health Model, the Multi-year Plan, 2015-2021) and budgetary allocations. As a result of policy prioritization and the implementation of successful community-based intervention strategies (utilizing maternity waiting homes and community referral systems), the maternal mortality ratio declined from 121 per 100,000 live births in 2006¹⁵ to 31.4 per 100,000 live births in 2021.¹⁶ Although the COVID-19 pandemic increased the number of maternal deaths from 41 in 2019 to 45 in 2020,¹⁷ the number of maternal deaths decreased by 17.8 per cent in 2021, compared to 2020. Of the total number of maternal deaths occurring between 2016 and 2022, 85.3 per cent correspond to direct obstetric causes and 14.7 per cent to indirect obstetric causes. The main causes are postpartum haemorrhage (40 per cent) and pregnancy-related hypertension (23 per cent). Despite progress, maternal mortality reduction has been uneven across the country and among different population groups. Women from Afro-descendant and indigenous communities and those living on the Caribbean Coast and in the centre-north regions record the highest maternal mortality ratios: ix local SILAIS, with higher concentrations of populations in situations of greatest vulnerability, present significantly higher cumulative figures for 2017-2021, compared to the average ratio – the South Caribbean Coast (139.9); Bilwi (64.5); Las Minas (58.3); Jinotega (54.9); Zelaya Central (54.8); and Chontales (51.1). One out of four maternal deaths occur at home, particularly in the above-mentioned regions. Adolescents account for an estimated 18.6 per cent of maternal deaths.

7. To sustain and accelerate the reduction of preventable maternal deaths, the country needs to: (a) improve access and quality of health services, including modern contraceptives, during pregnancy and childbirth, including emergency obstetric and neonatal care, with intercultural and humanized care, in development and emergency contexts; (b) improve the coverage and quality of community strategies, ensuring an intercultural approach to reach the poorest, rural, indigenous and Afro-descendant people; (c) enhance the articulation between maternal mortality, adolescent pregnancy prevention and GBV strategies, particularly in local SILAIS with the highest maternal mortality ratios, adolescent pregnancy and GBV rates.

8. Nicaragua has made progress in promoting gender equality and non-discrimination through an enabling legal and policy framework, including the Law on Equal Rights and Opportunities (2008), the Comprehensive Law on Violence against Women (2014) and the Law on the rights of People with Disabilities (2011). Between 2006 and 2011, among women aged 15-49 years, physical violence decreased (from 27 per cent to 20 per cent), as did intimate partner violence (from 50 per cent to 39.3 per cent) and sexual violence (from 13 per cent to 10 per cent).¹⁸ However, an estimated 36.7 per cent of women who had ever been married or in a union had been verbally or psychologically abused by a partner or ex-partner. In addition, gaps persist, linked to key strata (geographic location, level of education and age), often intersecting. Sexual violence is more prevalent in urban than in rural areas (12.1 per cent versus 7.3 per cent). An estimated 61.6 per cent of women survivors of sexual violence report violence incidents before the age of 20. Intimate partner violence is high at all educational levels, although higher percentages are recorded among more educated women (42.1 per cent in high school versus 38.9 per cent in primary school), pointing to linkages between higher education and increased awareness about the problem. Despite progress, negative social and gender norms persist at the community level, reflected in practices such as early unions, particularly in rural areas of the centre-north and the Caribbean coast, where 47.9 per cent of women enter in unions before age 18, compared to 26 per cent in urban areas.¹⁹ An estimated 70 per cent of women agree that problems

¹² Encuesta Nacional de Demografía y Salud (ENDESA), 2011.

¹³ Jinotega: 7.3%, Matagalpa: 7.3%, Estelí: 6.2% y Chinandega: 6.4%.

¹⁴ Sistema Integrado de Vigilancia Epidemiológica (SIVE-VIH), 2021.

¹⁵ PNDL-DH, 2022-2026.

¹⁶ Ministry of Health, 2022.

¹⁷ Recent United Nations projections indicate that Nicaragua is among 24 countries where excess COVID-19 mortality was less than 10% of all deaths of women of reproductive age in 2020.

¹⁸ Encuesta Nacional de Demografía y Salud (ENDESA), 2011.

¹⁹ UNFPA, Situation of early unions in Nicaragua, 2019.

should be discussed within the family, particularly among rural women and women living in the Caribbean and North-Central regions who are much more likely to express these views.²⁰

9. Key gaps need to be addressed to accelerate the reduction of gender-based violence and early unions: (a) persistence of gender and social norms that sustain, naturalize and justify GBV and early unions; (b) the lack of an articulated strategy for GBV prevention with intersectional, inclusive and intercultural approaches; (c) gaps in the implementation of existing legal frameworks and regulations for the provision of comprehensive and essential high-quality services focused on GBV survivors; and (d) the lack of updated and disaggregated data for adequate decision-making.

10. The midterm evaluation of the country programme, 2019-2023, highlights the following lessons learned: (a) the theory of change based on the socio-ecological framework has allowed to scale up interventions to populations in situations of greatest vulnerability, in both development and emergency settings; (b) quality technical assistance has contributed to the institutionalization of SRH services for adolescents and CSE strategies, enabling greater impact and scaling up of interventions for the prevention of adolescent pregnancy and early unions; (c) art, culture and sports, when based on human rights, gender equality, interculturality and positive masculinities, have a high potential to transform social norms; (d) partnering with key institutions and local and community-based teams in emergency contexts contributes to strengthening the capacity of response. Based on the lessons learned, the midterm evaluation recommends to: (a) continue advocacy to enhance the common analysis on the determinants of adolescent pregnancy and early unions among different institutions; (b) increase advocacy and policy dialogue to achieve the institutionalization and scaling up of in-school and out-of-school CSE; (c) improve adolescents' access to modern contraceptives, including LARCs, especially for the prevention of first pregnancies, based on evidence-based counselling and free, informed choice by adolescents; (d) increase high-level advocacy and partnerships for the generation and use of updated and disaggregated statistical data, in collaboration with Regional Office, to position UNFPA as a trusted partner in the field of data and population dynamics; and (e) expand strategies for resource mobilization, including regionally and globally.

II. Programme priorities and partnerships

11. The proposed programme was developed through a participatory process, in consultation with institutional counterparts (Ministries of Health, Education, Family, the National Institute of Statistics and the National System for Disaster Prevention, Mitigation and Response), and incorporates lessons learned and recommendations from the midterm evaluation of the previous country programme. It is aligned to national priorities, as reflected in the National Plan to Combat Poverty and Promote Human Development, 2022-2026, and related sectoral policies and strategies; the Agenda 2030 for Sustainable Development; ICPD Programme of Action and ICPD25 voluntary national commitments; the Montevideo Consensus; and UNFPA Strategic Plan, 2022-2025.

12. The programme will leverage the UNFPA added value in a lower-middle-income country facing the effects of multiple crises, with persisting challenges in the implementation of universal public policies. UNFPA will aim to ensure that by 2028, women and adolescents, particularly from populations in situations of greatest vulnerability (people living in rural areas and belonging to indigenous and Afro-descendant communities, persons with disabilities, among others), exercise their sexual and reproductive rights and are empowered to prevent adolescent pregnancy, in an enabling environment that promotes gender equality and a life free from gender-based violence and other harmful practices, notably early unions.

13. The entry point of the programme will be adolescent pregnancy, as a barrier to the full benefit of the demographic dividend, with a rights-based and intersectional approach, addressing early unions as one of its main determinants. Building on the achievements, lessons learned and recommendations of the current programme cycle, UNFPA will continue positioning the prevention of adolescent pregnancy, addressing its key determinants, while considering the crucial differences between the respective age groups (aged 10-14 years; and aged 15-19 years), as they require different targeted intervention strategies. UNFPA will use the following integrated strategies across four priority outputs: (a) promoting selected public policies and targeted budgets towards adolescent pregnancy and early unions prevention and reduction, including a shift from funding to financing, when applicable; (b) ensuring the scaling-up of access to contraceptives, particularly LARCs, using a human rights-based approach; (c) increasing the quality standards of adolescent services, strengthening health care provider competencies and skills in counselling and contraception; and (d) strengthening empowerment of adolescent and young girls, particularly

²⁰ Encuesta Nacional de Demografía y Salud (ENDESA), 2011.

improving the coverage and quality of CSE for in-school and out-of-school programmes, to promote increased knowledge of adolescents on SRH and promoting positive masculinity models. This approach will have an amplifying effect on progress on the goals of the National Plan to Combat Poverty and Promote Human Development, 2022-2026, and the three transformative results of UNFPA, considering the relationships between adolescent pregnancy and maternal mortality, as well as the causal-consequence relationship with early unions and gender and social norms. Considering that most maternal deaths are concentrated in the coastal Caribbean and northern regions, where populations are more dispersed, and 75 per cent of maternal deaths occur in health units, UNFPA will strengthen the quality of maternal health services through an intercultural approach and community-based strategies.

14. This integrated approach will be complemented by a data strategy, which aims to strengthen the availability of updated and disaggregated data as a foundational element for achieving the three transformative results in Nicaragua. Data and evidence will be a key component of advocacy and resource mobilization efforts, building on key evidence (including the MILENA study to estimate the costs of adolescent pregnancy, and the MEMI study to estimate the effective coverage of modern contraceptive methods and pregnancies prevented) and other studies.

15. The programme will leverage three accelerators: (a) leave no one behind, focusing on subnational territories that record the highest levels of adolescent pregnancy, GBV and maternal mortality (Caribbean Coast and North-Centre regions) and concentrate populations in situations of greater vulnerability; (b) transformative approaches to gender equality, through evidence-based advocacy work with institutions, communities, families and individuals to promote behavioural change; (c) partnerships and resource mobilization, through evidence-based advocacy efforts aimed at government institutions showing the need to increase public investment in the most vulnerable populations and use more cost-effective strategies (moving from funding to financing) as well as through partnerships with United Nations organizations for enhanced coordination and synergies and with the Regional Office and UNFPA headquarters for the mobilization of resources, through regional and global projects or programmes.

16. The country programme will also apply human rights, gender, generational, intercultural and intersectional approaches, focusing on the population in situations of greater vulnerability (women and adolescents living in poverty in urban or rural areas, indigenous and Afro-descendant women and adolescents, those living in rural areas, people with disabilities). Emergency preparedness and response will be a crosscutting strategy. Together with national and local partners and other United Nations agencies, UNFPA will strengthen the resilience of health, protection and education systems, as well as the integration of SRH and GBV into emergency response and climate change adaptation plans.

17. To reach the most vulnerable populations, the programme will strengthen partnerships with the social sector that works with interventions on the determinants of adolescent pregnancy and early unions, following the socio ecological approach at both national, subnational and local level, such as health, education and protection, as well as those linked to the development of data and information systems. At the same time, UNFPA will develop advocacy and coordination strategies with regional government entities, with the technical units created by the UNFPA country programme in partnership with other United Nations agencies and community engagement at the territorial level. The programme will prioritize the regions and territories with the highest adolescent pregnancy, early unions and GBV – the Caribbean Coast, Jinotega, Matagalpa and Chontales –and depending on the resources to be mobilized, it may include other regions (Chinandega, Río San Juan and Nueva Segovia).

A. Output 1. Strengthened capacity and resilience of institutions and communities to provide high-quality SRH and GBV information and services using an equity-based approach, focusing on adolescents and young girls, particularly from Afro-descendant and indigenous communities, those living in rural areas and the Caribbean Coast, and people with disabilities, in development and emergency settings.

18. This output will contribute to increasing access to the comprehensive package of integrated and high-quality SRH services (including emergency obstetric and neonatal care) and GBV services to prevent and reduce the high levels of adolescent pregnancy, maternal mortality and gender-based violence, particularly sexual violence. It will do so by strengthening the capacities and resilience of the health, education and protection systems of and of communities, with an emphasis on the Caribbean coast, rural areas and North-Centre areas of the country. Coordination with the Pan American Health Organization (PAHO)/WHO, UNICEF and the World Food Programme (WFP) will be key to ensuring synergies and impact, particularly as it refers to adolescent and maternal health.

19. Key strategic interventions include advocacy, capacity development, partnerships and coordination to: (a) enhance the implementation of intercultural and high-quality care standards, to expand access to SRH services by Afro-descendant, indigenous and rural women; (b) strengthen the capacities of the Ministry of Health for forecasting and procurement of modern contraceptives, particularly LARCs, to strengthen the supply chain to reach the “last mile”, across development and emergency settings; (c) strengthen the competencies of health service providers to ensure age-appropriate, culturally-sensitive, inclusive and accessible SRH services and counselling for women, adolescents and young people, especially from Afro-descendant and indigenous communities, people with disabilities or living in rural areas, notably the Caribbean coast; (d) strengthen the primary healthcare system and timely referral systems among Afro-descendant, indigenous and rural communities to ensure high-quality basic and comprehensive emergency obstetric and neonatal care services, with an emphasis on the use of community strategies and intercultural approaches that have proven effective in maternal mortality reduction; (e) strengthen the competencies and capacities of sectoral service providers to implement CSE in school and out-of-school settings, ensuring the inclusion of an intercultural perspective and attention to the needs of specific populations, particularly Afro-descendant and indigenous people, people with disabilities and those living in rural areas; and (f) strengthen the capacities of service providers in GBV prevention and attention to GBV survivors, at national and subnational levels, in the prioritized territories.

B. Output 2. Improved intersectoral coordination for the inclusion of sexual and reproductive health and rights and gender equality in universal health coverage, GBV and CSE policies, strategies, plans, monitoring and financing systems, focusing on the prevention of adolescent pregnancy and early unions, at institutional and community levels, in development and emergency settings.

20. This output will strengthen intersectoral coordination for the inclusion of sexual and reproductive health and reproductive rights and gender equality into universal health coverage as well as GBV and CSE policies, strategies and plans, with a special focus on the prevention and reduction of teenage pregnancy and early unions. It also aims to integrate SRH and GBV protection and attention into multisectoral policies and strategies, such as those related to resilience, preparedness and disaster risk reduction. UNFPA will complement its interventions with those of UNICEF and PAHO/WHO.

21. Key strategic interventions include: (a) advocacy with the Government for evidence-based SRH and GBV policies, plans and programmes, particularly on adolescent pregnancy and early unions, which tackle the needs of the most vulnerable populations, particularly Afro-descendant and indigenous communities, people with disabilities, people living in rural areas and on the Caribbean Coast, taking into account an intercultural perspective; (b) advocacy and capacity building for sustained and increased financial commitment towards adolescent pregnancy prevention and access to modern contraceptives, particularly LARCs, for adolescents and young girls, leveraging data and evidence, such as Multiple Indicator Cluster Surveys (MICS) and other studies; (c) evidence-based technical assistance to the Ministries of Health, Education and Family to update plans and strategies and plans on SRH and GBV, with emphasis on the prevention and reduction of adolescent pregnancy and early unions; (d) technical assistance to the Ministries of Education, Health and Family to strengthen the intersectoral coordination for the implementation of the CSE strategy in in-school and out-of-school settings, based on United Nations International Technical Guidelines, and enhancing the incorporation of gender and intercultural approaches into the CSE strategy; (e) advocacy and technical assistance to establish an inter-institutional monitoring system to follow up on SRH and GBV indicators for enhanced implementation of plans and strategies for the prevention of adolescent pregnancy and early unions at national and subnational levels; and (f) advocacy with SINAPRED, the Ministry of Health and Family for the integration of the Minimum Initial Service Packages for SRH and GBV into sectoral and risk reduction plans.

C. Output 3. Strengthened capacities of institutions, communities and individuals, at national and subnational levels, to transform gender and social norms that undermine progress towards gender equality, gender-based violence prevention and informed decision-making on sexual and reproductive health.

22. This output will contribute to empowering adolescent girls through strategies that address discriminatory gender and social norms and stereotypes, affecting their bodily autonomy and ability to make informed decisions about their sexuality and effectively exercise of their sexual and reproductive rights. Building on positive

community and social norms and experiences, UNFPA will contribute to an enabling environment by addressing behaviours that expose women and young girls to gender-based violence and harmful practices, particularly adolescent pregnancies and early unions. UNFPA will partner with government institutions, particularly the Ministries of Health, Education and Family and regional governments, as well as community-based organizations, including indigenous territorial governments, and Afro-descendant and indigenous women leaders. UNFPA will also coordinate interventions in the Caribbean Coast region with UNICEF, PAHO/WHO, WFP and UNOPS, to achieve maximum impact in the reduction of adolescent pregnancy and early unions.

23. Key strategic interventions include advocacy, capacity development and coordination and partnerships to: (a) strengthen institutional capacities for the implementation of comprehensive sexuality education in out-of-school settings, based on the United Nations International Technical Guidelines, leveraging sports, art and culture for increased access to SRH and GBV services and transformation of behaviours, focusing on indigenous, Afro-descendant women and those with disabilities, particularly in rural areas and the Caribbean coast; (b) promote positive masculinities through training of trainers that use socio-constructivist approaches of the popular education theory to transform the knowledge, attitudes and practices of public officers, community leaders and adolescents as well as young girls and boys; (c) promote broad and intergenerational participatory dialogues, at national and subnational levels, between decision-makers, community-based organizations, including religious and community leaders, women, adolescents and young people, among others, to establish a national conversation and increase commitment around prevention and reduction of adolescent pregnancy and early unions; and (d) foster strategic communication to increase awareness on adolescent pregnancy and promote social and behavioural change to prevent and reduce gender-based violence and harmful practices, particularly early unions, using multiple communications and technological channels.

D. Output 4. Strengthened capacity of national statistical information systems for the generation and use of disaggregated data related to SRH and GBV for enhanced evidence-based policy making, taking into account demographic dynamics and emerging megatrends (demographic dividend, climate change and emergencies).

24. Strategic interventions under this output will underpin UNFPA work across all four outputs of this programme, contributing to the achievement of the country's development priorities and the three transformative results. High-quality, disaggregated data and evidence are key for achieving the national development and the Sustainable Development Goals, the ICPD Programme of Action, the voluntary national commitments related to ICPD25, and the Montevideo Consensus. These interventions will facilitate a clearer understanding of demographic trends and causes of adolescent pregnancy, early unions, GBV and maternal mortality as well as shed light on gender and social norms, within the context of emerging megatrends.

25. Key strategic interventions include advocacy, capacity development, partnerships and coordination, including South-South and triangular cooperation, to: (a) provide technical assistance to the National Institute of Development Information (INIDE) in the successful implementation of the population and housing census, in collaboration with the Economic Commission for Latin America and the Caribbean and other United Nations organizations; (b) improve the quality and coverage of administrative records through technical assistance for the strengthening of vital and administrative records, on adolescent pregnancy, early unions, social and gender norms, as well as GBV and maternal mortality; (c) strengthen national and subnational capacities for the generation, analysis and use of socio-demographic data from the census, surveys and other sources for evidence-based public policies, programme planning, monitoring and evaluation, in both development and emergency settings, leveraging the use of the most up-to-date sources (MICS 2024) and innovative methodologies; (d) strengthen national capacities to analyse, visualize and monitor the situation of the populations in situations of greater vulnerability, including through surveys and research studies, taking into account population change and emerging megatrends (demographic dividend, climate change); (e) strengthen the skills of health managers and providers to support sound maternal and perinatal death surveillance and response systems that contribute to national and subnational health facility efforts; and (f) strengthen national capacities to generate and use high-quality data from the national statistical system and periodically monitor progress on the 2030 Agenda and the SDGs, the Montevideo Consensus, the ICPD Programme of Action and the voluntary national commitments related to ICPD25.

III. Programme and risk management

26. The programme will be implemented through institutional and other partners, to ensure programme interventions at national and local levels. UNFPA will foster participatory planning among counterparts as well as monitoring of workplans with key partners. UNFPA will participate in the implementation of the United Nations business operations strategy and, where feasible, the harmonized approach to cash transfers. Where this is not possible, activities will be conducted through direct implementation. National and international technical experts will support programme implementation, if required, in agreement with the Government.

27. UNFPA will strengthen its partnership and resource mobilization strategy to leverage additional resources and ensure effective and efficient programme implementation. Coordination with other United Nations agencies will ensure synergies and maximum impact of interventions at territorial levels. Special emphasis will be placed on reaching populations in situations of greater vulnerability, including through the establishment of a technical unit in Bilwi, to enhance coordination and monitoring of the implementation on the Caribbean coast and other prioritized territories. The programme will continue to rely on the support of key donors, including Luxembourg, Norway and Canada, as well as other types of funding, including UNFPA Strategic Investment Facility funds to support and scale up strategic interventions for the reduction of adolescent pregnancy, promotion of comprehensive sexuality education, and prevention of gender-based violence and early unions. UNFPA will also leverage evidence on the opportunity costs of adolescent pregnancy and early unions to increase financial investment from different partners, including prospective donors, multilateral organizations and international financial institutions. Innovative joint ventures will be fostered at global, regional and local levels to achieve programme objectives, including the census.

28. The country office structure will be adapted to the strategic priorities of the proposed programme, strengthening internal capacities in: (a) evidence-based advocacy and partnerships to leverage the use of data and evidence; (b) intersectoral coordination at territorial level, aided by territorial units to strengthen programme implementation at the local level, in development and emergency contexts; (c) transformation of gender and social norms, including through comprehensive sexuality education and the promotion of positive masculinities; (d) financing or scaling up of investments in sexual and reproductive rights. The country office will also mobilize support from the Regional Office and UNFPA headquarters, as well as national or regional centres of excellence and technical experts, including through South-South and triangular cooperation, in line with national priorities and programmatic needs.

29. UNFPA has identified the following main programmatic risks: (a) limited funding for sexual and reproductive health, which may affect national budget allocations and availability of financial resources for the three transformative results; (b) the persistence of conservative views that hinder sexual and reproductive health, reproductive rights and gender equality; and (c) the intensifying effects of climate change and increased migration flows. To mitigate these risks, UNFPA will: (a) strengthen resource mobilization efforts at national, regional and global levels, leveraging evidence resulting from a set of economic models to demonstrate opportunity costs for investment in areas of the three transformative results; (b) strengthen strategic communication and partnerships with other United Nations organizations to develop a positive narrative around sexual and reproductive health and rights and gender equality; and (c) strengthen national and subnational emergency preparedness and disaster risk reduction plans by including SRH and GBV components.

30. This country programme document outlines UNFPA contributions to national results and serves as the primary unit of accountability to the Executive Board for results alignment and resources assigned to the programme at the country level. Accountabilities of the managers at UNFPA with respect to country programmes are prescribed in the UNFPA programme and operations policies and procedures, and the internal control framework.

IV. Monitoring and evaluation

31. UNFPA and the Government will monitor the implementation of the country programme, following mutually agreed procedures, including UNFPA procedures, results-based management principles and standards, and the jointly agreed monitoring and evaluation plan.

32. The country programme's monitoring and evaluation plan is aligned with the UNFPA Strategic Plan, 2022-2025, and the National Plan to Combat Poverty and Promote Human Development. This includes field monitoring visits, semi-annual reviews with implementing partners, a midterm review of the country programme, periodic

financial performance reviews, thematic and programmatic evaluations, annual progress reports, risk assessment and mitigation actions, and knowledge management initiatives.

33. UNFPA will conduct a final evaluation of the country programme, which will inform the design of the next country programme. Capacity-building sessions with national and local counterparts and country office staff will be organized to strengthen their capacities to apply results-based management in planning, monitoring, evaluation and reporting.

34. UNFPA will also contribute to strengthening national capacities to monitor and report on the 2030 Agenda and SDGs (voluntary national reports), the Montevideo Consensus, the ICPD Programme of Action, and the voluntary national commitments on ICPD25.

RESULTS AND RESOURCES FRAMEWORK FOR NICARAGUA (2024-2028)

<p>NATIONAL PRIORITY: National Plan for Reducing Poverty and Promote Human Development (PNDL-DH, 2022-2026). Guideline 4: Consolidating public assets and services; (a) continue to develop infrastructure, equipment, supply chain, networks and health services in all its forms; (b) consolidating social security for the well-being of all working families. Guideline 5: Gender equality: (i) increasing women's participation in human development; (ii) empowering women for the exercise of a transforming, equal, inclusive and complementary leadership; (iii) ensuring human rights, peace building and non-violence in the lives of women and their families; (iv) guarantee the enforcement of laws and norms for gender equality and human rights for women.</p>				
<p>RELATED UNFPA STRATEGIC PLAN OUTCOME(S): 1. By 2025, the reduction in the unmet need for family planning has accelerated. 2. By 2025, the reduction of preventable maternal deaths has accelerated. 3. By 2025, the reduction in gender-based violence and harmful practices has accelerated.</p>				
UNSDCF outcome indicators, baselines, targets	Country programme outputs	Output indicators, baselines and targets	Partner contributions	Indicative resources
<p><u>Related UNFPA Strategic Plan Outcome indicator(s):</u></p> <ul style="list-style-type: none"> Proportion of women of reproductive age (15-49 years) ever in union who have had their need for family planning satisfied. <i>Baseline (2012): National: 15-19 years: 72.2%; 20-24 years: 79%; 25-49 years: 81.6%; Regional: North Caribbean Coast Autonomous Region (RACCN): 65.4% South Caribbean Coast Autonomous Region (RACCS): 76.4% Target: N/A (2028)</i> Proportion of service delivery points reporting no stock-out of any contraceptives <i>Baseline: 46% (2021); Target: 90% (2028)</i> <p><u>Related PNDL-DH, 2022-2026 indicator(s):</u></p> <ul style="list-style-type: none"> Maternal mortality ratio (per 100,00 live births) <i>Baseline: 33.2 (2021); Target: 30.7 (2026)</i> Number of assisted deliveries <i>Baseline: 112,005 (2021); Target: 117,719 (2026)</i> 	<p>Output 1. Strengthened capacity and resilience of institutions and communities to provide high-quality SRH and GBV information and services using an equity-based approach, focusing on adolescents and young girls, particularly from Afro-descendant and indigenous communities, those living in rural areas and the Caribbean Coast, and people with disabilities, in development and emergency settings.</p>	<ul style="list-style-type: none"> Number of health units of the prioritized territories with UNFPA support that improve the implementation of basic and comprehensive emergency obstetric and neonatal care through the incorporation of an intercultural approach, including timely referral systems for indigenous, Afro-descendant communities, and rural areas <i>Baseline: 23 (2023); Target: 40 (2028)</i> Number of primary health care units of prioritized territories with UNFPA support that implement quality standards for adolescent sexual and reproductive health services, including the supply of modern contraceptives, with emphasis on LARCs <i>Baseline: 27 (2023); Target: 43 (2028).</i> Number of health units from prioritized territories that report no stock-out of contraceptives at 'the last mile' within the last three months, because of UNFPA technical assistance <i>Baseline: 29 (2023); Target: 43 (2028)</i> Percentage of health, education and social protection units of the prioritized territories, at national and subnational levels, which implement GBV prevention and care services, with an emphasis on the women and adolescents in situations of greatest vulnerability, in development and emergency contexts <i>Baseline: 16.6% (2023); Target: 50% (2028)</i> 	<p>Ministries of: Health; Education; Family</p>	<p>\$2.1 million (\$1.1 million from regular resources and \$1.0 million from other resources)</p>
<p><u>Related UNFPA Strategic Plan Outcome indicator(s):</u></p>	<p>Output 2. Improved intersectoral coordination for the inclusion of sexual and</p>	<ul style="list-style-type: none"> Number of intersectoral policies, strategies and plans related to SRH, GBV and CSE that strengthen the prevention and reduction of adolescent pregnancy and early unions, formulated, updated or implemented with 	<p>Ministries of: Health; Education; Family; Instituto Nacional de</p>	<p>\$0.8 million (\$0.3 million from regular resources and</p>

<ul style="list-style-type: none"> ● Proportion of women of reproductive age (15-49 years) ever in union who have had their need for family planning satisfied. <i>Baseline (2012): National: 15-19 years: 72.2%; 20-24 years: 79%; 25-49 years: 81.6%; Regional: North Caribbean Coast Autonomous Region (RACCN): 65.4% South Caribbean Coast Autonomous Region (RACCS): 76.4% Target: N/A (2028)</i> ● Proportion of women aged 20-24 years who were married or in a union (a) before age 15; (b) before age 18 <i>Baseline (2012): (a) 9.7%; (b) 25.5% Target: N/A (2028)</i> 	<p>reproductive health and rights and gender equality in universal health coverage, GBV and CSE policies, strategies, plans, monitoring and financing systems, focusing on the prevention of adolescent pregnancy and early unions, at institutional and community levels, in development and emergency settings.</p>	<p>technical support from UNFPA <i>Baseline: 1(2023); Target: 6 (2028)</i></p> <ul style="list-style-type: none"> ● Government financial commitment towards contraceptives procurement, particularly LARCs, for the reduction of adolescent pregnancies, increased because of UNFPA evidence-based advocacy and technical assistance <i>Baseline: 87% (2023); Target: 100% (2028)</i> ● Inter-institutional monitoring system, established with UNFPA support, to follow up on disaggregated data and indicators for SRH and GBV at national and subnational levels <i>Baseline: No (2023); Target: Yes (2028)</i> ● Minimum standards of GBV and SRH services in emergencies are integrated into national and subnational emergency preparedness and response frameworks, with technical support from UNFPA <i>Baseline: No (2023); Target: Yes (2028)</i> 	<p>Información de Desarrollo (INIDE); Sistema Nacional para la Prevención, Mitigación y Atención de Desastres (SINAPRED)</p>	<p>\$0.5 million from other resources)</p>
<p><u>Related UNFPA Strategic Plan Outcome indicator(s):</u></p> <ul style="list-style-type: none"> ● Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence in the previous 12 months, by age and place of occurrence. <i>Baseline: 17.5% (2012); Target: N/A (2028)</i> 	<p>Output 3. Strengthened capacities of institutions, communities and individuals, at national and subnational levels, to transform gender and social norms that undermine progress towards gender equality, gender-based violence prevention and informed decision-making on sexual and reproductive health.</p>	<ul style="list-style-type: none"> ● Number of adolescents participating in CSE programmes in (a) in-school and (b) out-of-school settings from prioritized territories (disaggregated by age, gender, residence, ethnicity and disability status), who present favourable attitudes in relation to gender equality, gender-based violence prevention and informed decision-making on sexual and reproductive health <i>Baseline: (a): 246,6052 (2023); Target: 346,6502 (2028) Baseline: (b): 1,632 (2023); Target: 3,440 (2028)</i> ● Number of institutional units (protection, health, education) prioritized implementing CSE in (a) in-school and (b) out-of-school settings (based on UN International Technical Guidelines) <i>Baseline: (a): 1,193 (2023); Target: 2,566 (2028) Baseline: (b): 89 (2023); Target: 181 (2028)</i> ● Number of public officers and community actors participating in UNFPA training initiatives in prioritized territories who have favourable attitudes, knowledge and practices towards positive social and gender norms, including masculinities <i>Baseline: 8,433 (2023); Target: 9,200 (2028)</i> ● Number of participatory multi-stakeholder dialogues or communications initiatives, carried out with UNFPA support, at national and subnational levels, to address in service provision discriminatory gender and social norms and stereotypes, GBV and other harmful practices, particularly early unions <i>Baseline: 24 (2023); Target: 90 (2028)</i> 	<p>Ministry of: Health; Education; Family; INIDE.</p>	<p>\$3.0 million (1.1 million from regular resources and \$1.9 million from other resources)</p>

<p><u>Related UNFPA Strategic Plan Outcome indicator(s):</u></p> <ul style="list-style-type: none"> Country has conducted at least one population and housing census during the last ten years <i>Baseline: No (2023)</i> <i>Target: Yes (2027)</i> 	<p>Output 4: Strengthened capacity of national statistical information systems for the generation and use of disaggregated data related to SRH and GBV for enhanced evidence-based policymaking, taking into account demographic dynamics and emerging megatrends (demographic dividend, climate change and emergencies).</p>	<ul style="list-style-type: none"> INIDE capacities strengthened for the execution of the next population and housing censuses, with technical support from UNFPA <i>Baseline: No (2023); Target: Yes (2028)</i> Number of sectoral institutions (health, education and social protection), including INIDE, whose capacities have been strengthened, with UNFPA technical assistance, for the implementation of national and subnational administrative records related to vital statistics, SRH and GBV, following international quality standards <i>Baseline: 1 (2023); Target: 5 (2028)</i> Number of studies and research (including MILENA and MEMI studies) developed through advocacy and capacity development support by UNFPA, related to SRH, GBV, CSE and demographic change and megatrends, which make intersectional inequalities visible <i>Baseline: 3 (2023); Target: 7 (2028)</i> Number of health managers and providers in the prioritized local systems of integrated health care (SILAIS) with strengthened skills for maternal mortality surveillance and response <i>Baseline: 0 (2023); Target: 113 (2028)</i> 	<p>Ministries of: Health; Education; Family; INIDE; Institute of Legal Medicine.</p>	<p>\$2.4 million (\$0.8 million from regular resources and \$1.6 million from other resources)</p>
<p>Programme coordination and assistance</p>				<p>\$0.5 million from regular resources</p>