



**Executive Board of the
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Programme, the United Nations
Population Fund and the
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Project Services**

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UNFPA – Country programmes and related matters

United Nations Population Fund

Country programme document for Senegal

Proposed indicative UNFPA assistance:	\$50 million: \$10.4 million from regular resources and \$39.6 million through co-financing modalities or other resources
Programme period:	5 years (2024-2028)
Cycle of assistance:	Ninth
Category:	Tier I
Alignment with the UNSDCF Cycle	United Nations Sustainable Development Cooperation Framework, 2024-2028

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I. Programme rationale

1. In 2023, the population of Senegal is estimated at 18.3 million, with 50.2 per cent women, and a high population growth rate of 2.5 per cent. Over 62 per cent are under the age of 25 and 42 per cent under the age of 15. The population is predominantly rural (54.8 per cent rural against 45.2 per cent for urban areas). The proportion of young people in the urban population is 32.5 per cent (10-24 years) and 49.5 per cent (10-34 years). The prevalence of disabilities is estimated at 5.9 per cent of the population (5 years and over), with 6.2 per cent among women and 5.6 per cent for men. Senegal is ranked 170 out of 191 countries, with a Human Development Index of 0.511 in 2021. Economic growth decreased during the COVID-19 pandemic (from 6 per cent in 2019 to 1.3 per cent in 2020), recovering to 6.5 per cent in 2021, thanks to better control of the pandemic and also through infrastructure investments as part of the continued implementation of 'Plan Sénégal Emergent 2035' projects. The poverty rate dropped from 42.8 per cent in 2011 to 37.8 per cent in 2018 but is still higher in rural areas (53.6 per cent), among households led by men (42.7 per cent; 21.8 per cent among households led by women) and people aged 50-59 years (39 per cent). However, the COVID-19 pandemic caused an economic slowdown (increasing poverty by 4.81 percentage points in 2020) that negatively affected the well-being of households. The unemployment rate was 15.2 per cent in 2019, affecting women (35.8 per cent) more than men (13 per cent) and young people aged 15-34 years (38 per cent) as well as in rural areas (29.8 per cent). The demographic dependency ratio of 83 per 100 people of working age accentuates a high social demand.

2. The unmet need for family planning reached 21.7 per cent in 2019 (and 23.6 per cent among women in a union in 2016), despite widespread knowledge of contraception (93.2 per cent). The modern contraceptive prevalence rate rose from 23.1 in 2016 to 25.5 per cent in 2019; it is lower in rural areas (20.9 per cent) and among youth (20.2 per cent) and especially adolescents (7.6 per cent). The total fertility rate is relatively stable (4.7 in 2016 and 2019), according to the Demographic Health Survey (DHS). The adolescent fertility rate is 71 per 1,000 aged 15-19 years and even higher in rural areas (102 per 1,000 aged 15-19 years).

3. Although the maternal mortality ratio is declining (from 315 per 100,000 live births in 2015 to 236 per 100,000 live births in 2017; DHS 2017), it is still high, with greater urgency in rural areas (450 per 100,000 live births). Direct causes are haemorrhage (42.5 per cent); high blood pressure/eclampsia (17 per cent); and anaemia (10.1 per cent); these are aggravated by the insufficient availability of functional emergency obstetric and newborn care (31 per cent in 2022). Complications of early pregnancy remain the fifth leading cause of maternal death. With a rate of 0.12 per 1,000 women-years of exposure, maternal mortality also affects those under 20 years. The percentage of women with four or more prenatal visits is 55.5 per cent (66.9 per cent in urban areas and 48.1 per cent in rural areas). The rate of childbirth attendance by health workers rose in urban areas to 95 per cent but is still weak in rural areas (67 per cent). As part of the health coverage policy, the State has opted for free deliveries and caesarean sections since 2005, and the community health insurance schemes have integrated the management of reproductive health and family planning activities.

4. According to the National Council of the Fight against AIDS (CNLS), HIV infection rates decreased from 0.5 per cent in 2019 to 0.32 per cent in 2021. In 2022, 527 youth structures (adolescent and youth spaces and centres) offered such services.

5. The gender inequality index was 0.533, ranking Senegal at 168 out of 189 countries in 2019. The gender analysis showed that the persistence of gender-based violence (GBV) and harmful practices against women and girls is due to deeply rooted harmful social norms. The rate of early marriage is high: 30.5 per cent of women aged 20-24 years are already married before the age of 18 (DHS 2019). These early marriages remain linked to deeply entrenched practices and discriminatory legislation that sets the minimum age of marriage at 18 for boys versus 16 for girls. Moreover, the consummation of marriage is only criminalized if the girl is under the age of 13. This persistence of GBV and harmful practices is reinforced by the low status of women. Still, 39.1 per cent of women believe that the husband should beat his wife for at least one particular reason against 23.6 per cent for men. Rates of physical and sexual violence decreased (from 12.2 per cent in 2017 to 6.1 per cent in 2019) (DHS 2017 and 2019). Physical or sexual violence is higher among women aged 35-39 years (8.1 per cent) and in urban areas (7.3 per cent) (DHS 2019). The 1999 law 99-05 prohibiting female genital mutilation (FGM) has been adopted; however, the prevalence of FGM stood at 25.2 per cent in 2019 among women aged 15-49 years and 16.1 per cent among girls aged 0-14 years (DHS 2019). There is a decreasing trend in FGM among children aged 0-4 years (from 18 per cent in 2012 to 14 per cent in 2017) (DHS 2017). FGM prevalence varies little, from 31 per cent in the northern region to 30 per cent in the southern region. There are reports of FGM and child marriages in transborder

areas where some parents escape from their local community control mechanisms prohibiting FGM to perform FGM in a neighbouring country with little control.

6. In terms of data production, Senegal has conducted regular and timely censuses, and demographic and health surveys, and has established a strong health information system. However, it still faces limitations in terms of the timely availability of disaggregated data. The administrative sources of data on sexual and reproductive health (SRH) and GBV show insufficient coverage.

7. Although Senegal is a stable country with no huge acute humanitarian crises in the last five years, annual floods occur due to climate change and poor infrastructure. Each year between 100,000 and 300,000 people are affected by floods (OCHA).

8. The evaluation of the previous country programme has highlighted the following contributions: (a) alignment with and contribution to the UNDAF; (b) the programme has responded to the needs of beneficiaries, particularly the most vulnerable, especially women and girls in rural areas, and the undereducated; (c) it has made significant contributions to strengthening the health system to deliver high-quality and integrated SRH services through emergency obstetric care. Thus, the country programme has contributed to preventing 514,686 unwanted pregnancies; 76,904 complications from early pregnancies; 1,068 maternal deaths; and 1,276,419 women using contraceptive methods from 2019 to 2022. A number of high-impact initiatives have been implemented: the New Deal, with 408 girls' clubs and 11,040 members who avoided early marriages and pregnancy thanks to the community pact validated with their parents; the Ndiatiagué initiative, or host families of women who come from remote areas to increase assisted childbirths (241 beneficiaries); 132,142 girls completed the FGM capacity development programme through the cultural change approach; 250 communities publicly declared the abandonment of FGM and child marriage (between 2019 and 2022), with post-declaration monitoring mechanisms established.

9. Lessons learned from the programme are: (a) innovating and building alliances with all stakeholders (youth and women's organizations, technical and financial partners, traditional/religious leaders) on GBV and harmful practices is likely to contribute to the achievement of the three transformative results; (b) involve youth in the eradication of GBV and harmful practices in order to achieve total elimination of FGM in future generations; (c) technology and social networks are an efficient way to promote the three transformative results and to assess public interest on SRH issues; and (d) investing in youth as agents of change in the digital world allowed the country to respond effectively to the COVID-19 pandemic.

10. The programme faced the following challenges: (a) low demand for reproductive health and family planning services and low access to GBV services in rural, peripheral and border areas; (b) low use of youth-friendly SRH and family planning services; (c) weakness in post-declaration monitoring mechanisms for FGM abandonment; (d) persistence of unequal socio-cultural norms; (e) discriminatory texts in the penal and family codes that do not comply with international policy instruments on child marriage; (f) necessity to review the 2005 law on reproductive health, which has not yet been updated; (g) poor mobilization of domestic resources; and (h) the unfolding climate crisis (annual floods) as well as other humanitarian aspects and cross-border operations affecting FGM and obstetric fistula.

II. Programme priorities and partnerships

11. The new country programme is aligned with the 'Plan Senegal Emergent 2035', the United Nations Sustainable Cooperation Development Framework (UNSCDF), particularly Outcome 2 and Outcome 3. It is also aligned with the UNFPA Strategic Plan, 2022-2025. The three transformative results of UNFPA have been integrated into the UNSCDF and the Government's vision of universal access to SRH (women, girls, youth) and reproductive rights for harnessing the demographic dividend and 'Plan Senegal Emergent 2035'. In addition, the country programme aligns with Sustainable Development Goals (SDGs) 1, 3, 5, 10, 13, 16 and 17 and the Africa Union Agenda 2063.

12. Senegal has an enabling environment for achieving the three transformative results, as was evident during the Nairobi Summit when the country made four major voluntary ICPD25 commitments: (a) strengthening women's leadership, female economic empowerment, youth employability as well as the fight against GBV, child marriage, FGM and other harmful practices; (b) empowerment of all relevant actors in the implementation of the African Youth Charter and the African Union Roadmap for harnessing the demographic dividend; (c) achieving the goal of zero preventable maternal deaths by integrating a comprehensive package of health interventions and the goal of

less than 10 per cent of unmet need for family planning; and (d) scaling up successful initiatives: more focus on universal health coverage (at policy and community levels), accountability to results (domestic financing, community engagement), the Minimum Initial Service Package (MISP) for SRH in crisis situations, the Ndiatigué initiative, the Guindima campaign and the use of mobile clinics.

13. Nonetheless, the achievement of the three transformative results remains a major challenge, given the high rates of maternal mortality, unmet need for family planning and GBV, FGM and child marriage. The priority of the new country programme is to accelerate the implementation of high-impact interventions to achieve the three transformative results. The vision of the programme is that by 2028, the most vulnerable groups of women, adolescents, young people and people with disabilities in rural and remote areas benefit from better access to high-quality integrated SRH services and rights, family planning, prevention and response to GBV and harmful practices, including in humanitarian situations.

14. The new programme will contribute to reducing the unmet need for family planning, from currently 21.7 per cent to 18 per cent by 2028. Entry points will be family planning (which alone can reduce maternal deaths by one-third) to address neonatal mortality, unwanted pregnancies and complications from early pregnancies; and contribute to accelerating the demographic transition and the reduction of GBV, in line with the UNSDCF targets.

15. Within the Joint Programme on the Elimination of Female Genital Mutilation, with UNICEF, and in partnership with World Health Organization (WHO), among others, UNFPA will strengthen: (a) universal health coverage integration in policies to increase coverage and alleviate the financial burden; (b) community financing to resist FGM and other harmful practices. UNFPA collaborates with women's organizations and local authorities to improve adherence to health insurance schemes for vulnerable women and girls, including those affected by FGM, through a co-financing strategy for the three transformative results called 'Eco 3.0'. With UN-Women and civil society organizations, UNFPA will intensify advocacy for gender equality. Positive masculinity will be strengthened to transform social norms. Partnership with UNDP will facilitate synergies in strengthening the data management system.

16. The new country programme was designed with the participation of the Government, United Nations agencies, universities, national and international non-governmental organizations, civil society, youth and women networks, representatives of people with disabilities and of left-behind groups. Three Ministry of Health institutions in charge of people with disabilities will be integrated into all planning, monitoring and evaluation processes, including the technical and steering committees meetings of the project focused on people with disabilities. Those actors will be actively involved in programme implementation to ensure accountability, ownership and effective progress.

17. The main drivers of change for the programme are: (a) strengthening partnerships with religious community leaders, parliamentarians, traditional communicators, women's and youth networks, the media and journalists in order to transform harmful social norms, reduce fertility (the reproductive health of young people); particular attention will be paid to empowerment of youth from urban and suburban settings and partnerships with young people as agents of change; (b) ensuring effective integration of rights-based SRH, adolescent and youth SRH, STI/HIV and GBV services; (c) mobile clinics as a strategy to reach vulnerable groups in rural and remote areas; (d) scaling up initiatives implemented in the previous programme (Guindima, village solidarity fund, use of mobile clinics, advocacy with parliamentarians, women's organizations to accelerate the abandonment of certain harmful practices, participation of youth as agents of change).

18. The programme will use six accelerators to intervene in maternal health, family planning and GBV through the three outputs: (a) using human rights-based and gender-transformative approaches in challenging social norms and practices, tackle roots causes of gender equality and support delivery of rights-based SRH and GBV services; (b) leveraging innovative partnerships and coalitions to advocate for policies and resource allocation or sustainable financing with the Government, local authorities, the private sector and non-traditional donors; using South-South and triangular cooperation with other entities and countries (including Morocco) for knowledge sharing and skills transfer in key areas; (c) supporting innovation (Ndiatigué, midwifery mentorship, 'Eco 3.0', among others) and digitalization (including digital campaigns, use of social media and mobile learning) to leverage technological advances in delivering SRH and GBV services to the hardest-to-reach populations; (d) supporting data and evidence-generation systems for accelerating progress towards the three transformative results, through various data collection approaches, effective data analytics, and use of evidences; (e) using resilience and adaptation to ensure the implementation of the programme through MISP and other assistance to people affected by humanitarian crises and climate change, taking into account the youth in peace and security factor in the programming process; (f) leaving no one behind by reaching those left furthest behind, including people with disabilities.

19. Mobilizing additional resources, especially domestic resources, will remain an objective. With a favourable funding landscape, the country office will broaden partnerships with a wide range of donors, including traditional donors (ongoing negotiations with Canada, Luxembourg), non-traditional donors (Italy, World Bank-SWEDD, the Catalan Agency for Development and Cooperation-ACCD) and the private sector. Ongoing and planned advocacy efforts with other donors will be reinforced to support the implementation of the programme. While the current human resource structure from the 2021 realignment is still appropriate, staff capacity building will boost the programme implementation and the achievement of the three transformative results. The country office will pursue partnerships, resource mobilization and leveraging of resources to fund additional strategic positions.

20. In agreement with the Government, the programme will prioritize regions (rural and peri-urban areas) where indicators are furthest behind to accelerate the reduction of preventable maternal death, a main component of the second axis of the 'Plan Senegal Emergent 2035'.

A. Output 1. By 2028, strengthened capacities of the health system and communities to increase the demand for and the continued provision of respectful care and high-quality, integrated sexual and reproductive health and HIV-related services that are accessible to women, adolescents, youth and people with disabilities, especially the most vulnerable, including in humanitarian emergencies.

21. This output will: (a) expand equitable access to high-quality family planning products and services by mobile clinic, including the promotion of new modern methods and self-administration of contraceptives; (b) expand rights-based and skills-based training for emergency obstetric and newborn care, family planning, adolescent and youth SRH service providers by mentorship and digitalization, such as mobile learning (m-Learning); (c) scale up self-care interventions in family planning; (d) strengthen resilient supply chains for the timely delivery of contraceptives and reproductive health products to 'the last mile' (using particularly advocacy and policy dialogue); (e) support efforts for sustainable family planning financing, including domestic resources mobilization, in line with the compact commitments between UNFPA and the Government; (f) support preparedness for humanitarian response, and the implementation of emergency reproductive health (MISP); (g) accelerate accessibility to high-quality adolescent and youth SRH services through adequate service delivery points, mobile clinics and community workers; (h) strengthen national networks of emergency obstetric and newborn care, including prevention and treatment of obstetric fistula and maternal death surveillance; and (i) support emergency obstetric and newborn care referral mechanisms and medical equipment.

22. The programme will support: (a) strengthening the leadership of girls in school and out-of-school settings by expanding the 'zero early pregnancy' strategy and the 'New Deal' approach; (b) involvement of youth, men and religious leaders to promote family planning, adolescent and youth SRH and reproductive rights; (c) scaling up digitalization of reproductive health information in local languages for adolescents and youth in urban areas; (d) strengthening South-South cooperation to promote best practices of community-based approaches to family planning; (e) strengthening accountability for respectful care through user feedback mechanisms; (f) strengthening partnerships beyond health sector, including the private sector, for resources mobilization and with civil society actors to mitigate religious and social barriers; (g) digitalization of reproductive health information and services in local languages with community workers and midwives; (h) strengthening rural mechanisms for covering healthcare expenses (scale up village insurance to increase assisted childbirth in rural areas, advocacy to integrate family planning in health assurance); (i) strengthening the capacity of the health system to prioritize primary healthcare delivery systems in the areas of readiness, functionality, quality and resilience to address emergency needs while simultaneously addressing the root causes of vulnerabilities; (j) strengthening both health workforce capacity and deployment by investing in addressing the unmet need of midwifery professionals and improving the pre-service and in-service education of midwives, according to international standards; (k) strengthening the knowledge and skills of service providers to deliver comprehensive, inclusive high-quality SRH, family planning and GBV services through the implementation of evidence-based standards, norms and guidelines; and (l) building the capacity of persons with disabilities and other left-behind populations to exercise their rights and access SRH services.

B. Output 2. By 2028, strengthened capacities of actors and institutions to prevent and respond in a holistic manner to GBV and harmful practices against women, adolescents, young people and people with disabilities, particularly those living in rural areas, including in humanitarian emergencies.

23. This output will contribute to (a) strengthening the implementation of international and regional agreements, making reference to the Convention on the Elimination of All Forms of Discrimination against Women and the

Maputo Protocol, national laws and policies for the respect of fundamental rights, particularly those related to reproductive health; (b) promoting gender equality and women's and girl's empowerment through a transformation of gender roles and social norms; (c) strengthening capacities to end GBV and harmful practices and to offer high-quality care services; (d) establishing active partnerships with networks, particularly those of men and young people as agents of change, to promote positive behaviours; and (e) promoting sex-disaggregated data and gender-sensitive analysis.

24. The programme will support: (a) advocacy to harmonize laws related to GBV, harmful practices and reproductive health with international human rights standards and to support their implementation; (b) follow-up to the Universal Periodic Review and treaty body recommendations (including the Committee on the Elimination of All Forms of Discrimination against Women); (c) encouraging positive masculinity to change discriminatory social and legal norms, in partnership with networks (men, religious, parliamentarians, young girls/boys, women, traditional communicators, the media, social networks and local elected officials) through strategic advocacy at community levels; (d) strengthening the capacities of young people to become agents of change and the capacities of police, justice, health and education services providers and community stakeholders to prevent and manage GBV, FGM and child marriage cases, in accordance with standard operating procedures, including during humanitarian crises and in cross-border areas; (e) contributing to the improvement of the socio-economic situation of GBV survivors' and of vulnerable girls and women by supporting income-generating activities; (f) strengthening the digitization and use of sex- and age-disaggregated data systems on GBV and harmful practices through the implementation of an information management system; (g) strengthening the capacity of civil society organizations to advocate for and monitor the implementation of public declarations of communities for the abandonment of harmful practices; and (h) strengthening the capacity of government and decision-makers, particularly the women's caucus, with advocacy tools to strengthen and enforce laws and policies for ending harmful norms and practices and for improving SRH services.

C. Output 3. By 2028, strengthened capacities of stakeholders and the national statistical system to generate, analyse and disseminate high-quality evidence and disaggregated sociodemographic and reproductive health data for planning, monitoring and evaluation of intervention strategies, particularly those related to harnessing the demographic dividend, including in humanitarian emergencies.

25. This output will contribute to (a) strengthening national capacities in the generation, analysis, dissemination and use of data, including disaggregated data (by sex, age, district and region) and the common data set on population statistics, to better reach the most vulnerable groups, in particular women and young people from rural areas, those who migrate to urban areas, and people with disabilities; (b) reinforcing vital statistics systems to generate vital demographic data to support family planning and other SRH and GBV services; (c) establishing and building capacity of information management systems in reproductive health and rights, adolescent and youth SRH, family planning and GBV; (d) strengthening advocacy and partnerships for the operationalization of realizing the demographic dividend. UNFPA will reinforce its normative role to (i) reinforce and reframe its position as a leading partner that provides the evidence and data needed to inform and support government decision-making and advance dialogue; and (ii) promote a programmatic approach that helps partners understand what is happening, based on evidence.

26. The programme will support: (a) expanding of civil registration and vital statistics coverage through a pilot civil registration system; (b) capacity building in national human resources (demographers, statisticians) and the production and dissemination of materials; (c) ongoing training on data entry and quality assurance for the DHIS2 software platform; (d) development of population projections to inform humanitarian situations, understanding and accounting for demographic trends, at all levels, in development and demographic transition strategies; (e) development of a reproductive health and GBV vulnerability map based on small area estimation models; (f) combining big data with survey and census data to shed light on societal trends and global patterns on GBV and reproductive health, with a focus on adolescents, youth and the elderly, as well as family solidarity systems related to urbanization and migration; (g) diverse networks, including those of parliamentarians working on population and development; (h) development and implementation of the demographic dividend sectoral action plans (education, youth, employment, family, health); (i) analysis of the social and economic implications of demographic change to highlight new and emerging vulnerabilities and identify appropriate responses to support those left furthest behind; (j) in-depth studies to assess the impact of ongoing initiatives to change social norms in relation to SRH and rights; (k) raising awareness among the younger generation on population issues and their role in public service delivery,

and empowering women and government officials to strengthen the national capacity to harness the demographic dividend; (l) making data and knowledge products (particularly those provided by the population and housing census) available through online portals, databases, social media and traditional media channels; (m) use of data on SRH and rights, gender equality and young people in the formulation and monitoring of development policies; and (n) promoting qualitative data to understand people's attitudes, behaviours, beliefs, opinions, experiences and priorities.

III. Programme and risk management

27. The Ministry of Economy, Planning and Cooperation coordinates the programme, in line with UNSCDF. It will oversee the programme in coordination with sectoral ministries and international and national non-governmental organizations (NGOs) as implementing partners. Implementing partners will be selected based on their comparative advantage linked to the UNFPA transformative results to better contribute to outputs, with the participation of left-behind groups in programme implementation. The sectoral ministries for health, youth and the family will coordinate and monitor programme interventions. A capacity assessment of implementing partners will be conducted at the beginning of the programme.

28. UNFPA will align the coordination of the programme with UNSDCF mechanisms, providing strategic leadership in the outcome working group and providing high-quality contributions to relevant UNSDCF workplans. Collaboration with the United Nations organizations will be harnessed through joint programmes, where feasible, to strengthen alliances and leverage resources, in line with the 'delivering as one' approach and the UNSDCF. The programme will strengthen South-South and triangular cooperation to leverage financial donations as well as the exchange of knowledge and will benefit from technical, operational and programmatic support from UNFPA headquarters and the regional office. The country office staffing profiles will be adapted to the requirements of the new programme. In the spirit of 'delivering as one', the programme will contribute to the three transformative results by strengthening synergies with existing and future initiatives, to strengthen cooperation and complementarity.

29. An integrated resource mobilization and partnership plan, with a focus on innovation in health financing, including the Government and South-South and triangular cooperation, is being established with the United Nations agencies, bilateral donors and the private sector, to better contribute to the SDGs 1, 3, 5, 10, 13, 16 and 17.

30. National implementation and leadership will strengthen ownership and mutual accountability. The programme will continue to build national capacity on the harmonized approach to cash transfers, in coordination with the United Nations system, to enhance risk management. Pre-audits, spot checks and annual audits will be conducted per UNFPA rules and procedures, and the country office will ensure implementing partners fully implement their recommendations.

31. Programme risks include (a) persistence of socio-cultural barriers to achieving positive change for women; (b) lack of resources to address social sector priorities due to the post-COVID-19 pandemic economic crisis, climate change and geopolitical shocks; (c) understaffing of health facilities in rural areas and recurrent healthcare strikes; (d) emergence of new epidemics; and (e) large inflows of migrants due to the vulnerable regional security context.

32. To mitigate these risks, the programme will: (a) enhance partnerships with community networks and provide evidence-based advocacy for human rights to address socio-cultural barriers to gender equality; (b) identify new and innovative financing opportunities to sustain resource mobilization; (c) continue advocacy for compliance with staffing norms and standards and for keeping a peaceful social environment in the health sector; (d) implement a continuum of activities plan focused on digitalization of information and service delivery; (e) strengthen national capacities for integrated reproductive health and GBV service delivery in humanitarian emergencies; (f) consider youth, peace and security factors in the programming process; and (g) implement cross-border strategies to prevent FGM and strengthen accountability frameworks related to GBV.

33. 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 managers at country, regional and headquarters levels with respect to country programmes are described in the UNFPA programme and operations policies and procedures, and the internal control framework.

IV. Monitoring and evaluation

34. The programme monitoring and evaluation plan will be updated and implemented with national partners to facilitate the application of the seven results-based management standard principles of UNFPA. It will be aligned with the national and UNSDCF monitoring and evaluation systems, and the results and resources framework indicators will be disaggregated (by zone, residence, age and disability). Information on actual results will allow programme adjustments and the production of high-quality periodic reports and facilitate the final evaluation of the country programme. The programme will continue to improve the quality of data produced and analysed for humanitarian emergency preparedness, in collaboration with the humanitarian country team and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA). Strengthening the technical capacity of partners and staff will lead to better monitoring of results and the collection of disaggregated, comprehensive and timely data, production of high-quality reports, communication of results, and strengthening of a results culture. Innovative and more efficient digital approaches will be implemented to (a) support the collection and analysis of primary data using a real-time monitoring tool, among others, to inform quarterly, annual and midterm reviews; and (b) pursue results-based management commitments and, together with programme stakeholders, learning from quarterly and annual reviews and the midterm review.

35. UNFPA will play a central role within the United Nations country team in UNSCDF programming and monitoring, particularly in managing UNInfo and joint field monitoring missions, to improve the quality of the reports produced. The programme will continue its support to the United Nations country team outcome groups, the United Nations Monitoring and Evaluation Group and the national evaluation coordination mechanisms to improve the quality of consolidated reports, particularly those monitoring the implementation of the SDGs.

36. The costed country programme evaluation plan will build the capacity of staff and key stakeholders, enhance the value of lessons learned and strengthen accountability. This will ensure the final evaluation of the country programme contributes to the UNSDCF evaluation and to the implementation of the new UNFPA evaluation strategy, 2022-2025.

37. The support of UNFPA is also crucial for the Universal Periodic Review with national stakeholders and will provide technical support to the national committees on the Convention on the Elimination of All Forms of Discrimination against Women.

RESULTS AND RESOURCES FRAMEWORK FOR SENEGAL (2024-2028)

NATIONAL PRIORITY: ‘Plan Senegal Emergent2035’ Axis 2: Human Capital Development, Social Protection and Sustainable Development.				
UNSDCF OUTCOME: 2. The most vulnerable among children, women, adolescents, youth, the elderly, people with disabilities, migrants, people living with HIV and the chronically ill, living in island, peri-urban, rural or border areas have equitable access to quality and appropriate basic social services and social protection generated by inclusive public policies by 2028.				
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.				
UNSDCF outcome indicators, baselines, targets	Country programme outputs	Output indicators, baselines and targets	Partner contributions	Indicative resources
<p><u>UNSDCF Outcome indicator(s):</u></p> <ul style="list-style-type: none"> Rate of skilled birth attendance <i>Baseline: national:74%; rural:67%; urban:95% (2023); Target: national:90%, rural:82%; urban:100% (2028)</i> Universal health coverage index for essential health services <i>Baseline: 46.8% (2019); Target: 62.4% (2028)</i> <p><u>Related UNFPA Strategic Plan Outcome indicator(s):</u></p> <ul style="list-style-type: none"> Rate of birth attendance <i>Baseline: 74%; Target: 90%</i> Modern contraceptive prevalence rate <i>Baseline: 25.5% (2019); Target: 46% (2028)</i> Country has laws and regulations that guarantee full and equal access to women and men aged 15 years and older to SRH care, information and education <i>Baseline: Yes; Target: Yes</i> 	<p>Output 1. By 2028, strengthened capacities of the health system and communities to increase the demand for and the continued provision of respectful care and high-quality, integrated sexual and reproductive health and HIV-related services that are accessible to women, adolescents, youth and people with disabilities, especially the most vulnerable, including in humanitarian emergencies.</p>	<ul style="list-style-type: none"> Modern contraceptive product stockout rate <i>Baseline:12%(2023); Target: 4% (2028)</i> Number of women adolescents and youth, including those with disabilities, receiving SRH services <i>Baseline:1,474,104 (2023); Target: +1,000,000 (2028)</i> <i>Disaggregation: Age: (10-24 years): 54%; (25+ years):46%; Residence (urban): 45%; (rural): 55%</i> Proportion of maternal deaths audited <i>Baseline: 69% (2023); Target: 90% (2028)</i> Proportion of health facilities offering effective emergency obstetric care <i>Baseline: 31% (2023); Target: 50% (2028)</i> Number of people with disabilities benefiting from integrated (SRH, adolescent and youth SRH and GBV) services <i>Baseline: 0 (2023); Target: 1,500 (2028)</i> <i>Disaggregation: Residence: (urban): 45%; (rural): 55%</i> 	<p>Ministries in charge of health, youth, family; national and international NGOs; National AIDS Council, various networks(religious, youth, women, traditional communicators, parliamentarians, communities, and journalists); bilateral and multilateral partners, United Nations system, SWEDD</p>	<p>\$34.3 million (\$6.4 million from regular resources and \$27.9 million from other resources)</p>
NATIONAL PRIORITY: ‘Plan Senegal Emergent2035’ Axis 2: Human Capital Development, Social Protection and Sustainable Development.				
UNSDCF OUTCOME: 2. The most vulnerable among children, women, adolescents, youth, the elderly, people with disabilities, migrants, people living with HIV and the chronically ill, living in island, peri-urban, rural or border areas have equitable access to quality and appropriate basic social services and social protection generated by inclusive public policies by 2028				
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.				
UNSDCF outcome indicators, baselines, targets	Country programme outputs	Output indicators, baselines and targets	Partner contributions	Indicative resources
<p><u>UNSDCF Outcome indicators:</u></p> <ul style="list-style-type: none"> Proportion of women and girls aged 15 years and older subjected to physical or sexual violence in the previous 12 months, by type and author -Women (15-49 years) who experienced physical violence: <i>Baseline: 17% (2019);</i> 	<p>Output 2. By 2028, strengthened capacities of actors and institutions to prevent and respond in a holistic manner to GBV and harmful practices against women,</p>	<ul style="list-style-type: none"> Number of communities that have made a public declaration of abandonment of FGM with an operational community post-declaration monitoring system <i>Baseline: 185 (2023); Target: 435 (2028)</i> <i>Disaggregation: Zone: (North): 44%; (South): 46%</i> 	<p>Ministries of health; youth; family; national and international NGOs; various networks of religious, youth, women, traditional</p>	<p>\$9.2 million (\$0.8 million from regular resources and \$8.4 million from other resources)</p>

<p>Target: 14.5% (2028)</p> <p>-Women (15-49 years) who experienced sexual violence: Baseline: 3.4% (2019); Target: 2.9% (2028)</p> <p>-Girls (15-17 years) who experienced physical violence: Baseline: 18.2% (2019); Target: 15.7% (2028)</p> <p>-Girls (15-17 years) who experienced sexual violence: Baseline: 2.9% (2019); Target: 2.4% (2028)</p> <ul style="list-style-type: none"> Number of people receiving social protection in the form of assistance Disaggregation: by age, programme (if possible): -Number of children supported by the National Programme of Family Security Grants (PNBSF) Baseline: 1,047,291; Target: +20% -Number of beneficiaries of the Equal Opportunity Card (CEC) Baseline 25,614; Target: +20% -Number of households that received cash transfer assistance: Baseline: 43,856; Target +20% -Number of people living with disabilities benefiting from integrated services Baseline: 0; Target: 1,500 	<p>adolescents, young people and people with disabilities, particularly those living in rural areas, including in humanitarian emergencies.</p>	<ul style="list-style-type: none"> Number of girls, women who benefit from integrated FGM and GBV prevention and case management services Baseline: 143,844 (2023); Target: +60,000 (2028) Disaggregation: Residence: (urban): 45%; (rural): 55% A national information management system for GBV is functional Baseline: No (2023); Target: Yes (2028) A draft revised legislative framework on FGM and GBV, aligned with international standards, available Baseline: No (2023); Target: Yes (2028) 	<p>communicators, parliamentarians, and journalists; bilateral and multilateral partners; United Nations system; SWEDD</p>	
<p>NATIONAL PRIORITY: ‘Plan Senegal Emergent 2035’ Axis 3: Governance, institutions, peace and security.</p>				
<p>UNSDCF OUTCOME: 3: The most vulnerable populations (especially those living in rural and peri-urban areas) participate in inclusive and transparent public policies, are self-reliant and resilient, and have equitable access to natural resources and public services.</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>Related UNFPA Strategic Plan Outcome indicator(s):</p> <ul style="list-style-type: none"> The country has conducted at least one population and housing census in the past decade Baseline: Yes (2023); Target: Yes (2028) 	<p>Output 3. By 2028, strengthened capacities of stakeholders and the national statistical system to generate, analyse and disseminate high-quality evidence and disaggregated sociodemographic and reproductive health data for planning, monitoring</p>	<ul style="list-style-type: none"> Number of national surveys supported on reproductive health and rights-related issues (DHS, GBV, reproductive health and commodities security) Baseline: 5 (2023); Target: +3 (2028) Number of ‘in-depth analyses/thematic studies on transformative outcomes ‘leaving no one behind’ and ‘the three zeros’ produced and disseminated, to inform strategies Baseline: 19 (2023); Target: +14 (2028) 	<p>Ministries of Planning; Health; Youth; Family; communities, National Centre of Civil Status, universities, various networks of religious, youth, traditional communicators, parliamentarians, communities, and journalists, bilateral and</p>	<p>\$5.4 million (\$2.1 million from regular resources and \$3.3 million from other resources))</p>

	<p>and evaluation of intervention strategies, particularly those related to harnessing the demographic dividend, including in humanitarian emergencies.</p>	<ul style="list-style-type: none"> • Number of policy briefs on reproductive health, family planning and disability developed <i>Baseline: 11 (2023); Target: +14 (2028)</i> • Number of experts from the national statistical system and other actors trained in data production, analysis and valorization <i>Baseline: 294 (2023); Target: +116 (2028)</i> 	<p>multilateral partners, United Nations system</p>	
<p>Programme coordination and assistance</p>				<p>\$1.1 million from regular resources</p>