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UNFPA – Country programmes and related matters

United Nations Population Fund

Country programme document for Somalia

Proposed indicative UNFPA assistance:	$203.5 million: $12 million from regular resources and $191.5 million through co-financing modalities or other resources
Programme period:	Five years (2021-2025)
Cycle of assistance:	Fourth
Category per decision 2017/23:	Red
Alignment with the UNSDCF Cycle	United Nations Sustainable Development Cooperation Framework for Somalia, 2021–2025

Proposed indicative assistance (in millions of $):

Programme outcome areas		Regular resources	Other resources	Total
Outcome 1	Sexual and reproductive health	5	88.0	93
Outcome 2	Adolescents and youth	1.4	23.0	24.4
Outcome 3	Gender equality and empowerment of women	2.3	36.5	38.8
Outcome 4	Population dynamics	3.3	44.0	47.3
Total		12.0	191.5	203.5

Note: The present document was processed in its entirety by UNFPA.

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I. Programme rationale

1. Since 2011, peace and security have improved in Somalia; the country has seen a trend towards stabilization, with the Government increasing areas of control and the International Monetary Fund (IMF) and the World Bank now considering Somalia eligible for debt relief. This is a major milestone to ensure a resilient economy and financial system. Somalia has taken important steps towards the establishment of a federal system of government with four new Federal Member States emerging in the past seven years. According to the 2014 Population Estimation Survey, the official population of Somalia is 12.3 million people, with around 78 per cent of the population below the age of 30. Nomads and semi-pastoralists make up a quarter of the population.

2. In past years, the Government took commendable steps to build the institutional capacity for improved functioning of emergency obstetric and neonatal care (EmONC) facilities and maternity homes. The Government also worked on the expansion of midwifery schools, the implementation of innovative community reproductive health outreach campaigns, reproductive health commodity security, availability of clinical management of rape services and improved rule of law and access to justice for gender-based violence (GBV) survivors. Somalia has also made notable progress in producing data to guide policy formulation and planning. This led to the implementation of the first-ever Somali Health and Demographic Survey (SHDS) in 2020, including a nomadic survey and the launch of the National Statistical Act. Consequently, sound and reliable national population-based data for evidence-based planning, policy making, and programming has become available, and the national capacities to collect, analyse, disseminate and utilize disaggregated data have been strengthened.

3. Despite this progress, Somalia is still beset with fragmented and weak governance and institutional systems. The country continues to experience protracted conflict and natural disasters such as recurrent drought, floods, cyclones and recently a massive locust infestation affecting the fragile food security system. The fragile health system and access constraints due to security concerns, contribute to poor reproductive and maternal health outcomes, especially among the most vulnerable. As of 2020, over 5.2 million people need humanitarian assistance. Nearly 3 million people require immediate access to emergency health services and hygiene. The number of internally displaced persons (IDPs) is estimated at 2.6 million. Integrating development and humanitarian interventions, building community, institutional systems and individual resilience are critical to respond and prevent humanitarian emergencies.

4. The emergence of the COVID-19 pandemic has deeply affected the economic situation in Somalia. Movement and import restrictions impacted the availability of basic commodities and led to price surges and reduced purchasing power. A 30-50 per cent decline in livestock exports has been witnessed. Sudden new spikes in COVID-19 cases may overwhelm health facilities and present serious challenges to the already overstretched health care system.

5. According to the estimates from the 2020 SHDS, the maternal mortality ratio has declined (from 732 per 100,000 live births in 2015 to 692 per 100,000 live births in 2020) but despite the progress, it remains among the highest in the world. Access to skilled birth attendance or facility-based births has decreased (from 36 per cent in 2011 to 32 per cent in 2020). The lifetime risk of a 15-year-old woman dying from maternal causes in Somalia is 1 in 20. Obstetric fistula is widespread; evidence points to early marriage, early pregnancy and childbirth, lack of access to EmONC, and female genital mutilation (FGM) as contributing factors.

6. According to SHDS 2020, Somalia has the second highest total fertility rate in the world (6.9). The modern contraceptive prevalence rate for Somalia is low, with only 1 per cent of married women using modern methods and 37 per cent of women at reproductive age reporting unmet needs for family planning. This high unmet need shows that women want modern methods but lack access due to insufficient availability at the health facilities, or they are not empowered to use them. Post-abortion care and medical care for survivors of GBV are rarely available.

7. Adolescents and youth face enormous challenges such as high unemployment and poor educational attainment; close to two thirds of the adolescents and youth aged 15-24 years have not completed basic education. Adolescents and youth also deal with political exclusion, lack of civic engagement and substance abuse – notably the use of *khat*. Poor access to adolescent sexual and reproductive health (SRH) services and lack of access to correct information put adolescents and youth at risk of unwanted pregnancies and sexually transmitted infections (STIs), including HIV. Comprehensive sexuality education is not part of the curriculum, and cultural barriers discourage dialogue on questions relating to adolescent SRH. According to the Youth Behavioural Survey Report (2018), most adolescents and youth had very basic knowledge of HIV and AIDS, and misconception and misinformation about the mode of transmission was widespread. Only half knew a person can protect themselves from HIV infection by using a condom correctly.

8. Sexual violence and other forms of GBV remain a major protection concern for women and girls. Decades of conflict, insecurity and environmental shocks have led to internal displacement and international migration, which put women and girls more at risk of GBV. Displaced women and girls are unable to easily access SRH or clinical management of rape services or sanitary items; this increases their vulnerability to poor reproductive health and complications. Harmful traditional practices such as child, early and forced marriage, traditional birth attendance and the preference to educate male children over female children are common in Somalia. Child, early and forced marriage leads to a higher risk of abuse within marriage, death and injury due to early family life and childbearing and denied educational and economic opportunities. Nearly half of women and girls aged 6 and above have never been to school and approximately only one-third of women and girls are literate. Discriminatory socio-cultural practices, values and norms, weak legal and policy frameworks, and limited government protection mechanisms perpetuate GBV and harmful practices Most GBV survivors depend on traditional justice mechanisms, including customary law, which has limitations in ensuring legal redress for survivors. International treaties such as the Convention on the Elimination of All forms of Discrimination against Women (CEDAW) are yet to be ratified. National laws such as the Sexual Offences Bill and the Zero Tolerance for FGM Bill are yet to be enacted.

9. FGM is a widespread and deeply entrenched harmful practice. According to SHDS 2020, virtually all Somali women (99 per cent) have undergone the procedure, 64 per cent of whom have been subjected to ‘infibulation’, the most severe form of FGM, often causing lifelong trauma. The normalization of FGM, and its non-recognition as rights violations for women and girls, is a major obstacle for ending the practice. The observed trend of “medicalization” of FGM, wherein the procedure is performed by health providers, also constitutes a threat to its abandonment. Several factors motivate medical professionals to continue the practice, including prospects of economic gain, social pressure and a sense of duty to serve community requests.

10. The Government signed a national commitment document, reflecting its determination to accelerate the implementation of the ICPD Programme of Action. These commitments include reducing maternal mortality by at least 25 per cent by 2030, eliminating gender-based violence and female genital mutilation by addressing vulnerabilities and strengthening policy and legal frameworks, and ratifying the CEDAW, in line with the Somali Women’s Charter.

11. Some key achievements from the third country programme include: (a) 27 basic and 9 comprehensive emergency obstetric and newborn care EmONC facilities supported, which have assisted 98,552 deliveries, performed 3,708 Caesarean deliveries, provided 446,000 antenatal care consultations and family planning services to 7,480 clients; (c) 15 midwifery schools supported for the training of midwives, resulting in more than 1,381 midwives graduating to date; and (d) 25,257 beneficiaries reached with GBV essential services through one-stop centres.

12. The lessons learned from the previous country programme include: (a) the importance of mainstreaming humanitarian-development linkages; (b) improving visibility and better engagement at the local level to understand the issues, problems and priorities of Somalis;

(c) the importance of requesting knowledge and evidence from the Government for inclusive service-delivery models and policy options; (d) scaling up cross-sectoral collaboration through multisectoral endeavours and joint programmes in the context of the Sustainable Development Goals (SDGs) and ICPD25 commitments is essential; and (e) using operational research to test programme hypotheses for systematic improvement in the performance of programme interventions should be prioritized.

II. Programme priorities and partnerships

13. The new country programme was developed in consultation with the Federal Government of Somalia, Federal Member States, United Nations agencies, development partners, donors, civil society organizations and the youth advisory board. The Programme is aligned to the National Development Plan (NDP9); Federal Member States plans; the UNFPA Strategic Plan, 2018-2021; the Common Country Assessment; the United Nations Sustainable Development Cooperation Framework (UNSDCF); the Management and Accountability Framework; the 2030 Agenda for Sustainable Development; the commitments on accelerating the ICPD made by the Somali Government at the Nairobi Summit; the Somali Reproductive, Maternal, Newborn, Child and Adolescent Health Action Plan; the National Youth Policy and Family Planning 2020 Action Plan; the Essential Package of Health Services 2020, Somali Midwifery Strategy Document 2019-2024, Somalia Human Resources for Health Policy; and the Somali Road Map for Achieving Universal Health Coverage by 2030. The programme will build on past achievements and lessons learned; employ flexible strategies within the humanitarian, development and peace nexus; and adjust to the existing and emerging realities of federalism.

14. The overall goal of the programme is to improve the health, well-being and rights of women, adolescents and youth, and the most vulnerable populations. To successfully contribute to the implementation of NDP9, UNFPA will adopt a context-specific four-by-five strategy, with a focus on achieving four transformational results supported by five strategic enablers. The four transformational results for UNFPA Somalia are: (a) zero preventable maternal deaths; (b) zero unmet need for family planning; (c) zero GBV; and (d) zero FGM.

15. To realize these four transformative results, UNFPA Somalia has identified the following five strategic enablers: (a) cultivating meaningful adolescents and youth engagement and advocacy initiatives to equip them with the effective skills and capacities; (b) ensuring high-quality, integrated and inclusive service delivery models to advance SRH, including family planning, preventing and responding to HIV, GBV and FGM, and enhancing adolescent and youth health, knowledge and well-being; (c) enhancing evidence-based policy, legal and accountability frameworks to advance gender equality, preventing and responding to GBV and FGM, and empowering women and adolescents and youth to exercise their reproductive rights; (d) strengthening linkages between humanitarian and development action, securing sufficient emergency response capacities, and enhancing resilience at individual, community, institutional, and system levels; and (e) strengthening national capacity to generate, analyse, disseminate and utilize high-quality disaggregated data on population and development and SRH issues, including in humanitarian settings. Different modes of engagement will be used to achieve the programme objectives, including advocacy and policy dialogue, capacity development, knowledge management and service delivery. The programme will be implemented in collaboration with the Government, other United Nations agencies, civil society organizations, including faith-based, adolescent and youth-led organizations, with the aim to reach those with the least access, the most marginalized, persons with disabilities, and disadvantaged and underserved populations.

A. Sexual and reproductive health

16. Output 1. Strengthened national and subnational capacities to ensure universal access to high-quality sexual and reproductive health information, services and supplies, including in humanitarian affected, hard-to-reach and marginalized communities.

17. The programme will: (a) strengthen and expand EmONC facilities to provide integrated SRH services targeting pregnant women and mothers, adolescents and youth, and survivors of

GBV; (b) support the scaling up of high-quality, integrated SRH services based on the Essential Package of Health Services 2020 to ensure increased access; (c) support the availability of SRH lifesaving services in humanitarian contexts, including IDPs, nomadic populations, and disenfranchised and vulnerable populations; (d) strengthening the capacity of the health workforce at facilities on lifesaving skills, maternal and perinatal death surveillance and response and other reproductive health-related services, by developing in-service training guidelines and protocols; (e) support the development of a comprehensive and innovative plan for increasing nomadic communities' access to basic health services, including reproductive care and cash voucher assistance; (f) integrate prevention of mother-to-child transmission and voluntary HIV counselling and testing services at the district and first referral hospitals; (g) strengthen the national capacity to provide obstetric fistula prevention, treatment and social reintegration; (h) increase the capacity of health care service providers on the Minimum Initial Service Package and clinical management of rape; (i) support the implementation of Midwifery Strategy and SRH Policy, including training, production and deployment of qualified midwifery cadres, building capacity of associations and regulatory bodies; (j) support and increase the national capacity in supply-chain management processes; (k) procure, pre-position and distribute reproductive health kits, essential drugs and hygiene kits at the community, primary health care and referral hospital levels; (m) invest in community-level resilience and continue system-building efforts aimed at building the resilience of national institutions; (n) support the analysis, dissemination and utilization of national information from SHDS 2020 and information sources regarding SRHR, adolescents and youth; and (o) integrate Maternal Death Surveillance and Response in the national Health Management Information System to report and analyse maternal deaths.

18. Output 2: Increased demand and utilization of maternal health, family planning and other SRHR services through outreach and behaviour change communication, including in humanitarian settings.

19. This will be achieved by: (a) supporting information, education and communication, social media and behaviour change communication campaigns for wider use of family planning and SRH services; (b) raising awareness on family planning, using civil society organizations and local networks; (c) advocacy for favourable political, legislative and regulatory family planning provisions; (d) advocating for increasing the allocation of resources for integration of family planning within the primary health care, with a focus on adolescents and youth demands and needs; (e) strengthening advocacy for the inclusion of SRH and GBV within national emergency preparedness and response plans; (f) supporting the engagement with educational institutions to include the adolescents and youths' family planning and SRH information in the curricula; (g) expanding the provision of evidence-based high-quality family planning services at the health facility level, including in rural, nomadic and IDP communities; (h) improving and supporting the provision of rights-based high-quality family planning information and counselling; (i) increasing the number of community health workers and female health workers to deliver high-quality family planning and SRH counselling and improve the connections between communities and health facilities; (m) strengthening capacity to collect, analyse and track key indicators in family planning and reinforcing feedback mechanisms; and (n) conducting operational research and in-depth analytical studies on barriers and norms affecting access and utilization of family planning and SRH services.

B. Adolescents and youth

20. Output 1: Young people have opportunities to exercise leadership and participate in sustainable development, humanitarian action and sustaining peace.

21. The programme will focus on (a) the integration of adolescent SRH information and services, including HIV, at the youth centres and health facilities; (b) ending menstrual poverty among young women and girls; (c) building the capacity of partners to deliver culturally-sensitive, evidence-informed advocacy and policy dialogue initiatives, with a focus on SRH, GBV, life skills and citizenship education; (d) support the development and implementation of laws, policies and programmes that promote adolescents and youth SRHR; (e) support the implementation of the Security Council resolutions 2250 and 2419 in Somalia; (f) support

youth-led platforms and civic spaces by engaging adolescents in the design, implementation and evaluation of programmes; (g) provide skills development and entrepreneurship opportunities to adolescents and youth in IDP, crises-affected and host communities; (h) establish youth funds that will provide seed funding to promote innovation and social enterprise; and (i) strengthen multisectoral coordination in youth and adolescent services and development. The above strategies will be pursued in partnership with youth-led organisations and associations, Somali National University and other local partners, to stimulate uptake of services for SRH, GBV prevention and FGM abandonment.

C. Gender equality and women empowerment

22. Output 1: Enhanced multisectoral capacity to prevent and address gender-based violence using a continuum approach, including in humanitarian settings.

23. Programme interventions include: (a) supporting the development and updating of integrated referral pathways; (b) enhancing the provision of the essential services package, including clinical management of rape, psychosocial first aid and mental health support and counselling, legal aid, and safety and security services to GBV survivors through one-stop centres, cash voucher assistance, and safe spaces for women and girls; (c) providing integrated lab services to deliver forensic-related services for GBV survivors; (d) increasing the capacity of national service providers to provide gender-responsive, age and culturally appropriate GBV services: (e) strengthening the coordination mechanism and localization agenda for humanitarian and development bodies to respond to, and prevent and mitigate the risks of GBV in Somalia; (f) advocating for the enactment and implementation of gender-related legislation such as on sexual offences and FGM; (g) supporting the training of security personnel to implement legislative provisions and to assist GBV survivors using a survivor centred approach; (i) supporting the advocacy and skills of young persons to end GBV; (j) supporting the facilitation of in-depth analytical studies on GBV and women's reproductive rights; and (k) supporting the production of technical papers and reports from the Gender-Based Violence Information Management System.

24. Output 2: Strengthened response to abandon female genital mutilation and other harmful practices, including in the humanitarian context.

25. This will be achieved by: (a) enhancing the voice and action of youth and crises-affected communities to advocate an end to FGM and other harmful practices; (b) providing technical support to Somali women's networks and justice ministries to review, draft and advocate for the enactment and implementation of legislation and policies prohibiting FGM and other harmful practices; (c) advocating and establishing an alliance to support the passing and ratification of the 'abandonment of all forms of FGM' bill by the Government as well as the parliament, including with key religious networks; (d) supporting and leading the intergenerational dialogue with communities for promoting peace building and facilitating adolescents and youth initiatives for combating all types of harmful practices; (e) supporting a broad media campaign to promote national discourse to end FGM, including in IDP settings; (f) supporting the production of policy briefs on FGM and harmful practices to guide decision-making processes; (g) support programme to focus on behaviour change to end FGM by engaging IDP communities, men and boys; (h) producing evidence-based information on the determinants and prevalence of FGM and child marriage; (i) supporting the provision of health, psychosocial and mental health and protection services in humanitarian contexts to alleviate the associated complications of FGM on the girls in Somalia, in particular within IDP and host community settings; and (j) increasing counselling services for girls who underwent FGM as a harmful traditional practice.

D. Population dynamics

26. Output 1: Improved national population data systems, with a focus on mapping and addressing inequalities and to strengthening response in humanitarian crises.

27. This will be achieved by: (a) supporting the newly established Independent National Bureau of Statistics to carry out its mandate to maintain standards as outlined in the National

Statistical Act, through technical and financial assistance, advocacy with target audiences, as well as South-South cooperation; (b) supporting pre-population and housing census activities; (c) strengthening civil registration and vital statistics by establishing a legal framework governing the collection of civil registration and vital statistics and assisting in the development of guidelines and data collection tools; (d) producing disaggregated knowledge products on population dynamics and demographic profiles, the health and social consequences of maternal deaths, unmet need for family planning, the needs of the youth, GBV, FGM and other harmful traditional practices; (e) enhancing the national capacity to enable partners to undertake needs assessments, and prevention and response activities, as well as track progress towards achieving SDGs, ICPD Programme of Action, and the National Development Plans; and (f) providing support to prepare and respond to humanitarian interventions, including early warning and action, and risk mapping for the COVID-19 pandemic, floods and other disasters.

III. Programme and risk management

28. UNFPA, the Government of Somalia, non-governmental organizations (NGOs), academia and other United Nations organizations will jointly coordinate programme planning, implementation, monitoring and review, in compliance with relevant policies and procedures. National execution will continue to be the main implementation modality for the proposed programme to ensure national ownership and accountability to beneficiaries through the involvement of affected people as active agents in the design, execution and monitoring of UNFPA-supported interventions. Civil society organizations, in particular, will play a key role in supporting accountability processes, help understand local contexts, promote local ownership and provide important platforms that can enable women and adolescents and youth to play a greater role in processes for setting programme and budgetary priorities. UNFPA will ensure focus on accountability in its programme and build the capacity of partners in results-based management. Implementing partners will be competitively selected based on their ability to deliver high-quality programmes, strategic relevance and appropriate risk analysis.

29. The UNFPA Representative, together with responsible ministries, will direct and oversee the programme. UNFPA will earmark programme funds for staff to provide technical and programme expertise, with human resources aligned to the needs of the programme. Funding for staff will come from different sources, including non-core resources. UNFPA will adopt a flexible approach to its presence in Somalia, with a desire to have presence in each Federal Member State, according to programmatic needs based on the existing presence – in Mogadishu, Baidoa, Garowe and Hargeisa, including a service unit in Nairobi, as required – to ensure that relevant programmatic interventions are determined by needs and partnerships on the ground in close proximity to the end-beneficiaries.

30. The aim of this inclusive approach is to ensure that the UNFPA programme reaches the farthest first to strengthen social accountability by being closer to key relevant counterparts and beneficiaries. Subject to improving security context and declining risks, all international staff will be based in Somalia, and UNFPA will continue to strive for gender balance throughout its operations in the country. UNFPA will apply the United Nations standard operating procedures and implement the harmonized approach to cash transfers, incorporating preventive and risk mitigation measures, including periodic audits and evaluations.

31. UNFPA will pursue avenues for resource mobilization from both traditional and non-traditional donors, and multilateral partners for the programme. UNFPA will employ a collaborative approach to work with various donors and build on lessons learned and best practices from the previous programme. In the previous programme, a funding arrangement was adopted where a consortium of donors decided to co-finance the programme in its totality over its full term (2018-2020). To fund the new programme, UNFPA Somalia would strive to follow a similar model. Opportunities for counterpart funding arrangements with the Government will be explored and broader partnerships, joint programmes and strategic projects may be pursued for complementarity. UNFPA will pursue funding for needs of populations affected by humanitarian crises; and may, in consultation with the Government, make ad-hoc emergency fund allocations, adopt implementation arrangements or re-

programme activities to ensure the delivery of life-saving and humanitarian interventions that respond to emerging needs.

32. Major programmatic risks include pandemics, protracted conflict and climate phenomena such as droughts and floods. The COVID-19 pandemic remains a serious risk to the health and well-being of the Somali people. Conflict prevents access to many parts of the country for the delivery of needed services by implementing partners. Climate change poses a serious threat to livelihoods and survival, causing recurrent emergencies. Bottlenecks related to the national execution modality and harmonized approach to cash transfer may occur, including unfavourable sociocultural and legal barriers, high national human resources turnover and sensitivities attached to geographically disaggregated data hindering timely analysis and use of data.

33. Issues that may affect access to and quality of service delivery include poor infrastructure, logistics challenges, poor coordination among development partners, and insufficient number of health workers to provide maternal health services, adolescents and youth-friendly services, clinical management and legal redress for GBV survivors, especially in remote and underserved areas. This includes protection against sexual exploitation and abuse as well as accountability to affected populations in aspects of programme implementation. UNFPA has a working agreement with the United Nations Risk Management Unit and will regularly assess the operational, security, socio-political and fraud risks of the programme.

34. Taking into account the country's security context, UNFPA will prioritize business continuity and regularly conduct programme criticality assessments for managing security risks. Long-term programmes will be able to address the drivers of the humanitarian emergency as they address the underlying causes of vulnerabilities, preventing or decreasing the impact and frequency of humanitarian emergencies. UNFPA will continue to safeguard principled humanitarian action, support localization, strengthen the national emergency preparedness planning, and implement minimum preparedness actions for a timely and effective response to affected populations.

35. 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 the country, regional and headquarters levels 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

36. UNFPA will develop jointly with its partners, mainly line ministries and institutions, a results-based framework to serve as the umbrella for its plans of action and the implementation of the programme interventions. UNFPA will deploy a customized data collection and monitoring system that will help to track, monitor and generate evidence-based information as a real-time data from its thematic programmes. UNFPA will strengthen the feedback mechanism with beneficiaries and partners to inform evidence-based programme design and implementation. A summative evaluation will be conducted by the end of the programme, which will be preceded by a midterm review, to assess the progress towards achievement of the programme targets and outputs. UNFPA will also support surveys and studies to determine the attitudes and opinions of people on issues like family planning, FGM and GBV, as well as further enhance evidence-based planning and targeting, accountability and ensure efficient use of resources.

37. Guided by UNFPA policies and procedures, UNFPA and partners will have joint supervision, observation and monitoring field visits to the different locations of the programme interventions. When needed, monitoring in inaccessible areas will be done through remote and third-party arrangements. UNFPA and partners will work throughout to ensure efficient utilization of programme resources, including accountability, transparency and integrity. Each programme log-frame will be used as a mechanism of monitoring progress and achieved

results. Adjustment and modification will be applied wherever needed for each thematic programme.

38. Under the leadership of the Resident Coordinator, UNFPA will scale up cross-sectoral collaboration, including as a member of United Nations country team (UNCT) and the monitoring and evaluation working group, by continuing to contribute to UNSDCF and country team coordination, joint programming and harmonized results-based management approaches. UNFPA will participate in joint United Nations assessments and evaluations. It will actively support the functioning of the systems and tools developed to monitor and track performance results related to the UNSDCF and the SDGs. UNFPA will consider using third-party monitoring in remote and security-comprised areas, if the need arises.

RESULTS AND RESOURCES FRAMEWORK FOR SOMALIA (2021-2025)

NATIONAL PRIORITY: Pillar 4. Social development: Improve access to health, education, clean water and sanitation; Strengthen social protection and food security safety nets; Strengthen institutional capacities for disaster risk management and public service delivery				
UNSDCF OUTCOME INVOLVING UNFPA: Outcome 4.1. By 2025, more people in Somalia, especially the most vulnerable and marginalized, benefit from equitable and affordable access to government-led and regulated high-quality basic social services at different state levels.				
RELATED UNFPA STRATEGIC PLAN OUTCOME: Outcome 1. Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence				
UNSDCF outcome indicator(s), baselines, target(s)	**Country programme outputs**	**Output indicators, baselines and targets**	**Partner contributions**	**Indicative resources**
• Maternal mortality ratio *Baseline*: 692 (2020); *Target*: 600 (2025) • Percentage of live births attended by skilled health personnel *Baseline (2020):* 31.9% *Target:* 40% • Modern contraceptives prevalence rate *Baseline (2020):* 0.9% *Target:* 6% • Unmet need for family planning *Baseline (2020):* 36.6%; *Target:* 26.6%	Output 1. Strengthened national and subnational capacities to ensure universal access to high-quality sexual and reproductive health information, services and supplies, including in humanitarian affected, hard-to-reach and marginalized communities, as well as nomadic populations	• Number of midwives who graduated in accordance with the International Confederation of Midwives (ICM)-World Health Organization (WHO) standards *Baseline:* 0; *Target:* 770 • Number of health service providers and managers trained on the Essential Package of Health Services and the Minimum Initial Service Package for Reproductive Health in emergencies *Baseline:* 0; *Target:* 1,000 • Percentage of supported delivery facilities providing at least three modern family-planning methods *Baseline:* 46%; *Target:* 60% • Number of obstetric fistula repairs conducted *Baseline:* 0; *Target:* 1,000	Ministries of Health; Action for Relief and Development; national NGOs; international NGOs; midwives associations; midwifery and nursing colleges and faculties; Somalia Birth Attendants Cooperation	$76.2 million $4.0 million from regular resources and $72.2 million from other resources)
	Output 1. Increased demand and uptake of maternal health, family planning, and other SRH services and through behaviour change communication and advocacy outreach, including in fragile and humanitarian settings	• Number of people who have utilized integrated SRH services, including in humanitarian setting *Baseline:* 0; *Target:* 1,650,000 • Percentage of supported health facilities with personnel that have the capacity to implement the new human rights protocol for family planning *Baseline:* 68; *Target:* 85%		$16.8 million $1.0 million from regular resources and $15.8 million from other resources)
NATIONAL PRIORITY: Pillar 4. Social development: Improve social protection for the vulnerable, particularly in times of crisis				
UNSDCF OUTCOME INVOLVING UNFPA: Outcome 4.2. By 2025, the number of people impacted by climate change, natural disasters and environmental degradation is reduced.				
RELATED UNFPA STRATEGIC PLAN OUTCOME: Outcome 2. Youth and adolescents are empowered to realize their sexual and reproductive health and reproductive rights and participate in sustainable development, humanitarian action and sustaining peace				
• Somali Youth Development Index *Baseline*: TBD (2020) *Target*: increased by 10% (2025) • Number of adolescents and youth transformed as a result of life skills education	Output 1. Young people have opportunities to exercise leadership and participate in sustainable development, humanitarian action and sustaining peace	• Number of youth centres established to provide adolescents and youth with reproductive health services, including HIV prevention services. *Baseline:* 4; *Target:* 15 • Number of adolescents and youth who are capacitated and meaningfully engaged in peace building process,	Ministries of Youth and Sport; Ministries of Health; Ministries of Women; Academia; Y-PEER; National AIDS Commission; NGOs; international NGOs	$24.4 million $1.4 million from regular resources and $23 million from other resources)

Baseline: 0; *Target:* 5,000 (cumulative) • Proportion of young girls who married before age 15 *Baseline (2020):* 16.8% *Target:* 10%		including life skills *Baseline:* 0; *Target:* 50,000 • Number of adolescents and youth who benefited from social and economic asset-building initiative to enhance youth leadership *Baseline:* 0; *Target:* 2,500		
NATIONAL PRIORITY: Pillar 4: Social development: To improve access by all Somali citizens to health, education and other essential services, including social protection systems in times of extreme need				
UNSDCF OUTCOME INVOLVING UNFPA: Outcome 4.3. By 2025, the proportion of vulnerable Somalis with scaled-up and sustained resilience against environmental and conflict related shocks is increased, based on better management of life cycle risk, food security, and better nutrition outcomes.				
RELATED UNFPA STRATEGIC PLAN OUTCOME: Outcome 3. Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings				
• Gender-based violence prevalence rate *Baseline (2020):* 14.4% *Target:* 7% • Female genital mutilation prevalence rate *Baseline (2020):* 99.2% *Target:* decreased to 75%	Output 1. Enhanced the multisectoral capacity to prevent and address gender-based violence using a continuum approach in all contexts, with a focus on advocacy, data, health and health systems, psychosocial support and coordination	• National mechanisms to engage multiple stakeholders, including civil society, faith-based organizations, and men and boys, to prevent and address GBV is in place *Baseline:* No; *Target:* Yes • Proportion of health facilities providing essential health services package for survivors of sexual violence *Baseline:* 10%; *Target:* 40% • Number of women and girls who received the essential services package for GBV survivors, including in IDP settlements *Baseline:* 0; *Target:* 136,000 • Number of women sheltered in accommodations to provide safety, protection and skill-building services *Baseline*: 0; *Target*: 2,500	Ministries of Women and Human Rights Development; Ministries of Justice and Religious Affairs; Initiative for Research; national NGOs; international NGOs	$32.8 million $2.0 million from regular resources and $30.8 million from other resources)
	Output 2. Strengthened response to abandon female genital mutilation and other harmful practices, including in humanitarian contexts	• Number of communities that made public declarations to eliminate harmful practices, including child, early and forced marriage and FGM, with support from UNFPA *Baseline:* 0; *Target:* 750 • Number of girls and women who received, with support from UNFPA, prevention or protection services and care related to FGM *Baseline:* 0; *Target:* 19,300 • Number of key religious leaders and adolescents and youth networks/platforms that advocate to end FGM *Baseline:* 0; *Target:* 800		$6.0 million $0.3 million from regular resources and $5.7 million from other resources)
NATIONAL PRIORITY: Economic and social development pillars				
SPECIFIC FRAMEWORK OUTCOME: Outcome 4.4. By 2025, the capacities of local, national, and customary institutions and communities are strengthened to achieve durable solutions and increase the resilience, self-reliance and social cohesion of urban communities affected by displacement.				
RELATED UNFPA STRATEGIC PLAN OUTCOME: Outcome 4. Everyone, everywhere is counted and accounted for in the pursuit of sustainable development				

• Percentage of Somalia SDGs reported *Baseline (2020)*: 58.8%; *Target*: 100% • Percentage of the national sectoral (health, protection, youth) strategies that include and respond to the population-related dynamics, including in humanitarian settings *Baseline (2020):* 0 *Target:* 5	Output 1. Improved national population data systems with a focus on mapping and addressing inequalities and to strengthening response in humanitarian crises	• Capacity building of relevant personnel of institutions conducted, promoting inclusivity *Baseline (2020):* 0; *Target:* 700 • Number of supported drafts including Census Act, governance structures, civil registration and vital statistics legal framework endorsed to facilitate a population and housing census *Baseline:* 0; *Target:* 5 • Pre-census activities, including preparedness, risk assessment, census manuals and guidelines undertaken and a report produced *Baseline (2020):* No; *Target:* Yes • Number of measurement points of population-based SDGs and/or ICPD composite indicator *Baseline:* 0; *Target:* 4 • Somali Data Management System developed, with maternal death surveillance and response, health and the GBV information management system as an integral part *Baseline:* 0; *Target:* 1	Ministries of Planning; national statistics offices; Ministries of Health; academia	$47.3 million $3.3 million from regular resources and $44 million from other resources)