Democratic Republic of the Congo

Thematic Young Child Survival and Development Report

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I. TABLE OF CONTENT

II. ABBREVIATIONS AND ACRONYMS

AFM	Acceleration Framework for Millennium Development Goals 4 & 5
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ARV	Antiretroviral treatment
C4D	Communication for Development
CMAM	Community management of acute malnutrition
DHS	Demographic Health Survey
DPS	Health Provincial Divisions
DPT	Diphtheria, pertussis (whooping cough), and tetanus
DRC	Democratic Republic of the Congo
EFP	Essential Family Practices
EPI	Expanded Programme of Immunization
Gavi	The Global Alliance for Vaccines and Immunization
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HII	High Impact Interventions
HIV	Human Immunodeficiency Virus
IMEP	Integrated Monitoring and Evaluation Plan
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide-treated net
ITFP	Intensive Therapeutic Feeding Programme
IYCF	Infant and Young Children Feeding (Practices)
KFP	Key Family Practices
LLIN	Long-lasting insecticidal net
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MNT	Maternal and neonatal tetanus
MTCT	Mother-to-child transmission (of HIV)
NGO	Non-governmental organization
NHDP	National Health Development Plan
OTPF	Outpatient Therapeutic Feeding Programme
PCR	Program component result
PMTCT	Prevention of mother-to-child transmission (of HIV)
RRMP	Rapid Response to Movement of Population
RUTF	Ready to Use Therapeutic Food
TB	Tuberculosis
SAM	Severe acute malnutrition
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

III. EXECUTIVE SUMMARY

The Child Survival and Development programme aims at reducing maternal, newborn and child mortality rates in the Democratic Republic of the Congo (DRC), caused by pneumonia (13.4%), malaria (14.9%), diarrhoea (10.3%) and HIV/AIDS (1.4%) of all child under-5 deaths[1]. This will be done by increasing effective coverage of High Impact Interventions (HII), which have proven to be highly effective in the reduction of maternal and child deaths.

Three operational strategies were put in place to ensure effective coverage of HII. These include (i) a systemic approach to a gradual scaling-up of HII through leveraging strategic partnerships with The World Bank (WB), The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Gavi; (ii) a nationwide implementation of campaigns on polio, measles and long lasting insecticide nets (LLIN); (iii) a timely response to health and nutrition emergencies. These strategies have yielded positive trends in increasing effective coverage for a number of HII, as demonstrated by the DRC health sector monitoring system (IMA/MAA) and Health Management Information System (HMIS), which is the primary tool for monitoring of health system performance.

Strategic partnerships (GFATM, WB, The European Union (EU) and The United States Agency for International Development (USAID)) strengthened in 2016 have allowed the programme to expand operational zones in a convergent manner. Based on comparative advantages, it led to addressing key systemic bottlenecks, such as availability of commodities, financial and geographical accessibility, regular and local monitoring, community development and strengthening of health system management.

The intensification of mass campaigns has significantly contributed to increasing effective use of LLINs among children under-five from 62% in 2014 to 95% in 2016 in Sud Ubangi province. Vaccination campaigns have enabled DRC to maintain its polio free status since November 2015. Campaigns to vaccinate children against measles have significantly reduced the number of Health Zones (HZ) experiencing measles outbreaks from 77 in 2015 to 24 in 2016. Campaigns targeting Maternal and neonatal tetanus (MNT) elimination led to a decrease in the number of HZ with high risk for MNT from 75 in 2013 to 6 in 2016.

The practice of exclusive breastfeeding for children under six months increased from 62% in 2015 to 74% in 2016 in 9 targeted HZ where the community-based nutrition approach was piloted.

UNICEF has timely responded to a high number of outbreaks (measles, cholera and yellow fever) and nutrition crisis. UNICEF's ability to deliver a timely and effective response in 2016 was enhanced by the development and implementation of contingency plans, including the prepositioning of contingency stocks, and standby agreements concluded with NGOs to enable a swift activation of Rapid Response Teams.

[1] Demographic Health Survey, 2013-2014

The overall progress results achieved in 2016 included:

- Routine Immunization: DRC maintained its polio-free certification status and reduced measles outbreaks from 77 HZ in 2013 to 24 in 2016 by elaborating integrated micro-plans in 516 HZ and improving cold-chain management. 19 million and 11 million children were reached during polio and measles campaigns, respectively, and Routine Immunization (RI) coverage remained above 90%.

- Management of the main killer diseases of under-5 children: The distribution of family kits and Integrated Community Case Management (iCCM) commodities, supported by UNICEF, increased treatment of main killer diseases for 1 million Under-5 children, antibiotics use for treatment of 143,000 pneumonia cases and use of therapeutic food to prevent anaemia for 358,182 children (68% of the target).

- Multisectoral actions to ensure nutritional security: Over 1.7 million mothers and caregivers were sensitized on Infant and Young Child Feeding (IYCF) practices through Community-based Management of Acute Malnutrition (CMAM), pre-school consultations and community-based nutrition approach; more than 7 million children were reached with Vitamin A intake.

- Health System Strengthening: The Ministry of Health, with UNICEF's support, developed decentralized policies and strategies for strategic planning and decision making in all 26 provinces and improve coverage of Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) High Impact Interventions (HII) in the 129 HZ.

- Appropriate and timely response to health and nutrition emergencies: Timely response to 260 health emergencies in 2016, partnerships and cluster coordination (nutrition) resulted in fatality rates of 2.8% (total of 26,147) for cholera, 1.4% (total of 15,147) for measles and 20.5% (total of 78) for yellow fever; and 84.1% cure rate for Severe Acute Malnutrition (SAM) treatment in affected populations spread across 13 provinces.

Progress made in 2016 suggests there is a positive trend towards expanding effective coverage of HII, with the potential to address killer diseases affecting children and women. It is reasonable to expect that this trend is going to be confirmed by the results of the Multiple Indicator Cluster Survey (MICS6), to be carried out in 2017.

In 2017 several recurring challenges will be addressed, including (i) persisting fragmentation of donors' support despite efforts to harmonize and align external assistance to national priorities; (ii) low functionality of the health sector reform, both at national and intermediate levels; (iii) delays in disbursement by national counterparts for the purchase of traditional vaccines; (iv) insufficient funds raised for the nutrition sector; (v) weakness of the national procurement and supply management system; and (vi) insufficient national budget allocation to the health sector. The political transition period in DRC, leading up to general elections, constitutes a major risk that may further compromise programme implementation in 2017 and beyond.

Nevertheless, a number of opportunities point towards areas for engagement in 2017, such as: (i) the new National Health Development Plan (NHDP) 2016-2020, which prioritizes RMNCAH and WASH interventions, with a focus on the underfunded sectors (nutrition and family planning). The NHDP is particularly promising in that it embeds the concept of effective coverage of key interventions, and the bottleneck analysis approach; (ii) DRC's commitment to universal health coverage; (iii) availability of the RMNCAH standards and guidelines; (iv) emerging funding mechanisms, such as GFATM, Global Financing Facility (for which DRC is one of the frontrunner countries), President's Emergency Plan For AIDS Relief (PEPFAR) Country Operational Plan 2017; and (v) continued engagement in partnership and coordination fora, notably the thematic donors groups on health (GIBS), nutrition (GIBNUT), WASH (GIB-WASH) and education (GPE).

In the coming years, UNICEF's strategy will be focused on building the bridge between humanitarian assistance and development (resilience approach) from the onset of an emergency reponse.

UNICEF has been able to scale up and continue its child survival programme, reaching millions of children, thanks to the establishment of partnerships and support with the governments of Belgium, Canada, Japan, Korea, Sweden, Switzerland, UK, USA, EU/ECHO, RMNCAH Trust Fund, GFATM, GAVI, World Bank, UNFPA, WHO, WFP, FAO, UNHCR, Bill and Melinda Gates Foundation, Rotary International, Sabin Vaccine Institute, International and national Non-Governmental Organizations.
The Thematic contribution of the Swedish Cooperation is amongst the most important contributions to the Health Programme in DRC. **UNICEF would like to express its sincere gratitude to the Government of Sweden for its continued support to UNICEF DRC.**

IV. STRATEGIC CONTEXT

The Democratic Republic of Congo (DRC) has an area of more than 2.3 million square kilometres, and a population of more than 71 million people, including 54 per cent under 18 years old and over 18 million below 5 years old. **DRC is characterized by excessive infant, neonatal and child mortality** (58, 28 and 104 per thousand live births) **and maternal mortality** (846 deaths per 100,000 live births)[2] due to diseases that could be prevented with simple or inexpensive measures, including fever/malaria, acute respiratory infections, diarrhoea, malnutrition and neonatal affections. Major bottlenecks in **the delivery of health services** are frequent **stock-outs of essential commodities**; numerous but **inadequately trained and motivated medical staff**; and **poor quality of health care**.

2 Demographic Health Survey II 2013-2014

Following the launch of "A Promise Renewed" (APR)[3] in 2013 and to accelerate progress towards the Millennium Development Goal (MDG) 4&5, UNICEF and partners supported the Government in the development and scale up of the Acceleration Framework for MDG 4&5, including the "family kit" approach. This pilot project is a major strategic initiative combining the empowerment of families through wide spread distribution of family kits containing drugs and vouchers, with performance based financing system to improve the quality of care.

The DRC Government at the 121th place of 133 countries ranked from lowest to highest stunting prevalence[4] joint the "Scaling up Nutrition" (SUN)[5] movement in 2013. UNICEF has also been strongly involved in supporting the Government fighting chronic malnutrition, which enormously affects the country, as 43% of children under-5 (over six million children) are stunted[6]. This prevalence is higher than 50% in 3 provinces: North Kivu, South Kivu and West Kasai.

The current Child Survival and Development programme is monitored through key indicators (see table below) that have been adopted in the five year Country Programme cycle (2013-2017) signed between UNICEF and the DRC Government.

Table1: Main child survival indicators

Programme Areas	Indicator	Baseline		Target	
		Year	Value	Year	Value
Child health	Children aged 0-59 months with diarrhoea receiving ORS	2015	39%	2016	45%
				2017	50%
	Children aged 0-59 months with diarrhoea receiving zinc	2015	39%	2016	45%
				2017	50%
	Children aged 0-59 months who had fever in the last two weeks who received anti-malarial drugs	2015	47%	2016	51%
				2017	60%
	Children aged 0-59 months with symptoms of pneumonia taken to an appropriate health provider	2015	47%	2016	54%
				2017	60%
PMTCT and infant male circumcision	Percentage of children aged 0-14 years and adolescent girls and boys aged 10-19 years living with HIV that are receiving ART	2015	22%	2016	39%
				2017	60%
Infant and Young child feeding	Children aged 0-23 months old who were put to the breast within one hour of birth	2015	69%	2016	70%
				2017	80%
	Children aged 0-5 months old who are exclusively breastfed	2015	31%	2016	54%
				2017	60%
	Children aged 6-23 months provided with minimum dietary diversity	2015	19%	2016	28%
				2017	30%

Source: UNICEF Programme Monitoring, 2016

3*Ending Preventable Child and Maternal Deaths: A Promise Renewed* (APR) brings together governments, civil society, the private sector and individual citizens to stop women and children from dying of causes that are easily avoidable. *APR* promotes two goals. The first is to keep the promise of Millennium Development Goals 4 and 5, which aim to reduce the rates of child and maternal mortality by 2015.The second goal is to sustain the progress towards MDGs 4 and 5 beyond 2015, until no mother, newborn or under-5 dies from preventable causes. Evidence shows that all countries, rich and poor, can lower their national under-5 mortality rates to 20 or fewer deaths per 1,000 live births by 2035. http://www.apromiserenewed.org/

4 Countries ranked from lowest to highest, stunting prevalence, UNICEF Global Nutrition report 2016 " From promise to impact"

5 Scaling Up Nutrition, or SUN, is a unique Movement founded on the principle that all people have a right to food and good nutrition. It unites people—from governments, civil society, the United Nations, donors, businesses and researchers—in a collective effort to improve nutrition. http://scalingupnutrition.org/

6 Demographic Health Survey II 2013-2014

V. PURPOSE

The Child Survival and Development (CSD) programme corresponds mainly to the third pillar of the Strategic Document for Growth and Poverty Reduction, second generation (SDGPR -II): **improving access to social services and strengthening human capital**. It contributes to the achievement of the outcomes sought by the National Health Development Plan (NHDP 2016-2020) and aims to **accelerate the reduction of maternal, neonatal and child mortality through increasing accessibility to efficient, effective and equitable basic health services**. This is addressed through support to the health sector system and the scaling up of evidence based high impact health and nutrition interventions.

The CSD programme component is closely linked to the *United Nations Development Assistance Framework* (UNDAF) pillar 3, to **improve access to social services and reduce vulnerability,** and contributes to the achievement of the Sustainable Development **Goals: *1-No Poverty; 2-No Hunger and 3- Good Health and Well-Being***.

The expected outputs of the Country Programme Action Plan (CPAP) for 2013-2017 period are the following:

Outputs, 2013 – 2017

1.1 **By 2017, poliomyelitis is eradicated, maternal and neonatal tetanus is eliminated, measles mortality is reduced by 95%, vaccination coverage rates for all routine antigens are improved and sustained above 90% and the part of children unreached or not sufficiently vaccinated decreases from 23% to 5%.**

1.2 **As of end of 2017, treatment coverage of children main killer diseases (malaria, diarrhoea, IRA, severe acute malnutrition (SAM), HIV/AIDS and neonatal diseases) is at least at 60% and their incidence is reduced.**

1.3 **By 2017, multisectoral actions to ensure nutritional security of the most vulnerable groups are undertaken, particularly in malnutrition-affected provinces, and stunting is reduced by at least 5%.**

1.4 **By 2017, all 207 PNDS health zones are planning, implementing and monitoring the minimum and complementary packages of activities as stated in the PNDS and the 308 other health zones are planning, implementing and monitoring the minimum package of high impact interventions and clinical at community levels.**

1.5 **All crises (epidemics, natural disasters, population displacements, nutritional) receive an adequate and timely response and a minimum and complementary package of health activities is available in health zones with displacements of population.**

1.6 **Communities gain sustained access to, and use safe drinking water and hygienic sanitation, adopt improved hygienic practices, and act collectively to protect and maintain their healthy environment.**

1.7 **Governance structures in the Water, Sanitation and Hygiene sector - at national, provincial, and local levels – enable an efficient management and scale up of sustainable WASH results.**

1.8 **Between 2013 and 2017, children and families in crisis receive a humanitarian WASH response that is predictable, timely, accountable, universal, non-discriminatory and coordinated, and which promotes post-crisis recovery.**

In 2016, the child survival programme aimed at reducing maternal, newborn and child mortality rates in DRC by fighting killer preventable diseases which are responsible for child deaths: pneumonia (13.4%), malaria (14.9%), diarrhoea (10.3%) and HIV/AIDS (1.4%). The programme also aimed to contribute to the reduction of undernutrition (acute malnutrition and stunting mainly), which is responsible for 45% of children deaths in DRC. The programme contributed to global initiatives such as the eradication of poliomyelitis, the elimination of maternal and neonatal tetanus, control of measles, and the elimination of new HIV infections through the prevention of HIV transmission from mother-to-child.

The country programme established threeoperational modes to ensure effective HII coverage, namely:

I. A systemic approach for gradual HII scale-up through strategic partnerships with potential partners to address major health system barriers. Partnerships have been built with the WB, GFTAM and Gavi in 48 HZ (target population of 6,8 million), with the EU in 23 HZ (target population of 4 million) and USAID/CANADA in 11 HZ (target population of 1,6 million);
II. Implementation of natiowide campaigns (Polio, Measles, Vitamin A mass supplementation, deworming, and LLINs);
III. Timely response to health and nutrition epidemics and humanitarian crisis.

Actions have been implemented in close collaboration with the DRC Government through the Ministry of Health and its decentralized administration at intermediary and HZ level, thanks to partnerships and contributions from the Governments of Belgium, Canada, Japan, Korea, Sweden, Switzerland, UK, USA, EU/ECHO, RMNCAH Trust Fund, GFATM, GAVI, World Bank, UNFPA, WHO, WFP, FAO, UNHCR, Bill and Melinda Gates Foundation, Rotary International, Sabin Vaccine Institute, international and national Non-Governmental Organizations. **The Thematic contribution of the Swedish Cooperation is amongst the most important contributions to the Health Programme in DRC**.

This report focuses on outputs 1.1 to 1.5 as the Swedish Thematic contribution specifically supports the Health Programme in the UNICEF Strategic Plan 2014-2017.

VI. RESULTS IN THE OUTCOME AREA

The analysis below is based on the CPAP indicators and demonstrates the progress made for each output aiming to increase access of mothers and children to efficient, effective and equitable basic health services.

1.1

By 2017, poliomyelitis is eradicated, maternal and neonatal tetanus is eliminated, measles mortality is reduced by 95%, vaccination coverage rates for all routine antigens are improved and sustained above 90% and the part of children unreached or not sufficiently vaccinated decreases from 23% to 5%.

The Immunization output aims to maintain the polio free status within the Poliomyelitis eradication frame and to eliminate Measles and Maternal and Neonatal Tetanus (MNT) through the reinforcement of routine immunization with emphasis on the hardest-to-reach and vaccination campaign.

DRC **maintained the certified polio-free** status obtained in November 2015, thanks to campaigns and the Government's implementation of the roadmap developed during the African Regional Certification Commission for Poliomyelitis Eradication, which counted with the support from UNICEF and partners. As a result, two National Immunization Days (NID) and two others Sub NID (SNID) took place in 34 HZ and 137 HZ, respectively. Specifically, UNICEF supported:

(i) Micro-planning exercises with population census in all the 26 provinces that enabled the establishment of 516 integrated micro plans that included polio and measles campaigns aspects, as well as routine through technical assistance at all levels;

(ii) All campaign communication aspects, including mobilization of local authorities, traditional and religious leaders; dissemination of information to caregivers on campaigns and their knowledge regarding diseases that are preventable through vaccination. This was done through a mix of channels which disseminated holistic messages such as sensitization on Essential Family Practices (EFP); development of targeted advocacy interventions through social dialogue to mobilize local leaders of specific and hard-to-reach groups (people resistant to vaccination, migrants, displaced people). Campaign communication activities were also implemented in unsecured area where negotiation was held with armed group to facilitate the implementation of campaign in those area.

(iii) Implementation of innovative strategies: increasing the number of social mobilizers and community caregivers from 2 to 4 per AS (Aires de santé) after analyses and lessons learned from previous campaigns; Improving trust in the vaccine thanks to public vaccination of authorities and celebrities; Increasing perception of the benefits of immunization against polio with public testimonies of victims (parents of polio victims, walks of polio victims, spread of spots and sketches based on the testimonies of polio victims who talk about the importance of vaccination); ensuring follow-up through community leaders, who have been recruited as focal points to reach unvaccinated children during SIAs.

The above-mentioned efforts contributed to the notable progress recorded with regards to information rate of parents **before the campaign - from 89% - to 93% at the end of the campaign**. Resistances - including those based on religious beliefs - have been reduced so that refusal vaccination during the last NIDs (April 2016) was only 0.78% of the targeted population and the rate of no-vaccinated target population remained under 5% as required[7].

In terms of **Measles elimination**, the number of HZ that experienced a measles outbreak reduced from 77 from 2013 to 24 to 2016. In 2016, DRC organized measles follow-up campaign in 17 out of 26 provinces.

In order to ensure the quality of those campaigns, UNICEF:

(i) Provided technical assistance at all level through: (a) 3 international consultants; (b) 12 national consultants; (c) the UNICEF technical staff. This technical support included: the elaboration and validation of quality campaign guidelines; the elaboration of management

[7] Independent Monitoring data

tools; coordination of activities through regular meetings of the National Coordination Committee and the Provincial Committees; timely implementation of communication activities in accordance with the provincial campaign communication plan; advocacy to the provincial politico-administrative authorities in order to ensure their commitment and leadership in the campaigns; supervision and monitoring before and during campaigns; placement of vaccines and cold chain equipment in all health areas; establishment of daily data collection, analysis and submission at all levels to enable well-informed decision-making;

(ii) Ensured the timely availability of management tools, vaccines and other immunization supplies in all provinces.

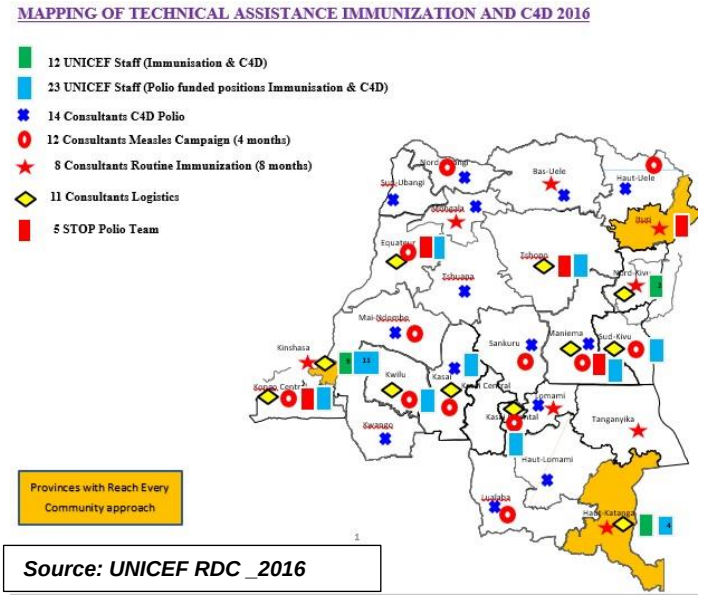
(iii) Ensured the efficiency of the communication for campaigns through the elaboration and implementation of communication plans.

As a result, in the 17 target provinces[8], 10,922,448 children under-5 were immunized. 94% of the HZ reached the initial target of having over 95% of vaccine coverage. The Independent Monitoring showed more than 92% of children received the vaccines which varies from 87% in Kinshasa to 98% in Bas Uelé.

For **Maternal-Neonatal Tetanus Elimination(MNTe)**, the number of MNT high risk HZ decreased from 75 in 2013 to 6 in 2016. In 2016, UNICEF led the organization of a workshop that included an equity analysis to assess the MNT elimination progress, which counted with hearquarters and regional technical support from UNICEF. Participants included MNTe stakeholders, as well as EPI, Health Reproduction & Disease Control departments and partners supporting those programs (WHO and UNICEF). All 516 HZ were assessed and showed that 6 HZs reported a MNT incidence rate > 1/1000 live births, remaining at high risk. A roadmap was elaborated for endgame activities before the 2018 MNTe certification assessment.

To ensure the follow up of effective roadmap implementation, UNICEF advocated for the creation of a MNT elimination sub-committee under the leadership of the Disease Control departments which includes the EPI department and Reproductive Health management programs with partners, including WHO and UNICEF.

To support and sustain such initiatives, UNICEF made specific effort to **strenghten routine Immunization.** In 2016, Reach Every Community Approach was implemented in 90 HZ in three high risk provinces (Kinshasa, Ituri and Haut Uelé). This approach aims to re-establishing regular outreach services in addition to the fixed strategy; supportive supervision: on-site training; community links with service delivery; monitoring and use of data for action; better planning and management of human and financial resources. It encourages actors to analyse data in order to identify specifics local issues



[8] Administrative data: 17 provinces: Bas Uele, Haut Uele, Ituri, Equateur, Maniema, Mongala, Nord Kivu, Sud Kivu, Nord Ubangi, Sud Ubangi, Tshopo,Tshuapa, Kinshasa, Kongo Central, Kwango, Kenge, Maidombe

and adopt corrective solutions. UNICEF led a workshop on the analysis of equity in immunization with the involvement of stakeholders at all levels to identify inequities and marginalized populations. This notion of equity analysis is now part of the micro plan guidelines and has already been introduced in HZ supported by UNICEF. To ensure quality of implementation, UNICEF provided technical assistance through the provision of 12 C4D, 12 logistics and 8 technical national consultants to closely support high risk provinces including provinces financed by others partners, such as GAVI, on the preparation, implementation and monitoring of activities.

In terms of **community development**, in collaboration with others partners such as a network of Civil Society Organization (SANRU): 25,315 community relays, Red Cross volunteers, faith-based facilitators and Community Based Organization (CBO) members benefited from capacity building with their CODESA; 15,621 *Cellules d'Animation Communautaires* (community dialogue forums) were put in place.

At the end of 2016, 79% of all HZ recorded a DTC-HepB-Hib3 vaccine coverage above 80%. The result is 81% in Health Provincial Divisions (DPS) supported by UNICEF where 14,731 children under-1 where recovered by community relays. For the last 4 years, pentavalent vaccine coverage has been maintained above 90 %. It's important to note that these results are based on administrative data. The quality of administrative data requires further improvement as there is a difference of about 10 to 15 points between administrative data and WHO/UNICEF estimates. Therefore, it has been decided that from 2017 onwards, an annual immunization coverage survey will be organized to validate the administrative data.

When it comes to **cold chain coverage**, there has been an increase from 23% in 2014 to 51% in 2016 at the health facility level due to improved Cold Chain Logistics (CCL) that included (i) procurement of 80 solar refrigerators and 65 motorcycles; (ii) training of 96 health workers on the CCL and vaccine management; (iii) procurement and installation of 2,522 solar refrigerators by UNICEF through Gavi funding. The three modern warehouses currently under construction will further reinforce the vaccine supply chain. UNICEF provided technical expertise to successfully develop and submit a proposal to Gavi for a large scale-up of solar cold chain capacity in the country. This resulted in the mobilization of about 49 million USD by GAVI, the Government, World Bank, USAID, Save the Children and UNICEF, which will allow the procurement and installment of 6,087 additional solar refrigerators. The aim is to increase to 99% of cold chain coverage by 2018. This major investment in renewable energy will bring positive contributions to the environment.

To sustain the gains, UNICEF will continue advocating for Government's commitment to traditional vaccines procurement and fulfill 2015 co-financing, which remains a bottleneck identified in the 2015.

Finally, UNICEF significantly contributed to facilitation and strategic decision-making through coordination committees and mechanisms, including the National Coordination Committee (survey of diseases), the Inter Agency Coordination Committee (IACC), CAGF Comity follow-up, GAVI Ad Hoc comity, as well during periodic reviews of EPI annual work plan (AWP) and GAVI joint appraisal.

1.2 As of end of 2017, treatment coverage of children main killer diseases (malaria, diarrhoea, IRA, severe acute malnutrition (SAM), HIV/AIDS and neonatal diseases) is at least at 60% and their incidence is reduced.

UNICEF supported the Ministry of Health scaling up HII for Maternal, New-born and Child Health (MNCH) services and practices through specific approaches that include improving local availability of essential drugs, promotion of community development, improved financial access and monitoring system at decentralized level.

Efforts have been put in place, at various levels to ensure the availability of essential drugs and other commodities for the management of diarrhea, pneumonia and fever at household and health facility level including in community care sites.

- **At national level**, the main actions focused on policy and strategy improvement, strategic partnership mobilization for more efficiency and equity. One of the key result is the development of the first strategic plan for Procurement and Supply Management (PSM) of essential drugs that will be validated during the first quarter of 2017.

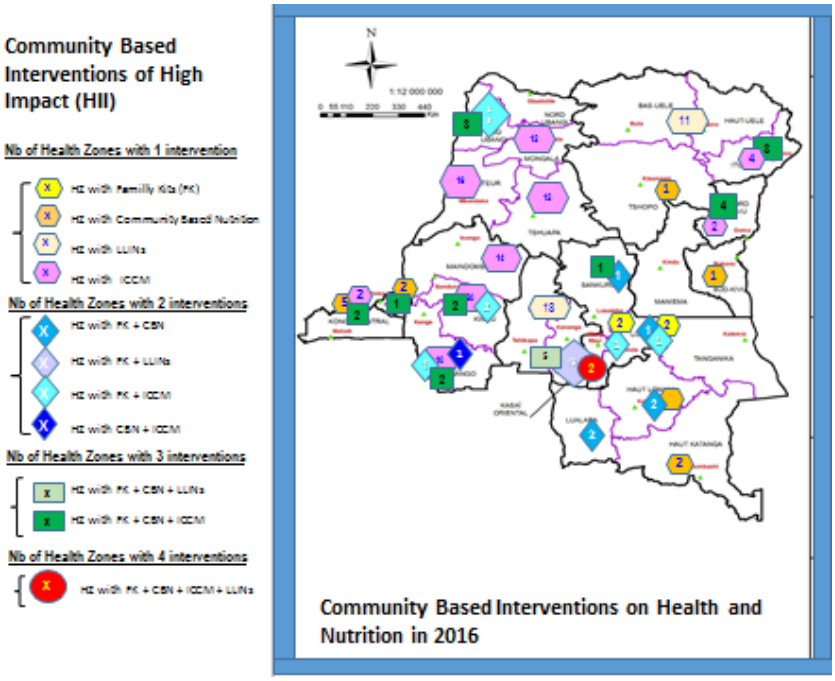
- **At provincial level**, a collaboration with Global Fund Principal Recipient (SANRU[9]) , based on the global MoU with Global Fund, was implemented for reconditioning of family kits and replenishment of essential medicines at Regional Medical Stores (*CDR*) on quartly basis to ensure availability of: (i) Family Kits[10] at household levels in 37 target HZ in six provinces for proper management of dearrhea diseases, fever and prevention of SAM and anaemia; (ii) essential drugs and commodities[11] at health facility and iCCM site to treat pneumonia and diarrhea. In 2016, 15% of children with SAM were succesfully cured.

- **At community level**, community structure was strengthened (village approach) in 60 HZ to increase access to health services in 2016. In each village, community members elected trusted Community Health Workers. As driving forces, Community Health Workers and Community Based Organisations (village committee) were fully engaged in following activities (empowerment), (i) Household census, (ii) promote essential family practices, (iii) foster demand for services in health facilities and iCCM sites, (iv) monitor the use of services at the household level through family visit, and (v) engage in the overall management of the health activities.

[9] The SANRU Rural Health Program (Projet Santé Rurale) of the Democratic Republic of the Congo works to improve the quality of and access to primary health care through the rural "health zone" system, a geographically-based network of hospitals, health centers, and community groups.

[10] ORT+Zinc, paracetamol , multimicronutrients, and delivery kits

[11] ORT+Zinc, Amoxicillin,



Towards the scale-up of HII to manage diarrhoea, fever and anaemia among U5, UNICEF distributed 1.7 million 'family kits' (ORS+Zinc, paracetamol and multi-micronutrients), in line with the Integrated Management of Childhood Illness (IMCI) approach, to increase the availability of essential drugs in households. Quality of intrapartum and postnatal care was improved with distribution of 112,000 'family delivery kits' in 37 HZ. Overall, 1 million U5 children in these 37 HZ across 12 provinces out of 26 and pregnant women have improved access to essential health services. In addition, access of 22 million people to commodities against pneumonia and diarrhoea through integrated community case management (iCCM) was improved. In 2016, pneumonia case management was extended from 48 to 129 HZ and allowed to treat 143 000 U5 compared to 10 000 cases in 2015. To generate evidence on the strategy with the perspectives of end users, Knowledge, Attitude and Practice (KAP) study on distribution and use of family kits is currently under preparation to conduct in 3 HZs in 2017.

Treatment of severe acute malnutrition cases among U5 remained a priority. To ensure effective treatement of acute malnutrition among children, UNICEF supported: (i) the procurement and distribution of Ready to Use Therapeutic Food (RUTF) and therapeutic milk (F100, F75) and drugs (ReSoMal) in 3,656 health facilities; (ii) the monitoring and supervision through UNICEF Nutrition technical staff based in 14 UNICEF offices; (iii) nutrition international NGO ensured rapid response in areas with nutrition crises and (iv) coordination activities in nutrition cluster to increase quality compliance of protocols, approaching sector partners for better performance (cured rate) as children with SAM have a 4 to 9 times increased risk of death when compared to other children.

In 2016, 358,182 U5 children were treated for SAM in 2,850 health facilities with Ready to Use Therapeutic Food (RUTF), therapeutic milk (F100, F75) and drugs.

Taking into account the limited capacities and resources for ensuring the scaled up of IMAM services in the country, the nutrition strategic and operational plan adopted in 2016 focused on the prioritization of areas with nutrition crisis and prevention strategies nationwide.

As part of the malaria control programme, in Sud-Ubangi Province, through the community-based approach, UNICEF supported 2,410 village committees (CAC) and Community health workers; successfully managed the distribution of 1.7 million LLINs and covered 104% of 600 500 targeted households including 633,000 children under-5 and 147,000 pregnant women in 16 HZ (100%) of the province without any reports on stolen/lost LLIN. The positive results were based on community-led distribution, adopted for the first time. Community-based organisations took full engagement in micro planning, household census, transporting of LLIN from health centers to each village and distribution to household. This community-led distribution will be continued during the distribution planned in Kasai Central Province in 2017.

UNICEF's advocacy and technical support on **adolescent and youth health** resulted in the development of the National Strategic Plan (2016-2020), focused on HIV and early pregnancies, key national priorities identified in national adolescent assessment. UNICEF supported the DRC Government in the development of the HIV Paediatric SITAN, as a basis for elaboration of HIV Paediatric acceleration plan for 2016-2020.

UNICEF contributed to the implementation of **National HIV new infection Elimination Plan** through a pilot project implementing Option B+[12] for PMTCT in 12 HZ in two provinces (Katanga and Nord Kivu). This experiment has generated a learning model which has been duplicated beyond the 12 UNICEF-funded HZ. As a result, and with the objective of preventing new HIV infections in newborns, the Option B+ model was scaled up to 400 HZ out of 516 HZ, through Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR) funding. As a result, (i) 100% of facilities offer testing and counselling to children aged 0-19 years, (ii) 2,194/8,740 facilities in 326 HZ offer PMTCT and ANC services and (iii) 1,480/8,740 facilities in 316 HZ offer paediatric ART".

A clinical mentorship programme co-funded by Bill and Melinda Gates Foundation was developed to improve the problem of quality of care for antenatal and delivery care, effective treatment of complications during childbirth and postnatal periods. This pilot programme will be implemented for 3 years, targeting 75 health facilities and 12 first level referral hospitals in Kwango and Kwilu provinces. This mentorship programme to urban setting has been launched together with Mutombo Dikembe Foundation. This pilot will be rigorously monitored and evaluated by Tulane University with the perspective of using the results to potentially scale up.

Ownership by the DRC Government and availability of up-to-date data to influence decision making remain major challenges. The Multiple Indicator Cluster Survey (MICS), expected to be carried out in 2017, will enable to assess the impact of HII in target zones by comparing results with the baseline data of 2013-2014 Demographic Health Survey (DHS).
To minimise harm to climate change, family kits and LLIN are packed in biogredable bags.

[12] DRC's Option B+ programme is helping to eliminate mother-to-child transmission (MTCT) of HIV during pregnancy, birth and breastfeeding. Options B and B+: a simplified approach to integrated PMTCT & ART at the primary care level. This simplified protocol contribute to progressively eliminate new HIV infections among children; the treatment is provided lifelong and ensures improved maternal health.

1.3 By 2017, multisectoral actions to ensure nutritional security for the most vulnerable groups are undertaken, with a focus on provinces least 5%.

UNICEF's contribution towards efforts to reduce the number of stunted children remained focused on improving Infant and Young Child Feeding (IYCF) practices, ensuring adequate intake of micronutrients among young children and strengthening coordination of nutrition interventions across sectors (including nutrition-sensitive sectors) and at decentralized and community levels.

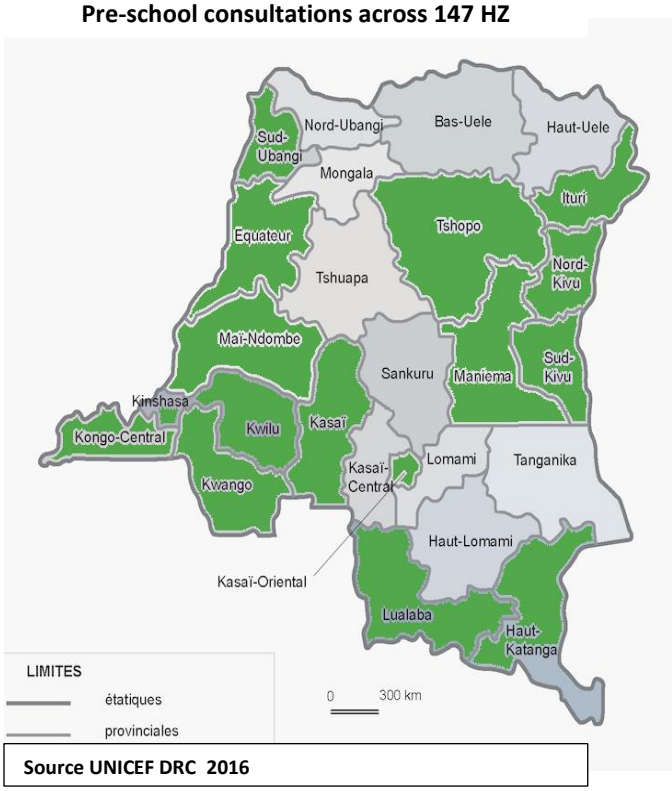
Under nutrition is the consequence of (i) inadequate care and environment, (ii) inadequate feeding practices and dietary intakes, (iii) incidences of illness and infections and other causes linked to lack of access to basic and social services, lack of education, poverty and unfavourable social norms.

- **At national level**, UNICEF significantly contributed to push for nutrition to be regarded as a national priority by both Government and Partners; as a result, the new NHDP as well as the investment case for the GFF (Global Financing facility) now addresses undernutrition as a national priority. The advocacy also enhanced multi-sectoral coordination of nutrition intervention by:

Providing technical advice and support: in view of strengthening nutrition governance at national and decentralized levels, UNICEF contributed through several measures. (i) Engagement in coordination mechanisms, such as Scaling Up Nutrition movement (SUN), UN interagency networks and nutrition donors groups (GIBNUT), and organization of two nutrition conferences in South Kivu and Central Kasai provinces, which led to the establishment of provincial multisector committees for reducing undernutrition. (ii) A national nutrition strategy and costed operational plan were developed to scale up nutrition interventions in all sectors. (iii) Modelling of multisectoral approaches to addressing nutrition were explored, such as embedding of WASH interventions in nutrition outpatient facilities in areas affected by nutrition crisis. As an example, a joint UN programme on food security, nutrition and WASH interventions is implemented in Bunyakiri health zone in South Kivu province.

Raising the nutrition situation in DRC and reinforcing advocacy: advocacy and technical support helped ensuring that stunting is recognized as a priority in the national health development plan and nutrition is integrated in the allocation of Global Financing Facility. To address challenges related to human capacity, health professionals were trained in managerial skills across 13 provinces. The major result of the advocacy conducted by UNICEF was the creation of a national multisectoral committee for nutrition, through a decree adopted by the Prime Ministry.

Pre-school consultations across 147 HZ



Source UNICEF DRC 2016

UNICEF supported nutrition specific interventions targeting young children and women, through the 1,000 days opportunity window to revert the chronic cycle of stunting. **Regarding improvement and promotion of Infant and Young Children Feeding (IYCF) practices**, three delivery platforms were utilized: (i) community-based management of acute malnutrition involving 3,563 health centers that contributed to reaching 1,539,696 mothers and caregivers; (ii) pre-school consultations in 2,418 health centers across 147 HZ, which reached an additional 164,720 mothers and caregivers, and (iii) community-based nutrition approach, which was rolled-out in 95 health areas in ten HZ in four provinces: Kongo central, Kinshasa, Haut Katanga and South Kivu, reaching 52,407 children aged 6-23 months and 44,083 pregnant and lactating women.

Increasing micronutrients intake: to improve Vitamin A supplementation: 7,181,770 children aged 6-59 months (93.4% in targeted areas) received vitamin A supplementation and 6,350,748 children aged 12-59 months (92.5% in targeted areas) were dewormed in 19 provinces.

Preventing malnutrition is a very cost efficient intervention in terms of health expenses that could be avoided during the time a child is growing up, as it provides the child with an adequate diet that leads to a strong immune system. Nevertheless, despite several efforts to integrate a multisectoral approach to chronic malnutrition, coverage of most interventions remains limited: for the management of acute malnutrition programme, only 15% of the annual caseload is treated, this coresponding to 39% of geographical coverage. Government's engagement needs to be boosted with additional domestic and external resources to reduce the burden of stunting (6 million children are affected by stunting[13]). Besides specific-nutrition interventions, integration of sensitive initiatives related to nutrition (social protection, education, agriculture, WASH) will also be a priority to increase acceleration of efforts towards the Sustainable Development Goal (SDG) 2: ***End hunger, achieve food security and improved nutrition and promote sustainable agriculture*** (SDG #2 - Zero hunger).

[13] Demographic Health Survey II 2013-2014

1.4 By 2017, all 207 NHDP's focus health zones are planning, implementing and monitoring the minimum and complementary packages of activities as stated in the NHDP and the 308 other health zones are planning, implementing and monitoring the minimum package of high impact interventions at clinical and community levels.

In 2016, **UNICEF supported health system strengthening in all 516 health zones in the DRC**.

At national level, UNICEF focused on (i) strengthening strategic partnerships and review of national strategies and (ii) capacity strengthening of various departments of the Ministry of Health in the areas of financial management, procurement and strategic planning.

Regarding partnerships, the main objective was to reduce thinspread support and harmonize and consolidate interventions and approaches. In 2016, UNICEF's technical support focused on the enhancement of the Government's capacity to coordinate and strengthen partnerships, including resource mobilization next to organizations such as the Global Financing Facility (GFF). UNICEF proactively worked on effective partnerships in the five sub-committees of the health sector donor group (*GIBS*), involving procurement and supply management of essential drugs and commodities (led by UNICEF), service delivery, governance, human resources and financing. UNICEF advocated for the establishment of a single multi-donor contracts system, called '*contrat unique'* for less fragmented partner support and better alignment of aid to the provincial funding needs.

As for Health System Strengthening, UNICEF aims to support the Government developing a health policy and strategy documents to foster minimum and comprehensive package of interventions at a decentralized level.

Sectoral and intervention coverage analyses using equity-focused tools such as EQUIST (Equitable Strategies to Save Lives), supported by UNICEF, contributed to prioritise the most effective interventions and select the appropriate approaches to increase coverage. In the development of national strategic policies, UNICEF succeed in lobbying a focus on MNCAH. Key national strategic documents were developed, including the National Health Development Plan (NHDP) 2016-2020, the strategy and guidelines for community participation, the revised Strategic Plan on Essential Drug Procurement, National Plan on Reproductive Health, the National Strategic Plan against HIV, the National Malaria Control Plan and the National Plan for Adolescent Health.

At provincial level, the priority was to support the establishment of 26 new provincial health divisions (DPS), and maintain six technical assistants in six provinces to support decentralized delivery and monitoring of essential health services. This resulted in an increased coverage of provincial health divisions with improved monitoring of key performance indicators (KPI) in the provincial health plans from 12 (2015) to 26 (2016).

At health zonal level, **UNICEF provided technical and logistic support to the Government** by procuring healthcare equipment and supplies (1,000 health facilities and 200 referral hospitals), purchased under the national project, totally funded by domestic resources. In 2016, UNICEF continued to support the implementation of the Government's equipment project for health facilities (*PESS*). Since the launch of the project in 2013, 945 out of 1,200 target health facilities have received supplies.

UNICEF also leveraged partnerships to improve the coverage of high-impact interventions at sub-national level. In particular, through an agreement with SANRU (the Global Fund Principal Recipient in DRC), UNICEF contributed towards ensuring the availability of essential drugs and commodities for iCCM in 129 HZ out of 516. In addition, UNICEF continued to strengthen collaboration with the 10 Regional Drug Distribution Centres to ensure storage, reconditioning and distribution of drugs and commodities.

To ensure a regular monitoring of the effective coverage of high impact interventions at decentralized level, UNICEF supported the improvement of the national monitoring system (monitorage ameliore pour action - MAA), inspired from the Tanahashi model that helps the analysis of the interventions coverage using health determinants. These participative exercices have helped the identification and analysis of critical systemic bottlenecks (supply, demand and quality) of MNCAH interventions. Since September 2015, UNICEF supported the approach organised at provincial level. In 2015, 12 out of 26 provinces provinces conducted the monitoring session. In 2016, the remaining 14 provinces have implemented the improved monitoring system (*MAA*) (100 % of all 516 HZ).

2.7 million people improved financial access to health services through the introduction of a flat rate fee system with subsidies in 6 HZ. It led to establish community solidarity funds aimed to remove financial obstacles to referral care. The Directorate of Planning in the Ministry of Public Health is currently analysing the approach for development of national guidelines with regards to cost recovery at health facility level and flat rate approaches.

Despite noticeable efforts by the DRC Governement, challenges remain significant in the health sector, particularly the management of human resources for health; irregular payment of salaries; the slow operationalisation of the DPS in the 15 new provinces; the low capacity of the national essential drugs programme to make safe and affordable essential drugs to the most deprived communities and households; the capacity of the health information system to provide timely and quality data on effective coverage of high impact MNCAH interventions; and the financing barrier to access to health services by the poor and the most deprived households. Furthermore, the enveloppe allocated to the health sector in the national budget remains far too modest in light of the declared objective to achieve universal health coverage by 2030.


1.5 All crises (epidemics, natural disasters, population displacements, nutritional) receive an adequate and timely response and a minimum and complementary package of health activities is available in health zones with displacements of population.

Emergency activities are designed to provide an appropriate response to epidemics (cholera, measles, and yellow fever in 2017) as well as medical assistance to people displaced by conflict and natural disasters, and to ensure the management of severe acute malnutrition in emergency situations.

In 2016, UNICEF worked at strategic level with the Division of Disease Control (DLM) and the National Laboratory to strengthen the epidemiological surveillance system by providing technical, financial, material and equipment support to organize meetings and the dissemination of information to all stakeholders.

The availability of contingency plans and pre-positioning of essential supplies helped delivering adequate responses to 26,147 cholera cases in 149 HZ in 14 provinces; in collaboration with WASH interventions, CSD provided medicine for the management of 45,520 cases, and mobilized resources through a joint **cholera** epidemic response plan, in particular for provinces along the Congo River. Responding to the declaration of **measles** outbreaks in 25 HZ, UNICEF supported **case management** by distributing medical kits for 10,000 children. 351,029 children were vaccinated against measles in 25 affected HZ. More than 15,147 suspected cases were reported with 212 deaths (fatality rate: 1.4%).The first case of **yellow fever** imported to DRC from Angola was reported in February 2016, and the epidemic quickly spread to 45 HZ across 9 provinces, including Kinshasa. UNICEF procured 5.8 million doses of vaccine and provided technical and financial support for epidemiological surveillance, logistics and communication. 78 cases among which 13 autochthones have been confirmed with 16 deaths (fatality rate: 20.5%). Immunization response to the yellow fever outbreak involved 62 HZ, reaching more than 14.2 million people.

In response to the influx of internal displaced populations and refugees, through health programme and Rapid Response to Population Movements (RRMP) mechanism, 172,973 people displaced by conflict received medical assistance in 4 provinces out of a total of 817,000 affected population (North Kivu, South Kivu, Tanganyika and Haut Katanga).

In the context of managing Severe Acute Malnutrition in emergency situations, UNICEF continued to provide life-saving assistance to children diagnosed with SAM, allowing treatment of 51,323 children in 713 health centers. Quality of SAM treatment was aligned with international standards, which helped to achieve an estimated cure rate of 84.1%, a death rate of 1.9%, a default rate of 11.9% and a non-response rate of 2.2%.

Nutritional surveillance and early warning system (*SNSAP*) supported by UNICEF was functional in 516 HZ. The effectiveness of this system was demonstrated through the identification of 36 HZ facing a

nutritional crisis and 64 nutrition alerts. Up to 60% of the alerts received a rapid response mechanism though NGOs.
The WaSH in Nutrition strategy was successfully implemented in 6 targeted HZ through the Nutrition Crisis Rapid Response Mechanism. Synergies between WaSH and nutrition activities in emergency contexts (called the *Wash in Nutrition* strategy) were significantly strengthened.

As the lead agency of the Nutrition Cluster, UNICEF worked with 37 actors (Government, UN Agencies, 24 international NGOs, 6 local NGOs, and others partners) and convened a number of partners such as ECHO, EU, UKAID, FFP/USAID, KOIKA, Japan and NGOs.
Despite efforts, it is estimated that only 15% of children with SAM had access to treatment in 2016. Main challenges to scale-up the response include lack of skilled capacity on the ground and insufficient funding.

VII. ADDED VALUE

- ✓ ***Added value of the thematic contribution and its flexibility on the achievement of the planned results:***

Thanks to the thematic funding from the Government of Sweden, innovative approaches were piloted and scaled. These include i) the strategy of gradual universal coverage of care for the children, treatment for killer diseases (malaria, diarrhoea, pneumonia, malnutrition) through the "Family kits" approach, ii) the introduction of improved monitoring system (*MAA*) at decentralized level, which enable managers and health care providers to assess the situation, conduct analysis and develop evidence-based plans. The flexibility of the thematic funding received from Sweden played a significant role in accompanying the Ministry of Health in a sustainable capacity development, such as prompt response addressed to populations in critical situation.

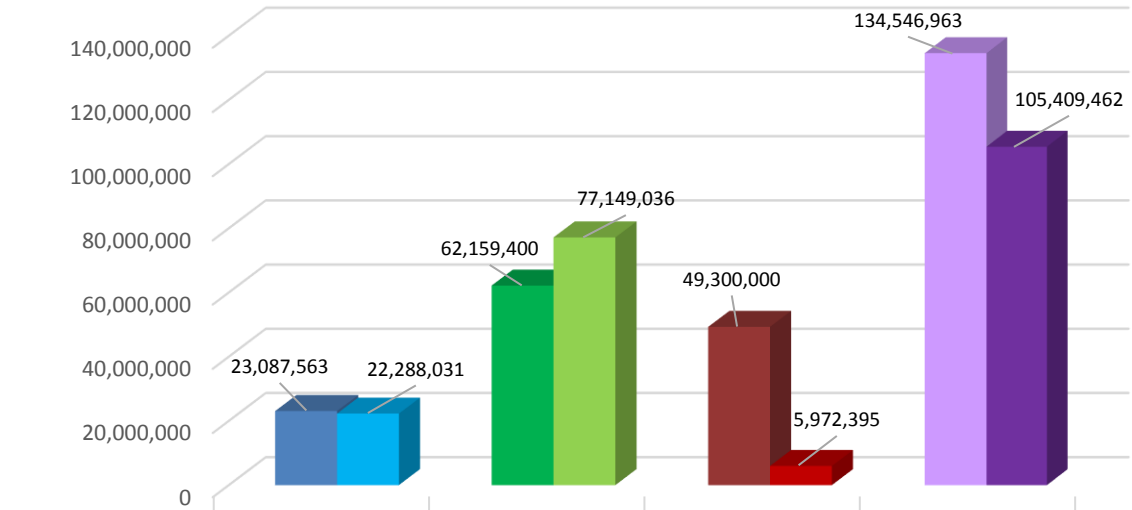
The piloting of the Option B+ protocol for Prevention of Mother-To-Child Transmission of HIV (PMTCT), implemented with the support of the Government of Sweden through the OHTA project (Optimizing HIV Treatment and Access), provided great opportunity to the Government of DRC to scale up a replicable model for the elimination of HIV new infections.

Nutrition intervention coverage remains insufficient, especially when it comes to the prevention of stunting. The thematic funds contributed to provision of a multisectoral response to nutrition and to increase the package of interventions and coverage. Interventions at community level are the ones that could potentially change stagnant stunting trends in DRC and increase community participation.

VIII. FINANCIAL ANALYSIS

In 2016, UNICEF resources for Health programme in DRC were comprised of Regular Resources (21%) and Other Resources (79%) received from donors. The programmable amount of the thematic funding received from Sweden at the end of 2014 and implemented in 2016 (7,369,778 USD) represented 11% of the available Other Resources (for regular programme – ORR, and for emergency ORE) in 2016 and 8% of the planned health expenditure for 2016.

<u>Graph 1</u>: Analysis of resources for Child Survival (Health, Nutrition, HIV/AIDS), as of December 2016 *in US Dollar*



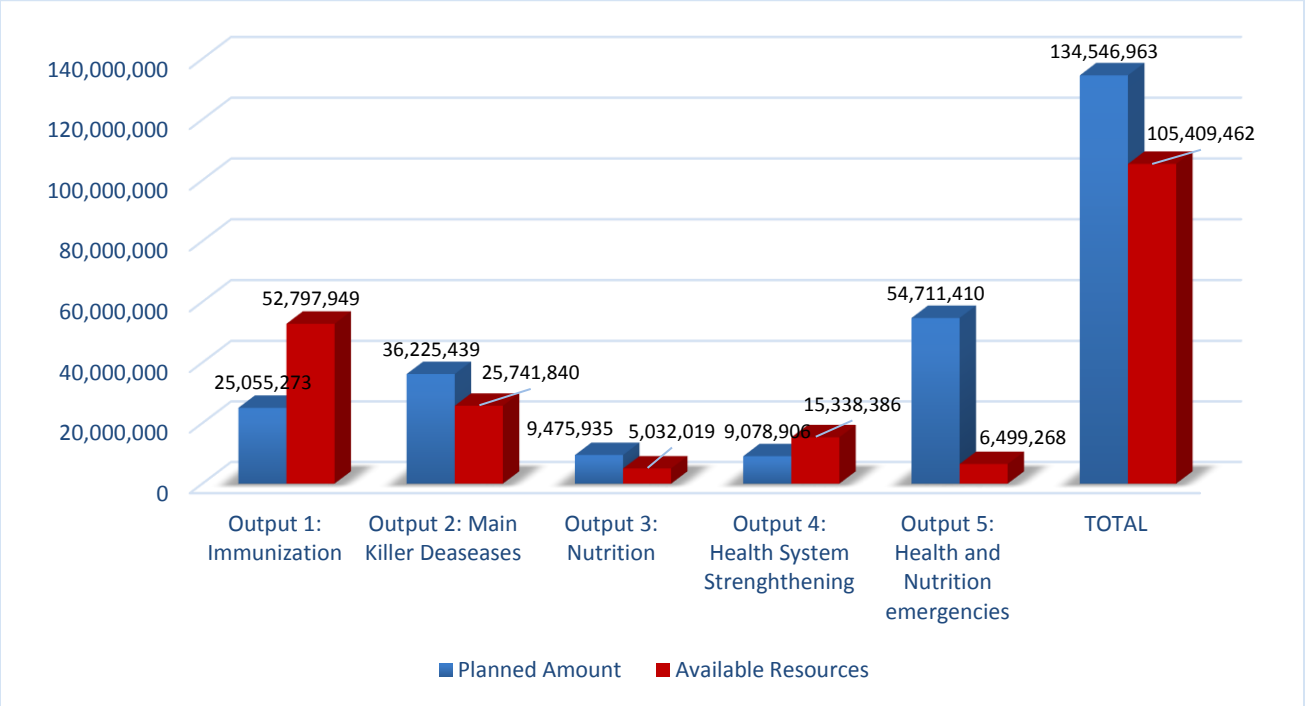
	Regular Resources	OR – Regular	OR – Emergency	Total (RR and OR)
Planned Amount	23,087,563	62,159,400	49,300,000	134,546,963
Available Resources	22,288,031	77,149,036	5,972,395	105,409,462

In 2016, the programme was able to **mobilize 77%** of its planned budget.

***<u>Carry over of Other Regular Resources</u>*:** approximately 24 % of the resources allocated for CSD were carried over to 2017 to continue projects or begin new ones in 2017. These include: the budget to support the Long-Lasting Insecticide Treated Nets mass distribution campaign in Kasai Central (USAID); Clinical Mentoring Project funded by The Bill and Melinda Gate Foundation; and Strengthening of Cold Chain (Gavi). These carry-over funds explains the high level of available Other Resources Regular at the end of 2016.

<u>Underfunding of Other Regular Emergency resources</u>: UNICEF continues to strengthen the humanitarian response and funding gaps for UNICEF humanitarian response in DRC remain a challenge. In 2016, UNICEF requested US$130,360,000 to help children and families in need of humanitarian assistance in the Democratic Republic of the Congo in 2017 and only 48% of need was covered.

Graph 2: Planned vs Available resources for Child Survival (Health, Nutrition, HIV/AIDS), as of December 2016 by output *in US Dollar*

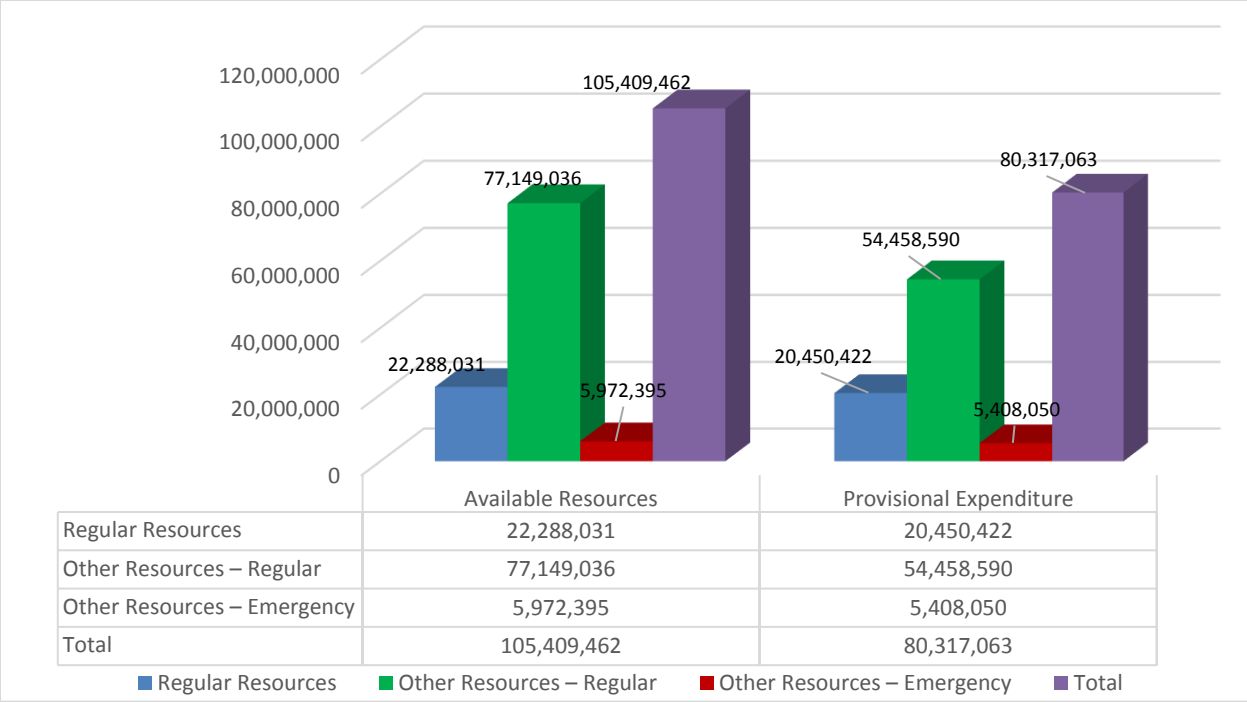


Nutrition: principal challenges faced in efforts to address stunting involved inadequate nutrition care and practices and insufficient funds to ensure appropriate coverage of preventive interventions countrywide and response to SAM cases amongst children.

In order to render nutrition-related interventions more effective, UNICEF and partners are taking measures to improve planning and to raise the profile of such interventions through a resource mobilization strategy focused on improving infant feeding.

Emergencies: emphasis will continue to be placed on resource mobilisation to address the major challenges and needs. Without continued strong support to DRC's protracted and often forgotten humanitarian emergency, UNICEF and partners will be unable to continue to support vulnerable populations. UNICEF aims to adapt its strategies according to the evolving humanitarian environment in 2017.

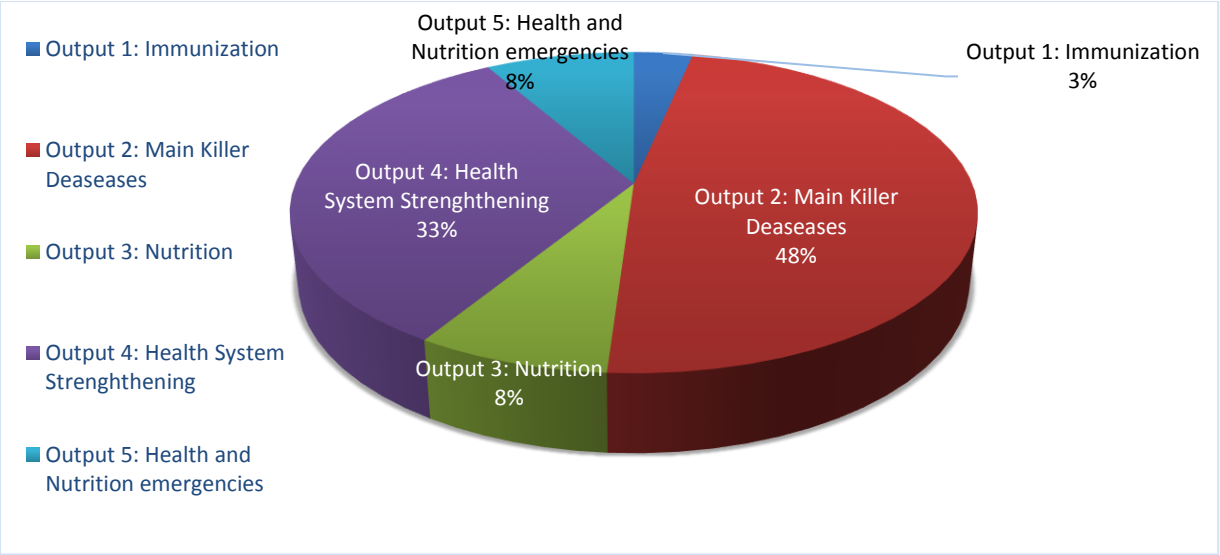
Graph 3: Summary of 2016 Financial Implementation for Child Survival (Health, Nutrition, HIV/AIDS) *in US Dollar*



	Available Resources	Provisional Expenditure
Regular Resources	22,288,031	20,450,422
Other Resources – Regular	77,149,036	54,458,590
Other Resources – Emergency	5,972,395	5,408,050
Total	105,409,462	80,317,063

In 2016, UNICEF resources for Health Programme utilized 76 % of available resources. Approximately 24 % of the resources have be carried over to 2017 for projects planned to start or continue in 2017. The utilized amount of the thematic funding represented 9% of the utilization rate.

Graph 4: Summary of Thematic expenses by programme area for Child Survival (Health, Nutrition, and HIV/AIDS) *in US Dollar*



In 2016, key priorities included the support to the reform of the health sector at provincial level, which was seen as an opportunity to scale-up high-impact interventions for the MDGs 4, 5 and 6 Acceleration Framework and linked with the Sustainable Development Goals as defined in Transforming Our World - the 2030. The focus was also on the scaling up of HII for Maternal, New-born and Child Health (MNCH) through specific approaches that include improving local availability of essential drugs, promotion of community development, improved financial access and monitoring system at decentralized level.

IX. FUTURE WORK PLAN

In 2017 several recurring challenges will be addressed, including (i) persisting fragmentation of donors' support despite efforts to harmonize and align external assistance to national priorities; (ii) low functionality of the health sector reform, both at national and intermediate levels; (iii) delay in disbursement by national counterparts for purchase of traditional vaccines; (iv) insufficient funds raised for the nutrition sector; (v) weakness of the national procurement and supply management system; and (vi) insufficient national budget allocation to the health sector.

The political transition period in DRC, leading up to general elections, constitutes a major risk that may compromise programme implementation in 2017 and beyond.

A key priority is to continue to support the reform of the health sector at provincial level as an opportunity to scale-up high-impact interventions for the MDGs 4, 5 and 6 Acceleration Framework and linked with the **Sustainable Development Goals** as defined in Transforming Our World - the 2030 Agenda, in close collaboration with The World Bank, The Global Fund for Aids, TB and Malaria, The EU, USAID, Canada and the strong support of Government of Sweden.
Priorities for 2017 will also seek to address the challenges identified above and to continue to build on partnerships with Government, multilateral and bilateral agencies, NGOs, academia and civil society organizations to scale-up the effective coverage of MNCH interventions.

With regards to immunization, the focus will be on: (i) scaling up the "Reach Every Health Zones" approach with is an opportunity to expand service offer to other hig impact intervention such as Vitamin A supplementation and deworming; (ii) improve the quality of SIAs; (iii) expand innovative activities such as CHD and AIW; (iv) strengthen cold chain and logistics. Existing strong partnerships with WHO, USAID, GAVI, World Bank, BMGF, Rotary, KOICA, Sabin Vaccine Institute and EU will continue.

Stopping the transmission of wild poliovirus remains among the key priorities of UNICEF and its partners in 2016. This requires high-level commitment from the Government at both national and provincial levels, significant funding to support countrywide immunization campaigns, and engagement by the Ministry of Health to ensure high-quality implementation of the planned campaigns.

To address the issue of major killer diseases of under five in DRC, the UNICEF programme will focus in 2017 on two major challenges: provision of integrated package and geographical coverage of high Impact interventions at operationnal level (health zone).
The focus will also be on the scaling up of maternal, newborn and child health interventions and the strengthening of the capacities of provincial medical stores in order to manage 5.3 million of iCCM kits and 414,000 clean delivery kits by quarterly distribution in 43 Health Zones. iCCM intervention133 zone reached.

The LLINs distribution campaign in Kasai Central will be implemented in second semester 2017, with the objective to reach the total population of the province or 5 million people.

Unmet needs to prevent stunting remain very significant. In 2017, stakeholders will continue to combine their efforts through coordination and advocacy for resource mobilization. UNICEF support will focus on improving coverage of preventive interventions, primarily through community approaches. Technical assistance aimed at policy development, programme implementation and evidence generation will be emphasized.

In 2017, **UNICEF will continue strengthening the Health System** and focus on (i) the development of sharpened decentralized annual operational plans, (ii) integration of specialized health programmes at the provincial level, (iii) organization and functionality of new provincial health divisions and; (iv) improving quality of care and services at health facilities.

Last but not least, UNICEF will seek to improve the quality of its response to humanitarian emergencies, through strict adherence to international quality standards. As only 15% of children with SAM were treated in 2016, emphasis will be placed on resource mobilisation, particularly in areas where the needs of affected people continue to exceed capacity of humanitarian actors.
Another priority is to support preparedness for health emergency response in HZ, build up a stock of emergency health supplies, timely response to disease outbreaks, and effective coordination of contingency stocks between national and provincial levels.

In the coming years, UNICEF's strategy will be to focus on building the bridge between humanitarian assistance and development (resilience approach) from the onset of emergency reponse[14].

[14] The Programme of Expanded Assistance for Returnees (PEAR +) financed by the Government of Sweden is an example where building community resilience bridges humanitarian and development goals.

X. EXPRESSION OF THANKS

Annika Ben David, Swedish Ambassador and Pascal Villeneuve UNICEF Representative

UNICEF 2016 /Mamadou Cisse

UNICEF would like to express its sincere gratitude to the Government of Sweden for the significant support of the Swedish Cooperation through its thematic contribution of about One Hundred Ninety Million Swedish Kronor (SEK 190 000 000), which enabled to support the implementation of outcome area 1: Health in UNICEF Strategic Plan 2014-17 in the Democratic Republic of Congo.

UNICEF is grateful for the flexibility of such funds, as it allowed the organization to support strategic sectors suffering from chronic or conjectural lack of resources and accompany the Ministry of Health in a sustainable capacity development and increased ownership.

XI. CONTACTS

In case of questions or comments please don't hesitate to contact:

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XII. ANNEXES

✓ *Human Interest Stories:*

Click on the icons in the report front page to see how UNICEF and its partners contribute to Millennium Development Goals 4 & 5 in DRC. For more stories and updates, follow us on www.ponabana.com !

Subscribe to the Po Na Bana Newsletter: every week, receive the best of Po Na Bana by signing up to our newsletter to discover interesting **articles, photos, cartoons, international campaigns** and the latest information about the humanitarian situation so you can follow the situation of children in the DRC right on the ground.
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✓ *Donor Feedback form:*

In order to improve our future reporting to you we would appreciate your feedback. Please visit the link: https://www.surveymonkey.com/r/9F8V98G and tell us your opinion about this report and how we could improve it.

✓ *Mapping of Community based interventions:*

Figure 1: Community Based Interventions of High Impact (HII)

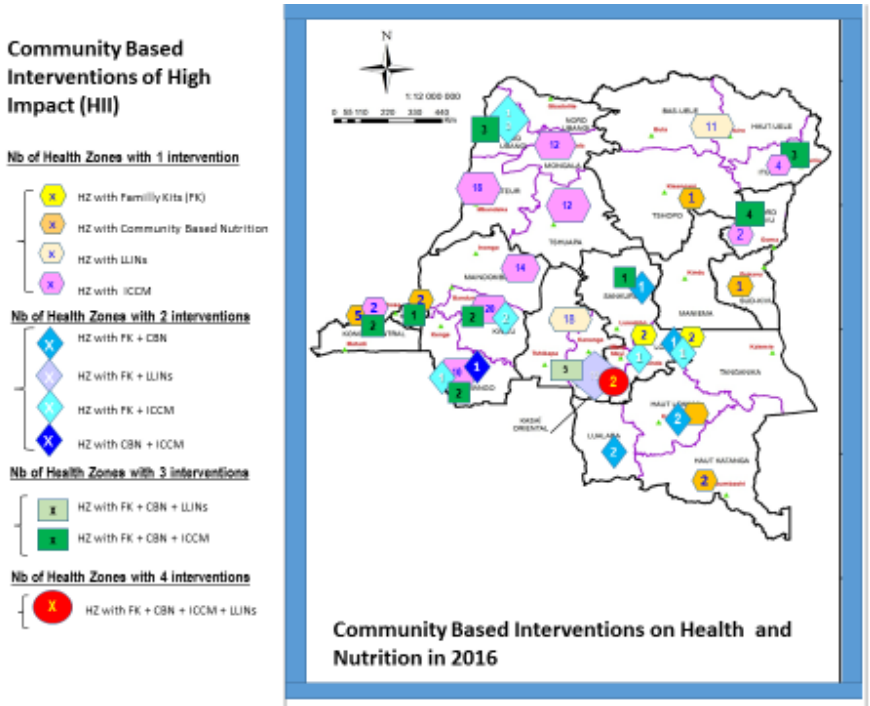

Figure 2: Community Based Interventions on Health and Nutrition in 2016

Community Based Interventions on Health and Nutrition in 2016

82 Health Zones with at least one interventions

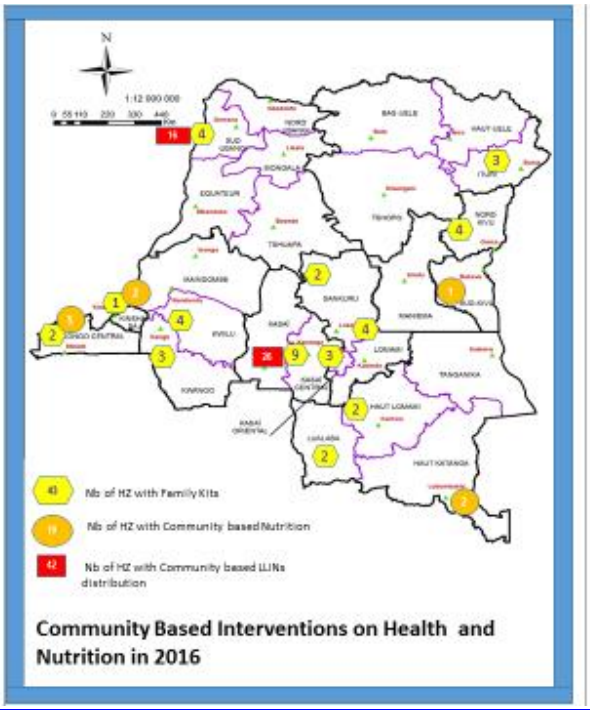

Figure 3: Community Based Interventions in 2016: ICCM Strategy + Family Kits

Community Based Interventions in 2016

ICCM Strategy + Family Kits

133 HZs including 31 HZs in commun

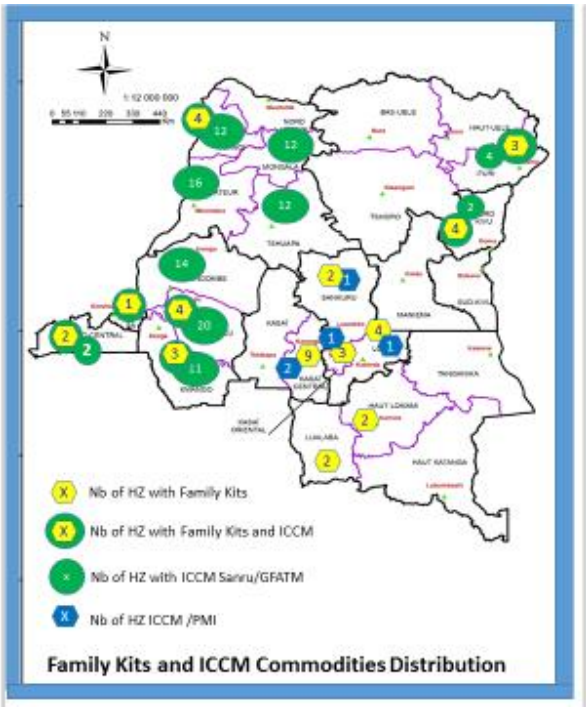

Figure 4: Community Based Interventions with Family Kits in 2016

Community Based Interventions with Family Kits in 2016

43 HZ in 13 DPS