Akuzwe, 1, sits on his mother Chucrani's lap while having his arm circumference measured by a community outreach worker, in their home in Goma, North Kivu province, DR Congo, on 19 May 2025

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Humanitarian Situation Report No. 2

Reporting Period
1 January to 31 December 2025

Democratic Republic of Congo

HIGHLIGHTS

- M23 expansion in North and South Kivu and intensified clashes in Ituri resulted in severe deterioration of the humanitarian context with massive population displacements, reshaping the humanitarian context of bordering provinces Tanganyika and Ituri
- By end 2025, around 10 million people[1] were on the move (IDP's and returnees) in four provinces of Eastern DRC, with constant new displacements
- Crisis evolved with the collapse of key health system functions, with rapid increases of epidemics outbreaks spreading throughout the country, notably cholera, mpox and measles
- 2025 has been the worst cholera outbreak nationwide in 25 years, with 71,147 suspected cases and 2,071 deaths, resulting in an overall Case Fatality Rate of 2.9 per cent.
- Children at greatest risk: Particularly from grave violations, affected education, mpox, cholera and measles, exacerbated by malnutrition and displacement.
- Humanitarian access dramatically affected with new constraints to humanitarian aid delivery

SITUATION IN NUMBERS

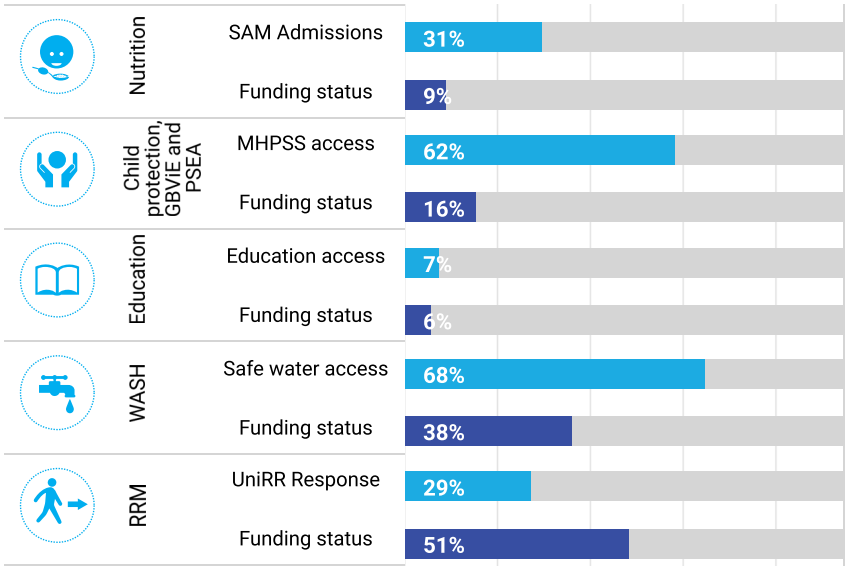
11,700,000
Children in need of humanitarian assistance

2,700,000
IDPs since january[2]

71,147
suspected cholera cases since january[3]

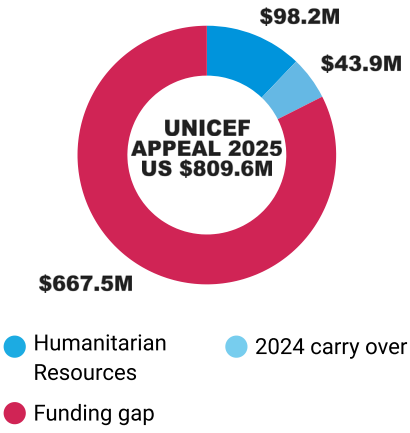
21,200,000
People in need of humanitarian assistance

UNICEF RESPONSE AND FUNDING STATUS*



* UNICEF response % is only for the indicator, the funding status is for the entire sector.

FUNDING STATUS (IN US$)**



** Funding available includes: funds received in the current year; carry-over from the previous year; and repurposed funds with agreement from donors

FUNDING OVERVIEW AND PARTNERSHIPS

Following the reprioritized Humanitarian Action for Children (HAC), UNICEF DRC sought US$809 million for the 2025 HAC appeal. These funds were crucial for delivering a comprehensive humanitarian response that provides integrated, life-saving assistance while simultaneously enhancing community resilience and fostering social cohesion to pave the way for recovery. Key considerations such as protection from sexual exploitation and abuse, gender-sensitive programming, and the prevention and response to gender-based violence were integrated into all interventions.

In 2025, UNICEF secured US$ 98.2 million[4] against its emergency funding requirements, in addition to US$ 43.8 million in carry-over funds from 2024. Despite these efforts, the funding gap was at 82 per cent (compared to 72 per cent in 2024), significantly constraining the scale and reach of the humanitarian response. UNICEF extends its sincere gratitude to all public and private donors for their generous contributions in 2025.

SITUATION OVERVIEW AND HUMANITARIAN NEEDS

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In 2025, eastern DRC experienced a dramatic humanitarian deterioration—driven by intensified conflict, massive displacements, grave child rights violations, the collapse of essential services, and widespread epidemics.

By year's end, nearly 10 million people[5] were on move in the country (5.3 million IDPs and 4.1 million returnees) .The M23 crisis reshaped the security and humanitarian landscape in the Kivus and the bordering provinces of Ituri and Tanganyika. The capture of key territories, including Goma and Bukavu between January and February, forced hundreds of thousands to return to devastated areas with limited access to basic services, while also triggering new displacements. Despite agreements negotiated in Doha and Washington, clashes persisted throughout 2025.

The rapid M23 advance in early December 2025, including the fall of Uvira, generated 500,000 new displacements in less than a week in South Kivu and Tanganyika[6] , while UNHCR reported 35,000 asylum seekers arriving in Burundi.

Humanitarian access severely deteriorated. The closure of Goma and Bukavu airports and no-fly zone over M23-controlled areas halted flights including humanitarian flights, disrupted supply chains, and forced costly rerouting through neighboring countries. Volatile security marked by shifting frontlines and guerrilla tactics, compounded these constraints. M23 established parallel administrations that imposed restrictive procedures, , limited needs assessments, and demonstrated hostility towards humanitarian actors . While negotiated crossings allowed some access in North Kivu, access to the Ruzizi Plain and Uvira from Bukavu remained impossible all year.

In Ituri and North Kivu, ADF activity intensified, exploiting FARDC's focus on M23 to expand in Irumu, Mambasa (Ituri province), Beni, and Lubero (North Kivu province), especially near mining areas. ADF shifted to small, mobile cells and avoided direct combat, carrying out deadly attacks: almost 50 civilians killed in a church in Komanda (July 2025) and 60 during a funeral in Ntoyo (Sept). In total, 113 attacks and over 950 civilians' deaths were recorded (OCHA, Dec 2025) in the two provinces. Thanks to strong local partnerships, UNICEF maintained activities in ADF-affected zones.

The Ituri crisis deepened as multiple armed groups, including CODECO, Zaire, FPIC, ADF, and newly emerging factions such as the Convention for the Popular Revolution (CRP), competed for territory, exacerbating inter-community tensions between Lendu and Hema. FARDC, in coordination with UPDF, attempted to counter ADF but efforts remain insufficient andUPDF interventions in Djugu during the year fueled tensions.

Beginning of December 2025 violent clashes between FARDC and a CRP/Zaire coalition led to the capture of the commercial town of Bule, in Djugu territory, Ituri. This new crisis led to 100,000 new displacements in a province that already accounted for more than one million IDPs[7] .

During this period, funding remained drastically insufficient. UNICEF announced an urgent appeal for its six months' Level three (L3) Corporate Emergency Activation Procedure (CEAP) for US$57 million, but only $35.6 million was secured, limiting effective response.

Despite severe access, security and funding constraints, UNICEF and its partners maintained lifesaving operations all year long. These included deploying 45 CATI teams to contain cholera, supporting emergency primary health care for 5,759 people at Shasha Health Centre through UniRR program after the fall of Goma by the M23, responding to over 3,300 suspected mpox cases through mobile vaccination teams in Goma, and supporting risk communication and community engagement, chlorination at displacement sites, WASH supply distribution, and emergency medical and psychosocial support.

In 2025, the child protection situation in the Democratic Republic of Congo deteriorated sharply, driven by intensified armed conflict in North Kivu, South Kivu, Ituri and Tanganyika. Children face heightened risks to family separation, recruitment and use by armed groups, sexual violence and abductions. The breakdown of protective environments and repeated displacement caused severe psychosocial distress to children and caregivers.

Grave violations against children, including killing and maiming, sexual violence and recruitment and use, continued to rise, with higher levels of UN-verified cases compared to 2024. Sexual violence against children escalated significantly (UNICEF report insight) while recruitment and use remained underreported in active conflict areas.

Children's access to essential services was further disrupted by attacks and occupation of schools and hospitals and by denial of humanitarian access, increasing protection risks and limiting life-saving assistance.

In 2025, education faced a challenging situation with 3.9 million children (46 per cent girls) in need of emergency education. A total of 6,294 schools and learning sites were damaged or turned into shelters, leaving 2,370,289 children[8] (46 per cent girls) out of school and affecting 57,159 teachers (33 per cent women), mainly in the provinces of South Kivu, North Kivu, Kasai and Ituri. The incidents were mainly due to armed conflicts (73.2 per cent), epidemics (25.5 per cent), and natural disasters (1.3 per cent). Additionally, 4.5 per cent of schools served as shelters for displaced persons, and 3.4 per cent were occupied by armed groups.

More than 3,225 schools were closed, with 1,379,818 children out of school (46 percent girls) and 21,895 teachers affected (34 per cent women) in the eastern, Tshopo and Greater Kasai provinces. These school disruptions expose children to violence such as forced recruitment and gender-based violence, highlighting the urgent need to integrate protection mechanisms into educational interventions.

Cholera has resurged as the worst epidemic in 25 years with over 71,147 cases[9] and 2,071 deaths (CFR 2.9%). Mpox remained widespread, with over 92,000 suspected cases and a 1.9 per cent fatality rate- children under 15 accounted for approximately 70 per cent of cases and approximately 85 per cent of deaths in the DRC. Measles caused over 87,059 cases nationwide, with 1,231 deaths (a 1.4 per cent fatality rate), driven by prolonged disruption of routine immunization.

Escalating armed conflict across eastern DRC has critically weakened the health system, triggering simultaneous outbreaks of mpox, cholera, measles and anthrax, compounded by mass displacement, flooding and prolonged disruption of routine health services. In North Kivu, more than 70 per cent of health facilities are non-functional, with 33 facilities damaged, while 48 facilities were affected in South Kivu during renewed fighting in late 2025[10] . Insecurity in Ituri further restricted access to essential care. The destruction of infrastructure, the health workers forced to flee and supply chain disruptions have left millions of people—especially children, pregnant and lactating women and displaced populations—without
reliable access to life-saving health services.

Additional health threats include a localized anthrax outbreak in Virunga National Park and an Ebola outbreak in Kasai, 64 cases reported and 45 deaths (a 70 per cent fatality rate), 14 children affected and 12 deaths. These overlapping crises underline acute humanitarian health needs for sustained access to essential services, epidemic control, vaccination and strengthened system resilience to prevent further avoidable child morbidity and mortality[11] [12] .

Meanwhile, global reductions in humanitarian funding have stalled aid delivery. In the DRC, only a fraction of urgent relief needs was covered, forcing agencies to scale back operations even as displacement and insecurity spikes. According to an analysis from OCHA DRC, 2025 has been the lowest level of funding since 2016 with only 23.9 per cent of the HRNP funded, leaving critical sectors such as WASH, Health, Nutrition, Education and Protection without adequate resources[13] .

Without drastically increases in funding and immediate protection and access corridors, the preventable morbidity and mortality will continue to rise across eastern DRC.

SUMMARY ANALYSIS OF PROGRAMME RESPONSE

Health (including public health emergencies)

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1. Public health emergencies

In 2025, the country faced a public health crisis of exceptional scale and complexity, resulting from the convergence of prolonged armed conflicts, multiple simultaneous epidemics, recurrent natural disasters—particularly flooding—and acute public health emergencies. The year was marked by the worst cholera epidemic nationwide in 25 years, an Ebola virus disease outbreak in Kasai Province and a chemical intoxication incident in Lubumbashi Province. These shocks occurred in the context of persistent structural fragility of the health system, exacerbating existing vulnerabilities and compromising the continuity of essential health services.

Eastern DRC remained the epicenter of the health crisis, marked by intense armed conflict in North Kivu, South Kivu, and Ituri. The impacts were particularly severe for children, pregnant and lactating women, and internally displaced populations as well as returnees, with direct effects on access to healthcare, prevention of vaccine-preventable diseases, and emergency response capacity.

In North Kivu, clashes during the first quarter of 2025 led to the destruction of 33 health facilities. UNICEF supported access to curative and preventive care in 16 health zones through the provision of essential medicines and medical kits. These interventions enabled 258,364 beneficiaries including 246,134 children under 18 years and 12,500 pregnant and lactating women to access essential health services. In addition, 1,456 health workers(747 females and 709 males) were trained in epidemic management and emergency medical care.

In South Kivu, following an initial wave of violence in February, the resumption and intensification of fighting in the fourth quarter of 2025 —marked
in particular by the takeover of the city of Uvira—severely disrupted the provincial health system. Forty-eight health facilities were affected, resulting in closures, the flight of healthcare personnel, and a significant reduction in service delivery, especially in the Ruzizi Plain. Throughout the year, UNICEF supported 38 health facilities across 20 health zones to maintain minimum access to quality care and strengthen system resilience. In total, 20,735 people including 19,846 children under 18 and 889 pregnant and lactating women benefited from essential health services.

In Ituri, persistent conflicts involving security forces and several non-state armed groups significantly hindered access to health services. UNICEF supported the distribution of medical kits in 18 priority

health zones, targeting internally displaced populations and host communities. These interventions enabled 177,932 people including 150,000 children under 18 and 27,932 pregnant and lactating women to access essential health services, although their scope and duration remained limited.

From an epidemiological perspective, eastern DRC was particularly affected by measles, cholera, and Mpox, with high morbidity and mortality, primarily affecting children. In North Kivu, 16,729 measles cases and 72 deaths were reported, while cholera remained endemic with 11,481 cases and 28 deaths, 74 per cent of which were concentrated in densely populated urban areas. UNICEF supported the vaccination of 39,128 children against measles and 81,523 people against Mpox, including 27,231 children under 18, as well as the provision of case management kits and support to treatment centers.

South Kivu, 12,146 measles cases and 188 deaths were recorded, and 11,524 cholera cases were managed. UNICEF supported Mpox vaccination, reaching 91,794 people, including 3,519 children, and provided inputs and incentives to 19 Mpox treatment centers. In Ituri, several simultaneous outbreaks were reported, including 884 Mpox cases and 5 deaths, 1,597 measles cases, as well as cases of plague and rabies, highlighting heightened health system vulnerability.

At the national level, of the 93,009 suspected Mpox cases recorded (32,683 confirmed) and 845 deaths, a significant proportion involved children, including 31,623 cases among children under five years of age. North Kivu and South Kivu together accounted for 13,628 confirmed cases, including 7,632 among children under 15.

In September 2025, an Ebola outbreak was declared in Kasai Province, with 64 cases and 45 deaths, a high proportion of which involved children under five. UNICEF supported Incident Management System coordination, surveillance, logistics, and continuity of care.

Cholera also remained a persistent emergency outside the eastern region, with 7,322 cases and 377 deaths in Tshopo, 6,821 cases and 245 deaths in Maniema, and 3,084 cases and 177 deaths in Kinshasa. UNICEF supported the response through cholera vaccine logistics, strengthening of the Incident Management System, epidemiological analysis, and geolocation of cases to guide public health action, and treatment of 16,486 patients including 9,890 children under 18 years old admitted in the different UTC/CTC supported in 05 provinces (Maniema, Tshopo, Kinshasa, North kivu and South kivu).

Beyond operational response, UNICEF contributed to strengthening preparedness and health governance by supporting the updating of multi-hazard contingency plans, monitoring preparedness indicators, and developing response plans, in close collaboration with the Ministry of Public Health and the Public Health Emergency Operations Center (COUSP).

Despite the disruption funding in 2025, baseline targets were largely exceeded, mainly due to increase cholera notification in 2025, during which support was provided in five provinces (Maniema, Tshopo, Kinshasa, South Kivu and North Kivu). In addition, the flexibility of certain Mpox emergency funds (FCDO and EU) was leveraged to support access to primary health care in areas with high Mpox case notifications. In Ituri Province, Internal and thematic resources were also mobilized during the last quarter of the year to support activities aimed at strengthening access to primary health care. By mid-July 2025, using social mobilization funds, UNICEF supported a measles vaccination campaign in 30 health zones, during which approximately 1,987,710 children aged 6–59 months were vaccinated.

2. Vaccination

Throughout 2025, the country faced simultaneous outbreaks of mpox, cholera, measles and Ebola in a context of protracted armed conflict, mass population displacement and prolonged disruption of routine immunization services (EPI), particularly in areas under the control of armed groups. These disruptions significantly widened immunity gaps among children and increased the risk of large-scale outbreaks.

In response, UNICEF provided technical, strategic and operational leadership to support the Government in the development and implementation of national vaccination strategies for mpox, measles, cholera and Ebola. This support included the updating of national guidelines, strengthening coordination mechanisms, and financing critical operational costs to ensure timely and safe vaccine deployment in highly insecure and hard-to-reach settings.

For the mpox response, UNICEF supported the rollout of large-scale vaccination using two vaccines (LC16m8 and MVA-BN). In total, 1,498,080 people were vaccinated against mpox, including 280,008 children under 18 years of age, contributing to reduced transmission in high-risk and conflict-affected areas.

During the Ebola outbreak in Kasai, UNICEF supported the logistical deployment of the vaccination response, including the installation of three ultra-cold chain systems to maintain vaccine integrity. A total of 48,523 people were vaccinated, including 5,208 children aged 1–5 years, significantly strengthening outbreak containment and community protection.

In parallel, UNICEF supported measles outbreak response vaccination across 30 health zones, reaching 1,987,710 children from 6-59 months, helping to close critical immunity gaps resulting from prolonged disruption of routine services[14] .

For cholera prevention and response, UNICEF provided logistical support for the supply and deployment of oral cholera vaccines (OCV), including the delivery of more than 350,000 OCV doses in Tshopo and Equateur provinces, reinforcing protection for populations in high-risk riverine, flood-prone and displacement-affected areas.

Together, these vaccination interventions were essential to interrupt transmission chains, protect children and vulnerable populations, and restore confidence in immunization services in a context of persistent insecurity and health system fragility.

To address the measles outbreak, UNICEF supported reactive vaccination activities in Nyankunde and Rimba health zones with MRI funding. Furthermore, a catch-up campaign using the Measles Rubella (MR) vaccine was conducted across 36 health zones of Ituri province to strengthen immunity among vulnerable children.

3. Integrated Outbreak Analytics and Integrated Analytics Cell (IAC)

The Integrated Analytics Cell (CAI) is a collaborative platform under the Ministry of Health with WHO, UNICEF, CDC-Atlanta, Epicentre, MSF, USAID, FCDO, ECHO and World Bank. CAI is involved in the Mpox response through several technical support activities for some of the country's Provincial Health Divisions as follows:

This year, CAI with its partners, carried out 09 investigations in various provinces of the DRC:

i. Integrated analyses of measles epidemics in the Lwamba Health Zone in Haut-Lomami province.

ii. Analysis of the determinants of malnutrition and low vaccination coverage Koica Project (Tanganyika Province, Nyunzu Health Zone).

iii. Evaluation of the level of confidentiality of data collected via the U Report platform, and the perception of its users in the DRC.

iv. In-depth investigation to understand the factors contributing to the persistence of cholera cases in Haut-Lomami province.

v. Analysis of MPOX exposure factors in the provinces of South-Ubangi, Sankuru and South-Kivu and Kinshasa.

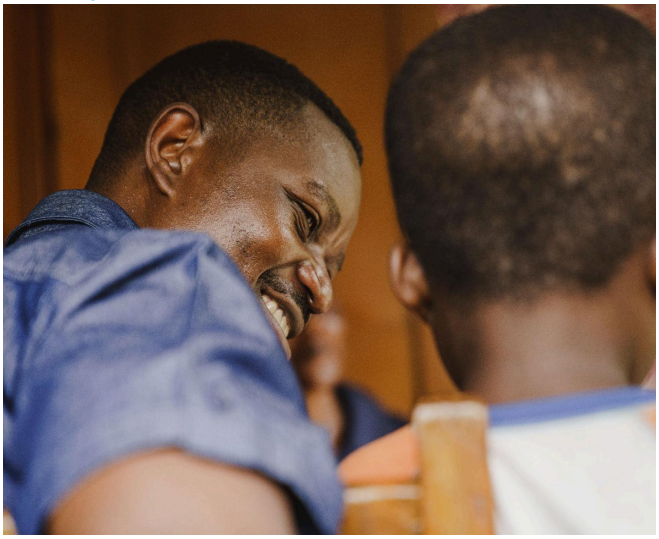
vi. AIE investigation into cases of febrile illness in Basankusu Health Zone in Equateur province.

vii. Community dynamics in the face of health challenges linked to the humanitarian crisis in the health zones of Goma, Kirotshe, Nyiragongo and Karisimbi.

viii. Assessment of the level of confidentiality of data collected via the U-Report platform and the perception of its users in DR Congo.

ix. Investigation into factors linked to the persistence of cholera in certain health zones endemic to cholera and experiencing epidemics in the provinces of Haut Katanga, Kinshasa, South Kivu and Tanganyika, compared to non-epidemic health zones.

Child protection, GBViE and PSEA



In 2025, children in the Democratic Republic of the Congo continued to face severe and compounding protection risks due to intensified armed conflict in the east, recurrent displacement and concurrent public health emergencies, including Mpox and Ebola. These crises heightened children's exposure to grave violations, sexual and gender-based violence (GBV), family separation and psychosocial distress, underscoring the urgent need for shock-responsive child protection systems.

In South Kivu, North Kivu, Ituri and Tanganyika, children, particularly those in IDP sites and displacement-affected host communities, faced interlinked risks: psychosocial distress, sexual violence, family separation, and recruitment and use by armed groups. Repeated displacements, fragmentation of armed actors, food insecurity and limited access to basic services further increased children's vulnerability, especially in overcrowded displacement settings.

Throughout 2025, the United Nations continued monitoring and reporting grave violations against children through the Monitoring and Reporting Mechanism (MRM). Verified violations cases remained alarmingly high, with recruitment and use of children the most prevalent violation, followed by abduction, killing and maiming, and sexual violence. South Kivu, North Kivu, Ituri and Tanganyika recorded the highest numbers of violations, particularly in Nyiragongo, Rutshuru, Masisi, Kalehe, Uvira, Djugu, Irumu and Mambasa. Sexual violence against children remained widespread, while insecurity, stigma and limited services continued to restrict access to survivor support.

Child Protection Response

In this context, UNICEF played a key role in sustaining and scaling child protection services, ensuring system continuity, coordination and frontline response. UNICEF supported the dedicated CAAC/MRM structure, strengthened provincial coordination and supported large-scale child release operations. Through advocacy and collaboration with the Government and P-DDRCS, 5,351 children formerly associated with armed forces and groups (CAAFAG) received protection and reintegration support, with major separation operations conducted in North Kivu, South Kivu, Ituri and Tanganyika. Targeted approaches ensured that 30 per cent of released children were girls, and government officials were trained on age verification to prevent child recruitment.

UNICEF also strengthened case management for 16,021 unaccompanied and separated children (47 per cent girls) through identification, interim care, family tracing and reunification, including in hard-to-reach and insecure areas. The rapid deployment of over 300 para-social workers and social workers, including members of displaced communities, enabled uninterrupted service delivery during escalations of violence, notably in Goma and Bukavu seizure by M23.

Responding to the sharp increase in conflict-related sexual violence, UNICEF scaled up survivor-centered services through health facilities and community structures. In 2025, 22,992 survivors accessed CRSV response services supported by UNICEF. GBV risk mitigation was systematically integrated across child protection, education, nutrition and WASH programs, benefiting nearly 1,000,000 women and children.

Community-based prevention and monitoring were reinforced to address access constraints. In South Kivu, more than 650 community actors across eight territories were trained on identifying, reporting and responding to child rights violations, strengthening early warning and local response mechanisms.

Finally, building strong partnerships with the Ministry of Social Affairs, the National Mental Health Commission and partners, UNICEF expanded mental health and psychosocial support (MHPSS) across humanitarian contexts. MHPSS services were rapidly activated during acute shocks, including the Ebola outbreak in Kasai, and sustained in conflict-affected provinces, reaching nearly 900,000 children, adolescents and caregivers and supporting resilience and recovery.

Water, sanitation and hygiene

In 2025, UNICEF's achievements, in collaboration with its implementing partners, in providing vital access to clean drinking water reached 1,2 million people (of whom 715,432 children and 652,271 female), representing 68 per cent of the HAC 2025 target. These results were made possible by emergency chlorination and water pumping interventions, as well as sustainable actions to construct and rehabilitate water supply systems, 77 per cent of which were in North Kivu, where 694,545 people (of whom 409,781 children and 361,163 female) benefited from safe drinking water thanks to UNICEF's support to REGIDESO for water pumping in Goma during the power outage following the takeover of the city by the M23.

In terms of sanitation and hygiene, UNICEF and its partners have enabled 88,838 people (of whom 52,414 children and 47,116 female) to access appropriate sanitation facilities, representing 15 per cent of the HAC 2025 target. Hygiene promotion interventions reached 1,165,284 people (of whom 687,517 children and 606,214 female), while 111,055 people (of whom 687,517 children and 56,638 female) benefited from WASH kits distributed to households.

During this period, UNICEF continued its response to various epidemics in the most affected provinces, both in the east and in the rest of the country. These included cholera, MPOX, and Ebola (the 16th epidemic). In Kasai province, UNICEF, in collaboration with its partners, provided considerable support for infection prevention and control activities in 23 health facilities and 31 schools considered at risk. In the post-Ebola phase, these efforts have continued: UNICEF is currently supporting 150 schools, 150 households, and three priority health facilities to improve their water, hygiene, and sanitation (WASH) conditions.

Overall, 422 healthcare facilities received Infection Prevention and Control (IPC) kits, and 2,575 healthcare workers (1,069 women) were trained in IPC practices in the context of Ebola, cholera, and Mpox. Of these facilities, 43 also achieved basic WASH service levels. In addition, 1,028 schools benefited from the provision of WASH equipment, training, and/or hygiene promotion. Among these schools, 15 received the basic WASH package, which served 9,718 students, including 4,925 girls.

As part of institutional strengthening, UNICEF, in collaboration with the School of Public Health and the Department of Hygiene, supported a seven-month diploma course in infection prevention and control for ten government officials. In addition, UNICEF supported the revision of standard operating procedures (SOPs) and the training module on infection prevention and control in the context of Mpox.

UNICEF's WASH response remained essential to mitigate outbreaks of waterborne diseases, particularly in the context of persistent cholera transmission and poor sanitation conditions in displacement sites.

Coordination with health authorities and partners enabled integrated and rapid service delivery, including support to Mpox treatment centers.

UNICEF is actively involved in the WASH response to cholera, both in endemic and epidemic provinces, by supporting affected health zones through the distribution of WASH kits and the provision of water and sanitation equipment.

Nutrition

In 2025, UNICEF maintained close collaboration with the Government of the Democratic Republic of Congo (DRC), as well as national and international partners, to address severe acute malnutrition (SAM) through the gender-responsive implementation of the Integrated Management of Acute Malnutrition (IMAM/PCIMA) program. A total of 367,118 new SAM cases were admitted to nutrition therapeutic units, including 168,372 boys (45.9 per cent) and 198,746 girls (54.1 per cent), indicating a slightly higher burden among girls. IMAM activities were implemented across 14 provinces and 168 health zones, ensuring access to life-saving treatment for both girls and boys. In parallel, 3,676,137 children (1,635,483 boys and 2,040,654 girls) were screened through community-based activities, strengthening early detection and timely referral of acute malnutrition cases.

Capacity strengthening remained a core pillar of programme delivery. UNICEF supported the training of 2,094 health providers, including 1,534 men and 560 women, as well as 7,704 community health workers (RECOs), of whom 5,178 were men and 2,526 were women, contributing to improved service quality at both facility and community levels.

In response to the mpox outbreak, UNICEF integrated nutrition services into the emergency response. A total of 1,512 children aged 0–59 months with mpox and acute malnutrition were admitted for therapeutic care (683 boys and 829 girls), while 4,303 children with mpox but without acute malnutrition were also admitted (2,073 boys and 2,230 girls). Additionally, 21,570 patients aged five years and above benefited from nutritional support (10,616 males and 10,954 females), including 1,108 SAM cases (515 males and 593 females).

Overall, these results demonstrate sustained progress in delivering equitable, gender-responsive nutrition services, while highlighting the continued need for investment to expand coverage, strengthen emergency preparedness, and enhance health system resilience.

Education

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In 2025, UNICEF scaled up its Education in Emergencies (EiE) response in the Democratic Republic of the Congo (DRC) to address the compounded effects of armed conflict and concurrent Mpox, cholera and Ebola outbreaks. Persistent insecurity in North Kivu, South Kivu and Ituri continued to severely disrupt access to education. A total of 2,986 schools remained closed due to the M23 crisis, leaving approximately 1.3 million children, including 598,033 girls, out of school. In close coordination with government authorities and implementing partners, UNICEF prioritized the restoration of safe learning environments and continuity of education for crisis-affected children.

To mitigate conflict-related risks, UNICEF implemented targeted protective and educational interventions in heavily affected areas. Risk education on explosive devices reached 180,840 children. In collaboration with the CATI program, disinfection of previously occupied schools was conducted to reduce cholera transmission risks. UNICEF established 229 Temporary Learning Spaces, enabling more than 75,570 children to access education, with girls representing approximately 51 per cent of beneficiaries.

Overall, 36,078 crisis-affected children (21,053 girls and 15,025 boys) accessed formal and non-formal education services across M23-affected and non-affected areas during the reporting period, representing 7 per cent of the annual target of 483,790 children. Of these, 33,540 children were reached in M23-affected areas, while 2,538 were supported in non-affected locations. Progress remained constrained by significant funding shortfalls, which limited program scale-up and geographic coverage.

Learning continuity was further supported through the distribution of 78,349 individual learning materials, reaching 38,887 girls and 39,462 boys, representing 23 per cent of the annual target. The shortfall was primarily due to procurement and distribution limitations linked to funding constraints. The majority of materials (76,697) were distributed in M23-affected areas, while 1,652 were delivered in non-affected zones.

UNICEF strengthened education system capacity by training 6,498

teachers and facilitators in basic pedagogy and mental health and psychosocial support, achieving 73 per cent of the planned target. Training coverage included 2,312 teachers in M23-affected areas, 415 in non-affected areas, and 3,771 teachers through Mpox response interventions. Among those trained, 2,057 were women and 4,441 were men.

In response to the Mpox outbreak, UNICEF implemented a multisectoral prevention and response strategy across South Ubangi, Équateur, South Kivu, Tshopo, Tshuapa and Sankuru provinces. Over 610,000 children received Mpox prevention and awareness messaging, and more than 86,000 education stakeholders were trained on preparedness and infection prevention and control measures. Of 1,278 suspected or confirmed Mpox cases among students, 483 were referred for medical care. Complementary WASH interventions reached 36,146 children, contributing to reduced transmission risks in learning environments.

To sustain access to education during disruptions, radio-based learning programs reached 4,737 children. UNICEF also supported adolescent girls' retention and protection through the distribution of 11,593 dignity kits. Additionally, 25,087 children received psychosocial support services, and 21,950 children, including 10,825 girls, participated in catch-up and remedial education programs to address learning losses.

Following the Ebola outbreak in Bulape (Kasai Province), UNICEF delivered integrated education and WASH interventions to ensure safe school operations and learning continuity. In partnership with the CREC, Ebola prevention awareness sessions reached 9,002 students, including 4,181 girls, and 439 teachers, including 77 women. UNICEF distributed 30 hygiene kits and conducted WASH assessments in 30 schools to identify infrastructure and safety gaps. Capacity strengthening efforts included training 55 education inspectors, including 16 women, and 1,671 teachers, including 294 women, on Ebola prevention, symptom identification and response protocols.

Despite these achievements, UNICEF was unable to fully meet planned EiE targets due to critical funding gaps. Limited financial resources significantly constrained the scope and scale of interventions, particularly in newly affected and hard-to-reach areas. Strengthened resource mobilization and sustained partner engagement remain essential to expand coverage, ensure continuity of education services and enhance resilience of the education system in 2026 and beyond.

UNICEF Rapid Response (UniRR)

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In 2025, UniRR continued to serve as the primary rapid response actor in Ituri, North Kivu, South Kivu, and Tanganyika provinces. During 2025, the crisis in the DRC was marked by the advance of the M23 non-state armed group (NSAG), which rapidly took control of large areas of North and South Provinces including their capital, the towns of Goma and Bukavu. The takeover by the M23, was followed by the dismantlement of IDP sites, forcing hundreds of thousands of people to return to their villages of origin. The constant fighting's also provoked massive internal displacement of people inside the two provinces as well as into the provinces of Ituri and Tanganyika. Faced with this situation and other crisis linked to armed conflicts and natural disasters, the UNICEF Rapid Response program (UNIRR) effectively provided lifesaving assistance to 1,016,943 crisis affected people, including 183,050 women and 664,098 children (318,767 girls and 345,331 boys) in the provinces of North Kivu, South Kivu, Ituri and Tanganyika.

A total of 46 lifesaving rapid interventions were undertaken in 2025, from which 50 per cent were distribution of relief supplies, 37 per cent were coupled with distribution and emergency health and nutrition assistance, and 13 per cent were only emergency health and nutrition assistance. 50 per cent of the responses included emergency health/nutrition assistance (43 per cent in 2024). This increase clearly reflects the collapse of the health system mentioned previously leading to a drastic decrease in access to health and nutrition assistance for the most vulnerable. The number of interventions in 2025, has been lower than in 2024 (60), however the number of beneficiaries per intervention was much higher in 2025 compared with 2024 (3,688 households versus 2,571). The total number of beneficiaries compared with 2024, increased by 14.6 per cent, thus showing the capacity of the program to adapt to a constant change of context, marked by access and security constraints, and the spreading of humanitarian needs among others (1,016,943 people in 2025 vs 887,499 in 2024). Finally, it is important to note that UniRR was able to reach highly vulnerable populations in very hard to reach areas, where no other actor has been responding (for example, Walikale (North Kivu) in September 2025, or Fizi (South Kivu) in May 2025).

A total of 154,909 NFI, Shelter, Wash and Hygiene kits were distributed to 952,662 highly vulnerable people in very hard to reach areas. All these interventions were carried out in less than 28 days after the alert and in less than 6 days after the end of the multi-sector rapid assessment, whereas the target is to intervene 7 days after the assessment. This indicator shows the speed with which UNICEF's rapid response mechanism is providing life-saving assistance to those affected. Complementing UNIRR activities, food distributions were carried out by WFP, FICR and ACTED following 7 UniRR interventions, mainly in South Kivu and North Kivu.

In addition, UniRR provided emergency assistance in health and nutrition, to crisis affected people (returnees, IDPs and host communities). 84,357 persons including 51,458 children (24,700 girls and 26,758 boys) and 19,402 women, benefitted from free primary health care, through the support to 64 public health centers (23.8 per cent of the 84,357 people were also assisted with NFI distribution). 2,913 (1,660 girls and 1,253 boys) severely acutely malnourished (SAM) children and 4,609 (2,627 girls and 1,982 boys) moderated acutely malnourished (MAM) children received nutrition assistance, following the screening of 22,422 children by community relays. In addition, 154 children with complicated cases and 131 women and girls' survival of GBV were referred to facilities with higher levels of technical expertise for appropriate care. Post-intervention surveys carried out 2 to 4 weeks after the assistance was provided showing that 97.7 per cent of beneficiaries were satisfied with the assistance received and 98 per cent used the kits received. This result shows that the assistance provided by the UNIRR program is crucial for the people affected by the crises in which we intervene. Despite insecurity, limited physical access and logistical constraints due to

the advanced deterioration of roads, UNICEF staff were present in 35.6 per cent of interventions in all target provinces to ensure the quality and monitoring of activities.

UniRR is actively engaged with the provincial authorities, in the RRM coordination and in the different COHPs led by OCHA, thus ensuring no duplication and complementarity in the response. UniRR also strengthened the coordination with second line actors/ sectors (internally and externally) to ensure continuity in the response, for example in the sector of humanitarian cash transfer.

In 2026, UniRR is planning to implement a pilot with vouchers, and to strengthen the coordination with UNICEF cash transfer unit, to ensure a second line response after the distribution of relief items. By doing this the program aims at reinforcing the resilience of the populations as well as follow its strategy of nexus.

Cholera Case Area Targeted Interventions - CATI

The beginning of 2025 was immediately marked by an increase of cholera cases; at first in the Haut Katanga and Haut Lomami provinces, but after important political and security changes in the Kivus, also these provinces were hit hard. The takeover by the M23 movement of considerable territory in North and South Kivu resulted in the dismantling of IDP camps around Goma and other cities and the massive displacement of populations which in its turn resulted in important increases in cholera cases. The movement of populations also contributed to the geographical spread of cases and by the end of the first half of the year, suspect cases were notified not only in the endemic provinces of North, South Kivu, Tanganyika, Haut Katanga and Haut Lomami, but also in non-endemic provinces such as Tshopo, Maniema, Equateur, Sankuru, Lualaba and Kinshasa. The lack of knowledge of local populations on cholera, their hesitation in consulting and difficulties in reaching an appropriate care facility, resulted in unacceptable case fatality rates, specifically in Kwilu (23.6 per cent), Tshuapa (18.6 per cent), Equateur (8.6 per cent) and Sankuru (7.6 per cent)[15] .

UNICEF's rapid response to this epidemic consists of so-called Case Area Targeted Interventions (CATI) in endemic areas: UNICEF deploys CATI teams to limit cholera spread in affected households and households around them in a 50-meter perimeter. In 2025, CATI teams have been deployed, not only in the endemic areas of North Kivu, South Kivu, Tanganyika, Haut Lomami, Haut Katanga, but also in the provinces of Lualaba, Tshopo and in Kinshasa, as cholera spread almost throughout the country, with 21 out of 26 provinces affected this year. To provide a first response in remote or otherwise difficult to reach areas, local teams (so-called Pre-CATI) provided a first response before a complete response from a CATI team could be secured.

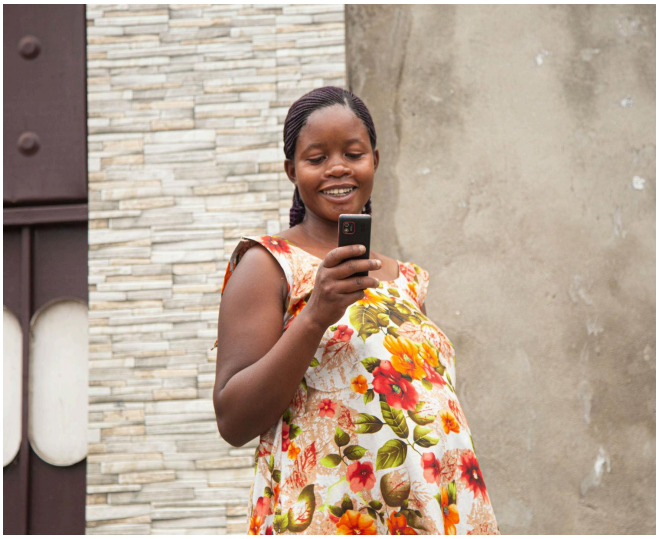
CATI teams conduct disinfection, cholera kit distribution, risk communication, and active case finding to interrupt transmission. Over the year, the 45 CATI teams that were activated throughout the different provinces responded to 20,381 suspected cases (out of which 59 per cent are children and 19 per cent women) out of the 29,528 cases reported during the period of activation of these teams. Ninety-seven per cent of responses occurred within 48 hours of notification, thereby substantially diminishing the relative risk for the surrounding population at contracting the disease. An impressive number of 3,669,327 persons were reached with sensitization messages against cholera (50 per cent were children and 31 per cent were women) including 3,578,568 people reached in less than 48 hours, while a total of 469,294 houses were disinfected during our rapid response. As a result of the dismantling of IDP sites, numerous schools were temporarily occupied by IDPs, and to prevent the spread of diseases, CATI teams proceeded to disinfect these schools after their evacuation. 19 schools in Goma, Karisimbi and Nyiragongo health zones were disinfected.

In 2025, UNICEF started a pilot program with flying CATI teams who were deployed to non-endemic provinces severely affected by the cholera outbreak, in order to train local populations in the provision of CATI activities, so that local teams supported by their local DPS or Health Zone could be deployed to affected areas to interrupt transmission. A total of 792 persons were trained in the provinces of Tshopo, Maniema and Equateur. For 2026, we continue to work also with PNECHOL (Programme National d'Elimination du Cholera) on the deployment of Rapid Intervention Teams who can be deployed in case of outbreaks in non-CATI supported areas.

Since the M23 take-over of parts of North and South Kivu, it remained impossible to cross from Bukavu into the southern Health Zones of South Kivu province, thereby hampering our responses, supplies, but also the transportation of stool samples to our partner lab in Goma for analysis. Other areas of North and South Kivu are also difficult to access due to security concerns, and access challenges have also been observed due to the remoteness of cases. Internal movements including returns have geographically expanded the outbreak, thereby also complicating the response. Most return areas have poorer WASH services and infrastructure than IDP sites.

UNICEF coordinates closely with the Ministry of Health, WHO, MSF, Red Cross, WASH Cluster and other partners to ensure targeted, timely cholera response through gap analysis, data sharing, and hotspot prioritization for resource allocation and technical alignment.

Humanitarian Cash Transfers



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This year, UNICEF has reached 17,574 households (representing 90,472 people) through humanitarian cash interventions and cash+ programs with nutrition and protection. This represents 15 per cent of the HAC target of 120,000 participant households.

Over half of those assisted (10,634 households, representing 51,106 people) were part of the country office's response to the M23 crisis in eastern DRC. The cash recipients were primarily displaced families, host families, and other vulnerable households in Minova, South Kivu – a town on the front lines of the conflict which was taken over by the M23 in February 2025. In 2024 these families participated in a different cash program implemented in coordination with WFP and had received mobile phones and sim cards to receive mobile money payments. As Minova was one of the frontline areas when hostilities erupted in January 2025, UNICEF's response plan included these households for one-off cash assistance. As families already had phones and mobile money accounts, this facilitated rapid payment once household accounts were verified as still active. The Country

office was able to locate these households and assess their access to mobile money transfer services using Rapid Pro SMS messaging. One-off transfers based on household size and an average of 116 USD per household started in March. Monitoring has shown households using the funds to address a vast range of needs including access to basic needs and services as well as investment in small-scale income generating activities to build resilience. Also, as part of the M23 crisis response, a targeted number of GBV survivors (666 individuals) were also assisted with punctual cash transfers in Goma.

The main cash+ activities were a cash/nutrition program in Kabalo territory of Tanganyika province (6,208 households).This is part of program looking at social protection and cash as a component of improving nutrition outcomes in highly food insecure communities. Other cash+ activities have included cash as part of support to foster families hosting children separated from armed groups and other vulnerable conflict-affected children awaiting family reunification.

Risk Communication, Community Engagement (RCCE) and Social and Behaviour Change (SBC)

From January to December 2025, UNICEF deployed a multipronged Social and Behaviour Change (SBC) interventions — with focus on Risk Communication and Community Engagement (RCCE) and Accountability to Affected Populations (AAP)— to provide timely life-saving information, facilitate the use of essential services, support community participation, and ensure that the voices and needs of crisis-affected populations were integrated into the multisectoral response to diseases outbreaks (Mpox, cholera, anthrax, Ebola), natural disasters (floods), and conflict (M23) in the east provinces of the Democratic Republic of Congo.

1. RCCE

UNICEF leveraged partnerships with mobile network operators, Radio Okapi, Community Animation Cells (CACs) and the U-Report platform (9 million users, 39 per cent girls) to deliver life-saving risk communication and community engagement messages in local languages[16] through radio, community dialogues, interpersonal communication and digital platforms. As a result, over 7.9 million people, including approximately 4 million women, received information on disease prevention, symptoms and available services during responses to Mpox, Ebola, cholera, anthrax, polio and measles outbreaks, as well as flooding and conflict-related crises in many provinces[17] and Kinshasa. In addition, UNICEF social and behavior change interventions reached more than 50 million people nationwide with key preventive messages supporting multiple epidemic responses.

2. Community Engagement

UNICEF intensified community engagement and outreach interventions to support responses to multiple disease outbreaks, including the rollout of Human-Centred Design (HCD) approaches to help communities identify and address local drivers of recurring challenges such as Ebola, Mpox, cholera and flooding. UNICEF leveraged and strengthened existing community platforms, including Community Animation Cells (CACs), youth U-Reporters committees, schools, religious and traditional leaders, and frontline workers to implement risk communication and community engagement (RCCE) activities. These interventions directly engaged 1.4 million people in promoting the adoption of healthy and protective practices in response to public health emergencies, climate-related disasters, and conflict-affected contexts. Community mobilization efforts engaged over 189,700 people in social and behavior change actions, contributing to contact tracing and the referral of more than 27,500 suspected Mpox and cholera cases to health facilities. During the Ebola outbreak in Kasai Province, UNICEF trained and deployed 396 community mobilizers who reached over 1.2 million people with prevention messages and service information, while 1,700 community members participated in community-led response actions that supported containment of the outbreak.

3. Feedback mechanism

UNICEF-supported feedback mechanisms, including U-Report and community-based data collection through Community Animation Cells CACs, enabled 413,738 people to share concerns and request information on Mpox and cholera in affected provinces. Beyond HAC targets, nearly one million people used these channels to provide feedback, mainly related to humanitarian assistance, vaccination campaigns, and disease persistence in communities. Two perception surveys perception surveys on Mpox and cholera and two Mobile Phone-Based Community Rapid Assessments on Mpox informed behavioral analysis and strengthened RCCE planning and messaging to meet community needs . In parallel, a network of 700 online rumor trackers identified over 35,000 misinformation cases, which were analyzed and addressed through the Public Health Emergency Operations Centre coordination platform (COUSP-SGI).

Protection of Sexual Exploitation and Abuse (PSEA)

From January to December 2025, UNICEF continued to strengthen protection from sexual exploitation and abuse (PSEA) in the Democratic Republic of Congo (DRC) amid a highly volatile operating environment characterized by protracted conflict, population displacement, and fluctuating humanitarian access, particularly in the eastern provinces.

Over the reporting period, 1,301,474 people (267,573 women; 314,063 men; 418,811 girls; 301,027 boys) gained access to at least one safe and accessible SEA reporting mechanism, representing 78 per cent of the annual target (1,666,848). Access to reporting channels evolved in line with humanitarian access, with periods of disruption followed by progressive restoration and adaptation of mechanisms. UNICEF and partners prioritized the re-establishment of community-based and service-linked reporting channels that had been partially or fully disrupted due to insecurity, displacement, and service interruptions.

In parallel, UNICEF significantly expanded PSEA awareness and risk communication. A total of 2,798,028 people (950,292 women; 1,001,410 men; 432,881 girls; 413,445 boys) were sensitized on PSEA principles, expected behaviors, and available reporting mechanisms through community-based activities, service delivery platforms, and locally adapted communication materials. This wide coverage contributed to increased community-level awareness, even where access to fully functional reporting mechanisms remained limited.

While access limitations affected both adults and children, children's access to SEA reporting mechanisms remained particularly constrained, due to prolonged school closures, reduced availability of child-friendly spaces, and continued reliance on mechanisms not yet sufficiently age-appropriate or adapted to children's communication capacities.

In 2025, UNICEF continued to act as provider of last resort, supporting over 70 child victims of SEA, including both newly identified and previously reported cases—predominantly children born of SEA—in line with survivor-centered and child-sensitive principles, particularly where other actors' response capacities were exceeded.

Priority actions for 2026: UNICEF will pilot innovative, child-centred

SEA reporting mechanisms, co-developed by children and for children, in close collaboration with communities and partners. These mechanisms aim to improve accessibility, safety, and age-appropriateness, and to inform potential scale-up in conflict-affected and hard-to-reach areas.

HUMANITARIAN LEADERSHIP, COORDINATION AND STRATEGY

WASH Cluster

In 2025, the WASH Cluster, led by UNICEF, coordinated the humanitarian response in the Democratic Republic of Congo (DRC) amid escalating conflict in the East, large-scale population movements, recurrent flooding, and a growing cholera outbreak. Despite very limited funding—only 16.5 per cent[18] of the Humanitarian Needs and Response Plan (HNRP) budget and 33 per cent of the prioritized budget—61 WASH partners assisted over 3 million people, representing 62 per cent of the initial target.

The year was marked by significant population returns in the Kivu provinces following intensified clashes between armed groups and national forces. WASH partners prioritized the rehabilitation of essential WASH infrastructure, restoration of community hygiene systems, improved access to safe water, and the safe decommissioning of facilities in former displacement sites. A technical guidance package was developed to support interventions in return contexts. Cholera response efforts were strengthened, particularly in newly affected western provinces, including Kinshasa, through CATI approaches and community-based prevention activities.

Throughout the year, the Cluster produced regular 5W matrices, response dashboards, and situation bulletins. Coordination was, however, constrained by the absence of a dedicated Information Manager at the national level. Despite this limitation, these tools supported evidence-based decision-making and alignment among partners.

The Cluster conducted 20 joint field missions in North Kivu and Ituri to assess needs in real time, provide technical guidance, and strengthen accountability to affected populations. Advocacy efforts were intensified, with three thematic advocacy notes (Goma site dismantlement, cholera outbreak, latrine congestion) and one global advocacy note highlighting the urgent need for funding.

Capacity strengthening remained a priority: six trainings and two briefing sessions enhanced the skills of over 160 actors on key technical and cross-cutting topics. Localization was further advanced through the election of a national co-lead within the coordination team.

However, due to insufficient funding, no contingency stock could be replenished in 2025, limiting the Cluster's capacity to respond rapidly to future emergencies.

Despite these constraints, the WASH Cluster demonstrated strong collective engagement, improved coordination, and delivered essential services to millions, laying a stronger foundation for a localized and effective response in 2026.

Education Cluster

In 2025, the Education Cluster, with technical support from the Global Education Cluster (GEC), strengthened coordination through four working groups: Safety and Security at School, Quality of Learning, Mental Health and Psychosocial Support (MHPSS), and Support to Back to School (BTS). Two Standard Operating Procedures (SOPs) were issued on school security and mpox prevention. Support was provided to five provincial clusters (North Kivu, South Kivu, Ituri, Tanganyika, Kasai) and the western region working group, and the Cluster contributed to the HNRP reprioritization.

Intersectoral collaboration with Child Protection was enhanced. A joint pilot project in North Kivu led to a case study supporting scale-up and collective learning with a package of complementary activities, covering education, protection, food security, and WASH.

The Cluster trained 243 partners (87 women) on Education in Emergencies (EiE), data collection, child protection, children's participation, accountability to affected populations (AAP), gender-based violence (GBV), PSEA, and anticipatory actions. Monitoring of the M23 crisis and floods showed 3,268 schools remained closed, affecting 1,068,000 children (46 per cent girls). An EiE response plan was issued with the Ministry of Education, reaching 21 per cent of targeted children, including 11,004 children with disabilities (5,753 girls). In partnership with the five ministries responsible for education and persons with disabilities, the Cluster finalized the Strategy for Education and Training in Emergencies in DRC. Through cluster support, over 708,000 affected children (50 per cent girls) participated in end-of-year examinations, including the transport of examination materials to non-government-controlled areas in North and South Kivu.

Despite these achievements, funding remained critical with $10.1 million (15.3 per cent)[19] of the $66 million HNRP requirement mobilized.

Child Protection AoR

The humanitarian and protection situation in the Democratic Republic of the Congo continued to deteriorate, particularly affecting children in the eastern provinces of North Kivu, South Kivu, Ituri and Tanganyika. Children in these areas face heightened and specific protection risks resulting from ongoing conflict and its consequences, including large-scale displacement and public health emergencies. Children are increasingly exposed to grave violations, including recruitment and use by parties to the conflict, sexual violence, and family separation, both in IDP sites and in displacement-affected host communities.

Beyond the conflict-related humanitarian crisis in the east, Mpox and Ebola outbreaks, as well as recurrent flooding, have profoundly affected children living in Équateur, North Kivu, Sankuru, South Kivu, South-Ubangi, Kasaï and Kinshasa provinces. Children have been exposed to direct health risks, including infection with Ebola and Mpox, as well as secondary protection risks, such as becoming orphans (165 children orphaned including 97 girls and 68 boys in Bulape following the Ebola outbreak), witnessing family members infected, being forced to leave their communities, and experiencing stigma or quarantine. For children whose parents were hospitalized, temporary childcare spaces were established near treatment centres, providing a safe, protective and nurturing environment with dedicated care teams.

In response, UNICEF and its partners delivered life-saving child protection services and strengthened the responsiveness of community-based child protection systems, including the provision of mental health and psychosocial support (MHPSS) services to address the psychological distress caused by conflict, displacement and public health emergencies.

Through coordinated interventions:

- 18,192 unaccompanied and separated children (8,556 girls and 9,636 boys) received transitional care and family reunification support.
- 5,810 children (1,827 girls and 3,983 boys) formerly associated with parties to the conflict benefited from community-based reintegration support.

- 46,018 survivors (18,082 girls, 9,510 boys, 18,426 women) of sexual violence received holistic and multidimensional assistance.
- 771,543 people accessed mental health and psychosocial support (MHPSS) services, including 620,305 children.
- UNICEF continued to provide leadership of the Child Protection Area of Responsibility (CP AoR) at national and provincial levels, strengthening coordination of the humanitarian child protection response in eastern provinces. UNICEF also actively contributed to the Protection Cluster and engaged in inter-cluster coordination mechanisms, including PSEA and AAP working groups, ensuring that child protection was effectively integrated across sectors.

Sustained and flexible funding remains essential to maintain and scale up child protection services, including MHPSS, and to respond effectively to evolving humanitarian needs.

Nutrition Cluster

In 2025, the Nutrition Cluster remained actively engaged in strengthening sector coordination at both national and subnational levels, including participation in the Inter-Cluster Coordination Group (ICCG). Under the interagency framework for humanitarian coordination in the DRC, led by the Humanitarian Coordinator, UNICEF continued to lead the Nutrition Cluster. The coordination team, composed of the National Coordinator and Deputy, an Information Management Officer, and three sub-cluster coordinators, provided technical and operational support to strengthen coordination mechanisms. Field missions were also conducted to enhance partner intervention quality and reinforce coordination practices.

The nutrition response was affected by funding-cuts in 2025, so the cluster conducted a reprioritization exercise to guide partners toward prioritized health zones. To support partners, the Nutrition Cluster developed and released an Emergency Response Plan (ERP) and a SOP on the CMAM Simplified Approach, improving response efficiency in eastern DRC in close collaboration with the government and partners.

The nutrition cluster with the support of the Global Nutrition Cluster (GNC) although the H2H funding, realized key activities to strengthen coordination and technical capacities at both national and sub national levels as included (1) Coordination mechanism training – to improve leadership, planning, and partner engagement, (2) Information management training and support– to enhance data quality, analysis, and reporting with the development of new sectorial prioritization matric and the improvement of the dashboard, (3) Preparedness and response planning session to develop a nutrition preparedness response plan and the development of key priorities activities with key stakeholders, (4) CMAM Simplified Approach workshop – to harmonize protocols for the treatment of acute malnutrition, particularly in hard-to-reach areas.

During the year, around 95 partners worked to implement nutrition response activities in emergency under the coordination and with the support of the Nutrition Cluster. These included UNICEF, WFP, and the World Bank-funded National Nutrition and Health Multisector Project (PMNS).

Despite the disruption funding in 2025, the nutrition sector reached 496,466 (268,972 girls and 227,494 boys) children suffering of SAM out of 533,000 targeted (93 per cent) and 1,165,923 pregnant and lactating women received YCFE counselling (110 per cent).

Non-Food Item Working group

The Non-Food Items (NFIs) Working group working group continued to strengthen national and provincial coordination with its partners. During this year 2025, the NFI working group, through its 19 partners (United Nations agencies, national and international NGOs), assisted 243,715 households representing 1,393,883 people (951,584 displaced; 411,357 returnees and 30,942 vulnerable host communities) with essential household items in-kind or through cash transfer. Among them, 219,771 women and girls of childbearing age benefited from an additional menstrual hygiene kit. Despite the disruption funding for humanitarian action, this result represents 77 per cent of HNRP 2025 target of 1.8 million people but needs remain enormous and unmet to address the sectoral needs of 3.3 million people. A total of 85 interventions were carried out in the provinces of Ituri, North Kivu, South Kivu, Tshopo and Tanganyika, in response to the multiplicity of crises.

HUMAN INTEREST STORIES AND EXTERNAL MEDIA

Throughout 2025, UNICEF sustained a strong and consistent digital presence across — X , Facebook , Instagram , and LinkedIn to support emergency response efforts. Regular, timely updates highlighted evolving humanitarian needs and response activities, while web stories played a central role in showing the human face of the crisis and fresh multimedia content is regularly uploaded to WeShare .

Human interest stories

- “Today, I say stop”
- Learning beyond classroom walls
- Knocking on every door to stop cholera
- Foster families: providing protection and comfort for children in times of crisis
- When a phone becomes a lifeline for families in emergencies

Press releases

- After reports of ‘mystery illness’ in DR Congo, UNICEF responds to health needs in the southwest where respiratory illnesses combined with malaria have caused spike in child deaths
- UNICEF launches urgent appeal for $22 million to provide emergency assistance to 282,000 children in eastern DR Congo amid spiralling violence
- Children in eastern Democratic Republic of the Congo increasingly exposed to sexual violence, abduction and recruitment – UNICEF
- Thousands more children deprived of education as crisis in eastern DR Congo escalates – UNICEF
- Reports of grave violations against children in eastern Democratic Republic of the Congo tripled in last month – UNICEF
- UNICEF reaches 364,000 children daily in Goma with clean water and sanitation after escalation in DR Congo conflict
- Tens of thousands of families displaced by fighting in DR Congo’s South Kivu as UNICEF scales up humanitarian response
- A child reported raped every half an hour in eastern DRC, as violence rages amid a growing funding crisis
- UNICEF Executive Director Catherine Russell briefing to the United Nations Security Council on the humanitarian situation in the Democratic Republic of the Congo
- John Agbor assumes duty as UNICEF Representative in the Democratic Republic of the Congo
- UNICEF’s humanitarian cash transfers to families in eastern DR Congo reach 14,000 children
- Over 130,000 additional children out of school in DR Congo’s Ituri province as violence escalates and aid shrinks

HAC APPEALS AND SITREPS

- Democratic Republic of Congo Appeals
  https://www.unicef.org/appeals/drc
- Democratic Republic of Congo Situation Reports
  https://www.unicef.org/appeals/drc/situation-reports
- All Humanitarian Action for Children Appeals
  https://www.unicef.org/appeals
- All Situation Reports
  https://www.unicef.org/appeals/situation-reports

NEXT SITREP: 30 JUNE 2026

ANNEX A - PROGRAMME RESULTS

Consolidated Programme Results

Sector			UNICEF and IPs response			Cluster/Sector response		
Indicator	Disaggregation	Total needs	2025 targets	Total results	Progress*	2025 targets	Total results	Progress*
Health (including public health emergencies)								
Children and women accessing primary health care in UNICEF-supported facilities	Total	12.9 million	236,212	457,301	▲ 194%	-	-	-
	Girls	-	115,085	211,733	▲ 184%	-	-	-
	Boys	-	111,725	204,247	▲ 183%	-	-	-
	Women	-	9,402	41,321	▲ 439%	-	-	-
Children vaccinated against measles, supplemental dose	Total	-	1.4 million	2 million	▲ 146%	-	-	-
	Girls	-	692,397	987,892	▲ 143%	-	-	-
	Boys	-	665,245	999,818	▲ 150%	-	-	-
Individuals receiving treatment for cholera/acute watery diarrhoea in UNICEF-supported facilities	Total	-	4,800	16,486	▲ 343%	-	-	-
	Girls	-	1,126	5,110	▲ 454%	-	-	-
	Boys	-	1,082	4,780	▲ 442%	-	-	-
	Adults	-	2,592	6,596	▲ 254%	-	-	-
Nutrition								
Children 6-59 months screened for wasting	Total	6.5 million	2.9 million[20]	3.7 million	▲ 127%	-	-	-
	Girls	-	1.5 million[21]	2 million	▲ 139%	-	-	-
	Boys	-	1.4 million[22]	1.6 million	▲ 116%	-	-	-
Children 6-59 months with severe wasting admitted for treatment	Total	-	1.2 million[23]	367,118	▲ 31%	533,453	496,466	▲ 93%
	Girls	-	608,130[24]	198,746	▲ 33%	268,032	268,972	▲ 100%
	Boys	-	574,340[25]	168,372	▲ 29%	265,421	227,494	▲ 86%
Primary caregivers of children 0-23 months receiving infant and young child feeding counselling	Total	-	878,490[26]	1 million	▲ 119%	1.1 million	1.2 million	▲ 110%
Children 6-59 months receiving vitamin A supplementation	Total	-	7.6 million	4.6 million	▲ 60%	-	-	-

Sector			UNICEF and IPs response			Cluster/Sector response		
Indicator	Disaggregation	Total needs	2025 targets	Total results	Progress*	2025 targets	Total results	Progress*
	Girls	-	3.9 million	2.4 million	▲ 60%	-	-	-
	Boys	-	3.7 million	2.3 million	▲ 60%	-	-	-
Child protection, GBViE and PSEA								
Children, adolescents and caregivers accessing community-based mental health and psychosocial support	Total	4 million	1.2 million[27]	756,289	▲ 62%	1.9 million	771,543	▲ 41%
	Girls	-	563,964[28]	313,546	▲ 56%	861,852	321,651	▲ 37%
	Boys	-	551,704[29]	296,361	▲ 54%	843,116	298,654	▲ 35%
	Women	-	61,300[30]	87,634	▲ 143%	93,680	88,444	▲ 94%
	Men	-	49,040[31]	58,748	▲ 120%	74,944	62,794	▲ 84%
Women, girls and boys accessing gender-based violence risk mitigation, prevention and/or response interventions	Total	-	1.6 million[32]	1 million	▲ 66%	-	-	-
	Girls	-	452,284[33]	146,803	▲ 32%	-	-	-
	Boys	-	467,880[34]	136,459	▲ 29%	-	-	-
	Women	-	467,880[35]	386,453	▲ 83%	-	-	-
	Men	-	171,556[36]	359,222	▲ 209%	-	-	-
People with safe and accessible channels to report sexual exploitation and abuse by personnel who provide assistance to affected populations	Total	-	1.7 million[37]	1.3 million	▲ 78%	-	-	-
	Girls	-	766,750[38]	418,811	▲ 55%	-	-	-
	Boys	-	750,082[39]	301,027	▲ 40%	-	-	-
	Women	-	83,342[40]	267,573	▲ 321%	-	-	-
	Men	-	66,674[41]	314,063	▲ 471%	-	-	-
Children who have received individual case management	Total	-	34,478[42]	33,925	▲ 98%	-	-	-
	Girls	-	16,198[43]	20,811	▲ 128%	-	-	-
	Boys	-	18,267[44]	13,114	▲ 72%	-	-	-
Education								
Children accessing formal or non-formal education, including early learning	Total	1.9 million	483,790[45]	36,078	▲ 7%	645,852	135,359	▲ 21%
	Girls	-	246,733[46]	21,053	▲ 9%	310,009	70,162	▲ 23%

Sector			UNICEF and IPs response			Cluster/Sector response		
Indicator	Disaggregation	Total needs	2025 targets	Total results	Progress*	2025 targets	Total results	Progress*
	Boys	-	237,057[47]	15,025	▲ 6%	335,843	65,197	▲ 19%
Children receiving individual learning materials	Total	-	338,653[48]	78,349	▲ 23%	-	-	-
	Girls	-	172,713[49]	38,887	▲ 23%	-	-	-
	Boys	-	165,940[50]	39,462	▲ 24%	-	-	-
Teachers and facilitators trained in basic pedagogy and/or mental health and psychosocial support	Total	-	8,960[51]	6,498	▲ 73%	-	-	-
	Women	-	4,570[52]	2,057	▲ 45%	-	-	-
	Men	-	4,390[53]	4,441	▲ 101%	-	-	-
Water, sanitation and hygiene								
People accessing a sufficient quantity and quality of water for drinking and domestic needs	Total	6.2 million	1.8 million[54]	1.2 million	▲ 68%	5 million	3.1 million	▲ 62%
	Women	-	905,156[55]	652,271	▲ 72%	2.5 million	1.6 million	▲ 63%
	Men	-	869,659[56]	560,327	▲ 64%	2.5 million	1.5 million	▲ 62%
People accessing appropriate sanitation services	Total	-	608,153[57]	88,838	▲ 15%	3.5 million	784,587	▲ 23%
	Women	-	310,158[58]	47,116	▲ 15%	1.8 million	400,139	▲ 23%
	Men	-	297,995[59]	41,722	▲ 14%	1.7 million	384,448	▲ 22%
People reached with critical WASH supplies	Total	-	532,445[60]	111,055	▲ 21%	-	-	-
	Women	-	271,547[61]	56,638	▲ 21%	-	-	-
	Men	-	260,898[62]	54,417	▲ 21%	-	-	-
Cross-sectoral (HCT, SBC, RCCE and AAP)								
Households reached with UNICEF-funded humanitarian cash transfers (including for social protection and other sectors)	Total	-	120,000[63]	17,574	▲ 15%	-	-	-
People reached with timely and life-saving information on how and where to access available services	Total	-	7.7 million[64]	7.9 million	▲ 103%	-	-	-
People engaged in reflective dialogue through community platforms	Total	-	175,519	189,709	▲ 108%	-	-	-
People sharing their concerns and asking questions through established feedback mechanisms	Total	-	421,247	413,738	▲ 98%	-	-	-

Sector			UNICEF and IPs response			Cluster/Sector response		
Indicator	Disaggregation	Total needs	2025 targets	Total results	Progress*	2025 targets	Total results	Progress*
Frontline workers supported with cash payments	Total	-	30,000[65]	17,404	▲ 58%	-	-	-
Rapid Response Mechanism								
People whose vital needs in terms of non-food items, WASH, health and nutrition were covered within 7 days of the needs assessment through a rapid response mechanism.	Total	4 million	1.1 million	315,205	▲ 29%	1.8 million	538,012	▲ 30%
People around suspected cholera cases receiving targeted assistance in less than 48h	Total	-	2.6 million[66]	2.1 million	▲ 80%	-	-	-

Progress in the reporting period 1 January to 31 December 2025

ANNEX B — FUNDING STATUS

Consolidated funding by sector

		Funding available		Funding gap	
Sector	Requirements	Humanitarian resources received in 2025	Resources available from 2024 (carry over)	Funding gap (US$)	Funding gap (%)
Health	35,607,916	7,106,728	9,973,210	18,527,978	52%
Nutrition	390,687,719[67]	21,180,048	15,081,114	354,426,557	91%
Child protection	112,189,520[68]	14,335,056	3,580,239	94,274,225	84%
Education	74,310,144[69]	2,771,165	2,052,409	69,486,570	94%
WASH	60,098,618[70]	18,302,670	4,801,101	36,994,847	62%
Cross-sectoral	60,025,124[71]	4,586,376	1,276,373	54,162,375	90%
RRM	72,903,600[72]	29,864,792	7,111,752	35,927,056	49%
Cluster coordination	3,750,000	28,814	19,623	3,701,563	99%
Total	**809,572,641**	**98,175,649**	**43,895,821**	**667,501,171**	**82%**

Funding available - funding available in the current appeal year to respond in line with the current HAC appeal.
Humanitarian resources– humanitarian funding commitments received from donors in the current appeal year.
Resources available from 2024 (carry over)– funding received in the previous appeal year that is available to respond in line with the current HAC appeal

Who to contact for further information:

John Agbor
Representative DRC
T +243996050399
jagbor@unicef.org

Mariame Sylla
Deputy Representative DRC
T +243996050399
msylla@unicef.org

Jerome Kouachi
Chief Emergency DRC
T +243996050399
jkouachi@unicef.org

ENDNOTES

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3. https://www.who.int/publications/m/item/multi-country-outbreak-of-cholera--epidemiological-update--33--27-january-2026

4. Unless otherwise stated, all amounts shown are in US dollars.

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17. Equateur, Ituri, North Kivu, Sankuru, South Kivu, South Ubangi, Tanganyika, Tshuapa

18. Sources FTS unocha

19. ibid.

20. UNICEF will target 30 per cent of the children under age 5 in high-priority health zones.

21. UNICEF will target 30 per cent of the children under age 5 in high-priority health zones.

22. UNICEF will target 30 per cent of the children under age 5 in high-priority health zones.

23. UNICEF will target 75 per cent of the total number of people in need for the cluster in high-priority health zones.

24. UNICEF will target 75 per cent of the total number of people in need for the cluster in high-priority health zones.

25. UNICEF will target 75 per cent of the total number of people in need for the cluster in high-priority health zones.

26. UNICEF will target 83 per cent of the cluster's target.

27. UNICEF supports 65 per cent of the Child Protection Area of Responsibility target.

28. UNICEF supports 65 per cent of the Child Protection Area of Responsibility target.

29. UNICEF supports 65 per cent of the Child Protection Area of Responsibility target.

30. UNICEF supports 65 per cent of the Child Protection Area of Responsibility target.

31. UNICEF supports 65 per cent of the Child Protection Area of Responsibility target.

32. Gender-based violence risk mitigation measures will be implemented across all sectors. Target includes beneficiaries of the child protection sector programmes and 540,000 for other sectors (WASH, education, health, nutrition, emergency). The target for risk mitigation includes 85 per cent women and girls, 15 per cent boys; for prevention, the target includes 60 per cent women and girls, 40 per cent men and boys; for response services, the target includes 30 per cent women, 60 per cent girls, 10 per cent boys.

33. Gender-based violence risk mitigation measures will be implemented across all sectors. Target includes beneficiaries of the child protection sector programmes and 540,000 for other sectors (WASH, education, health, nutrition, emergency). The target for risk mitigation includes 85 per cent women and girls, 15 per cent boys; for prevention, the target includes 60 per cent women and girls, 40 per cent men and boys; for response services, the target includes 30 per cent women, 60 per cent girls, 10 per cent boys.

34. Gender-based violence risk mitigation measures will be implemented across all sectors. Target includes beneficiaries of the child protection sector programmes and 540,000 for other sectors (WASH, education, health, nutrition, emergency). The target for risk mitigation includes 85 per cent women and girls, 15 per cent boys; for prevention, the target includes 60 per cent women and girls, 40 per cent men and boys; for response services, the target includes 30 per cent women, 60 per cent girls, 10 per cent boys.

35. Gender-based violence risk mitigation measures will be implemented across all sectors. Target includes beneficiaries of the child protection sector programmes and 540,000 for other sectors (WASH, education, health, nutrition, emergency). The target for risk mitigation includes 85 per cent women and girls, 15 per cent boys; for prevention, the target includes 60 per cent women and girls, 40 per cent men and boys; for response services, the target includes 30 per cent women, 60 per cent girls, 10 per cent boys.

36. Gender-based violence risk mitigation measures will be implemented across all sectors. Target includes beneficiaries of the child protection sector programmes and 540,000 for other sectors (WASH, education, health, nutrition, emergency). The target for risk mitigation includes 85 per cent women and girls, 15 per cent boys; for prevention, the target includes 60 per cent women and girls, 40 per cent men and boys; for response services, the target includes 30 per cent women, 60 per cent girls, 10 per cent boys.

37. Represents 15 per cent of all people to be reached by UNICEF.

38. Represents 15 per cent of all people to be reached by UNICEF.

39. Represents 15 per cent of all people to be reached by UNICEF.

40. Represents 15 per cent of all people to be reached by UNICEF.

41. Represents 15 per cent of all people to be reached by UNICEF.

42. This target includes 100 per cent of the unaccompanied and separated children and the children associated with armed groups and armed forces 'in need' number, plus 60 per cent of other at-risk/vulnerable children affected by conflict and displacement who require support with socioeconomic reintegration, in line with the Programme de Désarmement, Démobilisation, Rélevement Communautaire et Stabilisation.

43. This target includes 100 per cent of the unaccompanied and separated children and the children associated with armed groups and armed forces 'in need' number, plus 60 per cent of other at-risk/vulnerable children affected by conflict and displacement who require support with socioeconomic reintegration, in line with the Programme de Désarmement, Démobilisation, Rélevement Communautaire et Stabilisation.

44. This target includes 100 per cent of the unaccompanied and separated children and the children associated with armed groups and armed forces 'in need' number, plus 60 per cent of other at-risk/vulnerable children affected by conflict and displacement who require support with socioeconomic reintegration, in line with the Programme de Désarmement, Démobilisation, Rélevement Communautaire et Stabilisation.

45. UNICEF will target 75 per cent of the education cluster target.

46. UNICEF will target 75 per cent of the education cluster target.

47. UNICEF will target 75 per cent of the education cluster target.

48. UNICEF's target for distribution of learning materials is 70 per cent of the target of the first (access) indicator for education.

49. UNICEF's target for distribution of learning materials is 70 per cent of the target of the first (access) indicator for education.

50. UNICEF's target for distribution of learning materials is 70 per cent of the target of the first (access) indicator for education.

51. UNICEF has applied the pupil-teacher ratio formula, which uses the average number of pupils (students) per teacher of the first (access) indicator for education.

52. UNICEF has applied the pupil-teacher ratio formula, which uses the average number of pupils (students) per teacher of the first (access) indicator for education.

53. UNICEF has applied the pupil-teacher ratio formula, which uses the average number of pupils (students) per teacher of the first (access) indicator for education.

54. UNICEF will target 35 per cent of the WASH cluster target.

55. UNICEF will target 35 per cent of the WASH cluster target.

56. UNICEF will target 35 per cent of the WASH cluster target.

57. UNICEF will target 35 per cent of the WASH cluster target.

58. UNICEF will target 35 per cent of the WASH cluster target.

59. UNICEF will target 35 per cent of the WASH cluster target.

60. UNICEF will target 30 per cent of the WASH cluster target.

61. UNICEF will target 30 per cent of the WASH cluster target.

62. UNICEF will target 30 per cent of the WASH cluster target.

63. UNICEF aims to reach 30,000 households through the Rapid Response Mechanism with one-off multipurpose cash assistance to cover their basic needs for three months. In addition, 50,000 households will be assisted using a cash-plus approach for gender-based violence prevention and assistance and receive monthly multipurpose cash assistance for four months. Additionally, 10,000 households will receive 12 months of cash assistance through the national social protection system. Finally, through a cash for nutrition approach, 30,000 households will receive cash for four months to prevent malnutrition, improve food diversity for children aged 6–23 months, complement severe wasting treatment and prevent treatment default.

64. This target includes people reached by all activities related to the dissemination of life-saving information, messages aimed at social and behaviour change and access to basic social services, including door-to-door visits, outreach to specific groups, and communication through SMS, digital and traditional media.

65. UNICEF aims to support front-line health workers, and 30,000 workers will receive 12 months of cash incentive payments to support the government health system for the polio campaign and the mpox response.

66. The target is based on a projection of 24,500 suspected cases for 2025. Through the case area targeted intervention approach (CATI), an average of 15–18 households (six members each) are targeted around each suspected cholera case.

67. Nutrition is the largest component of UNICEF's funding requirement for the country. The proportion of funding required for severe wasting treatment compared with other nutrition interventions has increased compared with 2024, with an annual caseload now at 1.6 million children. The cost of treatment for severe wasting has been updated and harmonized within the nutrition cluster, which has resulted in a budget increase.

68. This line item includes $68,304,107 for child protection interventions; $38,051,445 for gender-based violence in emergencies interventions; and $5,833,968 for protection from sexual exploitation and abuse interventions.

69. The average unit cost for the education cluster response is $128 for a period between 7 and 12 months, as we want to link the education in emergencies response with the development (nexus) perspective. This package comprises the settlement of temporary learning spaces, provision of teachers and students with learning and teaching materials, menstrual hygiene kits for adolescent girls, teacher training, recreational kits, hygiene kits and teacher training in psychosocial support, child-centred methodologies, etc.

70. Unit costs: distribution of WASH kits: $35/person; access to safe water: $25/person for distribution of water via water trucking and $20/person for extension of the pumping system.

71. Includes $55,185,000 for humanitarian cash transfers, $4,840,124 for social and behaviour change activities and risk communication and community engagement.

72. Includes $62,055,000 for the UNICEF Rapid Response mechanism (UniRR) and $10,848,600 for the cholera rapid response using the case area targeted intervention approach.