



ADVOCACY NOTE

Securing Life-Saving Sexual and Reproductive Health (SRH) Services for Women and Girls in Democratic Republic of the Congo (DRC)

2026 DRC HUMANITARIAN NEEDS AND RESPONSE PLAN (HNRP)

The 2026 Humanitarian Needs and Response Plan (HNRP) for the Democratic Republic of the Congo (DRC) addresses a severe crisis driven by conflict, disease, and climate shocks.¹

KEY FIGURES AND FUNDING REQUIREMENTS

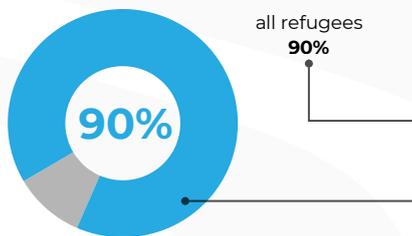


The overall response plan aims to target 7.3 million vulnerable individuals out of the 14.9 million people in need, requiring USD 1.4 billion.

REFUGEE AND HOST COMMUNITY ASSISTANCE



RESPONSE STRATEGY



- The plan targets 459,000 people for refugee assistance out of a total identified refugee population of 513,000 in need.
- The strategy aims to assist 90% of all refugees, covering those living both inside camps (planned or spontaneous) and off-site (with host families or in other localities).
- To foster social cohesion and service sharing, the plan also includes a target to assist 10% of the host population located in the affected zones.

HEALTH CLUSTER RESPONSE



- An estimated 7,5 million people have health-related needs.
- The 2026 Health response targets 2.5 million people and requires USD 105.3 million.
- A prioritized group of 1,7 million people is targeted for critical, life-saving interventions, appealing for a total of USD 67.5 million. This prioritized group includes approximately 425 000 women of reproductive age.



¹ https://reliefweb.int/report/democratic-republic-congo/republique-democratique-du-congo-besoins-humanitaire-et-plan-de-reponse-2026-janvier-2026?_gl=1%2A1994itk%2A_ga%2AMTEwMDQ4NTM2NS4xNzczMdAwMzQw%2A_ga_E60ZNX2F68%2AczE3NzMwMDAzMzkkbzEkZzAkdDE3NzMwMDAzMzkkajYwJGwwJGww

I. CRITICAL NEEDS, VULNERABILITIES AND DRIVERS OF MATERNAL & NEONATAL MORTALITY

Access to Sexual and Reproductive Health (SRH) services is severely affected in crisis zones, particularly in the East (Nord-Kivu, Sud-Kivu, Ituri, Tanganyika, Maniema) and the Grand Bandundu region, where populations face prohibitive costs, long distances to facilities, and a degraded quality of care. This increases the risk of maternal mortality, driven by low access to prenatal consultations, assisted deliveries, and Cesarean sections. Timely access to other lifesaving SRH services, such as the clinical management of rape, is critically compromised even as sexual violence is used as a tactic of war to terrorize populations, with over 90,000 cases of sexual violence documented between January and September 2025 alone. This situation has led to significant unmet needs regarding family planning and critical shortages of Interagency Reproductive Health kits specifically post-rape kits and contraceptives which are frequently out of stock following the suspension of vital funding that previously supported health capacities.

A. HEALTH AND FUNDING CRISES

Disease burden: Recurrent epidemics in the country, including cholera (over 71,900 cases in 2025), measles (over 87,000 cases), and monkey pox (over 93,000 suspected cases). The crisis in the health system, driven by epidemics and systemic strain, is severely compromising essential maternal, newborn and preventive healthcare services including:

- Low access to vital maternal healthcare services including antenatal consultations (ANC), assisted deliveries, and Cesarean sections is linked to the diversion of resources toward epidemic response and the institution of barrier measures in both cholera-endemic and non-endemic health zones. An SRH survey conducted in former IDP sites in Goma found a reduction in the number of women attending ANC during the peak of the monkeypox epidemic. Pregnant women for example are categorized as most vulnerable persons during these epidemics.
- The burden of responding to recurrent epidemics, such as cholera, measles and monkeypox, contributes to a systemic strain or "collapse" of health capacities, especially when combined with funding cuts. This strain leads to: vaccination gaps affecting routine vaccination, which is critical for maternal and child health, necessitating a strategy to relaunch routine vaccination within health structures. Nutritional vulnerability: recurrent epidemics (such as measles and cholera) are listed alongside conflict and food insecurity as factors worsening the nutritional situation of women and girls. Approximately 599,619 pregnant or breastfeeding women are expected to suffer from acute malnutrition and require emergency nutritional interventions for their survival.

Systemic collapse: A suspension of U.S. funding in 2025, which previously covered nearly 50% of the health sector, caused a systemic collapse in capacity, leading to 1.5 million people losing access to essential care, and an overall sector funding drop by 36%. Supporting the HNRP report, a May 2025 survey conducted by the Sexual and Reproductive Health Working Group (SRH WG) on the *immediate impact of U.S. funding cuts* found that over 50% of SRH interventions were temporarily suspended or disrupted. The most critical impact was observed in the availability of comprehensive Clinical Management of Rape (CMR) services, including post-rape kits, modern contraception, and the retention of skilled personnel.

Mental health: A silent crisis of acute psychosocial distress exists, but the mental health system is nearly inoperative. This is evidenced by a ratio of only 0.01 psychologists per 100,000 inhabitants. A September 2025 WHO report, which supports the Humanitarian Needs and Response Plan (HNRP), indicates that the global median number of mental health workers stands at 13 per 100,000 people, underscoring the extreme shortages in low- and middle-income countries. In support of the HNRP, a DRC case study published by UNFPA, [“Democratic Republic of Congo: Strengthening Mental Health and Psychosocial Support Integration in Sexual and Reproductive Health and Gender-Based Violence Emergency Interventions”](#) clearly highlights the deep interconnections between MHPSS and SRH, with poor mental health impacting reproductive outcomes and vice versa. Integrating MHPSS into SRH services is critical for holistic care, particularly in emergencies, to address issues like gender-based violence (GBV), maternal health challenges, and reproductive trauma. Mental health challenges in young people can lead to risky sexual behavior, resulting in unintended pregnancies and sexually transmitted infections (STIs), including HIV.

Repeated attacks on healthcare facilities severely hamper humanitarian response and access to vital care.

B. MATERNAL AND NEWBORN HEALTH CRISIS



Vulnerability: Approximately 100,000 pregnant and breastfeeding women require vital health assistance.

Access gaps to life saving services including obstetric care: Access to vital maternal healthcare services, including antenatal consultations (ANC), assisted deliveries, and Cesarean sections, is currently very low. Data from the 2023–2024 DRC Demographic Health Survey supports the Humanitarian Needs and Response Plan (HNRP) by showing that a large proportion of maternal and neonatal deaths occur during the first 48 hours following childbirth. This critical risk period is severely exacerbated in conflict-affected areas where access to skilled personnel and quality care is absent.



Immediate postnatal care is severely lacking: fewer than three in ten women (29%) who had a live birth or stillbirth in the two years preceding the survey received postnatal care within two days after delivery. Safe motherhood programs recommend examining the health status of all women within the first two days after childbirth, making the rapid provision of postnatal care to mother and child essential for treating potential complications and providing vital information on self-care and baby care practices.

Maternal Mortality statistics and accountability

The crisis is evidenced by rising fatality rates and poor tracking in the eastern region embedded in the general maternal mortality ratio, which stands at 746 EDS III 2023-2024. Statistics from the National Programme for Reproductive Health (PNRS) indicate an increase in reported maternal deaths in healthcare facilities in North Kivu, rising from 220 in 2024 to 230 in 2025. The majority of deaths were concentrated in the health zones of Goma, Rutshuru, Masisi, Beni, Katwa, and Rwanguba. Mortality reduction efforts were noted in Mweso and Walikale when comparing data between the two years.

The situation in Ituri province is similarly severe, underscoring the widespread maternal health crisis where access to Sexual and Reproductive Health (SRH) services is severely affected. In 2025, records show a total of 227 intrahospital maternal deaths and 87 community deaths. However, tracking and accountability measures are incomplete, as only 183 intrahospital deaths and 7 community deaths underwent the necessary audits. (NB. All data for 2025 is under verification).

The table below highlights the scale of maternal mortality (MM) in the eight provinces affected by humanitarian crises (North Kivu, South Kivu, Ituri, Tanganyika, Maniema, Kwilu, Kwango, and Mai-Ndombe). According to the Ministry of Health's Maternal and Perinatal Deaths Surveillance and Response (MPDSR) 2025 report, these provinces account for more than a third of national deaths, or 2,185 of the 5,609 deaths reported between 2023 and 2024.

PROVINCES	MATERNAL DEATHS NOTIFIED AT HEALTH FACILITIES		
	2023	2024	Total
NORTH KIVU	226	245	471
SOUTH KIVU	181	126	307
ITURI	188	225	413
TANGANYIKA	98	102	200
MANIEMA	125	156	281
KWILU	108	133	241
KWANGO	56	63	119
MAI-NDOMBE	67	86	153
TOTAL (8 PROVINCES AFFECTED BY HUMANITARIAN CRISIS)	1049	1136	2185
TOTAL DRC	2668	2941	5609

Data source DHIS2

Adolescent Pregnancy and Related Risks

Adolescent pregnancy in the eastern DRC is a major driver of high maternal mortality. This risk is compounded by widespread sexual violence and limited access to contraception, which had a prevalence of 7.5% according to the MICS 2013-2014. Approximately 1 in 5 adolescents aged 15–19 has already been pregnant. Among pregnant adolescents, 33% have no level of education. In North Kivu province, the adolescent birth rate is 73 per thousand (MICS 2017-2018), with 27% of pregnancies occurring before the age of 18. Adolescent fertility contributes significantly to maternal morbidity and mortality, as well as to obstetric fistula and other long-term gynecological conditions. Most adolescent and youth pregnancy deaths in North Kivu are recorded through obstructed labour and clandestine abortions owing to the lack of knowledge and access to safe comprehensive abortion care and (National Programme of Reproductive Health and Ipas DRC).

Nutrition crisis

A total of 1.9 million pregnant or breastfeeding women will be affected by malnutrition, with nearly 600,000 (599,619) suffering from acute malnutrition and requiring emergency nutritional interventions for survival. The closure of 1,178 nutrition centers due to funding cuts has amplified the risks of preventable morbidity and mortality. The Nutrition Cluster targets 169,137 pregnant or breastfeeding women for emergency supplementary feeding.

- Health crises and displacements often lead to the abandonment or interruption of antiretroviral (ARV) treatments, increasing viral loads and mortality.
- Funding crisis: The suspension of US funding (PEPFAR) in January 2025, which previously covered over 80% of the HIV response, caused widespread disruption of care in several provinces and increasing mortality risks.
- At-risk population: There are 27,000 people living with HIV (PVVIH) identified as being at risk of treatment interruption in crisis zones due to displacement, stockouts, or fear of disclosing their status.



II. STRATEGIC OBJECTIVES OF THE HNRP AND SRH LINKAGES

The 2026 HNRP is structured around two main strategic objectives designed to address the complex crisis in the Democratic Republic of the Congo:

Strategic Objective 1: Saving Lives and Alleviating Suffering The primary goal is to save lives and reduce the suffering of populations affected by recurrent shocks, specifically conflicts, natural hazards, and epidemics



This objective focuses on providing safe, equitable, inclusive, and principled multisectoral assistance. It targets immediate humanitarian needs with potentially life-threatening consequences (life-saving interventions) for the most vulnerable groups. The response will focus on rapid delivery of vital assistance to displaced persons, host communities, and those in epidemic or disaster zones using Rapid Response Mechanisms (RRM) and multisectoral cash transfers. Key interventions aim to reduce acute food insecurity, prevent severe malnutrition, and ensure access to primary health care, potable water, and safe shelter.

Strategic Objective 2: Improving Access to Basic Services and Preserving Coping Capacities The second goal is to improve safe, equitable, and dignified access to quality basic services for those affected by recurrent shocks, in accordance with fundamental rights and standards.

The aim is to prevent the further erosion of the population's coping capacities and preserve the well-being of vulnerable people. This objective includes supporting coping mechanisms, restoring essential community services, and strengthening preparedness for climatic and epidemic shocks. It is designed to reduce dependence on humanitarian aid, contribute to the operationalization of the Humanitarian-Development-Peace Nexus, and promote sustainable solutions for internally displaced persons.



The 2026 response strategy for SRH meets the HNRP and Health sectoral objectives aiming to ensure immediate equitable access to vital care including strategic goals to reduce preventable deaths, targeting those facing extreme deprivation of services:

- **Emergency Care and Service Restoration:** Ensure immediate and vital access to Maternal, Reproductive, Neonatal, and Infant Health Care, including Emergency Obstetric and Neonatal Care and safe delivery services to prevent deaths during childbirth and, Family Planning services.
- **Clinical Management of Rape:** Ensure the provision of comprehensive management of sexual violence,, including post-rape kits (emergency contraception, prevention and treatment for STIs, and availability of Antiretroviral (ARV) therapy), and the retention of skilled personnel.
- **HIV Integration:** Fully integrate the management of HIV and chronic conditions by focusing on maintaining antiretroviral (ARV) supply chains, voluntary testing, and the Prevention of Mother-to-Child Transmission (PMTCT) to reduce mortality among mothers and infants.
- **Supply Chain:** Ensure the provision of Interagency Sexual and Reproductive Health kits.
- **Logistics:** Strengthen medical logistics through digital monitoring and direct support to Provincial Health Divisions (DPS) to reduce critical stockouts of essential medicines.
- **Confidentiality:** Secure confidential spaces for SRH consultations.

III. ACCOUNTABILITY TO AFFECTED PEOPLE (AAP) AND OPERATIONAL ADJUSTMENTS

Accountability is a central pillar of the "Humanitarian Reset," centering the response on the needs and preferences of affected populations.

- Staffing adjustments: Planning includes the deployment of female providers for SRH services to ensure cultural sensitivity and comfort for patients.
- Communication preferences: Assessments show that communities prefer face-to-face communication, community meetings, and radio. A distinct gender divide exists: women prefer face-to-face interactions with known staff or focus groups, while hotlines are used almost exclusively by men (99%).
- Implementation: Feedback is actively used to adjust programming, such as modifying clinic hours or ensuring the presence of female staff for sensitive services.

IV. FINANCIAL REQUIREMENTS ON SRH AS INTEGRATED IN HEALTH (UNIT COSTS PER PERSON)

The total funding required for the Health response and \$105.3 million. Specific unit costs for SRH in 2026 can be estimated as follow:



Essential Health Services (including maternal and reproductive health)

\$36 per person (an increase from \$33 in 2025) amounting to approximately 15,3 Million USD for basic Maternal and Reproductive Health services for 425000 women of reproductive age.

GBV/Specialized Care including MHPSS

\$121 per person (up from \$105). This increase is specifically attributed to the high cost of post-rape kits and required clinical supervision.



The Health Cluster has integrated MHPSS into its essential response package alongside care for sexual and reproductive health and trauma. The strategy aims to strengthen access to mental health services for populations facing acute distress, particularly those exposed to high risks of violence.



HIV/Chronic Care Continuity

A dedicated unit cost of \$166 per person has been introduced to ensure the continuity of care for chronic diseases (including HIV) to prevent mortality associated with treatment interruption.

Nutrition Package

\$30 per person amounting to \$ 5 million for the approximately 169,137 pregnant or breastfeeding women targeted by the Nutrition Cluster for emergency supplementary feeding.



V. COORDINATION OF THE SRH RESPONSE IN EMERGENCY SETTING

In the Democratic Republic of the Congo (DRC), Sexual and Reproductive Health (SRH) activities are coordinated by the National Programme for Reproductive Health (PNSR) with support from partners including UNFPA responsible for leadership of the Sexual and Reproductive Health Working Group (SRH WG), which has been functional for the last decade.

Coordination Structure and Functions:

- National Level: The SRH WG functions as a specialized technical arm within the Health Cluster.
- Crisis zones: In crisis zones, this working group reports to the provincial-level Health Cluster SRH WG. This structure aims to coordinate life-saving interventions, prioritize funding, and ensure SRH services are integrated into the broader humanitarian response.
- Sub-Task Force: A clinical management of rape task force equally exists under the SRH WG.

Key objectives include:

Defining scope and priorities

Identifying key areas and strategies for the humanitarian response, specifically highlighting the needs of women, girls, and marginalized populations.

Facilitating coordination

Aligning SRH stakeholders (UN agencies, NGOs, Ministry of Health) to avoid duplication, identify coverage gaps, and ensure a cohesive approach, particularly in hard-to-reach areas.

Integrating comprehensive SRH

Prioritizing comprehensive SRH services including maternal care, family planning, and gender-based violence (GBV) response and mitigation support within the general health response. This aims to bridge the gap between emergency life-saving care (Minimum Initial Service Package - MISP) and long-term health system strengthening.

Mobilizing resources

Utilizing the plan as an advocacy tool to justify the financial requirements necessary to sustain SRH and GBV programs, which are often at risk due to funding shortages.



key advocacy messages on Sexual and Reproductive Health (SRH)

1

Stop the Surge in Maternal Deaths by Restoring Life-Saving Obstetric Care.

Urgently fund vital Maternal, Reproductive, Neonatal, and Infant Health Care, including Emergency Obstetric and Neonatal Care (EmONC). Maternal mortality ratios in the DRC are critically high, ranging from 746 per 100,000 live births, driven by low access to assisted deliveries and essential postnatal care during a critical 48-hour risk period following childbirth.

2

Treat Sexual Violence as an Emergency Requiring Immediate, Comprehensive Response.

Prioritize the provision of comprehensive Clinical Management of Rape (CMR) services, including post-rape kits, emergency contraception, and Antiretroviral (ARV) and strengthen confidentiality and data privacy. Over 90,000 cases of sexual violence were documented between January and September 2025, yet access to these life-saving services is critically compromised and was disrupted by funding cuts.

3

Address the Systemic Collapse of the Health Sector Due to Funding Suspensions.

Mobilize resources to meet the total \$105.3 million required for the Health response. The suspension of vital international funding caused a systemic collapse, disrupting over 50% of SRH interventions and placing 27,000 people living with HIV at risk of treatment interruption.

4

Invest in Adolescent Health to Curtail a Major Driver of Maternal Mortality.

Target interventions specifically toward adolescent SRH needs, as adolescent pregnancy is a major driver of maternal mortality in eastern DRC. In North Kivu, the adolescent birth rate is 73 per thousand, with many adolescent pregnancy deaths linked to obstructed labor and unsafe clandestine abortions.

5

Integrate Mental Health Support to Ensure Holistic SRH Care for Survivors.

Ensure the full integration of Mental Health and Psychosocial Support (MHPSS) into SRH services, especially for gender-based violence (GBV) survivors, recognizing the deep connection between mental health and reproductive outcomes. The existing mental health system is nearly inoperative, evidenced by a ratio of only 0.01 psychologists per 100,000 inhabitants.

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FOR MORE INFORMATION

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