STEPS TOWARDS SUCCESSFUL INTERSECTORAL COLLABORATION – A CASE STUDY FROM THE DEMOCRATIC REPUBLIC OF CONGO

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République Démocratique du Congo CLUSTER NUTRITION

République Démocratique Du Congo CLUSTER SÉCURITÉ ALIMENTAIRE

CLUSTER SANTÉ

Cluster EHA République Démocratique du Congo

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LIST OF ABBREVIATIONS

BSFP: Blanket Supplementary Feeding Programme
CV: Community Volunteers
DRC: Democratic Republic of Congo
EPI: Expanded Programme on Immunization
EU: European Union
FCDO: Foreign, Commonwealth & Development Office (UK)
FEFA: Femme Enceinte/Femme allaitantes (Pregnant woman/Breastfeeding mother)
FS: Food Security
GAM: Global Acute Malnutrition
GHO: Global Humanitarian Overview
HCF: Health Care Facility
HF: Humanitarian Funds
HNO: Humanitarian Needs Overview
HPC: Humanitarian Programme Cycle
HRP: Humanitarian Response Plan
HZ: Health zone
IDP: Internally Displaced Persons
IMCI: Integrated Management of Childhood Illness
IPC AFI: IPC Acute Food Insecurity Classification
IPC AMN: IPC Acute Malnutrition Classification
IYCF-E: Infant and Young Child Feeding in Emergencies
MICS: Multiple Indicator Cluster Survey
NHDP: National Health Development Plan
SAM: Severe Acute Malnutrition
SDG: Sustainable Development Goal
SNSAP: Surveillance Nutritionnelle et Suivi des Alertes Précoces (Nutritional Surveillance, Food Security and Early Warning System)
SUN: Scaling Up Nutrition
USAID: United States Agency for International Development
WASH: Water, Sanitation and Hygiene
WIN: WASH in Nutrition

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SUMMARY

The Democratic Republic of Congo has faced an acute, complex humanitarian crisis for almost 30 years. Armed conflicts, devastating epidemics, such as measles or Ebola, combined with high levels of chronic poverty and persistent structural deficits, have worsened humanitarian needs in numerous regions of the country. Moreover, one child in two suffers from stunting and around one in 15 from severe acute malnutrition. This critical prevalence of undernutrition is also driven by the high prevalence of food insecurity. According to the humanitarian response plan 2022[1], 27 million people will need humanitarian assistance in 2022.

In 2019, the water, sanitation and hygiene (WASH), Nutrition, Health and Food Security clusters identified the intersectoral approach as a genuine opportunity for significantly reducing the resurgence of crises in areas that were continually affected by cholera and measles epidemics, acute malnutrition and food insecurity. This intersectoral work is based on the geographical convergence of sectors focusing on the provision of a package of activities, at the same time, and for the same beneficiaries.

Organizing the multisectoral approach required a series of steps that were important for its success:

-intersectoral training to prepare the participants to work in an integrated way by highlighting the concepts of intersectorality, and presenting the tools and processes needed.

-the creation of an intersectoral sub-group of information managers, whose objectives were to conduct a cross-cutting analysis of the tools and databases used in the various clusters and then create a joint analytical tool.

-the creation of a technical intersectoral sub-group, with the primary objective of identifying minimum packages of activities for each cluster.

-the organization of an intersectoral workshop to define a package of activities, and its cost per sector, to respond to the various types of crisis commonly encountered in the DRC, as well as a list of criteria (indicators and thresholds) to prioritize the intervention areas. All of this has now been compiled in an intersectoral manual.

A number of these steps faced obstacles, in particular in relation to the security situation and the COVID pandemic, which significantly limited access to populations in need. Other issues include logistical difficulties, the limited capacity for intersectoral programming among partners, and the fact that none of the four sectors received the necessary funding expected for the HRP 2021.

Ultimately, however, the intersectoral collaboration between the four clusters resulted in an intersectoral Humanitarian Need Overview (HNO) and Humanitarian Response Plan (HRP) in 2022, and an increase in funded intersectoral proposals from 20 per cent in 2021 to over 50 per cent n 2022, along with the production of an intersectoral manual.

The process used in the DRC can be used as an example of the steps to follow for the successful implementation of an intersectoral approach. This is a holistic approach, which is transferable and applicable to different contexts, including emergencies, transition or development.

The documents produced, particularly the intersectoral manual and intersectoral package of activities, will be an excellent starting point for discussions on intersectoral collaboration and programming, and could be adapted to other contexts.

[1] Humanitarian Response Plan

CONTEXT & PROBLEM STATEMENT

The Democratic Republic of Congo has faced an acute, complex humanitarian crisis for almost 30 years. Armed conflicts, devastating epidemics, such as measles or Ebola, combined with high levels of chronic poverty and persistent structural deficits, have worsened humanitarian needs.

CONTEXT

The Democratic Republic of Congo has experienced continued unrest for almost three decades. This includes community conflicts and the corresponding population displacements. Around 5.2 million people were displaced inside the country in 2021, mainly because of conflicts in all its eastern provinces (GHO 2021). Unrest is an issue in around 13 of the DRC's 26 provinces and the people most affected are women and children.

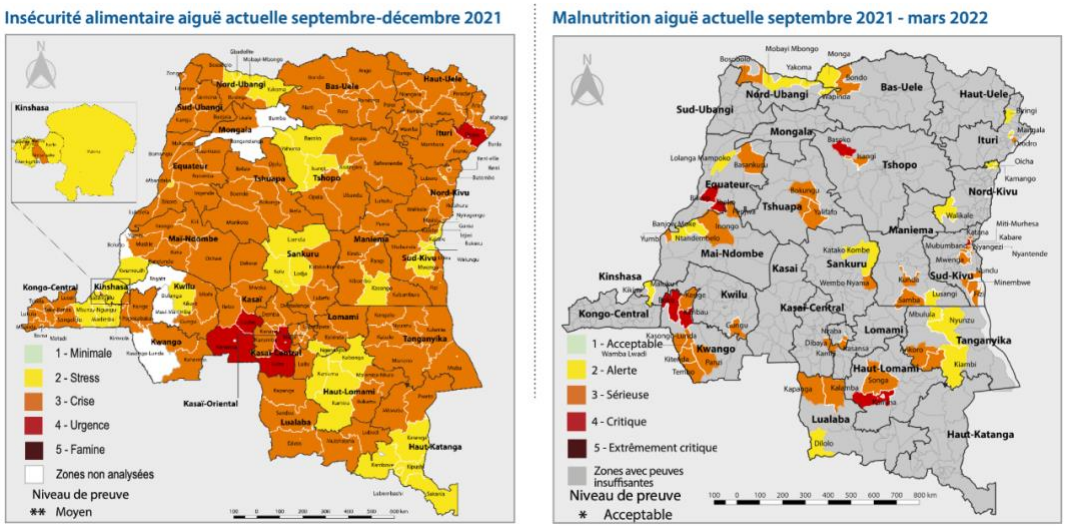
In addition to the unrest caused by the conflicts, the DRC has faced a number of recurring epidemics, including measles, cholera, Ebola and more recently, COVID-19.

It is important to emphasize that health care facilities and medical equipment are often damaged during these conflicts, medicines and other medical consumables stolen and health care workers sometimes even injured or killed. This continues to threaten access to care for people in need.

Infant and child mortality is still very high, at 70 deaths per 1,000 live births, while maternal mortality is at 846 per 100,000 live births (National Health Development Plan (NHDP) 2019 update). A majority of deaths among children aged under five years (53 per cent) are linked to undernutrition, which is due, in part, to infections during the neonatal period, pneumonia, diarrhoeal diseases, malaria, and measles and cholera epidemics, to name only the main causes.[2]

In terms of undernutrition, one child in two suffers from stunting and around one in 15 from severe acute malnutrition. This critical prevalence of undernutrition is also driven by the high prevalence of food insecurity. According to the IPC Acute Food Insecurity Classification (IPC AFI – 2021, coverage of 95 per cent of the country, 27.3 million people were in a situation of food insecurity. Moreover, the IPC Acute Malnutrition Classification (IPC AMN), which covered a very small part of the country (13.5 per cent), states that there are 857,000 children aged six to 59 months in a situation of acute malnutrition, 25 per cent of whom are suffering severe acute malnutrition, with 468,000 pregnant women and breastfeeding mothers also suffering from malnutrition.

The IPC AFI and AMN map 2021–2022 is shown below[3] (figure 1).



Figures 1 and 2: IPC AFI phase September–December 2021 and PC AMN phase September 2021 to March 2022.

[2] Bryce et al. (2005), "WHO estimates of the cause of death in children", The Lancet.

[3] IPC AFI and AMN, ipcinfo.org

While there has been massive investment to reduce the burden of malnutrition, no more than 30 per cent of acute malnutrition cases access treatment in health care facilities. This limited coverage is linked to funding that remain inadequate, but also to the fact that over half the population is at a distance (more than 50 km) from health centres, and that some centres do not have sufficient nutritional supplies, while others have been destroyed by the conflict.
The limited use of health centres is also striking for family planning, with only 30.9 per cent of needs covered. The antenatal consultation rate is close to 43 per cent.
Around 3.4 per cent of children aged under five years suffered from acute respiratory infections according to the Multiple Indicator Cluster Survey (MICS) 2018[4]. Just 27.4 per cent of all these cases were correctly treated with antibiotics.

Diarrhoeal diseases and cholera epidemics are an important direct cause of undernutrition and responsible for high mortality among children aged under five years. Just 24.1 per cent of diarrhoea cases are treated correctly and only 21.5 per cent of households have facilities for washing hands with soap and water (MICS 2018). Households' use of improved toilets stands at just 32.6 per cent, while the use of hygienically managed drinking water is 4.9 per cent.

Finally, the measles, cholera, Ebola and coronavirus epidemics have contributed significantly to morbidity and deaths among children aged under five years in the DRC. It was noted that 20 of the country's 26 provinces experienced a measles epidemic, sometimes with a high mortality rate, between January and August 2021. Thirteen provinces recorded cholera epidemics during the same period. The DRC experienced two major Ebola epidemics from 2018 to 2021, in Equateur, North Kivu and Ituri provinces. The coronavirus pandemic affected all of the country's 26 provinces from March 2020 to the end of 2021, with a mortality rate of 1.5 per cent.[5]

Synergic intersectoral interventions are the most effective and efficient means of responding to the humanitarian needs of the affected populations in response to these multisectoral challenges and in order to reverse the trend of high mortality in the population in general, and among children aged under five years and women of reproductive age in particular. Accordingly, the WASH, Nutrition, Health and Food Security clusters have worked on a joint strategic plan to pool multisectoral interventions in response to the population's urgent humanitarian needs in common geographical areas, at the same time and for the same beneficiaries.

PROBLEM STATEMENT

According to the observations of the WASH, Nutrition, Health and Food Security sectors, their isolated interventions prior to 2020 were limited in terms of effectiveness and efficiency. The projects they implemented, which were confined to their sectoral activities, very often resulted in a duplication of transport costs for basic supplies, as well as operational and human resources costs, among others, sometimes for interventions in the same areas. In addition to the high cost, isolated, sectoral interventions often have a limited impact, as the populations concerned do not necessarily receive all the interventions that would be beneficial to them in the short, medium and long term. It is also important to emphasize that many donors do not prioritize the funding of multisectoral projects and are limited by their sector-specific funding mandate, which limits the implementation of joint interventions.

[4]MICS 2018, UNICEF DRC
[5] DRC Ministry of Health Analysis Unit, 06/03/2022

not necessarily receive all the interventions that would be beneficial to them in the short, medium and long term. It is also important to emphasize that many donors do not prioritize the funding of multisectoral projects and are limited by their sector-specific funding mandate, which limits the implementation of joint interventions.

Combating malnutrition requires both nutrition-specific and nutrition-sensitive interventions[7] to reduce the prevalence of the different types of malnutrition. Nutrition-sensitive interventions are deployed mainly by the WASH, Health and Food Security sectors.

Despite the fact that the nutritional situation has been critical in the DRC for several years, less than half of acute malnutrition cases are correctly treated, since nutrition programmes are implemented in isolation from other sectors; there are also, of course, other problems, such as access difficulties and the limited resources allocated to health centres. For example, the relapse rate is still very high, sometimes more than 10 per cent, as there are rarely any health, food security and/or WASH interventions to support treatment at the household level and avoid children relapsing afterwards.

WASH interventions are also implemented in health districts, with very weak links to the other sectors. As a consequence, the results achieved after years of implementation have had a limited impact on diarrhoeal diseases and malnutrition.

Other examples include measles epidemics, for which there is no systemic treatment of malnutrition cases. The fact that the measles response does not take into account the treatment of children suffering from both measles and malnutrition has not resulted in a reduction in mortality. The responses to cholera epidemics have focused on treating cases and not on prevention through WASH interventions as such, which has meant they have lasted longer. A final example of the prevailing silo-based approach is that each of the WASH, Nutrition and Health sectors has used a different group of community workers to provide services to the same population, which increases the cost of interventions and undoubtedly causes confusion among the beneficiaries.

All these observations prompted the WASH, Health, Food Security and Nutrition sectors to collaborate with each other to find intersectoral solutions with greater impact for beneficiaries in the short, medium and long term, by reducing the costs of intervention overall.

[7] **Nutrition-specific interventions** are interventions and programmes that respond to the immediate causes of malnutrition, such as access to a varied and balanced diet, adequate care practices, access to treatment for malnutrition, distribution of micronutrients, etc. **Nutrition-sensitive interventions** are interventions and programmes that respond to the underlying causes of malnutrition, such as food security, access to health care, access to a sufficient quantity of drinking water, access to good care practices at home, in the community, etc..

INTERSECTORAL COLLABORATION PROCESS & PRESENTATION OF RESULTS

The WASH, Nutrition, Health and Food Security clusters identified an intersectoral approach as an opportunity for significantly reducing the resurgence of crises in areas that were continually affected by cholera and measles epidemics, acute malnutrition and food insecurity.

INTERSECTORAL COLLABORATION PROCESS

In 2019, in light of the issues outlined above, the WASH, Nutrition, Health and Food Security clusters identified an intersectoral approach as an opportunity for significantly reducing the resurgence of crises in areas that were continually affected by cholera and measles epidemics, acute malnutrition and food insecurity. The intersectoral collaboration and programming process was launched to do this in accordance with the Humanitarian Response Plan 2020 and the "Delivery as One" objective[7] (for United Nations organizations and their partners)[8].

This intersectoral work is based on:

1) Geographical convergence between the sectors
2) The provision of a package of activities at the same time
3) Putting the beneficiary at the centre of the intervention (Figure 1).

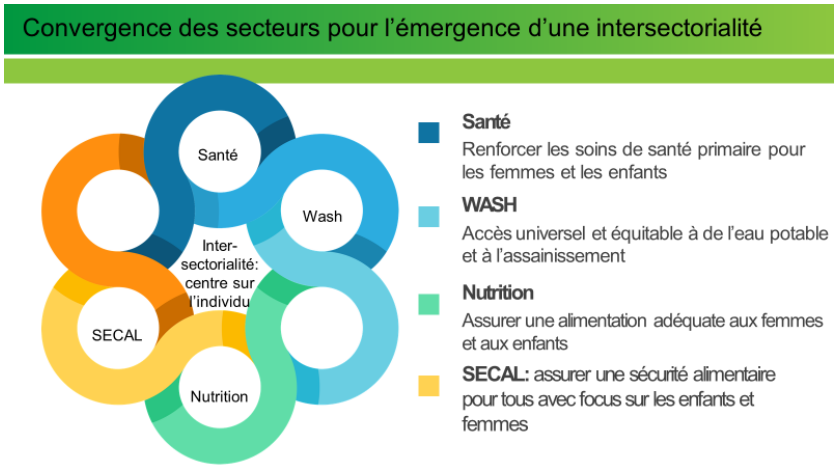


Figure 1. Convergence for an intersectoral response

STEPS FOLLOWED FOR INTERSECTORAL INTERVENTION IN THE DRC

All the activities below were implemented thanks to the determination of the coordinators and information managers of the four sectors, under the leadership of the Nutrition cluster in the DRC.

1) Intersectoral training

In late 2019, the WASH, Nutrition, Health and Food Security clusters in the DRC received in-person, intersectoral training with the support of the global Nutrition and Food Security clusters. This prepared the participants to work in an integrated way by highlighting the concepts of intersectorality, and presenting the tools and processes needed.

Following the training, the four clusters, the Humanitarian Fund (FH) and the nongovernmental organization (NGO) members of the clusters made a commitment to designing multisectoral projects in jointly selected geographical areas.

[7] United Nations General Assembly webpage on "Delivery as One"
[8] 2020 Humanitarian Response Plan

2) Creation of an information managers' intersectoral sub-group:

A working sub-group of information managers from the four clusters was set up, with the aim of conducting a cross-cutting analysis of the tools and databases used in the various clusters. The idea was to create a common management tool for the intersectoral data, which could respond to the various requirements of the four sectors, and provide a dynamic analysis demonstrating the presence of intersectoral operations and the operational results of the activities. The data collection tool has now been almost finalized and the first joint analysis is scheduled for the first quarter of 2022.

3) Formation of a technical intersectoral sub-group:

A technical working sub-group with representatives of the four clusters was set up after the training, in late 2019, with the primary aim of carrying out a cross-cutting analysis of the practicalities of intersectoral integration, by identifying minimum intervention packages for a better response to humanitarian crises in the DRC.
The technical group also produced a work plan and held regular quarterly meetings between themselves, as well as meetings with the global clusters, to get advice on the intersectoral approach used in other countries.

4) Organization of an intersectoral workshop:

The workshop was organized in May 2021 (initial date rescheduled due to COVID).
The aim of the workshop was to define:
- the elements of the intersectoral package of interventions by sector, based on the different types of crisis commonly encountered in the DRC
- the cost of a package of interventions selected by sector
- a list of criteria (indicators and thresholds) for prioritizing health zones for a multisectoral intervention.

All these documents and tools were compiled in an intersectoral manual. The manual reflects the results of the joint discussions and is designed as a reference document for planning, preparing and implementing intersectoral interventions in the sectors concerned at household, community and health centre level.

The manual is available online at:
https://drive.google.com/file/d/1HFb61ZyCnF7f0kBOA4lKQCXuAAHdA4Rc/view?usp=sharing

It has become the intersectoral reference document for the partners, the inter-cluster coordination group and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA), as well as for donors operating in the DRC.

The manual sets out a series of eight issues in the form of a summary sheet, namely: the nutritional emergency; the cholera epidemic; the measles epidemic; the population movement crisis; the Ebola epidemic; the COVID-19 epidemic; natural disasters; and the meningitis epidemic. It also contains multiple examples of intersectoral approaches, such as the implementation of WASH and food security activities, which helps to ensure that all families with children suffering from severe acute malnutrition are given access to WASH kits and support for small-scale gardening as well as treatment. Another example illustrates the fact that health care facilities offering nutrition and health services receive support for access to sources of drinking water, hand wash basins and hygienic latrines.

The manual also explains how to rationalize intervention costs while ensuring that:

- Partners are capable of implementing a multisectoral package, rather than specializing in one area in particular. This helps to reduce the support costs of implementation partners.
- Joint transport of supplies for all four sectors is organized through to the projects implementation areas.
- An integrated package of awareness-raising activities is developed at the community level and that a single set of actors is selected for each community, rather than having multiple actors in each sector, to provide the whole package.
- Capacity is built jointly.
- There is an evaluation mechanism in place before and after the intervention, as well as joint project monitoring, etc.

Overview of criteria for prioritization of intervention areas:

The four clusters agreed on criteria to prioritize geographical areas where the intersectoral interventions would be delivered at the same time, to the same population. These criteria were combined with severity scores ranging from 0 to 3, where 3 indicated the most severe situation. A total was then assigned to the zone concerned.

Indicators	**Thresholds**	**Scores**
Number of SNSAP alerts in the last 12 months	0-1	1
	2	2
	3-4	3
IPC classification	Phase 1 and 2	1
	Phase 3	2
	Phase 4 or higher	3
SAM prevalence	0–1.9%	1
	2–3%	2
	More than 3%	3
GAM prevalence	0–9%	1
	9.1–20%	2
	More than 20%	3

Stunting	0–10%	1
	10.1–20%	2
	More than 20%	3
Presence of epidemics:		
Measles	Yes	2
	No	0
Cholera	Yes	1
	No	0
COVID	Yes	1
	No	0
Ebola	Yes	2
	At risk	1
	No	0
Population movement	Yes	2
	No	0

The scores were totalled and the areas then prioritized as follows:

By summing the scores obtained, the zones are then prioritized as such:

- Low priority = Scores between 5 and 10
- Medium priority = Scores between 11 and 15
- High priority = Scores between 16 and 20

The map below shows the prioritization map for the second half of 2021 – Figure 3:

Where: green = low priority (61 health zones); amber = average priority (311); red = high priority (147)

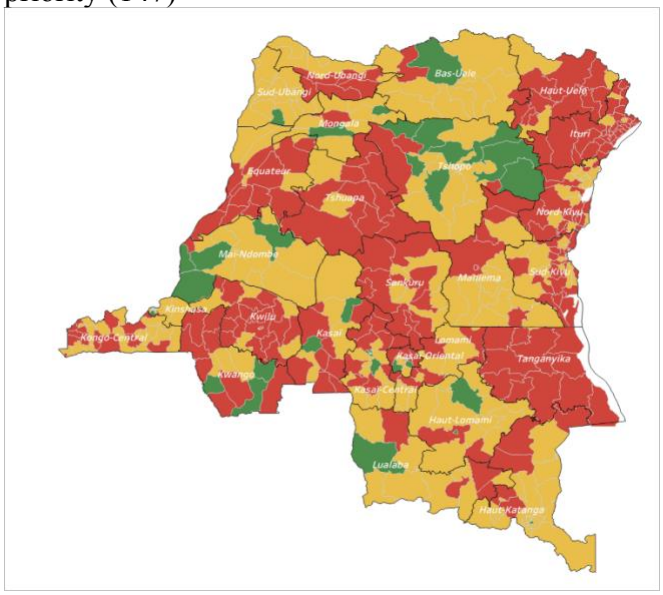


Figure 3, prioritization second half of 2021

The prioritization of the Nutrition cluster is intersectoral and also takes the criteria from other sectors into account.

Another exercise resulted in the prioritization of 229 health zones. Thirty-seven of the 229 were classed as "high priority" and will be prioritized for intersectorality in 2022. The HRP 2022 also included an intersectoral classification: the intersectoral response for the four clusters will concentrate on Ituri, North Kivu, South Kivu and some parts of Tanganyika (Figure 4), where humanitarian needs are worsening and levels of vulnerability are increasing.

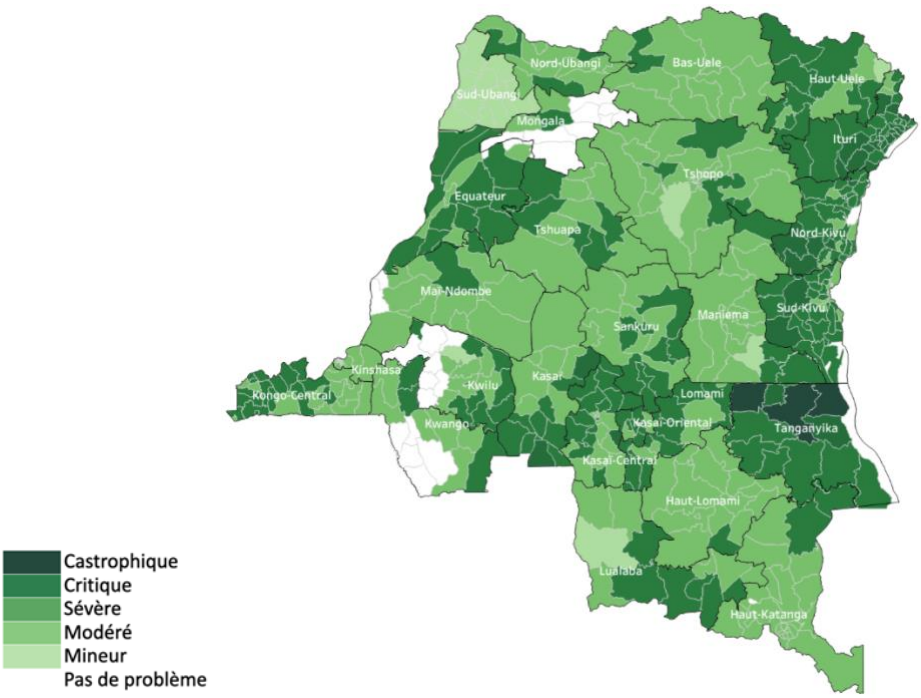


Figure 4: Severity of intersectoral needs in the DRC, HRP 2022.

PRESENTATION OF RESULTS

The intersectoral collaboration between the four clusters resulted in an intersectoral Humanitarian Need Overview (HNO) and an initial intersectoral Humanitarian Response Plan (HRP) in 2022. [9]

The collaboration also resulted in the development of an intersectoral manual, which has become the reference document for intersectoral work in the DRC.

Another positive outcome of the intersectoral collaboration is the closer cooperation between the four clusters, with the formation of a technical group and an information managers' group, which together analyse intersectoral data and produce intersectoral maps and reports.

The four sectors are persuaded of the relevance of working together and have developed an intersectoral emergency plan for 2022[10] that will allow the clusters to anticipate crises related to epidemics, malnutrition, any natural disasters and population movements.

[9] 2022 DRC Humanitarian Need Overview
2022 DRC Humanitarian Response Plan
[10] See 2022 DRC Humanitarian Need Overview.

MAIN CHALLENGES & BEST PRACTICES

At the community level, multiskilled actors trained in the various multisectoral approaches will help ensure that the activities are sustainable.

MAIN CHALLENGES

Alongside the good intentions and understanding of the necessity of intersectoral collaboration and programming, numerous obstacles were encountered from the beginning of the process.

- Complex working environment

The first obstacle was the delay in organizing the intersectoral workshop and rolling out the approach due to COVID-19, with almost a year lost. The finalization of the intersectoral manual, scheduled for the third quarter of 2021, was also delayed because of further disasters and the response needed to the eruption of the Nyiragongo volcano in late May 2021.

- Security situation

The DRC is a vast country with huge security challenges, particularly in the eastern part of the country, where several armed groups are still active. This prevents the regular physical presence of various implementation actors in all areas requiring humanitarian interventions, including intersectoral responses. It then becomes difficult to visit certain health areas to carry out activities or provide supervision and training. The transport of supplies, especially medicines, food, nutritional and WASH products, is also affected by the security situation, which then impacts the implementation of intersectoral interventions.

- Access to humanitarian assistance and logistical challenges

Globally, the road network in the DRC is ranked 140 out of 141[11], making it one of the worst in the world. Moreover, most humanitarian zones are in rural areas with the most precarious road networks, so that it sometimes takes three to five days to reach certain health zones. Humanitarian actors face difficulties accessing these zones and may be unable to be present as often or for as long as needed for implementation, including for the delivery of supplies and appropriate project monitoring. The lack and poor condition of roads also makes it difficult for the population to access the services available.

- Partners' capacity for intersectoral programming

Not all the various partners, including the government, have adequate capacity for implementing the multisectoral response. Numerous actors implementing interventions in the field find it difficult to do so, either because their projects are designed to be sector specific, or because their technical capacity is limited to a single sector. It is therefore sometimes difficult to persuade these actors of the relevance of intersectoral interventions and limited funding is often another significant constraint.

- Funding

None of the four sectors received the necessary funding specific to multisectoral activities expected for the HRP 2021. Up to December 2021, the WASH sector had received 12.3 per cent of the funds required to respond to the needs of the affected populations; the nutrition sector 26.5 per cent; the health sector 14.3 per cent and the food security sector 25.9 per cent.

The limited availability of funding means that the interventions needed – including intersectoral interventions – are not implemented. Funding disparities between the clusters hinders the implementation of intersectoral interventions on the scale required to respond to the needs of populations in the agreed geographical areas.

[11] Global Competitiveness Index 4.0 2019 edition

BEST PRACTICES

Collaboration between the four clusters was made easier by a number of best practices:

- All intersectoral work was carried out thanks to the determination of the coordinators and information managers of the four sectors, under the leadership of the Nutrition cluster in the DRC. Other key factors, however, were the funding opportunities offered to the Nutrition cluster by the DRC Humanitarian Fund and support from USAID.

- Regular communication between the clusters, i.e. between the coordinators and information managers. The four clusters hold a quarterly joint meeting to discuss problems and best practices related to intersectoral collaboration and programming and to discuss appropriate solutions. This close collaboration meant that these four sectors were the only ones to produce a joint HNO, which was taken into account in the HRP 2022.

- Joint commitment at the workshop held in May 2021, which was attended by all the clusters, the government and OCHA. An agreement was reached on: writing a joint strategy; holding regular joint meetings; an intersectoral HNO/HRP; establishing joint selection and monitoring indicators; and joint missions plans to monitor the intersectoral response.

- The commitment of donors such as USAID, the UK Foreign, Commonwealth and Development Office (FCDO), the European Union (EU) and the World Bank prompted detailed discussions around intersectoral collaboration and programming. In addition, the four clusters have embarked on joint advocacy on intersectoral programming with donors. This has led to an increased commitment to funding intersectoral interventions by most of the donors concerned.

- At the community level, multiskilled actors trained in the various multisectoral approaches will help ensure that the activities are sustainable. It was decided to bring everything together on a single community platform to offer an integrated community package, rather than each actor having its own community network for offering a sector-specific package.

Commitment of clusters at the global level to supporting intersectoral collaboration in the DRC. In particular, the GNC help desk shared information and examples of approaches, strategies and groups of intersectoral interventions that had been implemented in other countries. This gave the four clusters, in addition to the training they had delivered in 2019, a solid foundation for intersectoral discussions and decisions in the DRC.

TRANSFERABILITY AND SCALABILITY & NEXT STEPS

Intersectoral collaboration and programming in the DRC are based on the idea that when we focus holistically on the populations affected, we can respond to their needs more efficiently and effectively.

TRANSFERABILITY AND SCALABILITY

Intersectoral collaboration and programming in the DRC are based on the idea that when we focus holistically on the populations affected, we can respond to their needs more efficiently and effectively, while taking their point of view on the quality of interventions into account throughout the project cycle and as their needs change. This is a holistic approach, which is transferable and applicable to different contexts, including emergencies, transition or development. The process used in the DRC can be used as an example of the steps to follow for the successful implementation of an intersectoral approach. The documents produced, particularly the intersectoral manual and intersectoral package of activities, can be used by other countries starting point for discussions on intersectoral collaboration and programming, and adapted to the specific context to develop a new intersectoral plan for the particular country concerned.

NEXT STEPS

- A user guide will be developed on the basis of experience in the use of planning tools and activities in the intersectoral package to facilitate the use of tools further.

- The implementation of the intersectoral package will be documented in terms of lessons learned, strengths and weaknesses, sustainability, transferability and ownership.

- An intersectoral advocacy group was set up to prepare the advocacy notes, engage in advocacy and work actively with donors in the DRC to provide sustainable funding for intersectoral projects. Advocacy will continue and intensify in 2022.

- A joint analysis of intersectoral data will be prepared by the information managers' sub-group in 2022 and the data collection tool shared outside the DRC.

- A second case study, with the results and evidence of the multisectoral approach in the DRC, will be written up at the end of 2022.

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