
# At the last mile: COVID-19 vaccines in DRC

The Democratic Republic of the Congo (DRC) has one of the lowest COVID-19 vaccination rates in the world, with just 0.87% of people in DRC having received even one dose. While the country has received 8.2 million doses of COVID-19 vaccine, it has managed to administer 528,000 of them—just under 11% of vaccines available. In April of 2021, DRC became one of the first countries to return 1.3 million COVID-19 doses to COVAX because they could not deliver them to people before the vaccines expired.

The challenges that risked more than a million doses expiring are still in play for most of the country. In both January and February 2022, 114,705 vaccines expired in country because there was not enough investment in systems and health workers to deliver vaccines. To reach 70% of the population—62.7 million people—DRC will need to drastically scale up and accelerate COVID-19 vaccination.

CARE is working with 4 vaccination sites—2 in Butembo and 2 in Goma—to support with community mobilization in partnership with local leaders, health center operations, and training. With joint action and communication plans developed with chiefs, religious leaders, and local authorities, and additional equipment to protect health workers, those sites had vaccinated 1,132 people. In those 4 sites, we have also conducted several rounds of research and problem-solving using community dialogues between health workers and clients using the Community Scorecard, as well as the Social Analysis and Action tools, which provides the insights for this case study. The team has also supported local vaccination teams with IT infrastructure, personnel costs, and creating locally adapted COVID-19 communications plans.

## Major Challenges for DRC's Vaccines

### Keeping Sites Open

Of the 498 planned vaccination sites in 13 provinces, only 296 sites currently operate, and only 6 districts (Kinshasa, North Kivu, Upper

**10x higher rates**

*The vaccination rates in the area CARE supports is 9%--more than 10 times higher than the national average for DRC.*

Emily Janoch | Emily.janoch@care.org

> **"Having so many different kinds of vaccine for a single disease scares us. Even westerners are afraid of these vaccines."**
>
> **Patient, RDC**

Katanga, Lualaba, and South Kivu) have even started COVID-19 vaccinations. The seven other provinces have only 48 functional sites. The other 50% of provinces in DRC have not yet started vaccinations. Even among functional sites, there are significant differences in service quality and population coverage. For example, in the 2 sites in Butembo that **CARE is supporting, vaccination rates are 9%—more than 10 times higher than the national average for COVID-19 vaccines**. But of the 10 COVID-19 vaccination sites in Butembo, only 5 are operational.

DRC's National Vaccination and Deployment Plan had originally planned to do all vaccinations at existing health centers in an attempt to preserve some basic health services. Few people are willing and able to come to a health center for COVID-19 vaccines. The confusion caused by constantly changing eligibility criteria for the vaccine has compounded the problem. The teams were able to learn and adapt to create more mobile based vaccines in 14-day mobile vaccine campaigns. Health teams are consistently trying to learn and improve their work to get more people vaccinated. However, mobile delivery sites still often lack appropriate protective equipment for staff, handwashing facilities, electricity, and fuel that could keep the functioning. Even when they do run, they are only available 5 days a week, which excludes many people who can only come to get a vaccine on Saturday or Sunday.

## Protecting and Paying Health Workers

Health workers in DRC operate in an extremely high-risk context. They have faced successive waves of malaria, HIV, Ebola, and now COVID-19. Ebola was particularly dangerous. Not only did health workers contract Ebola because the lacked protective equipment, **hundreds were also threatened and killed** while trying to fight the 10th wave of Ebola in 2020 because communities did not trust the health workers trying to address the virus. In COVID-19, risks to health workers are less about violence and more about getting sick and dying because of the lack of PPE and protection for health workers. On any given day, **health workers have to choose between prioritizing Ebola, COVID-19, violence, malaria, or other deadly diseases**. COVID-19 does not always come first. In this context, **protective equipment, handwashing supplies, and security are at a premium**—and there are simply not enough to keep COVID-19 vaccination centers operating consistently.

At the same time, many health workers are on strike. Starting in July 2021, health workers started striking to demand better working conditions and pay. **Many health workers have not been paid for months—neither their regular salaries, nor the COVID-19 "danger pay" they had been promised**. Mobilizing enough health workers for massive COVID-19 vaccination campaigns is a challenge under the best of circumstances. It is nearly impossible without paying the health workers that make sure vaccinations get into people's arms.

Health workers are also in **dire need of mental health support** to deal with the stress and trauma of their working conditions. In addition to coping with successive waves of violence and disease, they face high levels of mistrust and lack of support from the communities they serve and the structures that are supposed to enable their work.

> **"I'm not getting vaccinated because I don't see my leaders getting vaccinated. If they aren't getting vaccinated, that means there is something suspicious happening. So I won't get the shot."**
>
> **Patient, DRC**

## Mistrust of the health system

In CARE's research with communities, both community members and health workers pointed to high levels of mistrust in the health system and a reliance on self-care or traditional remedies as key barriers to COVID-19 vaccines. There is deep suspicion of health workers, the COVID-19 vaccine, and COVID-19 generally. **Many Congolese do not believe it is possible to**

**have created a vaccine for COVID-19 so quickly. They note that there are no vaccines for HIV or malaria**, and that Ebola vaccines only became available quite recently. That breeds distrust in who is profiting from COVID-19 vaccines, and why it has taken such priority compared to diseases that are more common, more deadly, and with more history in their communities. This mistrust extends to coming in for health services, including vaccines. Many people believe health workers are actively spreading COVID-19 in order to continue to get additional pay and profit from the disease.

This is compounded by the fact that **very few health workers in DRC have been vaccinated**. WHO estimates that there are more than 831,000 health workers who have not gotten a COVID-19 vaccine. One of the most demotivating experiences community members cite is asking a health worker which vaccine they got, only to discover they have not gotten any vaccine. Similarly, few leaders—especially at local and district levels—have been vaccinated, giving people few role models they trust who are encouraging vaccination.

This means there is backlash for people who go to visit a health center—especially young people. People are afraid that someone has contracted Ebola or COVID-19. They may be considered to be corrupt, prostitutes, or someone spreading disease. That backlash is a strong discouraging factor in getting vaccinated.

### Targeting people for vaccine eligibility

The first wave of vaccines was supposed to reach health workers, people over 55 years old, and people with comorbidities. This created a lot of confusion, and many people were turned away from health centers when they sought vaccines. For people who were turned away, many never came back to get a vaccine, even when eligibility was open to bigger population groups. Opening eligibility more broadly is one of the reasons the vaccination rate is slowly growing.

### Information and misinformation

Sharing reliable information about vaccines—which brands of vaccine are available, what days a vaccination center will be open, how to decide which vaccine is most appropriate—has been an obstacle across DRC. The official advice about who should get vaccinated—what age brackets are eligible, if pregnant women should get vaccinated or not, what risks there are—has changed quickly over time, and communications have not kept up or built the trust required for mass mobilization. Misinformation and rumors are rampant, compounded by shifting official information and global news cycles about vaccines and their side effects.

Even basic logistics information is a major challenge. Commonly, a health center will have 3 or 4 different brands of vaccine available, but will only open a vial if they are sure they can use all of the doses inside it. People must either organize themselves to come in groups of 5 or 10 (something that requires very precise information about what is available and when), take a vaccine that is not the one they want, or leave and come back another day. Most people who get turned away do not come back.

## Signs of what works

**Engaging local leaders** has been a key success factor in the areas where CARE works. Leaders are not just getting vaccinated themselves, but also actively encouraging others to get vaccinated. CARE has worked with 40 Community Action Cells (CAC) in 4 health districts to create community education and mobilization plans. In Butembo—especially Kayina sub-district—mobilization is picking up momentum. This comes with a moderate cost; for every community engagement session they attend and for each weekly coordination and data meeting, local leaders get a $5 transportation allowance. That has contributed to higher belief in COVID-19, better attendance at health centers, and vaccination rates nearly 11 times the national average.

**Community dialogue sessions** have been a valuable bridge between communities and health center staff. They

provide space for people to ask questions, raise concerns, and understand the challenges health workers are facing. CARE has hosted 238 community health dialogues for 5,067 people (including 3,094 women). Local leaders have been key to organizing and participating in these dialogues. In places where CARE is hosting community dialogues, we are seeing lower rates of conflict between health workers and communities than we saw in Ebola. People are more likely to believe that COVID-19 exists. We see more people showing up at health centers because they are no longer afraid they will die from the vaccine.

**Facilitating discussions between health workers and community members** to identify and develop action steps to help address issues impacting health services, including vaccine delivery. Participants in these sessions shared that the open discussions between these groups helped to improve the trust that had been damaged during previous outbreaks. Example issues identified included rumors related to the vaccine, low motivation among some health workers at vaccination sites and vaccine hesitancy among both community members and health workers. Action steps included conducting dialogues with both community members and health workers to discuss concerns in effort to build confidence in the vaccine. The project team utilized CARE's Community Score card approach to facilitate these discussions.

**Training and sustaining community volunteers** who have experience from Ebola and other health campaigns has helped carry messages and services to the last mile. Those volunteers are doing disease surveillance, and take advantage of their frequent visits to communities to share information about COVID-19 prevention, answer any questions people have about COVID-19 and the vaccine, and help people organize to go to vaccine centers. Many of these informal health workers have prior experience from previous Ebola, health, or nutrition campaigns, which makes them trusted voices in the community. Because COVID-19 activities are integrated into these volunteers' regular activities, they are not receiving additional salary for COVID-19 activities. They do receive an additional $5 transportation allowance to attend weekly meetings where health teams review data, progress towards goals, and any changes they need to make to the vaccination strategies.

Inconsistency around payment for health workers is one of the challenges for coordination. Each actor has different policies and procedures for who gets paid, and how much. In principle, the Ministry of Health pays all of the salaries for all health workers. In practice—as evidenced by the continual health worker strikes—this is not always the case. The disparity between sites and actors creates difficult conditions to motivate and fairly support the health workers.

## Authors

This brief was written by Dr. Bergson Kakule, Nathan Lubukayi, Eugene Muhindo, Emily Janoch, and Allison Prather. The information in this brief is up to date as of April 27, 2022. Further updates will be made as more data becomes available.