



Strengthening routine immunization

Key lessons from the Democratic Republic of the Congo

The Gates Foundation launched the Routine Immunization Strengthening Program (RISP) in 2019 to improve routine immunization (RI) in subnational areas with low immunization coverage and high risk of polio transmission. From 2023 to 2026, the RISP Learning Consortium (LC) synthesized evidence across RISP countries to foster cross-country learning, identify lessons from different implementation approaches, and generate practical evidence to inform future immunization policies, programs, and investments.

KEY LESSONS



National-level convergence of donor and political will created an enabling environment for a cofinancing model.

The model succeeded in securing provincial commitments, but provincial political instability and limited fiscal capacity affected their fulfillment.



Strengthened monitoring and accountability drove substantial gains in immunization coverage and facility-level performance.

However, the improvements fell short of initial memorandum of understanding (MoU) targets, and the relationship between process improvements, resource mobilization, and coverage outcomes was not always consistent.



Enhanced and highly visible real-time performance data strengthened accountability and drove improvements in facility-level service delivery.

Tying performance to rewards created risks to data credibility and supervision quality.



The MoU model relied on health system capacity and structures that did not exist.

Chronic underpayment left frontline workers dependent on financial incentives, leading them to prioritize incentivized tasks and lose motivation when payments lapsed. The intensive monthly data collection model exceeded provincial technical and financial capacity, undermining both implementation quality and long-term sustainability.



Provincial financial management capacity and transparency improved with embedded technical assistance (TA) and new governance systems.

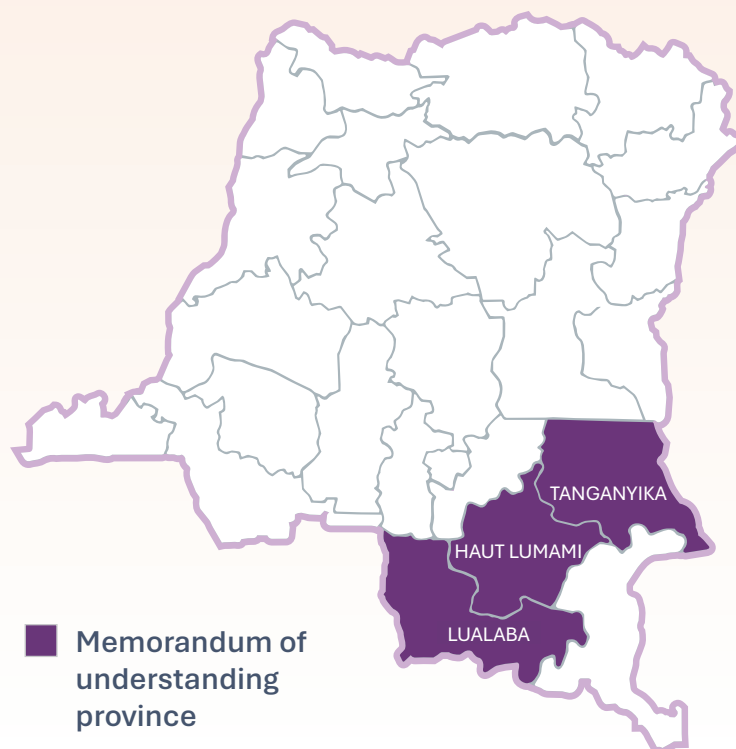
Gains were uneven and not fully corroborated by audit findings. Despite assuming responsibilities previously led by TA partners, provinces remain reliant on embedded TA to offset human resource (HR) shortages, manage turnover, and reinforce accountability.

BACKGROUND

The Gates Foundation signed MoUs with the provincial governments of Haut Lomami and Tanganyika in October 2018, followed by Lualaba in July 2021. After the initial five-year terms, new MoUs were signed in 2023, with the US Agency for International Development and Gavi, the Vaccine Alliance joining the agreements in Haut Lomami and Lualaba. The MoU scope expanded beyond RI to include malaria, nutrition, family planning, and safe delivery.

The three provinces were selected because of persistent disease outbreaks and low RI coverage. Haut Lomami and Tanganyika were affected by circulating vaccine-derived poliovirus type 2 outbreaks in 2017; Lualaba experienced a circulating vaccine-derived poliovirus type 1 outbreak in 2022.

These partnerships supported implementation of the Mashako Plan, an initiative launched in 2018 to revitalize the RI system. MoUs included pooled basket funding with phased government cost-sharing, transparent fiscal management, real-time monitoring and accountability, and capacity strengthening to gradually transfer immunization program management to the provincial authorities.



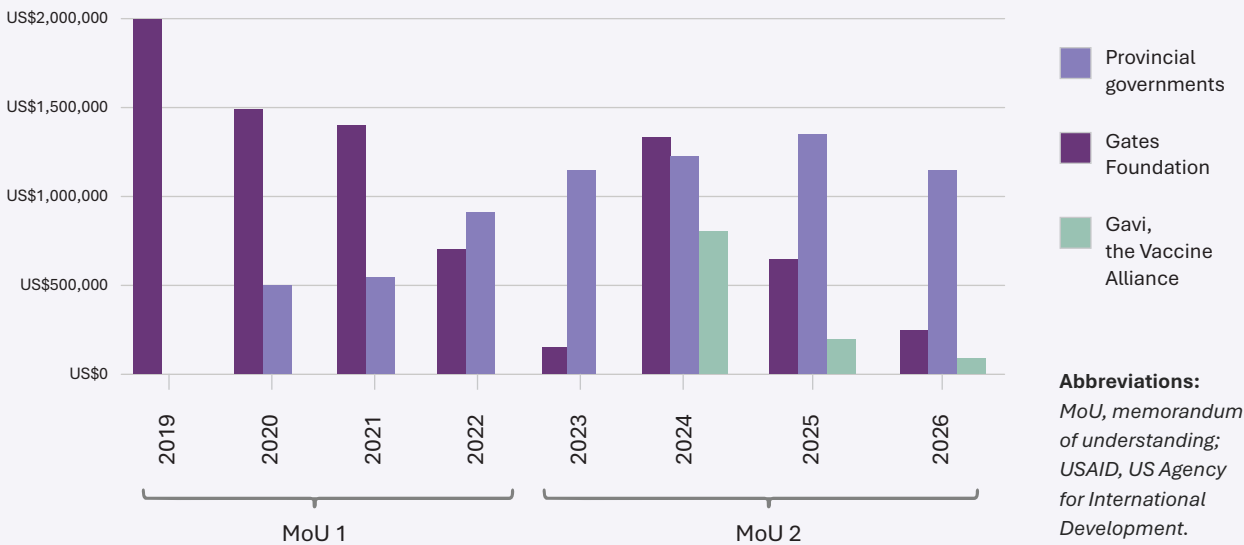
THE GOALS OF THE MOU INCLUDED:

- Achieve 80 percent coverage with the third dose of pentavalent vaccine (Penta3).
- Stop poliovirus transmission.
- Improve immunization equity.
- Reduce child morbidity and mortality.

INTERVENTION DOMAINS:

- Program coordination and performance reviews.
- Service delivery.
- Vaccine availability and cold chain functionality.
- Real-time monitoring.
- Assessment and evaluation.

The Gates Foundation, Gavi, USAID, and provincial governments collectively committed US\$17.9 million, with phased government cost-sharing.



TA PARTNERS:

- **Acasus**—data systems.
- **GRID3**—automated microplanning.
- **Kinshasa School of Public Health**—annual vaccine coverage surveys.
- **McKing Consulting Corporation**—political advocacy and coordination.
- **PATH**—political advocacy, coordination, and financial management.
- **University of California, Los Angeles**—evaluations.
- **VillageReach**—supply chain.

STRENGTH OF EVIDENCE

The RISP LC applied a strength-of-evidence rating (strong/moderate/limited) to each finding, reflecting the level of convergence across sources:

STRENGTH OF EVIDENCE: STRONG • Clear convergence across multiple, diverse sources; rich and credible evidence supporting program theory; minimal uncertainty.	STRENGTH OF EVIDENCE: MODERATE • Partial convergence or convergence within a smaller set of data sources; theory-supported with some remaining uncertainty.	STRENGTH OF EVIDENCE: LIMITED • Mixed or inconsistent signals; lower information power; exploratory interpretations.
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LESSON 1

National-level convergence of donor and political will created an enabling environment for a cofinancing model.

The model succeeded in securing provincial commitments, but provincial political instability and limited fiscal capacity affected their fulfillment.

STRENGTH OF EVIDENCE: **STRONG**

FINDINGS

- The MoU leveraged growing national momentum.** The Addis Declaration on Immunization in 2017, the Kinshasa Declaration on Vaccination and Polio Eradication in the Democratic Republic of the Congo in 2019, and the launch of the Mashako Plan in 2018 provided the impetus to secure, for the first time, provincial financing for RI. According to provincial authorities, the clearly defined governance and accountability mechanisms created sufficient trust and transparency to justify directing provincial resources toward a public-private initiative.
- Fulfillment of financial commitments varied widely across provinces. Political instability and fiscal capacity influenced variation across provinces.** Only mining-rich Lualaba achieved 100 percent of its commitment. Haut Lomami and Tanganyika reached 46 percent and 26 percent, respectively, by the fourth quarter of 2025. Except for Lualaba, provincial respondents stated that the basket-fund target was structurally unattainable, given their revenue base.
- Political instability and frequent leadership turnover required continuous advocacy from local groups to secure provincial financial disbursements.** Even sustained engagement from partners like the Parliamentary Network for Immunization Support (Réseau des Parlementaires Congolais pour l'Appui à la Vaccination) and the Foundation was insufficient to fully realize the cofinancing commitments in Haut Lomami and Tanganyika, where five and four governors, respectively, changed.
- In 2023, the Haut Lomami and Lualaba immunization-focused MoUs were expanded into primary health care (PHC) MoUs, with the US Agency for International Development and Gavi joining as financial partners.** This transition established a framework for supporting a wider range of PHC services, including malaria, nutrition, and family planning, although donor funding to date has supported immunization only.

“Given the challenges of conflict in the east, the central government has prioritized national security spending over provincial retrocession.”

—Provincial government actor

“In addition to the factor of institutional instability, which brings new governors ... there's also this factor of revenue at the provincial level. If we really want to do things properly and we're committed to supporting health ... then, regarding the [basket-fund target], I know that my province can't reach the target. We can't reach it; we won't.”

—Provincial government actor

CONSIDERATIONS

- Donors can target MoUs toward provinces with sufficient fiscal capacity and align cofinancing expectations with realistic revenue levels.
- Donors should carefully weigh the additional transaction costs of an MoU model against the likelihood that a province can sustainably meet its commitments.
- Donors and government partners should build mechanisms that buffer against political turnover and instability. Institutionalized cofinancing commitments can reduce vulnerability to leadership changes.
- Donors and government partners should invest in sustained, locally anchored advocacy to keep immunization financing visible to political actors.
- Donors should consider broadening the scope of MoUs beyond immunization where appropriate. There may be opportunities to pool financing across priority health areas, reduce fragmentation, and support stronger PHC integration in line with ongoing national PHC reforms.

FUTURE LEARNING

- *What political economy conditions enable provinces with limited fiscal capacity to realistically set and reliably meet cofinancing commitments?*
- *What mechanisms most effectively protect cofinancing commitments from leadership turnover and political instability?*
- *What alternative financing strategies are viable for provinces with weaker revenues?*

LESSON 2

Strengthened monitoring and accountability drove substantial gains in immunization coverage and facility-level performance.

However, the improvements fell short of initial MoU targets, and the relationship between process improvements, resource mobilization, and coverage outcomes was not always consistent.

STRENGTH OF EVIDENCE: MODERATE

FINDINGS

- **Immunization coverage improved markedly across the three MoU provinces**, with Penta3 coverage rising between 2017/2018 and 2024—from 50 to 83 percent in Haut Lomami, 35 to 62 percent in Lualaba, and 25 to 76 percent in Tanganyika.
- The magnitude of coverage gains varied across provinces. Penta3 coverage increased by 27 percentage points in Lualaba, compared with a 51 percentage point increase in Tanganyika; Haut Lomami was the only province to surpass the MoU target of 80 percent coverage.
- **Although Expanded Programme on Immunization (EPI) managers attributed improvements in immunization coverage to strengthened monitoring and accountability, the relationship between process improvements and coverage outcomes was not always consistent.** Service delivery readiness indicators—captured through the Mashako performance score—increased substantially, rising from below 48 percent in 2019 to over 90 percent in all MoU provinces by 2025, even as coverage trends showed periods of stagnation and volatility related to COVID-19, health worker strikes, and other constraints. For example, in Lualaba, Penta3 coverage plateaued between 2021 and 2022 (59 to 60 percent) and then fell to 48 percent in 2023, despite continued gains in Mashako performance scores during the same period.

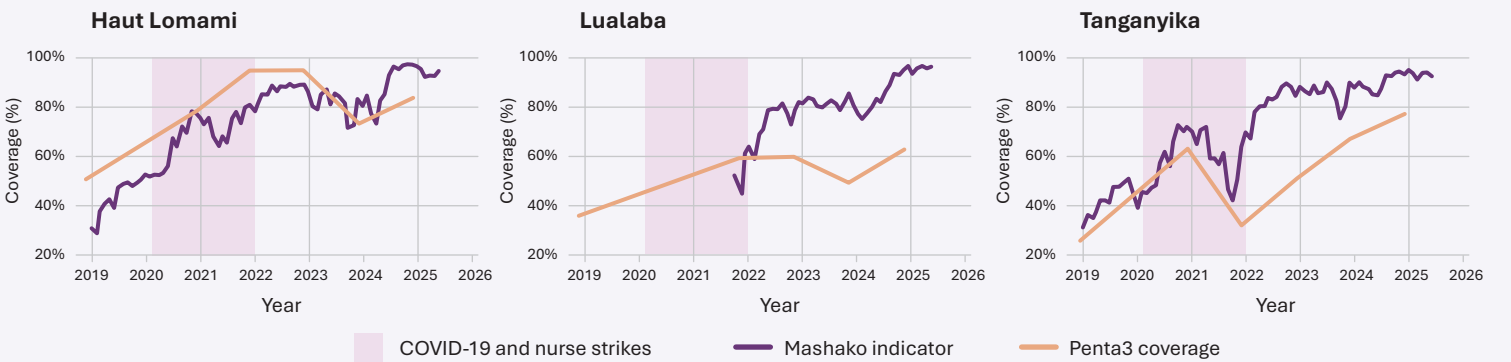
Findings from the 2024 coverage survey indicate that immunization coverage improved across all MoU provinces compared with the 2017–2018 baseline, although the gains were more modest in Lualaba.

	Penta1 (%)		Penta3 (%)		FIC (%)	
Haut Lomami	94%	+56	83%	+33	68%	+32
Tanganyika	90%	+47	76%	+51	68%	+47
Lualaba	82%	+30	62%	+27	47%	+26

Percentage point increase from the 2017–2018 baseline

Abbreviations: FIC, fully immunized children; MoU, memorandum of understanding; Penta1, first dose of pentavalent vaccine; Penta3, third dose of pentavalent vaccine.

Mashako provincial performance scores plotted against Penta3 coverage show a strong association in Haut Lomami and Tanganyika and a weaker relationship in Lualaba, likely due to unaddressed demand-side barriers and other challenges.



Note: Vaccine coverage survey results are plotted in the year that data were collected.
Source: Gestion PEV, Multiple Indicator Cluster Surveys 2017–2018, vaccine coverage survey 2021–2024.
Abbreviation: Penta3, third dose of pentavalent vaccine.

- **While all provinces achieved substantial improvements in immunization coverage, full resource mobilization did not consistently translate into stronger outcomes.**

For example, Tanganyika contributed the smallest share of committed funding (30 percent for 2020 to 2024) yet achieved the largest gains in Penta3 coverage (51 percentage points) and full immunization coverage (47 percentage points). In contrast, Lualaba met its full financial commitment but fell short of the 80 percent Penta3 coverage target. This suggests that factors beyond funding levels—such as implementation quality and local context—played a role in shaping coverage outcomes.

- **Facility-level performance improvements alone are insufficient to close coverage gaps.** Compared with other MoU provinces, survey data from Lualaba show lower intent to vaccinate, coupled with weaker community health worker (CHW) engagement and limited community mobilization. These demand-side barriers—together with Lualaba's later entry into the MoU and other contextual factors such as COVID-19 and health care worker strikes—likely contributed to weaker immunization coverage.

“We still face challenges in community ownership of vaccination. This includes the engagement of local leaders, CHWs, and families. Community animation cells are not fully functional, which limits social mobilization and awareness-raising. In our mining context, CHWs are attracted by activities in the mines, which creates a gap in the chain of communication and health promotion.”

—Health zone medical chief in
Lualaba Province

CONSIDERATIONS

- Donors and government partners should integrate demand-side metrics into routine performance monitoring. Metrics such as caregiver intent, community trust, and CHW activity can help generate a fuller understanding of the barriers that influence immunization coverage.
- Donors and government partners should pair service-readiness investments with strengthened and sustained community engagement strategies. This pairing helps effectively translate improvements at the facility level into higher uptake.

FUTURE LEARNING

- *What additional factors explain why improved service readiness does not consistently lead to higher immunization coverage across provinces?*
- *Which process monitoring indicators and targets provide the most actionable information to identify service delivery constraints and strengthen immunization performance?*
- *Which community engagement and CHW strategies most effectively increase immunization uptake in low-demand, high-barrier contexts?*
- *What service delivery configurations (e.g., bundled services, integration with other PHC interventions, timing and location of services) most effectively attract clients and increase utilization in low-coverage settings?*

LESSON 3

Enhanced and highly visible real-time performance data strengthened accountability and drove improvements in facility-level service delivery.

Tying performance to rewards created risks to data credibility and supervision quality.

STRENGTH OF EVIDENCE: **STRONG**

CONTEXT

The MoU supported the Mashako Plan's real-time monitoring system through routine supervision of health zones and facilities. Working with Acasus, the EPI developed the Gestion PEV smartphone app, allowing supervisors to collect data on six indicators that contribute to a composite performance score. Monthly scorecards, generated at the health zone and provincial levels, ranked each level based on its score and improvement in the tracked indicators.

FINDINGS

- **Across the three provinces, monitoring feedback loops worked to improve facility-level service delivery.** Respondents described more timely, usable, and frequent data compared with DHIS2 alone, and routine coordination meetings became regular ways to jointly interpret data. Improvements in Mashako performance indicators reflected the increased use of data to solve operational problems.
- **Monthly provincial scorecards were used to identify performance strengths and gaps.** In November 2024, Haut Lomami ranked first nationally with an overall performance score of 96 percent—a 54 percentage point increase compared with its average performance in 2019.
- **Monthly performance rankings proved highly motivating, driving actors to meet targets and improve results.** Many provincial respondents noted that public recognition of high rankings encouraged them to meet targets and sustain strong performance.

“Staff are motivated. There is competition and a desire to maintain the top position, especially for high-performing health areas.”

—Government actor in Haut Lomami Province

“Electronic supervision was too hasty, leading to only checking quantities rather than quality. You can have 100 percent of facilities supervised, but when we look at vaccination coverage, we're below 50 percent.”

—Government actor in Lualaba Province

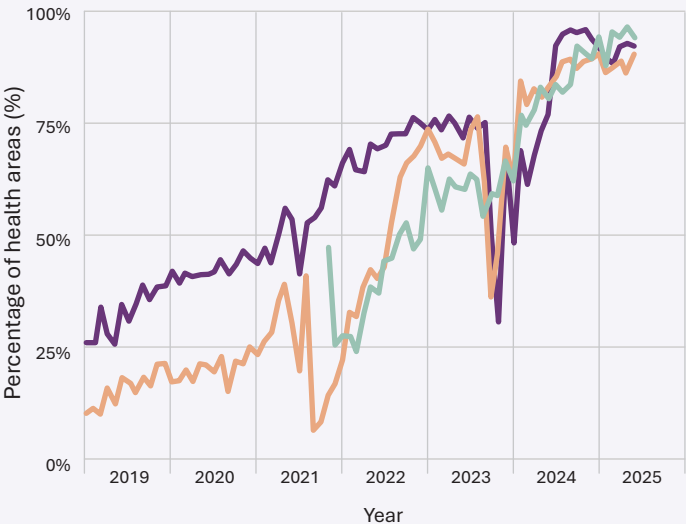
- **The prominence of the rankings created incentives to inflate performance metrics.** Some respondents described shifts in behavior, including supervisors prioritizing indicator collection over supportive coaching and problem-solving intended to translate supervision into better service delivery. Others reported work-arounds to meet supervision targets.
- **While these observations raised concerns about data reliability,** the overall improvements in coverage and service delivery indicators suggest that many of the gains likely reflected real progress at the facility level.

“The 100 percent supervision score at the provincial level is less credible. Some supervisors share the link to the app with health zone providers to fill out the form on their behalf. This explains the absence of financial costs associated with some supervisions, despite high scores.”

—Government actor in Tanganyika Province

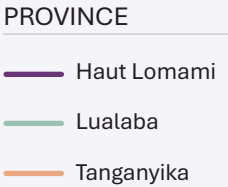
Monthly supervision indicators of service delivery readiness improved consistently between 2019 and 2025.

FIXED SESSIONS: Percentage of health areas that performed the minimum number of immunization sessions.

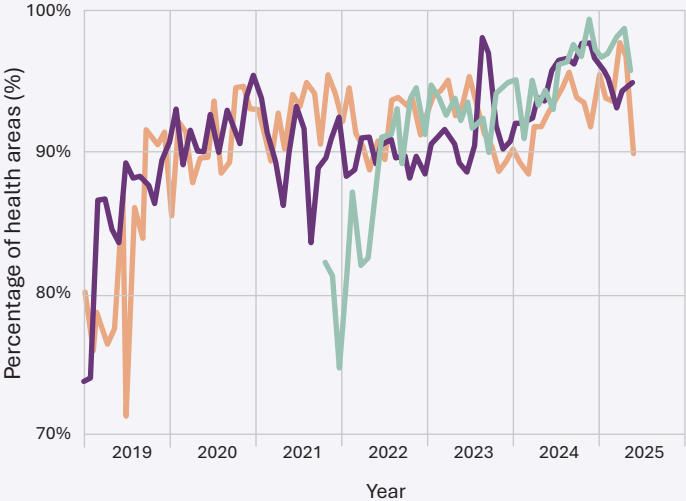


“The pressure linked to rewards, particularly performance bonuses, can lead to data manipulation, affecting their reliability and the quality of the decisions based on them.”

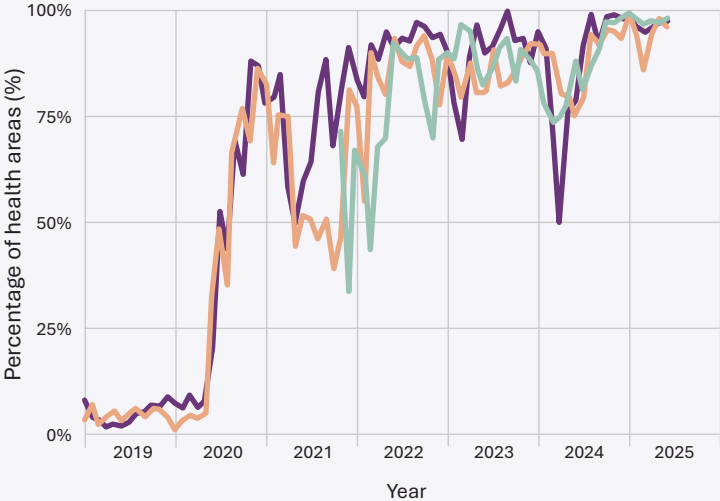
—Government actor in Lualaba Province



COLD CHAIN: Percentage of health areas with a functional refrigerator.



VACCINE AVAILABILITY: Percentage of health areas with sufficient vaccine availability.



Source: Gestion PEV.

CONSIDERATIONS

- Government and technical partners should ensure that performance measurement systems balance supervision quality with indicator reporting. Incorporate metrics that capture the quality of supervision (e.g., problem-solving actions taken and follow-up on identified gaps).
- Donors, government, and technical partners should consider the limits of a purely quantitative approach to monitoring. Strike a balance between simple, high-value indicators and providing sufficient time and resources to conduct high-quality supportive supervision to strengthen service delivery quality.
- Donors, government, and technical partners should design performance management systems that motivate teams without creating incentives for metric inflation. Pair scorecards with supportive feedback loops and ensure rewards focus on verified improvements in service quality and coverage rather than on achieving numeric targets alone.

FUTURE LEARNING

- *How can immunization performance measurement systems maintain accountability without incentivizing metric inflation or data manipulation?*
- *Which indicators and supervision approaches best measure the quality of immunization services rather than the quantity of supervision or activity reporting?*
- *What strategies are most effective for supporting immunization program managers to routinely use performance monitoring data for decision-making and problem-solving?*

LESSON 4

The MoU model relied on health system capacity and structures that did not exist.

Chronic underpayment left frontline workers dependent on financial incentives, leading them to prioritize incentivized tasks and lose motivation when payments lapsed. The intensive monthly data collection model exceeded provincial technical and financial capacity, undermining both implementation quality and long-term sustainability.

STRENGTH OF EVIDENCE: **STRONG**

FINDINGS

- **The performance monitoring model's reliance on monthly data collection created implementation challenges.** EPI program managers and supervisors reported that the workload associated with meeting supervision targets often exceeded capacity.
- **Provinces used work-arounds to cope with supervision demands, raising concerns about quality.** These practices reflected both capacity constraints and incentives to meet targets tied to performance-based bonuses. For example, in Haut Lomami, respondents described sending friends or family members to conduct visits.
- **The program paid salary top-ups to health care workers for meeting supervision and outreach session targets, which helped drive improvements in performance indicators but also created distortions.** Supervision rates reached 98 to 100 percent, and outreach sessions reached 89 to 91 percent by 2025. However, these incentives also influenced behavior, with health workers prioritizing incentivized tasks (e.g., outreach sessions) over nonincentivized ones, such as fixed sessions.
- **When incentives were reduced or payments lapsed due to resource constraints, motivation and operational performance declined.** These dynamics highlight the importance of balanced incentive structures and reliable government financing.

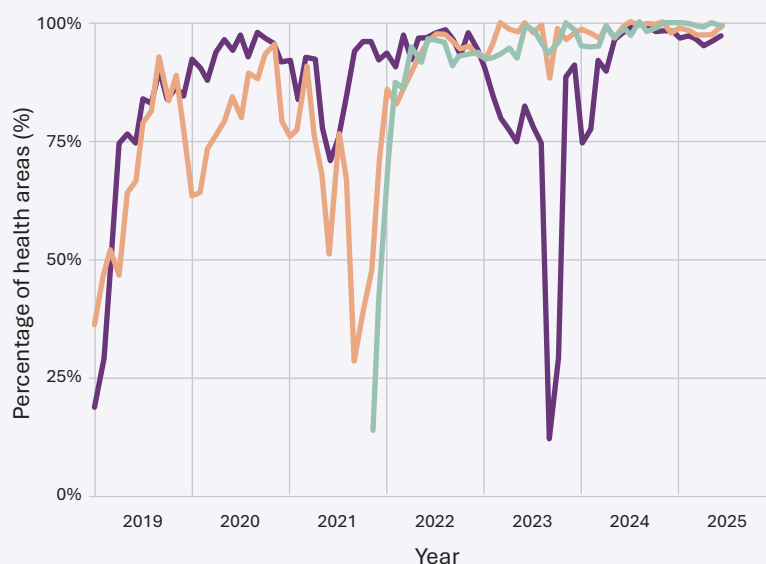
“Motivation is always low. We have not yet received the promised financial incentives. Lack of bonuses is a major barrier to staff motivation to act on the data.”

—Health zone nurse supervisor in
Lualaba Province

After initial improvements in supervision, performance fluctuated, with the largest declines in 2021 coinciding with health worker strikes.

PROVINCE

- Haut Lomami
- Lualaba
- Tanganyika



Source: Gestion PEV.

“Tools such as DHIS2 and Mashako 3.0 are essential for monitoring and using immunization program data, but their effectiveness depends heavily on the quality of the data entered into these platforms and the motivation of providers. Without increased government commitment to ensuring the payment of health workers’ salaries, building capacity, and simplifying procedures, the province will remain dependent on external support to maintain its performance.”

—Technical partner in Tanganyika Province

CONSIDERATIONS

- Government partners should calibrate supervision strategies to match the existing technical, financial, and HR capacity of provinces.
- Donors and government partners, where feasible, should consider shifting from monthly, blanket supervision to a tailored, risk-based, and integrated supervision model—covering multiple services rather than immunization alone—which may allow supervisors to reduce visit frequency while concentrating support where it is most needed, helping to maintain supervision quality and system-level efficiency.
- Donors and government partners should recognize the limits of project-funded salary top-ups and invest in more sustainable approaches to strengthen workforce motivation.
- Donors and technical partners should advocate for government reforms needed to sustainably finance the health workforce alongside improving supportive supervision and working conditions.

FUTURE LEARNING

- *Which combinations of monetary and nonmonetary incentives most effectively improve health worker performance without creating distortions?*
- *What supervision models (e.g., frequency, scope, integrated, quality-focused approaches) are most effective and sustainable within the existing technical, financial, and HR capacity of provincial-level health systems?*
- *How can health care worker remuneration transition from donor-funded top-ups to sustainable government financing without undermining motivation, performance, or essential service delivery functions?*

LESSON 5

Provincial financial management capacity and transparency improved with embedded TA and new governance systems.

Gains were uneven and not fully corroborated by audit findings. Despite assuming responsibilities previously led by TA partners, provinces remain reliant on embedded TA to offset HR shortages, manage turnover, and reinforce accountability.

STRENGTH OF EVIDENCE: MODERATE

FINDINGS

- Provincial health divisions developed financial management infrastructure to support oversight of resources channeled through the basket fund.** This included procedure manuals, accounting software such as Tom²Pro, and standardized routines supported by embedded TA. This enabled the provinces to produce auditable financial reports and maintain more transparent financial processes.
- Evidence suggests strengthened transparency and reporting systems but only partial and uneven transfer of capacity to provincial health authorities.** Annual audits showed improved systems, but recurring material findings such as ineligible expenditures, unexecuted mobile money payments, and accounting irregularities point to persistent weaknesses in compliance, documentation, and execution.
- Audit findings do not fully corroborate the capacity gains described by provincial authorities.** Interview data show that provincial authorities perceived increases in staff skills and the transfer of TA expertise from partners to provincial financial managers, yet audit results do not consistently reflect these gains.
- Baseline capacity varied across provinces, leading to different timelines for achieving functional financial management systems.** Tanganyika progressed slowly, requiring sustained training and follow-up after a weak initial audit in 2019, but showed marked improvement over time. In contrast, Haut Lomami adopted new practices more quickly, highlighting how starting capacity and local conditions influence the pace of progress.

“The provincial team is now able to manage MoU-related funding independently and compliantly. This represents a significant success in the process of gradually empowering local stakeholders. Although significant progress has been made, continued support remains essential. Managing funds within such a structured framework requires regular updating of knowledge, adaptation to new procedures, and close coordination between stakeholders.”

—Government actor in Tanganyika Province

“The financial team has acquired solid skills, and today, provincial officials can manage the entire process in compliance with MoU procedures, but some challenges remain. Incentives are still lacking for certain stakeholders, such as delegates from the Ministries of Finance and Budget, whose participation is irregular.”

—Government actor in Lualaba Province

- **The MoU anticipated a gradual phase-down of TA alongside the transfer of financial management responsibilities to provinces; however, this transition depended on supportive organizational conditions and stable staffing—conditions that were not consistently in place.** While provinces began taking on tasks previously handled by TA, such as preparing financial reports, even in Haut Lomami—the strongest performer—provincial actors described embedded TA as essential. It played a critical role not only in reinforcing skills but also in compensating for HR shortages, staff turnover, and limited operational resources.

CONSIDERATIONS

- Donors and technical partners should tailor financial management investments to provincial variations in baseline capacity and the pace of uptake.
- All project partners should agree on and set realistic expectations and milestones for capacity transfer that reflect each province's starting point, staffing stability, and absorptive capacity.
- Donors and technical partners should maintain embedded TA while transitioning to structured and intentional capacity transfer.
- Government and technical partners should shift from co-implementation to coaching and oversight and embed mechanisms (e.g., cross-training, standard operation procedures, and handover protocols) to mitigate turnover and support sustained provincial ownership.

FUTURE LEARNING

- *What conditions enable provinces to sustainably assume financial management responsibilities without long-term embedded TA?*
- *Which capacity transfer models most effectively build durable financial management skills and systems over time?*



ROUTINE IMMUNIZATION
STRENGTHENING PROGRAM
LEARNING CONSORTIUM