Independent Oversight and Advisory Committee for the
WHO Health Emergencies Programme

IOAC Mission report
Democratic Republic of the Congo
24 April – 2 May 2019

ACKNOWLEDGEMENTS

Any assessment of the state of the Ebola response in North Kivu must start with recognition of the bravery and dedication of the individuals working for the Ministry of Health, Congolese civil societies, WHO, UN agencies, and non-governmental organizations in a complex and insecure operational environment. The situation would be considerably worse if not for WHO's early intervention and the intensive efforts of all partners. The IOAC also commends the government's demonstrable commitment to containing the outbreak.

Throughout this mission, countless individuals generously offered their time to the IOAC and spoke openly in the hope of moving towards a more effective response. The IOAC wishes to thank every person it met, especially representatives of civil societies and business associations, traditional leaders, and religious leaders in Butembo, all of whom graciously accepted the invitation to meet with the IOAC mission team and provided invaluable insights.

This IOAC mission was conducted by Mr Jeremy Konyndyk, with support from Dr Gary Kobinger, member of the Strategic Technical Advisory Group for Infectious Hazards, WHO Emergency Programme, and Dr Guenael Rodier, senior adviser to the IOAC. The team would like to express its appreciation to the government of the Democratic Republic of the Congo and WHO Secretariat for facilitating the field visits to Butembo, Goma and Kinshasa during 24 April to 2 May 2019.

CONTEXT

The Democratic Republic of the Congo (DRC) is the largest country in sub-Saharan Africa and the 11th largest in the world, with a population of over 78 million. The country shares borders with Angola, Burundi, the Central African Republic, the Republic of the Congo, Rwanda, South Sudan, Uganda, the United Republic of Tanzania, and Zambia.

On 1 August 2018 the Ministry of Health of the DRC declared the country's tenth Ebola virus disease (EVD) outbreak in 40 years, in the province of North Kivu. The declaration followed immediately after the announcement of the end of the ninth recorded Ebola outbreak, in Equateur province.[1] The EVD outbreak in North Kivu has since spread to neighbouring Ituri province.

As the IOAC was completing its mission at the end of April 2019, a total of 1466 cases of EVD, including 1400 confirmed and 66 probable cases, had been reported in North Kivu and Ituri province, with an overall case fatality rate of 65%. Since then the outbreak has continued to worsen and Butembo, with a population estimated at approximately 900 000 inhabitants, has become the epicentre of the country's largest-ever Ebola outbreak.

The North Kivu region is politically turbulent, and its communities have endured persistent conflict and humanitarian need over the past two decades. Armed attacks continue to terrorize the population in parts of North Kivu, notably the areas around Beni where this outbreak first emerged. The affected area encompasses both rural and densely populated urban areas home to communities with a broad range of ethnic, linguistic, and socio-economic characteristics. The ongoing EVD response presents an extraordinarily intricate and difficult challenge owing to insecurity and community mistrust toward the response.

OBJECTIVE OF THE MISSION AND ACTIVITIES CARRIED OUT

The Independent Oversight and Advisory Committee (IOAC)[2] for the WHO Health Emergencies (WHE) Programme was created to provide independent scrutiny of the implementation of the WHO reforms that followed the West Africa Ebola outbreak, and of WHO's ongoing management of health emergencies.

Field missions are a critical part of the IOAC's work to probe the functionality of the WHE Programme across the different levels of WHO, and its relationships with a broader set of entities including government ministries, non-governmental organizations (NGOs), UN agencies and other partners at country level. The IOAC has carried out eight field missions[3] since its inception in May 2016.

[1] EVD outbreak in Equateur, May-July 2018, https://apps.who.int/iris/bitstream/handle/10665/279701/WER9403.pdf?ua=1

[2] IOAC (https://www.who.int/about/who_reform/emergency-capacities/oversight-committee/en/).

[3] Bangladesh, Colombia, Iraq, Mali, Nigeria, Pakistan, Uganda and Vietnam

The ninth field mission of the IOAC was conducted to review WHO's response to the ongoing Ebola outbreak in North Kivu, and to gain a deeper understanding of the successes and challenges faced by those involved in the current EVD response. The aim was to assess the collective capacity of WHO and other key actors, as well as to explore the progress made since the Ebola crisis in West Africa in 2013–2016, as commissioned by the Global Preparedness Monitoring Board (GPMB).[4] A separate written report will be submitted to the GPMB.

The mission involved visits and consultations in Kinshasa, Goma and Butembo between 24 April and 2 May 2019. The team conducted extensive interviews with personnel from the Ministry of Health, WHO, and UN and NGO partners at the respective sites and heard their views on WHO's performance on the ground, community engagement, security and strategy with regard to the current EVD outbreak. A substantial amount of time was dedicated to consulting with religious leaders, traditional leaders, representatives of civil society and business associations in Butembo, the epicentre of the current outbreak. The team also looked into security and community engagement aspects as they are critical to the success of the response. The agenda and list of participants is provided in the annex.

This report is focused on WHO's performance: progress with implementation of the WHE Programme, WHO's EVD response in support of the national authorities and partner coordination, the link between the reform measures implemented thus far and the effectiveness of WHO's response, and challenges specifically tied to the long-lasting humanitarian crisis and the current EVD outbreak that WHO is facing.

FINDINGS

The DRC Ebola response is simultaneously an impressive proof of concept for WHO's ongoing emergency reforms, and an indicator of numerous areas where further progress is needed.

Severe insecurity in and around North Kivu makes the province an extremely challenging environment in which to implement public health operations for the Ebola outbreak. It cannot be ignored that this outbreak is also occurring within the context of a large-scale protracted humanitarian emergency. Communities are understandably suspicious of the conspicuous and well-resourced response to Ebola – a disease many have not heard of before – compared with what they see as decades of neglect in the face of far greater threats to their health and security. Communities perceived the government's decision to exclude the Ebola-affected areas from voting in the Presidential election as a further cause of mistrust.

More crucially, community feedback was not used to shape and reshape the strategy driving the response by WHO, the government and all other partners. This made it difficult to correct elements of the response that had provoked deep community resentment and mistrust.

Against this backdrop, daily response operations in the field have become increasingly difficult in the face of general community hostility and targeted attacks by armed groups. The presence of armed groups and

[4] Global Preparedness Monitoring Board: https://apps.who.int/gpmb/about.html

targeted violence in North Kivu puts the staff of WHO and other responders at risk. WHO has put in place measures to ensure the safety of staff on the ground, but the situation in North Kivu requires a systematic approach and dedicated capacity for UN security management.
The specific findings and observations from the mission are described below.

WHO reform and its overall impact on the EVD response

The field mission reaffirmed the IOAC's assessment that WHO's emergency reform is paying off, and that WHO is making demonstrable progress towards establishing operational capacity for emergencies. Emergency Response Framework (ERF)[5] procedures were adhered to in the latest EVD outbreak in the DRC, as they were in the earlier outbreak in the province of Equateur. The IOAC noted the immediate establishment of an Incident Management System (IMS) and its alignment with the different levels of the organization; full delegation of authority to an Incident Manager; prompt release of funds from the Contingency Fund for Emergencies (CFE); rapid deployment of key staff and scale-up of WHO's operational capacity based on a no regrets approach; a robust logistics platform in support of relevant partners; and a move from delayed to real-time updates of epidemiological data through the IMS within 4 months from the declaration of the outbreak.

Additionally, WHO has stepped up preparedness in the countries neighbouring DRC.[6] About US$42 million has been mobilized for EVD preparedness work since May 2018, and more than 40 staff members are currently being deployed to support Ebola operational readiness in four priority countries (Burundi, South Sudan, Rwanda and Uganda).

However, further improvement is required in the following areas: internal coordination and communication across Headquarters (HQ), Regional and Country Offices and IMS in the field; the responsibility and accountability of each major office in the EVD response; HR capacity development including resource mobilization, in-country partners and donor relations; and financial management. WHO has also struggled to effectively coordinate its outbreak control operations with the larger humanitarian response in the region and to partner effectively with humanitarian organizations.

The Ebola outbreak in North Kivu has proved that WHO has made significant investment in security. However, it is unclear how WHO security functions in terms of line reporting, accountability and coordination among the country, regional and HQ levels.

Implementation of the WHE programme at country level

Considering that the DRC, the second most populous country in the WHO African Region, is in the midst of a protracted humanitarian crisis, the WHO Country Office (WCO) has surprisingly modest staff

[5] Emergency response framework, 2nd edition: http://www.who.int/hac/about/erf/en
[6] WHO Regional Strategic Plan for EVD Readiness Preparedness Plan in nine countries neighboring the Democratic Republic of the Congo: https://www.who.int/csr/resources/publications/ebola/preparedness/WHO-regional-strategic-EVD-operational-readiness.pdf?ua=1

capacity. Currently the Country Office has a total of 115 staff (12 international professional staff, half of whom are temporary appointments, 42 national professional staff, and 61 general staff) distributed across Kinshasa and 11 suboffices located in 11 provinces. The budget allocation for the WCO of US$55 million for the current biennium 2018–19 is inadequate to address the range of health issues (from communicable and non-communicable diseases to maternal and child health programmes) that the Country Office supports the Ministry of Health to address.

Despite of the multiple health crises in the country, a permanent WHO Representative (WR) had not yet been assigned and there is very limited health emergency capacity. A health cluster has been activated in the country since 2006, but since 2018 WHO has struggled to recruit a suitable health cluster coordinator, and the position is currently being filled on an interim basis.

The EVD response is managed directly by the Ministry of Health with support from the WHO incident management structure, with the WCO's role limited to supporting coordination with partners, coordination of implementation of preparedness activities in neighbouring provinces and non-affected health zones, and logistical and administrative support. The autonomy of the IMS has worked well in many ways, relieving the burden of the response from the WCO and ensuring that lines of internal communication are clear. However, the WCO staff expressed concerns that they have no control over transactions and contracts issued by the IMS for which they could be held accountable.

Incident management structure, HR deployment, and emergency business processes

WHO has demonstrated leadership in establishing effective internal incident management structures in Kinshasa, Goma, Beni, Butembo and Bunia. As of 29 April 2019, 745 people had been deployed to Kinshasa, Goma, Beni, Butembo, Bunia, Oicha, Katwa, Komanda and other locations. 74 deployed people are existing WHO staff and 650 were recruited on consultant contracts through a fast-track recruitment process for surge capacity. The rest are the individuals deployed through GOARN and Standby partners.

Owing to limited capacity to fill leadership roles in critical functions of the IMS, most of the senior WHE Programme staff based in the WHO African Region were redeployed to North Kivu in August 2018 immediately after the termination of their deployment to Equateur. This practice is unsustainable and may jeopardize the quality of the response due to staff exhaustion.

The IOAC welcomes the fact that WHO is reassigning WHO Representatives from other countries to serve in this response – this shows an appropriately robust degree of engagement and prioritization. However, the IOAC observed a lack of HR planning and management because of the urgency of providing surge capacity on the ground.

Significant progress has been made in terms of business processes and standard operating procedures for emergencies. But they are not consistently applied, and considerable confusion was found among staff unfamiliar with the WHE Programme and among consultants recruited from outside the Organization.

WHO finance: fundraising and financial management

The third iteration of the strategic response plan for the province of North Kivu over the period February–July 2019 (SRP3)[7] is suffering from a US$72 million funding gap out of a total funding requirement of US$148 million at the most challenging phase of the Ebola response. Donors noted that they do not perceive the SRP3 to be a viable basis for issuing funding, and conveyed concerns about accountability and transparency.

WHO has until now served as the principal funding platform for the response. This cannot continue at the increasing scale of operations. Donors expressed a preference to give money directly to implementing agencies rather than funding WHO as the principal recipient. However, there seems to be mutual misunderstanding between donors, WHO, the Ministry of Health and other implementing agencies on funding requirements, allocations, financial execution processes and accountability.

The IOAC was briefed that WHO is covering unforeseen operating costs, obligations to implementing partners, and payments to national workers to ensure there is no disruption to the response. These costs are estimated to amount to US$39 million and are in addition to WHO's budget requirements of US$57 million. As of March 2019, the WHO funding gap against its requirement in the SRP3 was about 56%. If the funds are not received, WHO will be unable to sustain the response at the current scale.

Donors appear willing to contribute more funding but require a well-articulated operational plan with an accountability framework. Donors added that it is unclear whether they should be talking to the Country Office, Regional Office or Headquarters in addressing their concerns.

EVD control strategy and coordination

WHO set up a response team on the ground within days of the declaration of the outbreak, and provided technical guidance to establish Ebola treatment units, vaccination of contacts and front-line health care workers, and administration of investigational therapeutics under the Monitored Emergency Use of Unregistered and Investigational Interventions (MEURI) protocol.

The rapid deployment of the vaccine has been particularly impressive. A preliminary analysis of the data being collected from the ring vaccination protocol[8] indicate that it has an effectiveness of 97.5% against EVD, and no deaths have been reported among vaccine recipients who developed EVD 10 or more days after vaccination. The IOAC mission team did hear, however, that initial data gathered by vaccination teams were not being shared with other parts of the response and that the communities did not understand the vaccination protocols, particularly why some people received the vaccine while others could not.

[7] Strategic Response Plan for the Ebola virus disease outbreak, February – July 2019: https://www.who.int/emergencies/crises/cod/drc-ebola-srp-v20190410-en.pdf?ua=1

[8] Preliminary results on the efficacy of rVSV-ZEBOV-GP Ebola vaccine using the ring vaccination strategy in the control of an Ebola outbreak in the Democratic Republic of the Congo: an example of integration of research into epidemic response: https://www.who.int/csr/resources/publications/ebola/ebola-ring-vaccination-results-12-april-2019.pdf

A planning and coordination structure, with the Ministry of Health in the lead, is in place across Kinshasa, Goma, Beni, Butembo, Mabalako, Tchomia and Komanda. The IOAC team attended several coordination meetings in different locations and consulted with numerous stakeholders. It judged that the process was not producing effective strategic or operational coordination. The meetings focused on information presentation rather than problem solving or strategic analysis based on community feedback, epidemiological data, or intelligence from partners on the ground. Partners noted that alignment among the different pillars of the response[9] is weak and siloed, and this makes strategic adjustment slow and unwieldy. This was a major impediment to response effectiveness.

While political issues played a role in community resistance to the EVD response, aspects of the response's technical approach, planning, and execution have also provoked community resentment and resistance. The IOAC mission team heard complaints from community leaders and NGOs about how suspect case referral and admission process was handled. The combination of broad admission criteria for suspected cases of EVD and delays in getting laboratory confirmation led to a surge of non-Ebola cases being admitted, sometimes under duress by security forces. As reported by a key treatment centre in Butembo, this approach overburdened the treatment centres, leading to suboptimal treatment and overly-long stays prior to discharge. Over time this significantly undermined community perceptions of the response and negatively influenced care-seeking behaviours; yet the response coordination structures proved slow to identify and begin to address the problem.

Partners commented that responders in the field had too little latitude to adapt the response to local conditions and concerns. The IOAC team was told that changes to the field approaches should be cleared at management level in Goma or in Kinshasa where there was no high-level technical adviser to push through the necessary changes of strategic direction. The absence of an effective forum for identifying, reviewing, and resolving shortcomings in response effectiveness is a significant constraint.

Partners noted a lack of coordination and information sharing between Kinshasa and the field level. WHO's current operational hub is Butembo, and other major partners are moving to Goma from Kinshasa to get closer to the epicentre. Partners welcomed the creation of a position of Special Representative of the WHO Director-General for the Ebola response. However, further clarity on the terms of reference of the position would be helpful to manage partners' expectations.

Partnership

Ministry of Health officials relayed to the IOAC that WHO is a reliable and competent partner. WHO has supported the Ministry to establish the EVD response configuration, develop a joint response plan, and manage daily operations. However, the IOAC mission team identified considerable challenges around partnership in the response. Periodic disparities in engagement and related technical shortfalls left WHO feeling as if it must take on a range of roles it is ill-suited for, rather than relying on partners.

[9] Coordination, Surveillance, case finding and contact tracing, Laboratory and diagnostics, Infection prevention and control, Case management, Psychosocial support, Communication and social mobilization, Vaccination and research, Operational and logistical support

The mission team was told that WHO's approach toward partners had at times been directive rather than collaborative, impeding effective partnership. UN and NGO officials relayed that WHO tended to approach them as service providers rather than peers and partners.
Relatedly, the mission team observed a lack of effective communication between WHO, the Ministry of Health, and UN and NGO organizations.

WHO is justified in noting a clear disparity between its scale of deployment and the level of engagement by other UN and NGO partners. However, responsibility for strained relations with partner organizations also rests with WHO. WHO must do a better job of communicating expectations to partners, collaboratively supplementing gaps in their technical expertise, and elevating performance concerns more consistently to leadership level rather than only relaying concerns to field level counterparts. WHO should proactively engage with humanitarian and other partners working in the region, and invest in supplementing their capacities for clinical management, surveillance, infection prevention and control, and other highly technical areas.

The IOAC mission team also perceived a gap in overall leadership of the international response at the time of the visit since there was no international position that had authority to engage with the government and other stakeholders across the health, security and political dimensions of the response.

Setting up response-wide management, multi-stakeholder operational planning and a finance platform is outside WHO's remit. Subsequent to the IOAC mission, the UN Secretary General appointed the UN Stabilization Mission in the Democratic Republic of the Congo (MONUSCO) Deputy Special Representative of the Secretary-General as his UN Emergency Ebola Response Coordinator in the Ebola-affected areas of the DRC to oversee the coordination of international support for the Ebola response and work to ensure that an enabling environment – particularly with respect to security and political stability – is in place to allow the Ebola response to be even more effective.[10] In addition, an Inter-Agency Standing Committee System-Wide Scale-Up for the Control of Infectious Disease Events was activated for an initial period of three months. The scale-up targets health zones in the DRC in which transmission is occurring and is likely to occur, with the possibility of including other geographical areas should the disease spread.

Community engagement

The IOAC mission team observed that the public health measures that proved sufficient in the Mbandaka outbreak in 2018 and earlier phases of the outbreak in Beni have not worked as effectively in Butembo and Katwa. Intentional politicization has been a significant factor in undermining community trust in the response. But equally important has been the slowness of the response in addressing feedback and concerns from affected communities and implementing organizations.

[10] UN News 'DR Congo: No time to lose says newly appointed UN Ebola Response Coordinator' https://news.un.org/en/story/2019/05/1039051

Partners noted that most of the community feedback that could be used to adjust the response was not discussed beyond the communication pillar and was not being used to recalibrate the response strategy. A similar situation that occurred in 2014 had a negative impact on response effectiveness, yet this important lesson seems to have been overlooked.

While community engagement and anthropological expertise have had considerably more attention than in the 2014 West Africa outbreak, they were structured as a subordinate activity, rather than a core of the response approach. Community outreach and engagement has focused on one-way transmission of information intended to alter community behaviours; it did not relay community concerns back into the strategic decision-making of the response. This appears to be a crucial weakness in the response. A recalibration of community engagement around two-way dialogue and adaptation to community feedback is greatly needed.

Community acceptance of vaccination is very high, with around 90% take-up among those eligible to receive the vaccination (more than 107 500 people had been vaccinated at the time of the IOAC visit). However, community understanding of the ring vaccination procedure, and particularly the criteria that govern eligibility, was limited and was causing confusion and mistrust. Partners shared concerns about communication issues that might arise from proposed changes to the ring vaccination protocol, and the possible introduction of a second vaccine. Effective communication on these issues is critically important to bring the communities on board.

During the meetings with community leaders in Butembo, the IOAC mission team observed that many refer to Ebola as "the disease of dirty hands" ("maladie des mains sales") rather than a disease transmitted by direct contact with infected individuals. This is a concerning sign that current community messaging has been ineffective. Partners noted that the official community outreach materials were in French and Swahili but not in the local languages spoken in most communities in the affected areas. Methods of communication that have a high rate of penetration in the affected communities, such as social media and short audio-visual clips that can be shared via mobile phone, are currently underutilised in the delivery of key messaging.

Security management

Insecurity continues to pose a formidable obstacle to mounting an effective response in affected communities. Security threats can be mitigated to some extent by improved dialogue and strengthened trust between the response and affected communities. However, there is an aspect of the security threat that is beyond the influence of WHO, the Ministry of Health, or any other partner in the response**.** Targeted attacks by armed groups on Ebola treatment facilities appear to be driven mostly by political or economic motives, rather than as a manifestation of organic community discontent. Political engagement, and attention to the implications of the response on the local economy, must be reinforced to put an end to this type of targeted violence.

A growing consensus within the response community is that some attacks are motivated by frustration over so-called "Ebola Business" – the local perception, driven by the conspicuous resources of the

response, that the primary motivation of responders and their local associates is financial profit, and that not all locals in Butembo are getting a fair share of these perceived profits.

The IOAC assesses that under current conditions, reliance on armed security is appropriate, and indeed unavoidable, in some locations. However, this must be carefully delimited and managed. Security forces should not play a role in enforcing compliance with public health measures. The use of armed forces is sometimes welcomed by community leaders but has also frequently alienated and intimidated communities. The IOAC heard community members and NGOs citing examples of times when the local security forces went beyond protection of response teams to carry out public health enforcement functions.

WHO has established unprecedented collaboration with MONUSCO and put in place protective security measures – including armed guards at treatment facilities and armoured vehicles – to attempt to ensure the safety of staff who are responding to the EVD outbreak in the field. However, given the large number of staff and the vast areas of epidemics, the current security capacity is overstretched.

The IOAC mission team observed that some basic security measures regarding its own field visits were not properly implemented on the ground and that their logistical movement was not shared with the security team systematically. WHO cannot and should not have to fill these gaps on its own.

CONCLUDING REMARKS

Overall, WHO has demonstrated positive and concrete improvement relative to the Ebola response in West Africa during 2013–2016. It has dramatically improved real-time updates of case statistics and made proactive investments in neighbouring country preparedness. The response strategy has employed innovations including the large-scale deployment of vaccination efforts, burial teams, and incentives for infection prevention in private health facilities. Substantial progress is also evident with regard to engagement of WHO senior leadership (particularly the Director General and Regional Director), the rapid implementation of a comprehensive incident management structure, and administrative business processes.

However, WHO has struggled to develop effective partnerships with various stakeholders and maintain donor confidence. In the face of a complex political and security environment, the response operation has also struggled to secure the trust and confidence of some communities, resulting in resistance and violence towards the response. This negative perception of the Ebola response flows from overt politicization and manipulation, but also from community frustration.

The Ebola outbreak is worsening, with the possibility of further geographical spread. The response effort needs a significant shift and adaptation in strategy and operational posture in order to succeed. The most urgent priority at this time is to re-establish community trust.

At the time of writing (May–June 2019), although the scale of the current outbreak remains well below that of the West Africa outbreak, the conflict and political dynamics in eastern DRC make this response arguably more challenging. The IOAC remains deeply concerned about the sustainability of the response given the WHO's overstretched capacity, a limited number of partners on the ground, insecurity and funding shortage. The IOAC is hopeful that these concerns can be addressed by newly empowered UN leadership and a collective response platform in close liaison with Congolese political leaders both in Kinshasa and eastern DRC.

The IOAC is impressed by WHO's wholehearted engagement and commitment, but WHO cannot succeed without the assistance of, and collaboration with, its UN and wider partners, and without further financial support from Member States and donors.

Annex: Programme of the field visits in Democratic Republic of the Congo by the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

24 April to 2 May 2019

IOAC delegation members: Peter Graaff, David Holmes, Gary Kobinger, Jeremy Konyndyk (Head), Munjoo Park, Guenael Rodier

Time	Agenda item and participants	Venue
Wednesday, 24 April 2019		
13:00	Head of the IOAC delegation (Jeremy Konyndyk) arrival in Kinshasa	Airport, Kinshasa
15:00	WR briefing with the head of the IOAC delegation	WHO, Kinshasa
16:00 – 17:00	Meeting with the Humanitarian coordinator for DRC (Kim Bolduc)	OCHA, Kinshasa
18:00	STAG-IH member (Gary Kobinger) arrival in Kinshasa	Airport, Kinshasa
20:00	IOAC delegation internal meeting	Hotel, Kinshasa
Thursday, 25 April 2019		
08:30 – 10.30	Visit to Institut National de Recherche Biomédicale Meeting with the Director-General (Prof Jean-Jacques Muyembe)	INRB, Kinshasa
10:30 – 11.30	Visit to EOC	MOH, Kinshasa
11:30 – 13:00	Meeting with ECHO, OCHA, USAID, DFID, CDC, and MSF	WHO, Kinshasa
13:00 – 14:00	Meeting with NGOs	WHO, Kinshasa
14.30 – 15.30	Meeting with the Minister of Health (Dr Oly Ilunga Kalenga)	MOH, Kinshasa
16:00 – 17:00	Meeting with UN agencies	WHO, Kinshasa
17:00 – 18:00	Meeting with WHO Country Office staff	WHO, Kinshasa
Friday, 26 April 2019		
10:00	IOAC delegation arrival in Goma	Airport, Goma
11:00 – 12:30	Meeting with Incident Manager and the IMT in Goma	WHO, Goma
13:00 – 14:30	Meeting with the national EVD response lead of the Ministry of Health	Chalet, Goma
14:00 – 15:00	Visit to the WHO sub-office and EOC Meeting with the field Coordinator	WHO Sub-Office, Goma
15:30 – 16:30	Meeting with USAID, DFID, ECHO, OFDA, and World Bank	WHO, Goma
16:30 – 18:00	Strategic Coordination meeting	WHO, Goma
18:30 – 20:00	Meeting with NGO partners	Chalet, Goma
Saturday, 27 April 2019		
08:30 – 10:30	MoH Coordination meeting	WHO, Goma
10:30 – 11:30	WHO security briefing Meeting with the WHO Security officer	WHO, Goma
11:00 – 12:00	Meeting with Alima	WHO, Goma
12:00 – 13:30	Meeting with CDC team	WHO, Goma
14.00 – 15.00	Meeting with MSF	WHO, Goma
15:00 – 16:00	Meeting with USAID/OFDA	WHO, Goma
16:30 – 18:00	Goma Coordination meeting on preparedness	MOH, Goma

Time	Agenda item and participants	Venue
Sunday, 28 April 2019		
07.00	IOAC delegation departure	Airport, Goma
11:00	IOAC delegation arrival in Butembo	Airport, Butembo
12:00 – 13:00	UN agencies meeting with DG and RD	WHO compound, Butembo
13:00 – 13:30	WHO Security briefing Meeting with the Security Officer	WHO compound, Butembo
14:00 – 15:30	Traditional Leaders meeting with DG and RD	WHO compound, Butembo
15:30 – 16:30	Meeting with representatives of business associations	WHO compound, Butembo
18:00 – 19:00	All staff meeting	WHO compound, Butembo
19:00 – 20:00	Group dinner	WHO compound, Butembo
Monday, 29 April 2019		
08:30 – 10:30	Religious leaders meeting with DG and RD	WHO compound, Butembo
11:00 – 13:00	Meeting with representatives of civil societies	Mayor's office
13.30 – 14.00	Debriefing with DG and RD	WHO compound, Butembo
14:00 – 15:00	Meeting with NGOs	WHO compound, Butembo
15:00 – 15:30	Meeting with sub commission Infection prevention and control	WHO compound, Butembo
15:30 – 16:30	Meeting with Deputy Humanitarian Coordinator (Julien Harneis)	WHO compound, Butembo
16:30 – 17:00	Meeting with sub commission communication	WHO compound, Butembo
18.00 – 20.00	Debriefing with ADG and IM	WHO compound, Butembo
Tuesday, 30 April 2019		
08.00 – 10.00	Meeting with Butembo commission lead	WHO compound, Butembo
16.00	IOAC delegation arrival in Goma	Airport, Goma
18.00 – 20.00	Additional interviews	WHO, Goma
Wednesday, 1 May 2019		
08.00	IOAC delegation departure	Airport, Goma
14.00	IOAC delegation arrival in Kinshasa	Airport, Kinshasa
16.00	Meeting with MOH	Hotel, Kinshasa
18.00	IOAC delegation internal meeting	
Thursday, 2 May		
08.00 – 18.00	IOAC delegation internal meeting	Hotel, Kinshasa
20.00	IOAC delegation departure	Airport, Kinshasa
	End of mission	