INTERNATIONAL HEALTH REGULATIONS (2005) MONITORING AND EVALUATION FRAMEWORK

THE REPUBLIC OF UGANDA

Report on the 2021 Uganda Multi-Sectoral Self-Assessment and Operational Planning

September 2021

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FOREWORD

The International Health Regulations (IHR) 2005, to which Uganda is a signatory, mandates member states to prioritize health security. Globally, there has been an acceleration in occurrence of global public health threats in the last 20 years. These include emerging and re-emerging infections, physical, chemical, biological and radio-nuclear events that cause unprecedented public health emergencies at national and international levels. Notably, the 2014-2016 Ebola Virus Disease (EVD) epidemic in West Africa, the 2018-2020 EVD epidemic in Democratic Republic of Congo and the ongoing COVID-19 pandemic have presented serious threats in Africa.

Governments must strengthen their capacities to prepare, detect and respond to potential public health threats in ways that limit their impact on human health and the socio-economic structures of society. Uganda strives to maintain active collaboration and partnerships to implement health security and was among the first African nations to join the Global Health Security Agenda in 2013. Uganda developed the National Action Plan for Health Security (NAPHS) 2019 - 2023 from the gaps identified in the 2017 Joint External Evaluation (JEE) of IHR capacities. The plan provides a platform for coordination and collaboration to address emerging health threats and improve national health security using a multi-sectoral and One Health approach. Since its launch in 2019, the plan has guided stronger commitment in health security interventions among government Ministries, Departments and Agencies (MDAs) and partners. In addition, in 2018 Uganda launched the Kampala Declaration, joining GHSA member countries in committing to "GHSA 2024" which calls upon countries to step up sustainable health security by 2024.

In 2020, a review of the NAPHS revealed improved capacities in IHR at points of entry and response to events as evidenced by Uganda's prompt detection and control of the imported EVD and COVID-19 outbreaks. The 2021 Internal Multi-sectoral self-assessment provides an opportunity for Uganda to measure its progress in improving health security capacities since 2017. This review of the strengths and weaknesses per technical area will enable us to identify bottlenecks to implementation of the NAPHS and propose feasible solutions before the next JEE. Specifically, this exercise will help the Government MDAs and partners to prioritize activities in the next one year to significantly improve Uganda's IHR capacities. These priority activities will form the basis of the 2021-2022 Operational Plan for health security. Success is not one big step in the future but is the accumulation of progress through small steps taken right now. Uganda plans to undergo this exercise annually to continue to monitor capacity building across sectors.

We humbly call upon all the Government and its partners to support this Multi-sectoral self-assessment and operational planning process to ensure a healthy and productive Uganda. We extend our appreciation to the Ministry of Health for its dedicated support in health security implementation in collaboration with other relevant sectors in Uganda.

For God and My Country,

Rt. Hon. Prime Minister,
Robinah Nabbanja

ACKNOWLEDGEMENT

The Office of Prime Minister and Ministry of Health would like to thank the MDAs, partners and individuals whose support made this 2021 Internal Multi-Sectoral Self-assessment and Operational Planning exercise possible. Using a whole-of-government approach, the secretariat engaged multidisciplinary stakeholders across government ministries, departments, agencies, development partners, academia and civil society organizations.

Special appreciation goes to the whole Government of Uganda including: Ministry of Agriculture, Animal Industries and Fisheries, Ministry of Water and Environment, Ministry of Defense and Veteran Affairs (Uganda People's Defense Force), Ministry of Justice and Constitutional Affairs, Ministry of Science, Technology and Innovation, Uganda Wildlife Authority and Atomic Energy Council.

The following partners played a key role in this assessment: Makerere University Infectious Diseases Institute, Resolve to Save Lives, US Centers for Disease Control and Prevention, World Health Organization, United States Agency for International Development, Makerere University Walter Reed Research Project, Food and Agriculture Organization, International Organization for Immigration, Baylor Uganda, MSF and UNICEF. *See section on list of participants in the 2021 Multi-sectoral Self-assessment.*

I thank you,

Dr. Aceng Jane Ruth Ocero
Hon. Minister of Health

LIST OF ACRONYMS

AAR	After Action Review
AEC	Atomic Energy Council
AFROHUN	Africa One Health University Network
AMR	Antimicrobial Resistance
ARIS-3	Animal Research Information System version 3
BSBS	Biosafety and Biosecurity
CBRNE	Chemical, Biological, Radiological and Nuclear Emergencies
CDC	Centers for Disease Control and Prevention
CONOPs	Concept of Operations
CPHL	Central Public Health Laboratories
DGAL	Directorate of Government Analytical Laboratory
DHE	District Health Educators
DHIS-2	District Health Information System version 2
DHT	District Health Team
DTF	District Task Force
EBS	Event Based Surveillance
EFMA	Emergency Funds Management Act
EIA	Entebbe International Airport
EMA-i	Event Mobile Application
FETP	Field Epidemiology Training Program
GAVI	Global Alliance for Vaccines and Immunization
GHSA	Global Health Security Agenda
GLASS	Global Antimicrobial Resistance Surveillance System
GoU	Government of Uganda
HPAI	Highly Pathogenic Avian Influenza
IBS	Indicator Based Surveillance
IDI	Infectious Diseases Institute
IDSR	Integrated Disease Surveillance and Response
IES & PHE	Integrated Epidemiology, Surveillance and Public Health Emergencies

IHR	International Health Regulations
INFOSAN	International Network of Food Safety Authorities
IPC	Infection Prevention and Control
JEE	Joint External Evaluation
MAAIF	Ministry of Agriculture, Animal Industry and Fisheries
MCM	Medical Countermeasures
MDA	Ministries, Departments and Agencies
MIA	Ministry of Internal Affairs
MoDVA	Ministry of Defense and Veteran Affairs
MoH	Ministry of Health
MoJCA	Ministry of Justice and Constitutional Affairs
MoU	Memorandum of Understanding
MWE	Ministry of Water and Environment
NADDEC	National Animal Disease Diagnostic Epidemiology Center
NAPHS	National Action Plan for Health Security
NDA	National Drug Authority
NECOC	National Emergency Coordination and Operations Center
NFP	National Focal Point
NMHPRP	National Multi-Hazard Preparedness and Response Plan
NMS	National Medical Stores
NOHP	National One Health Platform
NRRT	National Rapid Response Team
NTF	National Task Force
ODK	Open Data Toolkit
OIE	World Organisation for Animal Health
OPM	Office of the Prime Minister
PHA	Public Health Act
PHE	Public Health Emergencies
PHEOC	Public Health Emergency Operations Center

PoE	Points of Entry
PZDs	Priority Zoonotic Diseases
RDC	Resident District Commissioner
RDS	Results Dispatch System
RECDTS	Regional Electronic Cargo and Driver Tracking System
REOC	Regional Emergency Operation Center
RIA	Regulatory Impact Assessment
RRH	Regional Referral Hospital
SOP	Standard Operating Procedure
SPAR	State Parties Annual Reporting
TWGs	Technical Working Groups
UNBS	Uganda National Bureau of Standards
UNCST	Uganda National Council of Science and Technology
UNIPH	Uganda National Institute of Public Health
UPDF	Uganda People's Defense Force
UVRI	Uganda Virus Research Institute
UWA	Uganda Wildlife Authority
VHF	Viral Hemorrhagic Fever
VHT	Village Health Team
WHO	World Health Organization

EXECUTIVE SUMMARY

Uganda is one of the 196 countries that are signatory to the International Health Regulations (IHR) 2005 ensuring prevention, detection and timely response to public health emergencies. The IHR (2005) aim to prevent international spread of disease and to avoid unnecessary interruption to international travel and trade that may be caused by infectious, zoonotic, nuclear or radiological hazards. Following the Joint External Evaluation (JEE) in 2017, Uganda established a National Action Plan for Health Security (NAPHS) 2019-2023 to address the gaps identified in health security. Despite some progress made during concurrent public health emergencies, there was difficulty in closing the capacity gaps identified due to the large number of activities, cost, managerial burden, lack of accountability in the plan and change in the assessment tool.

To evaluate progress and accelerate multi-sectoral implementation, Uganda conducted the 2021 internal self-assessment of current capacities using the JEE 2.0 tool. The self-assessment led by the Office of the Prime Minister and Ministry of Health was conducted between 14-28 May 2021. Multi-sectoral workshops for each of the 19 Technical Areas were held with relevant ministries, departments and agencies (MDAs) and partners. The updated scorecard from the assessment was used when selecting activities for an operational plan for 2021-2022. Each activity was matched against the World Health Organization (WHO) Benchmarks for IHR Capacities to ensure the activity helped the country step up to the next JEE score. Activities were assigned clear timelines and points of contact to ensure accountability.

This report provides evidence of the successful capacity building efforts of Uganda since 2017. The most critical findings of the assessment and operational plan are highlighted below:

1. Uganda *"Got Out of the Red"* in 4 of 5 indicators in 3 technical areas (National Legislation, Policy and Financing; Emergency Preparedness; and Points of Entry - PoE)

2. Uganda increased capacity level scores in 18 indicators (P.1.2, P.1.3, P.2.1, P.3.1, P.3.2, P.4.1, P.5.1, P.5.2, P.7.1, P.7.2, D.1.2, D.4.4, R.1.1, R.4.3, R.5.5, PoE.1, PoE.2, and RE.1)

3. Uganda increased by 2 JEE levels of capacity in three indicators in National Legislation, Policy and Financing and Points of Entry

4. Due to changes in the tool and reductions in capacity, Uganda reduced capacity in 2 indicators Antimicrobial Resistance (P.3.3) and Medical Countermeasures and Personnel Deployment (R.4.2)

In 2021, there were more indicators at sustained (2%), demonstrated (29%) and developed (47%) capacities in comparison to 0% sustained, 20% demonstrated and 40% developed capacities in 2017. Between 2017 and 2021, indicators with limited capacity declined from 30% to 20% while indicators with no capacity declined from 10% to 2%. One indicator in immunization had sustainable capacity because of availability of vaccine delivery systems or mechanisms in all districts and optimal funding systems.

Multi-sectoral, multidisciplinary IHR focal points were nominated and oriented for IHR coordination resulting in demonstrated capacity. Uganda improved capacities from red in PoE because of designating three PoE which have the IHR core capacities. Leveraging COVID-19 funding, Uganda improved PoE infrastructure and resources for screening, testing travellers and use of electronic test validation systems.

Uganda maintained capacities for surveillance with improved indicator and event-based surveillance, use of electronic tools in the health sector, although coverage and usage in animal health is still sub-optimal. Emergency response operations maintained developed capacity due to the functionality of the Public Health Emergency Operations Center (PHEOC) and establishment of three functional sub-national EOCs.

Despite progress across multiple technical areas and sectors, there remain challenges to capacity building. To continue to mature health security capacity in Uganda, the government needs to increase sustainable financing of health security activities. There are several indicators which received lower scores because the plans, Standard Operating Procedures, policy, legislation, or other agreements are not finalized. There is an urgent need to finalize these plans so that all actors understand their roles and responsibilities in preparedness and emergency response. Finalized plans can continue to be updated as the country learns and improves from each emergency response. The 2021 assessment revealed that one indicator in Emergency Preparedness had no capacity because the National Multi-hazard Preparedness and Response Plan is not finalized.

Overall, Uganda has advanced over the past three years due to concerted efforts and collaboration by the different MDAs and partners. The gains will benefit from additional funding support, continued communication and coordination across sectors and strong documentation of policies and practices towards sustainable levels in all technical areas.

OBJECTIVES

The main objective of the internal multi-sectoral self-assessment and operational planning was to evaluate progress towards attainment of the capacities for health security

The specific objectives were:

1. To determine the status of the 19 technical areas using the JEE 2.0 tool
2. Agree on GHSA 2024 national commitments for which Uganda will be accountable for by 2024
3. To identify priority activities for implementation between 2021-2022 that will contribute to improvement of the JEE indicators

METHODOLOGY

The assessment process began with internal consultations within MoH and later with OPM since health security is a national responsibility of all MDAs. OPM led and coordinated the subsequent preparatory meetings in this exercise.

This was followed by training of multi-sectoral facilitators and participants. The training was held at the Ministry of Health Public Health Emergency Operation Center (PHEOC); facilitators and participants attended physically and online via Zoom. In the planning phase, the secretariat led by OPM and composed of members from MoH, IDI and CDC developed a schedule for meetings to conduct the self-assessment. The OPM also sent invitations to IHR implementing MDAs and partners to nominate focal persons to participate in the exercise (**Figure 1**).

Figure 1: Road map for self-assessment and operational planning

Between 21-28 May 2021, a multi-sectoral workshop was convened at the PHEOC in a series of meetings for each of the 19 technical areas. Most participants attended online via Zoom® in respect of the COVID-19 Standard Operating Procedures. The meetings were chaired by OPM and facilitated by Subject Matter Experts. Participants included nominees and technical staff from various government ministries, departments and agencies, implementing partners, academia and civil society organizations relevant to the technical areas. In total, 30 organizations participated in the self-assessment (**Annex 1**).

The self-assessment and scoring exercise per technical area involved three main steps (**Figure 2**). In step 1, participants reviewed the 2017 JEE report and NAPHS to identify strengths and gaps in each indicator. They discussed and documented the progress made since 2017, updated the score using the JEE 2.0 tool (50 indicators) and provided the rationale for the score. This second edition of the JEE tool has 49 indicators (increase of one indicator) and clarify issues in the interpretation of various indicators.

In step 2, participants identified priority actions to move to green using the WHO IHR benchmarks and NAPHS documents. Considerations for opportunities available and/or low hanging fruits were made. When necessary, actions in NAPHS were updated.

In step 3, participants created a simplified operational plan. This consisted of prioritized actions with specific activities, assigned focal persons, MDA responsible for implementation, timeline and a proposed source of funds for implementation.

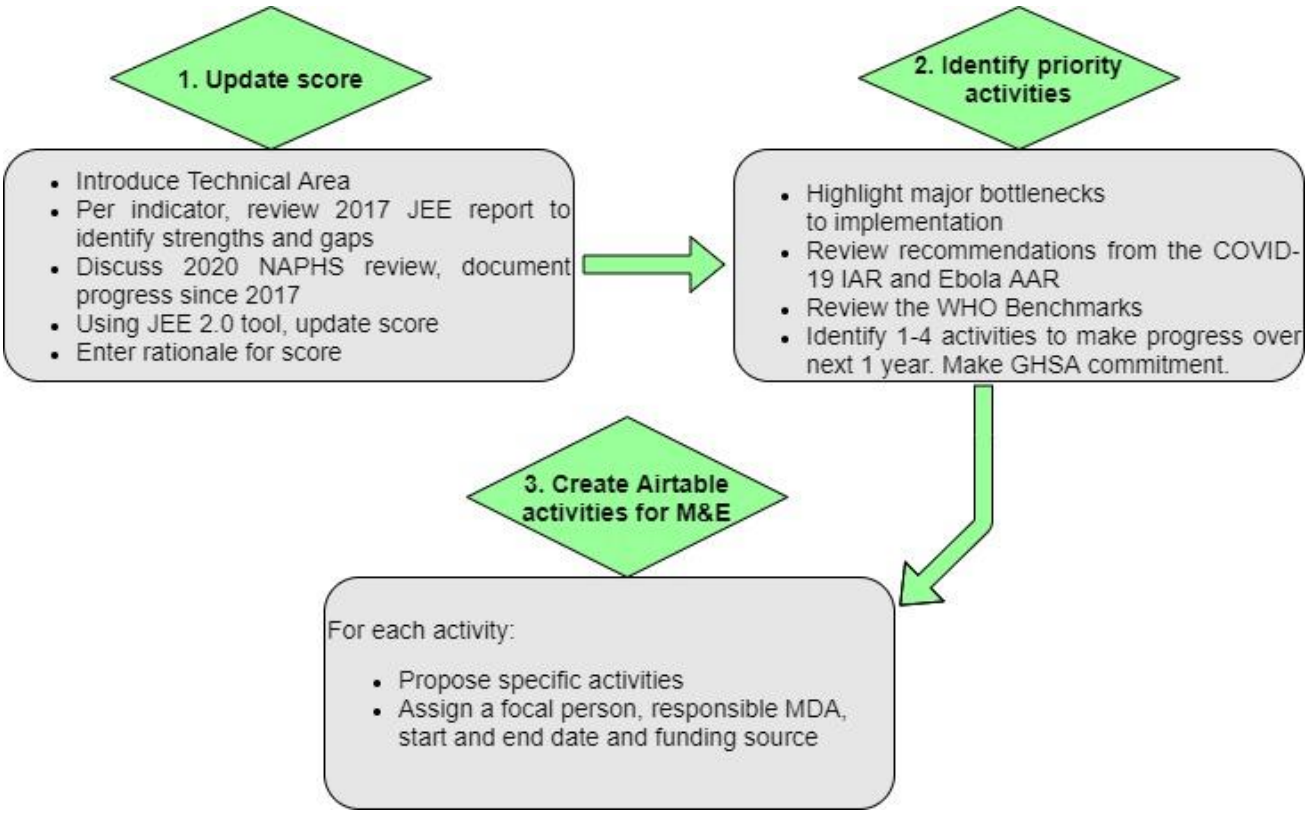

Figure 2: Procedure for the self-assessment, scoring and operational planning

A two-day consensus meeting was held in September 2021. Top-level government and partner officials reviewed the scores, prioritized activities in the operational plan and agreed on the GHSA 2024 national commitments. The final 2021-2022 Self-assessment and Operational Plan was disseminated to guide health security implementation in Uganda.

COLOUR SCORING SYSTEM

The following describes the level of advancement or scoring with colour coding

	Capacity Level	Colour code
1.	**No capacity:** Attributes of a capacity are not in place.	
2.	**Limited capacity**: Attributes of a capacity are in the development stage (implementation has started with some attributes achieved and others commenced).	
3.	**Developed capacity:** Attributes of a capacity are in place; however, sustainability has not been ensured (such as through inclusion in the operational plan of the national health sector plan with a secure funding source).	
4.	**Demonstrated capacity:** Attributes are in place and sustainable for a few years and can be measured by the inclusion of attributes or IHR core capacities in the national health sector plan and a secure funding source.	
5.	**Sustainable capacity:** All attributes are functional and sustainable, and the country is supporting one or more other countries in their implementation. This is the highest level of the achievement of implementation of IHR core capacities.	

RESULTS OF THE 2021 MULTI-SECTORAL SELF-ASSESSMENT

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
1. National Legislation, Policy and Financing	P.1.1 The State has assessed, adjusted and aligned its domestic legislation, policies and administrative arrangements in all relevant sectors to enable compliance with the IHR	3	The Ministry of Justice and Constitutional Affairs is supporting MOH in developing Rules for IHR Implementation. The relevant legislation, regulations, administrative requirements and other government instruments have been undertaken for the implementation of IHR and required adjustments have been identified. Existing Public Health Act was used to ably respond to COVID-19. The Public Health Act amendment is in progress domesticating IHR 2005. National IHR Focal Point and sector Focal Points have been nominated in main MDAs.
	P.1.2 Financing is available for the implementation of IHR capacities	3	MDAs obtain routine government release funds per quarter to support IHR implementation. **Human health (MoH)** has TWGs for Nutrition and Non-Communicable diseases which are funded. **Animal health (MAAIF and UWA) and MWE** are not adequately budgeting for One Health activities. A budget line for surveillance and response supports implementation of IHR activities.
	P.1.3 A financing mechanism and funds are available for timely response to public health emergencies	3	IES and PHE Department in MoH has been operationalized and has budget for PHEs. OPM has disaster preparedness, NECOC and contingency funds. The provision in Emergency Funds Management Act for PHEs; this was utilized for COVID-19 response and other public health emergencies since 2018. The Public Financing Act applies for regional and district level access to funds. However, timely release of funds remains a challenge.
2. IHR Coordination Communicatio	P.2.1 A functional mechanism established for the coordination and	4	A coordination mechanism within and between relevant ministries, including government agencies is in place. Multi-sectoral, multi-disciplinary IHR focal points have been nominated and oriented on their TORs. Multi-sectoral, multidisciplinary National Task Force established at OPM for COVID-19.

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
n and Advocacy	integration of relevant sectors in the implementation of IHR		Conducted AAR for EVD (updated response plan following this) and IAR for COVID-19 (developed a remedial and resurgence plan following this). Since 2018, we have been in response to events (EVD, COVID-19). Communication products in form of surveillance epidemiological bulletins are produced by MoH and OPM and disseminated across sectors.
3. Antimicrobial Resistance	P.3.1 Effective multi sectoral coordination on AMR	3	A Multi-sectoral AMR National Action Plan exists; activities are anchored in the OPM. Quarterly meetings are held by the National AMR subcommittee. Lately, the meetings are being held virtually. The operational plan is aligned to the five Good Agricultural Practices objectives with an implementation plan. M&E aspects of GAP objectives are indicated although monitoring is still in its infancy.
	P.3.2 Surveillance of AMR	3	A National AMR surveillance plan exists both for **human and animal health**. There are 25 laboratories that have capacity to conduct susceptibility testing. Laboratories can produce AMR data and have laboratory quality management systems. **Human health** regional laboratories are utilized for sentinel surveillance; data are submitted to the GLASS system. Sentinel surveillance sites for AMR exist across **human and animal health**. A**nimal health** laboratories through NADDEC and human health laboratories through National Microbiology Reference Laboratory participate in national and international proficiency testing activities for quality assurance.
	P.3.3 Infection prevention and control	2	**In human health**, the IPC committee steers the IPC program and has a draft strategic plan. IPC was rolled out during COVID-19 response. Systematic efforts in RRH include conducting annual surveys. Although there is no national AMR IPC policy, a **Health Policy under MoH** includes section on IPC; MoH Environmental Health Department leads implementation of the derived IPC guidelines. In **MAAIF, five guidelines** on IPC in animal production for poultry, pigs, cattle, fish and goats exist.

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
	P.3.4 Optimize use of antimicrobial medicines in human and animal health and agriculture	3	**Across human and animal health**, there are policies on appropriate use of antimicrobial medicines in the Crop, PH, and Animal Diseases Acts and NDA policy on veterinary drug use. **Animal health** developed surveillance guidelines for antimicrobial medicines use or control (AMU) have been approved. Strategy for surveillance for zoonoses was developed. Guidelines for AMU in animal health have developed and a veterinary drug desk was activated at MAAIF. There is a list for essential veterinary medicines to guide the use of antimicrobials.
4. Zoonotic Disease	P.4.1 Coordinated surveillance systems in place in the animal health and public health sectors for zoonotic diseases/pathogens identified as joint priorities	3	**Animal health** surveillance includes EBS through EMA-I and IBS through monthly paper-based reports. Poor reporting and reliance on paper-based tool is a challenge. **Human health** includes IBS through weekly paper-based and electronic reporting on epidemic prone diseases and seven priority zoonotic diseases. EBS utilizes electronic systems (eIDSR) that can log animal health alerts. Draft strategy for coordinated surveillance for priority zoonotic diseases (PZDs) was developed. One Health Epidemiological bulletin reports surveillance data and interventions across One Health sectors. However, there is no fully interoperable electronic surveillance system in place.
	P.4.2 Mechanisms for responding to infectious and potential zoonotic diseases established and functional	2	Mechanism in place that enables all the sectors to respond to zoonotic diseases although there is no National One Health Policy to support One Health activities. Regulatory Impact Assessment for National One Health Policy recommended development of National One Health Coordination Strategy. Developed One Health Risk Communication Strategy for PZDs.
5. Food Safety	P.5.1 Surveillance systems in place for the detection and monitoring of foodborne diseases	3	**Human health** conducts IBS and EBS surveillance for foodborne through IDSR which includes a priority list of notifiable foodborne diseases. **Environment health** (NWSC), DGAL, UNBS and **Animal health** (DDA, Fisheries) conduct routine surveillance (including market surveys of specific foods). No risk assessment protocol of acute foodborne events (chemical and microbiological). Risk assessment was done for Cholera and foodborne

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
	and food contamination		diseases are included in the national multi-hazard plan, which also describes response to foodborne disease outbreaks. Joined INFOSAN and report.
	P.5.2 Mechanisms are established and functioning for the response and management of food safety emergencies	3	National multi-hazard plan and IDSR describe and guide response and management of foodborne disease outbreaks.
6. Biosafety and Biosecurity	P.6.1 Whole-of-government biosafety and biosecurity system in place for all sectors (including human, animal and agriculture facilities)	3	Uganda lacks an enacted law on BSBS; RIA on BSBS policy finalized. Developed BSBS manual and national inventory of select agents. UNSCT approves laboratories handling different pathogens e.g. COVAB, UWA, Fort Portal RRH and UVRI.
	P.6.2 Biosafety and biosecurity training and practices in all relevant sectors (including human, animal and agriculture)	3	Training of BSBS in **human and animal institutions** conducted. Originally BSBS was only in MoH. Currently training is targeting **animal health and wildlife** as well. However, the national curriculum on BSBS has not been revised and training is conducted on an ad hoc basis. 20 BSBS professionals certified International Federation of Biosafety Associations. 900 persons trained in BSBS through AFROHUN-UG (OHW-NG) since 2016. MakCOVAB has set up a centre for Biosecurity and Global Health.
7. Immunization	P.7.1 Vaccine coverage (measles) as part of national programme	4	As of 2020, 70%-89% of the country's 12-month-old population has been vaccinated. Coverage was 87.2% in 2020 while in 2019 it was 86.9%. COVID-19 pandemic interfered with immunization activities. Have finalized efforts to incorporate yellow fever into routine vaccination.

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
	P.7.2 National vaccine access and delivery	5	In the last two years, there has been no stock out. Vaccine delivery is available in all districts (is at 100%). Systems for appropriate practices are in place. Vaccine delivery has been tested. Two sets of vaccine funding in Uganda: traditional financing that is funded by the Government and co- financing where the Government contributes 30% while GAVI funds between 60% to 70%. Uganda also contributes to GAVI.
8. National Laboratory System	D.1.1 Laboratory testing for detection of priority diseases	4	**Across human and animal health**, laboratory testing capacities exist for some priority diseases. However, some human and animal laboratories lack core test lack quality assurance systems. **Animal health** (NADDEC) still has gaps in diagnostic services.
	D.1.2 Specimen referral and transport system	4	**Human health** has specimen referral and transport systems in place (hub system). The 100 hubs support 146 districts. National hub system guidelines have not been reviewed for integrated sample transportation and coordination between **human and animal health**.
	D.1.3 Effective national diagnostic network	3	**Animal health** lacks farm-based advanced diagnostic techniques. **Wildlife** capacities included Mweya wildlife laboratory which will be activated in June 2021 while Murchison and Bwindi laboratories can conduct RDTs. **Human health** laboratories have limitations for Point of Care for Molecular and Serological Techniques.
	D.1.4 Laboratory Quality System	3	Quality systems at regional referral health laboratories have been accredited and improved. However, Uganda doesn't have own accreditation system; a joint human and animal laboratory accreditation body would be beneficial. Allied Health does not license laboratories every year and does not look out for accreditation status when assessing the laboratories, it is a voluntary exercise. Mandatory licensing of all laboratories in conformity to national quality standards is needed. Food safety testing laboratories should be licensed and included in national laboratory systems, currently, only UNBS is accredited.

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
9. Surveillance	D.2.1 Surveillance systems	4	**Human health** has an EBS and IBS system based on IDSR in place with robust immediate, weekly, monthly and quarterly reporting. Weekly reporting rate is 80% among public health facilities. **Animal health** has an EBS and IBS system with immediate and monthly reporting; gaps include low reporting (only 40% of districts) and poor coverage and use of tools. **Wildlife** surveillance system consists of annual wildlife disease surveillance reports, EBS (syndromic arc ranger system) and IBS. Surveillance in animal health needs strengthening to improve linkage with the health sector.
	D.2.2 Use of electronic tools	3	**Human health** has electronic tools for EBS and IBS i.e. mTrac and eIDSR; data is collated on DHIS2. Results Dispatch System for laboratory data and Open Data toolKit and Regional Electronic Cargo and Driver Tracking System for PoE. **In Animal health**, EMMA-i is used for EBS and ARIS-3 dashboard for IBS. UWA uses Spatial Monitoring And Reporting Tool (SMART) in all National Parks for IBS and Arc Ranger for EBS. **Environment sector** (MWE) uses GIS electronic systems. Gaps in animal health include: reliance on paper-based tools for monthly IBS, poor coverage and use of EMMA-i and ARIS-3. As a result, electronic surveillance across animal and human health is not yet interoperable. However, efforts to address this include use of eIDSR for EBS and case-based reporting.
	D.2.3 Analysis of surveillance data	3	**Human health** and OPM produce analytical reports e.g. routine (weekly and quarterly) bulletins, annual reports and situation reports during outbreaks. The One Health Epidemiological Bulletin shares surveillance information across human, **animal and environment health** sectors.
10. Reporting	D.3.1 System for efficient reporting to FAO, OIE and WHO	3	There are designated Focal Points for OIE (**animal health**) and WHO (**human health**) who immediately notify OIE and WHO. There's a multi-sectoral National One Health Platform (NOHP); it has challenges with functionality to identify potential threats. An ad hoc NOHP IMT is established but needs to be guided by the National One Health Policy. However, 24-hour

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
			reporting to WHO for zoonotic diseases is not done because of gaps in detection.
	D.3.2 Reporting network and protocols in country	3	Reporting networks and protocols established utilize the NTF, NOHP, OPM Disaster Management Department which are multi-sectoral.
11. Human Resources	D.4.1 An up-to-date multi-sectoral workforce strategy is in place	3	A multi-sectoral public health workforce strategy exists. MoH has a pronounced 15-year work force strategy which is being reviewed by stakeholders. Strategy defining OH worker in Uganda was drafted with support from AFROHUN.
	D.4.2 Human Resources are available to effectively implement IHR	4	HR to implement IHR have been increased including multi-sectoral FETP graduates (52 Advanced Epidemiologists and 400 Frontline epidemiologists trained). Challenge is the lack of sustainable/domestic funding for FETPs to increase our capacity. Epidemiologists are deployed as part of NRRTs and DRRTs but not incorporated in the national and district public service structure.
	D4.3 In-service trainings are available	3	There are several multi-sectoral in-service training across **human and animal health** namely: Frontline, Intermediate and Advanced FETP, AFROHUN and In Service Applied Veterinary Training (ISAVET).
	D4.4 FETP or other applied epidemiology training programme is in place	4	Three FETP levels exist: Frontline, Intermediate and Advanced. There is a need to develop a budget for the mid-term expansion expenditure for FETP and officially establish the NIPH within MoH. 90 frontline persons trained through AFROHUN's One Health Institute Infectious Disease Management course since 2016.
12. Emergency Preparedness	R.1.1 Strategic emergency risk assessments conducted and	2	We conducted a national health emergency risk assessment and created a national profile last year using the WHO Strategic Risk Assessment Tool

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
	emergency resources identified and mapped		(STAR). National level inventories and maps of health sector resources are available and updated yearly.
	R.1.2 National multi-sectoral multi-hazard emergency preparedness measures, including emergency response plans, are developed, implemented and tested	1	National multi hazard preparedness and response plan (NMHPRP) drafted but not yet approved. Response plans exist for select diseases (COVID-19, EVD, VHFs, Anthrax, Rabies, HPAI and Yellow fever) in **animal and human health**. CONOPS has been completed and updated regularly.
13. Emergency Response Operations	R.2.1 Emergency response coordination	4	The PHEOC serves as MoH's focal point for organizing, coordinating, conducting and managing all aspects of public health emergency response efforts utilizing resources in a coordinated, collective, and collaborative manner. The PHEOC reports to the NEOCC within the Office of the Prime Minister (OPM) for incidents requiring national major incident coordination which are broader than health in scope. Triggers/graded emergencies for emergency response are included in the NMHPRP. In addition to NECOC, OPM has established coordination structures in 11 pilot districts for REOCC capacities. Not all established RECOC have presence in the districts. The National Task Force for Public Health Emergencies provides national strategy and coordination of emergency response across sectors. District Task Forces are stood up based on the geographical need for emergency response. Uganda has tested EVD, Yellow fever and Cholera response at national and subnational levels through SIMEX and table top exercises.
	R.2.2 Emergency operations centre	4	A permanent PHEOC has trained staff dedicated to its operation and can be activated within 120 minutes of receiving a signal. EOC plans, activation and

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
	(EOC) capacities, procedures and plans		functions at the national level have been tested through multiple emergency response events in the past 2 years. There are 3 functional subnational EOCs but SOPS and funding for infrastructure and resources are not yet institutionalized.
	R.2.3 Emergency exercise management program	3	National and district response systems have been activated to respond to multiple major emergencies in the past two years. Uganda has conducted an IAR for COVID19 and corrective measures are being implemented to improve response. African regional cross border table top exercise involving 17 countries conducted in December 2019. Emergency response drills have been conducted at Districts and Points of Entry and corrective actions have been generated.
14. Linking Public Health & Security Authorities	R.3.1 Public health and security authorities (e.g. law enforcement, border control, customs) linked during a suspect or confirmed biological, chemical or radiological event	2	Focal Points have been officially nominated and there is informal communication. Draft MOU for coordinating health and security stakeholders has been developed awaiting approval. The cons UPDF Act takes presidencies over the MoU although other security agencies have to follow suit.
15. Medical Countermeasures & Personnel Deployment	R.4.1 System in place for activating and coordinating medical countermeasures during a public health emergency	2	The national MCM plan was drafted but has not been signed off or shared widely. The plan needs costing to be approved by top management. National Medical Stores established regional nodes for coordinating deployment of medical counter measures during public health emergencies.

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
	R.4.2 System in place for activating and coordinating health personnel during a public health emergency	2	The Ministry of East African Community Affairs is drafting a regional deployment plan for personnel in member states.
	R.4.3 Case management procedures implemented for IHR relevant hazards	4	Case management, patient referral & transport are implemented according to guidelines/SOPs
16. Risk Communication	R.5.1 Risk communication systems for unusual/ unexpected events and emergencies	2	There is a formal government arrangement, core team for risk communication and several focal points in different sectors. National response plans include risk communication. Government communication staff have job descriptions. One Health risk communication strategy for PZDs developed. There are shared agreements with response agencies. However, there is no dedicated budget line, heavy reliance on supplementary budgets.
	R.5.2 Internal and partner coordination for emergency risk communication	4	There are weekly multi-sectoral National Task Force meetings. PHEOC, NTF and DTFs coordinate risk communication during outbreaks. One Health risk communication strategy for PZDs, NOHP and risk communication subcommittees exist. Monthly partner and civil society meetings held at the MoH supported by UNICEF. Simulation exercise done. Different entities/private partners have different plans so there is lack of joint action planning and coordination.
	R.5.3 Public communication for emergencies	4	Public health communication structures in the form of national media center and District Health Educators in place. Mobile phones, print, T.V, radio, social media and internet used in emergencies. There is a national call center where communities can call in for health updates. There are ad hoc

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
			communication centers at the districts where communities can also access the information. Proactive media outreach during COVID-19. National Communication strategy that includes district PROs not operationalized; communication at district level relies on partner funding.
	R.5.4 Communication engagement with affected communities	4	Through the national media center, there is planned weekly communication. Airtime is given to RDCs; social mobilization committees (DHTs, DHEs, VHTs) in place. National and district risk communication sub pillars during response. Communication utilizes mainstream and social media. One Health communication teams reach animal workers in some districts; gaps in coverage and functionality exist. During COVID-19 a multi-level National Engagement Strategy was rolled out. Development of SOPs for the 7 priority zoonotic diseases in progress. Partner mapping has been done. Community engagement strategies for COVID-9, CCHF, EVD, Marburg, Cholera and natural disasters developed.
	R.5.5 Addressing perceptions, risky behaviors and misinformation	4	Baseline surveys on misinformation are now being harmonized but results are delayed. National call center is inadequate in the absence of regional call centers. Rumor management systems are still being developed and strengthened. There is a systematic way of collecting information e.g. the U-reports system from UNICEF, 6767 free sms, MoH rumor monitoring system and Epidemic Intelligence from Open Sources.
17. Points of Entry (PoE)	PoE.1 Routine capacities established at points of entry PoE	3	Uganda has 53 PoE and 4 seclusion points. Of these, 3 are designated (Mpondwe, Entebbe International Airport and Busia); these have the IHR core capacities including ambulances to transport sick travelers to appropriate referral health facilities. There are 6 one stop border posts. During COVID-19, Uganda got 17 thermal scanners, screening and specimen collecting staff, private laboratories, prefabrication facilities, office equipment and electronic test validation systems (RECDTS and RDS) at select PoE.

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
	PoE.2 Effective public health response at points of entry	3	**Human health** developed an operational manual for PoE, Influenza and Plague response plan and Public Health Emergency Response Plans (PHERPs) at designated PoE; these form the contingency plans. These guide PoE routine and emergency activities including safe transfer of sick travelers. Plans are incorporated in the NMHPRP. **In animal health**, MAAIF has plans to set up animal quarantine center at EIA. Currently, Uganda Wildlife Conservation Education Center is designated as the wildlife quarantine centre with one ambulance to respond to emergencies. Transport, referral of affected animals still needs support.
18. Chemical Events	CE.1 Mechanisms established and functioning for detecting and responding to chemical events or emergencies	2	DGAL has capacity in sampling and analysis in case of a chemical incident. 100 personnel trained in marking, handling, evacuation detection, sampling, analysis and decontamination of chemicals in case of chemical incident. Environment impact assessment done. Agrochemicals that are imported into the country and salt farmers are coded. Regulations from MAAIF are in place. Poison surveillance system in place. Occupational safety health management information system functional. It captures all hazardous chemicals in the country. However, limited chemical surveillance and monitoring.
	CE.2 Enabling environment in place for management of chemical events	2	National Environment Act covers environment pollutants. The East African Community Customs Act (2004) under schedule 2 and 3 prohibits and restricts imports and exports of banned items. The Toxic Chemicals Prohibition and Control Act 2016 guides control of hazardous chemicals in humans. Drafting guidelines for hazardous chemicals and training of teams underway. CBRNe Safety Policy (2017) not yet approved. A chemical incident and emergency response plan is being drafted by the Ministry of Gender.e.
19. Radiation Emergencies	RE.1 Mechanisms established and functioning for	3	The national nuclear and radiological response plan draft is in place. Strategy for protection of workers and radioactive waste under AEC are present. There is a communication strategy. Have auto monitors at some

JEE Technical Area	Indicator	2021 Score	Comments and Justification for Scoring Level
	detecting and responding to radiological and nuclear emergencies		PoEs such as Busia, Malaba, Mpondwe and Mutukula. Notification and reporting guidelines are available.
	RE.2 Enabling environment in place for management of radiological and nuclear emergencies	2	There is a multi-sectoral radiological emergency response committee which meets once a quarter hence slow progress. The National Radiation Response Plan is not yet approved.

SUMMARY RESULTS OF THE 2021 MULTI-SECTORAL SELF-ASSESSMENT

There were more indicators at developed (47%) and demonstrated (29%) capacity in comparison to limited (20%) capacity. One indicator in Emergency Preparedness had no capacity because the NMHPRP is not finalized. One indicator in Immunization had sustainable capacity because there is availability of vaccine delivery in all districts and optimal funding systems are in place.

Table 1: Summary of 2017 JEE and 2021 self-assessment results

Year	JEE, 2017		Self-assessment, 2021	
Capacity	**Indicators**	**%**	**Indicators**	**%**
1. No capacity	5	10	1	2
2. Limited capacity	15	30	10	20
3. Developed capacity	20	40	23	47
4. Demonstrated capacity	10	20	14	29
5. Sustainable capacity	0	0	1	2
Total	**50**	**100%**	**49**	**100%**

Of the five indicators in 2017 in National Legislation, Policy and Financing, Emergency Preparedness and Points of Entry, three improved to developed capacity, one improved to limited capacity and one remained at none. Both indicators in Points of Entry (PoE) improved from level 1 to 3 because Uganda designated three PoE, these have IHR core capacities including ambulances to transport sick travellers to appropriate referral health facilities. Leveraging COVID-19 funding, Uganda improved infrastructure and resources for screening, testing and transporting travellers, and use of electronic test validation systems (RECDTS and RDS). Uganda also developed contingency plans for PoE.

National Legislation, Policy and Financing improved because of existing mechanisms for accessing emergency funds. Multi-sectoral, multidisciplinary IHR focal points were nominated and oriented for IHR coordination.

Uganda maintained capacities for surveillance with improved IBS and EBS and use of electronic tools in the health sector. Despite the introduction of electronic tools for animal health surveillance, their coverage and usage is suboptimal and this interferes with interoperability across sectors. IBS and EBS surveillance and response for foodborne diseases in the health sector is conducted through IDSR. However, coordination of MDAs responsible for food safety is still scattered with legislation gaps and no National Food Safety Committee. Laboratory specimen referral and transport systems are in place (hub system) with 100 hubs that support 136 districts.

Uganda developed a BSBS manual, national inventory of select agents and the RIA on BSBS policy is underway. There was no change in the areas of chemical and radiological events. Despite the enabling legislation for chemical events management in place, there is no chemical event response plan. The national nuclear and radiological response plan is not operational.

IHR reporting capacity was improved by designation of Focal Points for OIE and WHO. Human resource to implement IHR has improved through increased multi-sectoral FETP graduates. Challenge is the lack of sustainable/domestic funding for FETPs, epidemiologists are not incorporated in the public service structure and the NIPH not officially established.

There was developed capacity for emergency response operations. The PHEOC plans, activation and functions at the national level have been tested through multiple emergency response events in the past two years. There are three functional subnational EOCs but SOPS and funding for infrastructure and resources are not yet institutionalized. Draft MoU for coordinating health and security stakeholders has been developed awaiting approval and currently there is informal communication. Risk communication during emergencies improved through routine multi-sectoral meetings at national and district levels, a functional national media center, OH risk communication strategy and proactive multi-media outreach during COVID-19.

COMPARISON OF MULTI-SECTORAL SELF ASSESSMENT SCORECARD IN 2017 VS 2021

JEE Category	Indicator	Year	
		2017	2021
National Legislation, Policy and Financing	P.1.1	3	3
	P.1.2	2	3
	P.1.3	1	3
IHR Coordination, Communication, and Advocacy	P.2.1	2	4
Anti-Microbial Resistance	P.3.1	2	3
	P.3.2	2	3
	P.3.3	3	2
	P.3.4	3	3
Zoonotic Diseases	P.4.1	2	3
	P.4.2	2	2
Food Safety	P.5.1	2	3
	P.5.2	2	3
Biosafety and Biosecurity	P.6.1	3	3
	P.6.2	3	3
Immunization	P.7.1	3	4
	P.7.2	4	5
National Laboratory System	D.1.1	4	4
	D.1.2	3	4
	D.1.3	3	3
	D.1.4	3	3

JEE Category	Indicator	Year	
		2017	2021
Surveillance	D.2.1	4	4
	D.2.2	3	3
	D.2.3	3	3
Reporting	D.3.1	3	3
	D.3.2	3	3
Human Resources	D.4.1	3	3
	D.4.2	4	4
	D.4.3	3	3
	D.4.4	3	4
Emergency Preparedness	R.1.1	1	2
	R.1.2	1	1
Emergency Operations and Response	R.2.1	4	4
	R.2.2	4	4
	R.2.3	3	3
Linking Public Health and Security Authorities	R.3.1	2	2
Medical Countermeasures and Personnel Deployment	R.4.1	2	2
	R.4.2	2	2
	R.4.3	3	4
Risk Communications	R.5.1	2	2
	R.5.2	4	4
	R.5.3	4	4
	R.5.4	4	4
	R.5.5	3	4
Points of Entry	PoE.1	1	3
	PoE.2	1	3
Chemical Events	CE.1	2	2
	CE.2	2	2
Radiation Emergencies	RE.1	2	3
	RE.2	2	2

SUMMARY: CHANGE IN INDICATORS 2017 VS 2021

SUMMARY: CHANGE IN INDICATORS 2017 VS 2021		
Change in indicator	**Number of Indicators**	**Frequency**
Improved	18	37%
Reduced	2	4%
No change	29	59%
Total	**49**	**100%**

2021-2022 OPERATIONAL PLAN FOR HEALTH SECURITY

No.	Activities	Responsible Authority	Time	Funding Source
1	**National Legislation, Policy and Financing**			
1.1	Enact PH amendment bill 2021 at cabinet awaiting parliamentary council	Mr. Brian Luswata (MoH), Martha Isabella Achan (IDI) and Comm. Ms. Sarah Mitanda (MoJCA)	Oct '21-May 2022	GOU,RTSL
1.2	Amendment of the Rules under the Public Health Act	Mr. Brian Luswata (MoH), Martha Isabella Achan (IDI) and Comm. Ms. Sarah Mitanda (MoJCA)	Oct '21-May 2022	GOU,RTSL
1.3	Sensitization of the Other sectors on the New Rules under the Public Health Act	Mr. Brian Luswata (MoH), Martha Isabella Achan (IDI) and Comm. Ms. Sarah Mitanda (MoJCA)	Oct '21-May 2022	GOU,RTSL
1.4	Engagement of Parliamentary committee of Health on the provisions in the bill with CSOs	Dr. Shaban Mugerwa (MoH) and Martha Isabella Achan (IDI)	Oct '21-May 2022	GOU, Civil Society
1.5	Implement and review the use of available financing and it's effectiveness (Contingency fund)	MoF, Juliet Kasule (CDC). Comm. William Ndoleriire, Nimrod Agasha and OPM	Oct '21-July 2022	GOU, OPM and MOH, RTSL
1.6	Review and ensure functionality of the emergency public financing mechanism	Mr. Kayima (Accounting Officer, OPM)	Oct '21-May 2022	OPM
2	**IHR Coordination and Advocacy**			
2.1	Review NOHCO MoU to formalize institutional roles, resource contributions and information sharing	Felix Ocom (MoH PEOC), Roland Taremwa (OPM), Betty Mbolanyi (MWE) and Musa Ssekamatte (NOHP)	Oct '21-July 2022	GoU

No.	Activities	Responsible Authority	Time	Funding Source
2.2	Refine SOPs & TORs for NFPs to include lessons from COVID-19	Anne Nakinsige (MoH), Solome Okware (WHO) and Roland Taremwa(OPM)	Oct ’21-July 2022	TDDAP
2.3	Advocacy campaigns to popularize IHR at all levels	Anne Nakinsige (MoH), Solome Okware (WHO) and Roland Taremwa (OPM)	Oct ’21-July 2022	TDDAP
2.4	Innovatively package IHR content for awareness creation and showcasing success; widely disseminate (e.g. video documentaries)	Julius Mucunguzi (OPM) and IHR Focal Points led by Dr Anne Nakinsige (MoH)	Oct ’21-July 2022	Partners
2.5	NFPs document and share lessons learnt		Oct ’21-July 2022	Partners
3	**Antimicrobial Resistance**			
3.1	Strengthen implementation of the Monitoring Framework	Musa Ssekamatte (National One Health Platform), Dr. Isingoma (MAAIF), Mr. Ibrahim Mugerwa (MoH UNHLS), Mr. Obua (MoH Pharmacy Dept)	Oct ’21 – July 2022	GoU, FF/IDI
3.2	Strengthen the coordination structures for AMR sub-committees/Functionalized Sub-committees		Oct ’21 – July 2022	GoU, FF/IDI
3.3	Designate Functional AMR surveillance sites both human and animal sector		Oct ’21 – July 2022	GoU, FF/IDI
3.4	Strengthening the laboratory capacity in functional AMR surveillance sites for both human and animal sectors.(enterococcus, campylobacter, E.coli and salmonella at NADDEC, CoVAB)		Oct ’21 – July 2022	GoU, FF/IDI

No.	Activities	Responsible Authority	Time	Funding Source
4	**Zoonotic Diseases**			
4.1	Draft strategy for coordinated surveillance for PZDs being finalized and Approved.	Dr. Deo Ndumu (MAAIF), Dr. David Muwanguzi (MOH)	Oct -Dec 2021	GOU and IDDS-USAID
4.2	Draft National One Health Coordination Strategy	NOHP	Oct -Dec 2021	GoU and RTSL-IDI/MOH
4.3	Review and Operationalize the One Health communication strategy	NOHP	Oct-Dec 2021	GoU, NOHP and USAID
5	**Food Safety**			
5.1	Revive Multi-sectoral National Food Safety Committee with revised ToRs	Commissioner Timothy Lubanga (OPM)	Oct ’21-July 2021	GoU and partners
5.2	Develop risk assessment protocol for acute foodborne events	Commissioner Timothy Lubanga (OPM)	Oct ’21-July 2022	GoU and partners
5.3	Undertake rapid risk assessments of acute foodborne events at the national and subnational levels	Commissioner Timothy Lubanga (OPM)	Oct ’21-July 2023	GoU and partners
6	**Biosafety and Biosecurity**			
6.1	Conduct and finalize the Regulatory Impact Assessment for the BSBS bill and policy	Dr. Musunga David (MoSTI)	Oct ‘21-May 2022	GOU, MOSTI, IDI
6.2	Updated trainings for laboratory teams at Local Government levels	Mr. Joseph Nkodyo and Mr. Atek (MoH-UNHLS)	Oct ‘21-May 2022	GOU,WHO,IDI,FAO
7	**Immunization**			
7.1	Decentralization the response to immunization using the Parish Model	MOH-UNEPI	Oct ’21 – July 2022	GoU and partners

No.	Activities	Responsible Authority	Time	Funding Source
7.2	Registration of Target groups	MOH-UNEPI	Oct ’21 – July 2022	GoU and partners
8	**National Laboratory System**			
8.1	Review and update the Hub guidelines to integrate animal samples.	Thomas Nsibambi (UNHLS), Rebecca Nakidde, Justine Bukirwa (IDI), MAAIF and UWA	Oct ’21- May 2022	GOU, RTSL
8.2	Liaise with Allied Laboratory council to conduct mandatory licensure	Thomas Nsibambi, Godfrey Mujuzi and Patrick Ogwok (UNHLS), Allied Health and UWA	Oct ’21- May 2022	GoU and partners
8.3	Development of QMS for National animal health networks	Thomas Semakadde,Gloria Akurut-UWA, Atim Stella-MAAIF, Suzan Ndyanabo-FAO	Oct ’21- May 2022	GOU,IDDS
8.4	Establish a national external quality assessment programme for public health laboratories e.g NADDEC and CPHL,UWA.	Patrick Ogwok (UNHLS), Akurut Gloria and Dr Atimnedi Patrick (UWA) and Nakanjako Gladys (MAAIF)	Oct ’21- May 2022	GOU,CDC
8.5	Establish national multi-sectoral laboratory accrediation body	MoH, MAAIF, UWA and MWE	Oct ’21- July 2022	GOU and partners
9	**Surveillance**			
9.1	Address bottlenecks to reporting in Animal, Environment and Wildlife sectors utilizing OH approach	MAAIF, UWA and MWE	Oct ’21- July 2022	GOU and partners
9.2	Roll-out and implement 3rd edition IDSR using a One Health approach that involves other sectors	MoH	Oct ’21- July 2022	GOU and partners

No.	Activities	Responsible Authority	Time	Funding Source
9.3	Optimize use of electronic reporting (MAAIF) to all district to have ARIS 3,EMA-I, eIDSR and linkage to the laboratory system	MAAIF	Oct ’21- July 2022	GOU and partners
9.4	Conduct One off training and mentorship of staff in electronic reporting and data analysis	MoH, MAAIF, UWA and MWE	Oct ’21- July 2022	GOU and partners
9.5	Data analysis, interpretation and dissemination of bulletins across sectors. Designate some officers for data analysis in MAAIF, UWA and OPM.	MoH, MAAIF, UWA and MWE	Oct ’21- July 2022	GOU and partners
10	**Reporting**			
10.1	Improve timeliness of reporting to WHO,OIE,FAO	IHR/OIE Focal Points, Commissioner Animal Health (Commissioner National Disease Control) and OPM	Oct ’21 – July 2022	GoU and partners
10.2	Functionalize the National One Health Platform role in identifying and reporting all PHEs	NOHP	Oct ’21 – July 2022	GOU/RSTL
10.3	Multisectoral PHE risk assessment	MAAIF and FAO	Oct ’21 – July 2022	GoU and partners
10.4	Streamline existing protocols on reporting	MOH and MAAIF	Oct - December 2021	GoU and TDDAP
11	**Human Resources**			
11.1	Document how the national public health workforce is locally financed	MoH-PHFP	Oct ’21 – July 2022	GoU, AFENET and CDC

No.	Activities	Responsible Authority	Time	Funding Source
11.2	Implement at National and Subnational Levels short in-service trainings	MoH-PHFP	Oct ’21 – July 2022	GoU and partners
11.3	Monitor and evaluate the implementation of the multisectoral workforce strategy	MoH-PHFP	Oct ’21 – July 2022	GoU, AFENET and CDC
11.4	Develop a budget for the mid-term expand expenditure and incorporate it in an MoH budget	MoH-OPM	Oct ’21 – July 2022	GoU, AFENET and CDC
11.5	Incorporate Epidemiologists in national public service structure	MoH-PHFP	Oct ’21 – July 2022	GoU and partners
12	Emergency Preparedness			
12.1	Implement the multi hazard response plan at the national level	MoH	Oct ‘21-July 2022	GoU and partners
12.2	Develop and implement a training plan for strengthening emergency preparedness measures and the multi hazard response plan at the national level	MoH	Oct ‘21-July 2022	GoU and partners
13	**Emergency Response Operations**			
13.1	Consultative meetings for UNIPH	MoH	Oct ’21 – July 2022	GoU and partners
13.2	Establish four fully functional REOC by 2022	MoH	Oct ’21 – July 2022	GoU and partners
13.3	Development of Strategic Plan to incorporate PHEOC in UNIPH	MoH	Oct ’21 – July 2022	GoU and partners
14	**Linking Public Health and Security Authorities**			

No.	Activities	Responsible Authority	Time	Funding Source
14.1	Top Management of Public Health should engage the National security council for awareness creation.	Faye Bagahunda (Ministry of Security)	Oct ’21 – July 2022	GoU and partners
14.2	Review the current MoU draft and incorporate all necessary information plus key agencies. Review existing MoUs i.e UPDF and MOH, UPDF and OPM and finalize MoU draft that brings all key players together.	Faye Bagahunda (Ministry of Security)	Oct ’21 – July 2022	GoU and partners
15	**Medical Countermeasures and Personnel Deployment**			
15.1	Review existing guidelines, including IDSR	MOH - EMS and Human Resources	Oct ’21 – July 2022	MOH and partners
15.2	Develop draft of national plan to send and receive health personnel, using the example plans from other countries	MOH - EMS and Human Resources	Oct ’21 – July 2022	MOH and partners
15.3	Hold a stakeholders meeting to gain consensus on the plan	OPM	Oct ’21 – July 2022	MOH and partners
15.4	Develop SOPs to operationalize the plan	MOH - EMS and Human Resources	Oct ’21 – July 2022	MOH and partners
16	**Risk Communication**			
16.1	Map and assess rumor monitoring and feedback mechanisms landscape at the national and subnational levels	MAAIF, NOHP, USAID/SBCA	Oct ’21-July 2022	USAID/SBCA
16.2	Develop SOPs for coordination of partners	David Mutegeki (MoH) and Musa Ssekamatte (NOHP)	Oct ’21-July 2022	USAID/SBCA

No.	Activities	Responsible Authority	Time	Funding Source
16.3	Develop risk communication implementation plans for PZDs	Emmanuel Kayongo (MoH), USAID/SBCA & NOHP	Oct ’21-July 2022	USAID/SBCA
16.4	Identify the OH stakeholders at national and district levels	Dr Fred Monje (MAAIF), USAID/SBCA & NOHP	Oct ’21-July 2022	USAID/SBCA
16.5	Conduct trainings at national and district levels	Dr Fred Monje (MAAIF), USAID/SBCA & NOHP	Oct ’21-July 2022	USAID/SBCA;
17	**Points of Entry**			
17.1	Approve and implement HR structure	Dr Allan Muruta, Commissioner (IES&PHE MoH), Harriet Mayinja, Border Health Focal Person (MoH)	Oct ’21-July 2022	GoU
17.2	Integrate border health budget into MoH	Dr Allan Muruta, Commissioner (IES&PHE MoH), Harriet Mayinja, Border Health Focal Person (MoH)	Oct ’21-July 2022	GoU
17.3	Regular meetings with stakeholders	Dr Michael Mwanga, Harriet Mayinja (IES & PHE, MoH) and Ass Commissioner, Dr Okuyo Bosco (MAAIF)	Oct ’21-July 2022	GoU and partners
17.4	Approve and disseminate plans (PoE manual, PHERPs, OH strategy, Influenza and Plague plans)	Dr Michael Mwanga, Harriet Mayinja (IES & PHE, MoH) and Dr Okuyo Bosco (MAAIF)	Oct ’21-July 2022	GoU and partners
17.5	Mobilize funds for vehicles from private sector/GOU	Harriet Mayinja (IES & PHE, MoH) and Ass Commissioner, Dr Okuyo Bosco (MAAIF)	Oct ’21-July 2022	GoU and partners
17.6	Train personnel to handle wildlife	Dr Patrick AtiminedI (UWA)	Oct ’21-July 2022	GoU and partners

No.	Activities	Responsible Authority	Time	Funding Source
17.7	Lobby for funds for procuring land and construction of animal quarantine sites	MAAIF, MODIP	Oct ’21-July 2022	GoU and partners
18	**Chemical Events**			
18.1	Conduct a Risk Assessment	MoGLSD	Oct ’21-July 2022	GOU
18.2	Develop National Chemical Safety and Security plan	MoGLSD	Oct ’21-July 2022	GOU
18.3	Approve the National CBRNE Safety Policy 2017	MoGLSD	Oct ’21-July 2022	GOU
19	**Radiation Emergencies**			
19.1	Approval of National Nuclear and Radiological Response Plan.	AEC	Oct ’21 -May-2022	GoU
19.2	Develop SOPs for detection and Response to Radiation emergencies by AEC for URA	AEC	Oct ’21 -May-2022	GoU

GHSA 2024 COMMITMENTS

Technical Area	Commitments	Rationale
National Laboratory System	Licensing of all laboratories in all sectors (Animal, Human, Food, Nuclear and Chemical) by 2024	This will strengthen the national diagnostic network and laboratory quality system across sectors
Zoonotic Diseases	Decentralize One Health in 50 districts by 2024	Decentralization will strengthen coordination of surveillance and response to potential zoonotic diseases
Points of Entry	Designate 05 high volume Points of Entry for Uganda by 2024	Strengthen implementation of IHR capacities and ensure effective public health response at high volume PoE

LIST OF PARTICIPANTS

No.	Name	Organisation	No.	Name	Organisation
1	Abutanula Joel	Makerere University Walter Reed Project	15	Babigumira Peter Ahabwe	Infectious Diseases Institute
2	Aceng Freda	Ministry of Health	16	Bagamuhunda Faye	Ministry of Security
3	Achan Martha Isabella	Infectious Diseases Institute	17	Bagashe Bagyenzi Godwin	Ministry of Defence and Veterinary Affairs (UPDF)
4	Adokorach Lucille	MAAIF	18	Bagaya Jamidah	NOHP
5	Ajilong Edith	Ministry of health, Public Health Emergency Operation Center	19	Bakiika Herbert	Ministry of Health
6	Ajulong Martha Grace	Ministry of Health	20	Balinandi Stephen	UVRI
7	Akurut Gloria Grace	Uganda Wildlife Authority	21	Baluku Joward	Ministry of Tourism, Wildlife and Antiquities
8	Amalla Bonny	Ministry of Health	22	Bayo Maliyamungu Richard	Infectious Diseases Institute
9	Amanya Geofrey	Uganda Public Health Fellowship Program, MoH	23	Bernard Luyima	Medecins Sans Frontieres
10	Amy Boore	CDC	24	Biribawa Claire	CDC
11	Angella Museewa	Africa One Health University Network	25	Birungi Joshua	Atomic Energy Council
12	Apercé Cédric	Resolve to Save Lives	26	Bukirwa Justine	Ministry of Health
13	Arinaitwe Emma Sam	Ministry of Health	27	Buregyeya Esther	Makerere University School of Public Health
14	Arinaitwe Gloria	Food Safety Associates Ltd	28	Busuge Andrew	Infectious Diseases Institute

No.	Name	Organisation	No.	Name	Organisation
29	Ario Alex Riolexus	Uganda Public Health Fellowship Program, MoH	44	Bwire Godfrey	Ministry of Health
30	Asimire Moureen	Ministry of Health	45	Chimbaru Alexander	WHO
31	Asingura Bannet	Makerere University Walter Reed Project	46	Dadinoh Ndibarema	Ministry of water and environment
32	Atim Stella	MAAIF	47	David Mutegeki	Ministry of Health
33	Atimnedi Patrick	Uganda Wildlife Authority	48	Dickson Ntungire	Africa One Health University Network
34	Aujo Deborah	Ministry of Health	49	Okuyo Charles Bosco	MAAIF
35	Ayebale Apolo	Ministry of Health	50	Dratibi Fred Athanasius	WHO
36	Ayebazibwe Chrisostom	FAO	51	Driwale Alfred	Ministry of Health
37	Lennox Kesington	Infectious Diseases Institute	52	Kayiwa Joshua	Ministry of health, PHEOC
38	Ebenezer Paul	Conservation Through Public Health	53	Komakech Innocent	WHO
39	Ebitu Emmanuel	Amref Health Africa	54	Kiconco Arthur	USAID Social and Behavior Change Activity
40	Edson Katushabe	WHO	55	Kimaanga Michael	MAAIF
41	Ekuka Godfrey	Ministry of Health	56	Kimbowa Musa	USAID Social and Behavior Change Activity
42	Ezama Arnold	Uganda Red Cross Society	57	Kintu Bonny	Ministry of Health
43	Gasanani Jonan	Infectious Diseases Institute	58	Kinyera Kenneth	Ministry of Defence and Veterinary Affairs (UPDF)

No.	Name	Organisation	No.	Name	Organisation
59	Lwanga Miriam	UNICEF	81	Musa Kwehangana	National Council for science and Technology
60	Mabumba Elly Donald	Ministry of Health	82	Mutegeki David	Ministry of Health
61	Mahmud Alias	DHO-ARUA Surveillance	83	Mutumba Beth	National Council for Science and Technology
62	Majalija Samuel	Makerere University-COVAB	84	Mwanga-Amumpaire Juliet	Medecins Sans Frontieres
63	Makanga Kizito Douglas	Ministry of Health	85	Mwebe Robert	MAAIF
64	Makoba, Wetaka Milton	Ministry of health, PHEOC	86	Nabatanzi Maureen	Infectious Diseases Institute
65	Masanja Veronicah	Uganda Public Health Fellowship Program, MoH	87	Nabatanzi Sandra	CDC
66	Mayinja Harriet	Ministry of Health	88	Nabatta Esther	Infectious Diseases Institute
67	Mbabazi Enid	Office of the Prime Minister	89	Nabukenya Immaculate	Infectious Diseases Institute
68	Mimbe Derrick	USAID Infectious Disease Detection and Surveillance	90	Nabunya Phoebe	WHO
69	Mitanda Sarah	Ministry of Justice and Constitutional affairs	91	Naigaga Irene	Africa One Health University Network (AFROHUN)
70	Mkandawire Glory	USAID Social and Behavior Change Activity	92	Nakamya Petranilla	Uganda Public Health Fellowship Program, MoH
71	Mohammed Lamorde	Infectious Diseases Institute	93	Nakanwagi Aisha	Infectious Diseases Institute
72	Monje Fred	MAAIF	94	Nakiire Lydia	Infectious Diseases Institute
73	Morukileng Job	Uganda Public Health Fellowship Program, MoH	95	Nakinsige Anne	Ministry of Health
74	Moses Ali	Office of the Prime Minister	96	Naluyima Prossy	Makerere University Walter Reed Project
75	Mubokyi Scarlet	Ministry of Gender, Labour and Social Development	97	Namanya Dianah	Uganda Wildlife Authority
76	Mugabe Raymond	Central Public Health Laboratories	98	Namatovu Carolyn	MAAIF
77	Mugenyi Stephen	Ministry of Internal Affairs	99	Namugga Judith	Ministry of Health
78	Mugerwa Ibrahim	Ministry of Health	100	Nansikombi Hildah	Uganda Public Health Fellowship Program, MoH
79	Mukiibi Peter Claver	Infectious Diseases Institute	101	Nassali Tamale Gloria	MAAIF

No.	Name	Organisation	No.	Name	Organisation
102	Muruta Allan	Ministry of Health	123	Natifu Barbra	USAID Social and Behavior Change Activity
103	Nauda Rhoda	MAAIF	124	Otim Onapa Maxwell	Ministry of Science, Technology and Innovation (MoSTI)
104	Ndibarema Dadinoh	Ministry of water and environment	125	Otita Morgan	Infectious Diseases Institute
105	Ndumu Deo	MAAIF	126	Oumo Peter	Uganda Police Force
106	Ndyanabo Susan	FAO	127	Owembabazi Wilberforce	USAID Uganda
107	Nelson Lisa	CDC	128	Paige Sarah	USAID Uganda
108	Nguna Joyce	Ministry of Health	129	Peter Elyanu	Baylor-Uganda
109	Nkodyo Joseph	Ministry of Health	130	Rigal Nicolas	World Food Program
110	Nsibambi Thomas	Centers for Disease Control & Prevention, Uganda	131	Ronald Ogwal Ssali	Conservation Through Public Health
111	Nsiimire Gonahasa Doreen	Uganda Public Health Fellowship Program, MoH	132	Saidon John	CDC
112	Obua Thomas Ocwa	Ministry of Health	133	Sekamatte Abdulrazak	NOHP
113	Ocom Felix	Ministry of health, Public Health Emergency Operation Center	134	Sekamatte Musa	NOHP
114	Ogaba Stephen	Ministry of Internal Affairs, DGAL	135	Senkatuuka Luke	Directorate of Government Analytical Laboratory
115	Ogwal Ssali	Conservation Through Public Health	136	Ssemakadde Thomas	USAID Infectious Disease Detection and Surveillance
116	Ogwang Simon	UNICEF	137	Stowell Daniel	Centers for Disease Control & Prevention, Uganda
117	Ojwang Joseph	Centers for Disease Control & Prevention, Uganda	138	Tamale Nassali Gloria	MAAIF
118	Okello Stephen	Makerere University Walter Reed Project	139	Taremwa Roland	Office of the Prime Minister
119	Okethwangu Denis	Ministry of Health	140	Temera Pius	Infectious Diseases Institute
120	Okuna Neville Oteba	Ministry of Health	141	Twemanye Vivian	Infectious Diseases Institute
121	Okware Solome	WHO	142	Walekhwa Abel Wilson	Presidential Scientific Initiative on Epidemics
122	Omodo Michael	MAAIF	143	Wamala David	Office of the Prime Minister

No.	Name	Organisation
144	Opolot John	Ministry of Health
145	Oryem Charles	MAAIF
146	Otim Julius Simon	Kampala Capital City Authority
147	Wejuli Alfred	Ministry of Health
148	Wilbrod Mwanje	Ministry of Health Public Health Emergency Operation Center
149	Wesonga Hilda Barbara	Ministry of Health
150	Yemanaberhan Rahel	Resolve to Save Lives
151	Yonas Tegegn Woldemariam	WHO
152	Zawedde Christine	Directorate of Government Analytical Laboratory
153	Wamboga Charles	Ministry of Health
154	Wanyeze Rhoda	Makerere University School of Public Health

PHOTO GALLERY

Photo 1: Facilitator and participants' training at the MoH PHEOC, 14 May 2021

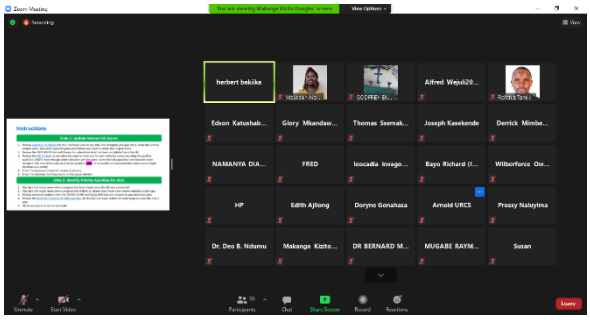

Photo 2: Online participants during the Zoonotic Diseases Technical Area meeting, 25 May 2021

Photo 3: Participants during one of the Technical Area assessments, 2 May 2021

Photo 4: Mr Timothy Lubanga (Commissioner M&E, Office of the Prime Minister at the consensus meeting

Photo 5: Dr Lisa Nelson (Country Director, CDC) gives remarks during the consensus meeting. Inset (R-L) are: Dr Yonas Tegegn Woldemariam (WHO Representative), Hon. Moses Ali (Office of the Prime Minister) and Dr Henry G. Mwebesa (Director General of Health Services) during the consensus meeting

Photo 6: Participants during the consensus meeting

Photo 7: (L-R) Dr Allan Muruta (Commissioner, IES & PHE), Dr Henry G. Mwebesa (Director General of Health Services), Dr Amy Boore (Program Director, Division of Global Health Protection and Security, CDC), Dr Sarah Paige, (Global Health Security Advisor, USAID) and Dr Immaculate Nabukenya (Project Manager Resolve to Save Lives, IDI) at the consensus meeting

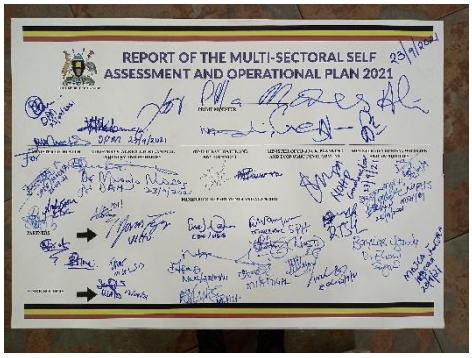

Photo 8: Signatures of representatives from the Ministers, Departments and Agencies

OUR PARTNERS

FOR GOD AND MY COUNTRY

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

World Health Organization

USAID FROM THE AMERICAN PEOPLE

MAKERERE UNIVERSITY

IDI INFECTIOUS DISEASES INSTITUTE

unicef

The Fleming Fund

RESOLVE TO SAVE LIVES

AFROHUN Advancing One Health

Department for International Development

IOM UN MIGRATION

COMITE INTERNATIONAL GENEVE ICRC

MUWRP Makerere University Walter Reed Project

Tackling deadly diseases in Africa
DAI global health