

WHO Health Emergencies EPI-WIN webinar: from framework to action: operationalizing emergency ready primary health care for community protection and resilient health systems

Emergency ready primary health care in Uganda's Ebola response

Plenary discussion 23 September 2026

Daniel Eurién, ERP Coordinator, Baylor College of Medicine Children's Foundation, Uganda
Dr Abdullah Wailagala, Program Manager, Infectious Diseases Institute (IDI), Uganda

1 How was ERPHC used in the EVD response?

ONE APPROACH

The Ministry of Health and partners adopted a common ERPHC mentorship model, with response data hosted centrally at the Ministry

INTEGRATED SUPPORT

One visit combined surveillance, clinical care, IPC, laboratory referral, risk communication and continuity of essential services

FACILITY COVERAGE

Districts prioritized public and private facilities and linked findings to district and national response structures

FOLLOW-THROUGH

Mentors tracked readiness over repeated visits and supported facilities with IPC and PPE supplies where shortages were acute

2 What enabled uptake? - Abdullah

LEADERSHIP

Early engagement of senior Ministry of Health leaders built on ERPHC's existing preparedness work

TECHNICAL FIT

National teams adapted the tools to Ugandan policy and response structures, then jointly reviewed workplans

DISTRICT OWNERSHIP

District leaders selected facilities and mentors, and reviewed findings with mentors during regular debriefs

LOCAL WORKFORCE

Public sector staff served as mentors, using a common approach that districts could adapt to local needs

3 What early benefits are emerging?

LESS DISRUPTION

Integrated visits reduced repeated, pillar-specific visits that could potentially overwhelm the sites and take time away from routine patient care

SHARED VIEW

Common measures made facility progress visible across districts and partners, including private facilities

ACCOUNTABILITY

Repeated mentorship tracked whether jointly identified gaps were addressed and who needed to act

PRACTICAL ACTION

Mentors and facilities identified specific solutions together instead of relying on one-off training

4 How did ERPHC strengthen clinical suspicion?

POINT-OF-CARE TOOLS

Clinicians received case definitions, screening tools, job aids and clear procedures for alerts, case management and referral

CASE DISCUSSIONS

Mentors used clinical scenarios and peer learning to practice recognizing possible BVD in routine care; cIDSR disseminated

REPEATED REINFORCEMENT

Follow-up visits helped maintain vigilance as outbreak risk perception declined

5 What constrained early implementation?

MENTOR EXPERTISE

Few individual mentors covered every domain. Pairing a clinical mentor with another specialist improved coverage

TIME PRESSURE

Clinical and response duties limited the availability of mentors and facility staff

DIFFERENT BASELINES

Facility resources, infrastructure and leadership engagement varied across districts

PERSISTENT GAPS

Supply shortages required action beyond mentorship, while regular follow-up remained essential after the acute phase