URGE INTELLIGENCE REPORT · UGANDA DIGITAL HEALTH

Bridging the Health Data Integration Gap

Uganda 2026–2030: From Fragmented Pilots to a National Digital Health Backbone

Investment-Grade Strategic Intelligence · Fact-Verified · June 2026

1 · Executive Intelligence Brief

Three quantified findings that define Uganda's digital health integration challenge. All figures verified against primary sources. Risk ratings follow each finding.

Finding 01 — The $2.3B US–Uganda MOU has already delivered $100M+ in digital health infrastructure — and the clock is running.

The US–Uganda Health MOU (signed December 10, 2025) commits $1.7B from the US and $577M in Ugandan co-investment over five years. On March 31, 2026, the US Government transferred over $100M in digital health infrastructure to Uganda's Ministry of Health: 725 servers, 4,700+ computing devices, solar power systems for nearly 800 facilities, and network connectivity for 1,300+ sites. The MOU explicitly commits US funding to EMR modernisation, system integration, and interoperability between platforms and the national data warehouse. The Joint Health Steering Committee (JHSC) was launched May 8, 2026 with $410M committed in Year 1. This is not a future promise — it is the largest active digital health investment in Uganda's history.

Finding 02 — DHIS2 is Uganda's backbone — with a 12% connectivity ceiling that makes real-time interoperability impossible without offline-first architecture.

Uganda adopted DHIS2 in 2012. A 2025 Leiden University / Kampala International University systematic review (84 sources, published November 2025) confirmed DHIS2 reached near-national coverage with ~12,000 trained users across 20+ programmes. However, only ~12% of Uganda's health facilities have stable internet connectivity, ~35% annual staff turnover among DHIS2-trained workers, and only ~25% of users possess intermediate analytics literacy. These are structural constraints that no governance mandate can overcome without offline-capable architecture, solar power, and sustained digital literacy investment.

Finding 03 — The Protection of Sovereignty Act, 2026 is enacted law — not a bill — with immediate implications for every health operator in Uganda.

The Protection of Sovereignty Act, 2026 (Act No. 13 of 2026) was passed by Parliament on May 5, 2026, and received Presidential Assent on May 17, 2026. It is the last piece of legislation enacted by the 11th Parliament. Criminal penalties of up to 20 years imprisonment and UGX 4 billion (~$1.06M) fines apply to entities classified as 'agents of foreigners' operating in health, education, water, or roads without Cabinet approval. Banks face UGX 4 billion civil penalties for releasing funds to unregistered agents. Every digital health vendor, NGO, donor-funded implementing partner, and development finance institution operating in Uganda must immediately assess their exposure and register if any doubt exists.

Risk Rating: HIGH | Investment Indicators: CONDITIONAL — strong pending Sovereignty Act compliance | Uganda digital health market 2029: $208M (Statista) to growing share of Africa's $16.6B projection.

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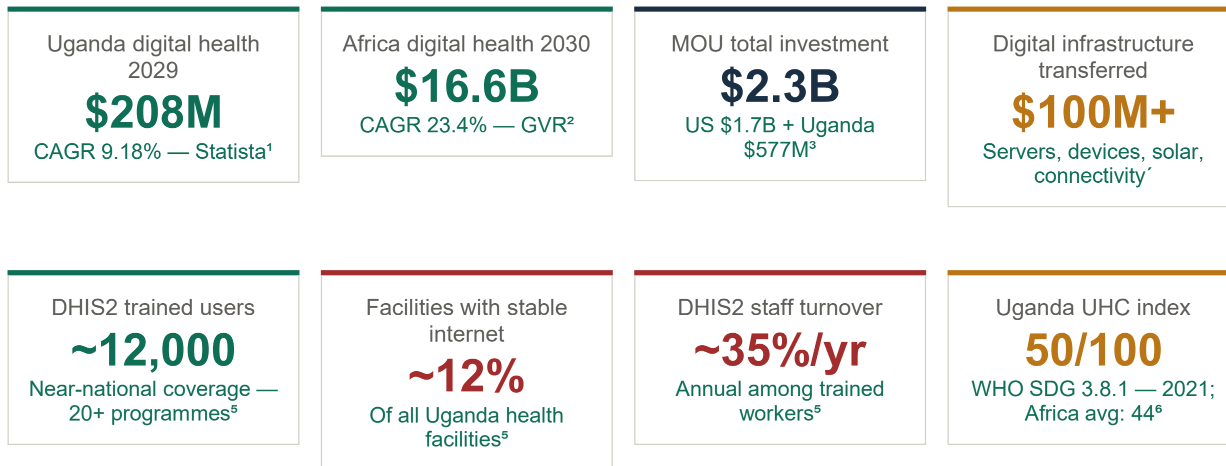
2 · Market Sizing: Uganda in East Africa Context

Uganda-specific and Africa-wide market data. All figures sourced from primary analyst firms and verified government data.



ANALYST NOTE — WHY UGANDA'S MARKET ESTIMATE UNDERSTATES THE OPPORTUNITY
Statista's $208M projection for Uganda's digital health market by 2029 (CAGR 9.18%) reflects a narrow consumer-facing definition of telemedicine and mHealth apps. It does not capture the institutional market: the $2.3B MOU digital health component, EMR digitisation, DHIS2 infrastructure, disease surveillance systems, or the data warehouse integration market. Uganda's true digital health opportunity is anchored by the MOU's explicit commitment to 'investments in data and disease surveillance systems, supporting improvements in EMRs and interoperability between existing digital platforms and the national data warehouse.' This institutional DPI market dwarfs the consumer estimate. For investment memos and government proposals, present the $208M figure as the minimum consumer floor, not the total addressable market. Sources: Statista Uganda Digital Health[1]; US Embassy Uganda MOU Factsheet.[3]

2.1 The $2.3B MOU: Digital Health Investment Breakdown

The MOU is the most important funding event in Uganda's digital health history. Its digital health provisions are explicit and actionable.

MOU Dimension	Verified Data and Source (June 2026)
Data systems commitment	The MOU explicitly commits: improvements in data capture, EMR use, integration of systems, interoperability between platforms and the national data warehouse, and enhancement of global health security and laboratory capacity. Source: US Embassy Uganda MOU Factsheet, December 10, 2025.[3]
Digital infrastructure transferred (March 31, 2026)	725 servers; 4,700+ computing devices (desktops, laptops, tablets); solar power systems for nearly 800 health facilities; network connectivity for 1,300+ sites; video conferencing for regional referral hospitals; skilled staff to manage systems. From 2010–2026, US CDC provided nearly $104M via PEPFAR to strengthen Uganda's HIV response and health information systems. Source: US Embassy Uganda Press Release, March 31, 2026.´
JHSC oversight structure	Joint Health Steering Committee launched May 8, 2026, Kampala. Co-chairs: US Ambassador Popp and Minister Jane Ruth Aceng Ocero. Provides strategic oversight, accountability, and alignment with national priorities and applicable US and Ugandan laws. $410M committed Year 1.

MOU Dimension	Verified Data and Source (June 2026)
	Source: US Embassy Uganda, May 8, 2026.[5]
MOU programme areas	HIV/AIDS, TB, malaria, maternal and child health, polio eradication, global health security, human resources, disease surveillance, and emergency preparedness. Transition of commodity procurement from US to Uganda over five years. Frontline workers to be absorbed into Ugandan civil service cadres. Source: US Embassy Uganda Joint Statement, December 10, 2025.[3]
MOU political risk	Parliamentary review of whether MOU requires ratification is an active process as of June 2026. Data-sharing provisions under scrutiny under Uganda's DPPA 2019. MOU structured under US 'America First Global Health Strategy' — subject to US political continuity. Maintain 6-month operating reserves for all MOU-dependent programmes.
Incremental Uganda co-investment	Uganda pledged to increase domestic health spending by more than $500M over five years. Finance Minister Matia Kasaija confirmed this commitment at the signing ceremony. The incremental new contribution is approximately $100M/year on top of existing domestic health spending. Source: MOU Joint Statement, December 10, 2025.[3]

3 · The Deep Integration Gap: Quantified

The 'Deep Integration Gap' is not a rhetorical concept. It is a measurable, documented structural failure with specific causes, specific costs, and specific solutions.

3.1 DHIS2: Uganda's Backbone and Its Structural Limits

VERIFIED — DHIS2 ADOPTION, COVERAGE, AND PERSISTENT BARRIERS (2025–2026 RESEARCH)

Uganda adopted DHIS2 in 2012. A systematic review published in Oxford Open Digital Health (January 2026, Leiden University / Kampala International University, 84 sources) found: DHIS2 reached near-national coverage with ~12,000 trained users across 20+ health programmes. Adoption scores ranged from 97% in high-performing districts to 60.3% in low-performing districts. Enablers: strong digital infrastructure, competent human resources, partner support, financial incentives. Barriers: inadequate rural internet (~12% of facilities with stable connectivity), server breakdowns, high staff turnover (~35% annually), low analytics literacy (~25% of users with intermediate skills), and limited use of DHIS2 data for actual decision-making. A separate 2026 BMC Health Services Research study in Uganda's Teso sub-region confirmed significant reporting challenges compromising data fidelity at facility level. Sources: Oxford Open Digital Health, January 14, 2026[7]; BMC Health Services Research, February 20, 2026.[8]

Uganda's MoH operates multiple parallel digital systems that do not yet talk to each other:

System	Status and Integration Gap
DHIS2	National aggregate reporting system. 12,000+ trained users. Near-national coverage. The primary national health data warehouse. Adopted 2012; rolled out to all 112 districts by July 2012.
UgandaEMR	Facility-level electronic medical records. Primarily deployed in HIV/ART programmes via PEPFAR funding. The US infrastructure transfer (March 2026) included systems that feed UgandaEMR data.
OpenMRS	Open-source medical records used in some facility-level programmes. Requires HAPI FHIR and Mirth Connect middleware (OpenHIE architecture) to achieve DHIS2 integration. When implemented, achieves 95% data concordance.

System	Status and Integration Gap
eLMIS	Electronic Logistics Management Information System. Supply chain data. Not yet integrated with DHIS2 at national scale.
eIDSR	Electronic Integrated Disease Surveillance and Response. Communicable disease reporting. Partially integrated with DHIS2.
Lab information systems	Multiple facility-level laboratory systems. Integration variable by facility tier and funding programme.
PDMIS	Parish Development Model Information System — 10.17M individuals profiled as of March 2025; Wendi digital wallet for disbursements. Currently tracks household economic data, not health indicators. Source: EPRC Uganda, March 2025.[9]

THE INTEGRATION IMPERATIVE — WHY THIS GAP HAS A DOLLAR VALUE
The US Embassy's March 2026 handover statement confirmed that 725 servers, 4,700+ devices, solar for 800 facilities, and connectivity for 1,300+ sites are now owned by Uganda's MoH. These are the physical prerequisites for integration. But hardware without software-defined architecture remains fragmented. The integration gap is now a governance and workflow problem, not a hardware problem. The MOU's explicit EMR and interoperability commitment means this is also a contract-performance requirement: Uganda's $577M co-investment is implicitly conditioned on demonstrating digital system consolidation over five years.

3.2 The Connectivity Ceiling: 88% of Facilities Cannot Support Real-Time FHIR

The 12% connectivity figure is the most important technical constraint in Uganda's digital health integration plan. It determines the architecture of every solution:

- Only ~12% of Uganda's health facilities have stable internet connectivity (Leiden/KIU systematic review, November 2025). This means real-time HL7 FHIR-based interoperability — the standard Kenya's DHA now mandates — is currently impossible in approximately 88% of Uganda's facilities.
- Solutions must be offline-first: FHIR-compatible clients that store data locally and synchronise when connectivity is available. Store-and-forward protocols. Cached local servers.
- Solar power for 800 facilities has already been transferred (March 2026). The MOU committed to expanding this. Solar is the prerequisite for digital reliability at rural facilities.
- The EPRC Uganda assessment (February 2026) confirmed that PDM's Wendi digital wallet (2.3M beneficiaries) and PDMIS infrastructure demonstrate that offline-capable, mobile-first digital tools can achieve scale in Uganda's rural context. This model is replicable for health data collection.

4 · Governance: Building the National Digital Health Backbone

Uganda's digital health governance must evolve from stewardship to architecture. The MOU handover creates the infrastructure; governance creates the mandate for integration.

4.1 The PDPO Mandate — And Its Current Legal Limits

The Data Protection and Privacy Act 2019 (DPPA, No. 9 of 2019) grants PDPO authority to regulate the processing of personal data — however, it does NOT grant PDPO authority to licence or certify technology products. IT product certification in Uganda falls under NITA-U under the IT Certification of Providers Regulations 2018. Medical devices fall under the National Drug Authority (NDA). Health information systems fall under the Ministry of Health.

What PDPO CAN do under current law:

- Register all entities processing Ugandan health data (mandatory under DPPA Section 29 and Regulation 15(1), confirmed by July 2025 Google LLC ruling).
- Require annual renewal of data controller/processor registrations at pdpo.go.ug.
- Conduct compliance audits and issue enforcement orders with criminal penalties of up to 5 years imprisonment and UGX 500M fines for DPPA violations.
- Assess cross-border data transfer arrangements: entities must document adequate safeguards without requiring advance permission for each transfer, but records must be available for audit (PDPO vs Google, July 2025).
- Uganda's first DPPA conviction: July 10, 2025 — Mr. Ronald Mugulusi, Director of Nano Loans Microfinance Ltd, convicted for failure to register and misuse of personal data. Precedent was set. Enforcement is real.

4.2 The JHSC: Uganda's Highest-Value Governance Mechanism — With a Legal Constraint

VERIFIED — JHSC MANDATE, STRUCTURE, AND DIGITAL HEALTH COMMITMENT

The JHSC was formally launched May 8, 2026. Co-chaired by former US Ambassador to Uganda William Popp and Uganda's former Minister of Health Jane Ruth Aceng Ocero. It provides strategic oversight, ensures accountability, and aligns programmes with both national priorities and applicable US and Ugandan laws (explicitly stated in the launch press release). The MOU Implementation Plan will provide a detailed trajectory for $410M in Year 1 US assistance plus Uganda co-investment. The MOU explicitly commits to EMR modernisation, digital system integration, and data warehouse interoperability. Source: US Embassy Uganda, May 8, 2026.

LEGAL RISK — JHSC ACTIVITIES REQUIRE COMPLIANCE ASSESSMENT UNDER THE SOVEREIGNTY ACT

The Protection of Sovereignty Act, 2026 (enacted May 17, 2026) requires Cabinet approval before any 'agent of a foreigner' carries out activities in health (Clauses 6–8). The JHSC involves US government agencies, implementing partners, and potentially CDC and other US entities directing or funding health activities in Uganda. These entities may meet the definition of 'agents of foreigners' under the Act's broad scope. The JHSC's launch statement explicitly says programmes must align with 'applicable US and Ugandan laws' — meaning the Sovereignty Act is an active constraint on JHSC operations. Implementing partners must: (1) conduct a Sovereignty Act compliance assessment; (2) register with the Ministry of Internal Affairs where required; (3) ensure all grants above UGX 400M (~$107,000) are declared. Source: Parliament of Uganda, Onyango Advocates 2026, MMAKS Advocates 2026.

4.3 The Ministry of Health's HIS Mandate

Uganda's Ministry of Health published the Health Information and Digital Strategic Plan 2020/2021–2024/2025 to address data quality and late reporting across health facilities. The Plan's mandate includes institutionalising use of patient-level digital systems at point of care. The MoH has published Uganda Health Data Protection, Privacy, and Confidentiality Guidelines (available on the MoH Knowledge Management Portal) aligned with the DPPA 2019, Data Protection Regulations 2021, and the Uganda Digital Health Enterprise Architecture, Standards and Knowledge Guidelines.

4.4 The PDM Integration Opportunity:

BUILDING ON PBMIS

The PDM already has the Parish Development Model Information System (PDMIS) — a Ministry of ICT-developed platform that has profiled 10.17 million individuals as of March 2025 and disbursed UGX 3.261 trillion via the IFMS to 10,589 PDM SACCOs. The Wendi digital wallet (2.3M beneficiaries, 53% women) is integrated with PDMIS via National ID numbers. An academic commentary published in The Monitor (Uganda) specifically recommended integrating PBMIS with existing community health information systems to improve birth and death registration and health-CVRS interoperability. Recommendation: The Ministry of

ICT add health indicators to PDMIS Pillar 4 (Social Services) data collection framework. Specifically: malaria incidence, antenatal care attendance, immunisation rates, and child mortality. Parish Chiefs as primary collectors, feeding into DHIS2. This is technically feasible, legally straightforward, and does not require a new system. Budget: minimal (data field additions + training). Responsible minister: Ministry of ICT (Dr. Jane Ruth Aceng) in coordination with MoH. Sources: EPRC Uganda, February 2026[9]; Ministry of ICT[9]; The Monitor Uganda.[12]

5 · Technical Architecture: Software-Defined Healthcare

The US infrastructure transfer creates the hardware foundation. This section specifies the software architecture required to transform that hardware into an integrated national health data backbone.

5.1 The Interoperability Stack

Component	Uganda-Specific Context and Status
HL7 FHIR	The RESTful API standard for health data exchange. Kenya's DHA has made FHIR compliance mandatory under LN 76/2025. Uganda's UgandaEMR-DHIS2 pipeline already uses HAPI FHIR and Mirth Connect (OpenHIE architecture), achieving 95% data concordance when properly implemented. FHIR must be mandated for all new EMR deployments under the MOU digital health workplan.
OpenHIE framework	Open Health Information Exchange — the architecture connecting EMRs, DHIS2, lab information systems, and pharmacy management into a single interoperability bus. Uganda's existing tech stack is already OpenHIE-compatible. The barrier is governance mandate and connectivity, not technical capability.
ICD-11	WHO International Classification of Diseases (11th edition). Disease classification standard enabling internationally comparable surveillance data. Required for WHO reporting and regional disease surveillance.
Offline-first FHIR clients	FHIR-compatible applications that store data locally and synchronise when connectivity is available. Essential for the ~88% of Uganda's facilities without stable internet. The 725 servers transferred in March 2026 provide local server capacity for facility-level offline operation.
Store-and-forward protocols	Asynchronous data synchronisation protocols that queue health records locally and push to DHIS2 when connectivity is available. Standard implementation in low-connectivity settings. Rwanda's CHW mobile reporting uses this approach.
Solar + decentralised servers	Solar power systems now deployed at ~800 Uganda health facilities (March 2026 transfer). Each facility with solar + a local server can operate as an offline FHIR node. This is the connectivity solution for the ~88% without stable internet: not fibre, but solar-powered local servers with periodic sync.

5.2 The EARDIP Regional Layer

EARDIP IS WORKING TOWARD REGIONAL HARMONISATION,

EARDIP's current status. EARDIP (Eastern Africa Regional Digital Integration Project, World Bank-supported) is working toward harmonised cybersecurity and data governance standards across the EAC. As of June 2026, it has NOT achieved formal cross-border data adequacy standards. Uganda's DPPA 2019 Section 19 prohibits transfer of personal data outside Uganda unless the receiving country has equivalent data protection standards OR explicit consent is obtained OR a regulatory exemption applies.

The PDPO's July 2025 Google ruling confirmed these cross-border provisions are actively enforced. Any EARDIP-based cross-border health data exchange must be accompanied by a legal pathway satisfying DPPA Section 19. Recommend Uganda's MoH and PDPO jointly develop a Data Transfer Impact Assessment framework as a prerequisite for any EARDIP integration.

6 · Financial Levers: Linking Data Compliance to Funding

The most effective way to drive interoperability is to make digital compliance a prerequisite for accessing funding pools. Uganda has three available mechanisms.

6.1 MOU-Linked Digital Compliance

The MOU's explicit EMR and interoperability commitment creates a natural compliance mechanism: US disbursements should be conditioned on demonstrated progress toward DHIS2 integration milestones. The MOU Implementation Plan (currently being developed by the JHSC) is the instrument for embedding these conditions. The JHSC's accountability mandate (per its May 8, 2026 launch statement) is the governance lever. Recommend the JHSC include: (1) a DHIS2 real-time reporting rate target by facility level; (2) a UgandaEMR-DHIS2 integration milestone timeline; (3) a PDMIS health indicator integration milestone.

6.2 Government Facility Funding and Digital Compliance

Following the model Uganda's own MoH Health Information Digital Strategic Plan 2020–2025 envisions: facilities that do not report outcomes into DHIS2 should face reduced access to government facility improvement grants. This is not a novel concept — it mirrors Kenya's SHA reimbursement-compliance linkage. The legal vehicle: amendment to Uganda's Primary Health Care Conditional Grants guidelines to include DHIS2 reporting completeness as a disbursement condition. Responsible: MoH + Ministry of Finance. Timeline: feasible within the MOU Year 2 digital health workplan (2027).

6.3 PDM SACCO Health Data as Proof of Concept

The Wendi digital wallet (2.3M beneficiaries, 53% women) already links National IDs to household financial data via PDMIS. This same NID linkage is the technical foundation for linking health encounter records to household identities at village level. A PDMIS-to-DHIS2 integration pilot would cost minimal additional development (the National ID backbone already exists) and would provide Uganda with the world's first parish-level health-and-economic integrated dataset — a model of significant global development interest.

7 · Legal and Regulatory Framework: Five Active Risks

This section documents active legal risks with specific provisions, enforcement precedents, and recommended actions. Not legal advice. Retain qualified Ugandan counsel before acting.

7.1 Risk 1 (CRITICAL) — Uganda Protection of Sovereignty Act, 2026

ENACTED LAW — IMMEDIATE COMPLIANCE ACTION REQUIRED

The Protection of Sovereignty Act, 2026 (Act No. 13 of 2026) was enacted May 17, 2026. It is NOT a bill. It is the last law enacted by Uganda's 11th Parliament and the first law assented to by the President in his seventh term. Scope: Any Ugandan employee of a foreign-funded organisation; any local NGO receiving an international grant; any company with a foreign shareholder or foreign-sourced loan; any entity implementing programmes on behalf of a development finance institution qualifies as an 'agent of a

foreigner.' Penalties: Up to 20 years imprisonment and UGX 4 billion fines (~$1.06M) for operating without Cabinet approval in health, education, water, or roads. Banks face UGX 4 billion civil penalties for releasing funds to unregistered agents (Clause 25). Immediately required: (1) Retain qualified Ugandan counsel (Onyango & Co., MMAKS Advocates, or similar). (2) Conduct a compliance assessment. (3) Register with Ministry of Internal Affairs if any doubt about classification. (4) Do NOT proceed with new Uganda market entry, new grant acceptance above UGX 400M, or new implementing partner arrangements without legal clearance. Sources: Parliament of Uganda; Presidential Assent May 17, 2026; Onyango Advocates, 2026; MMAKS Advocates April 2026; ENS Africa April 2026.

7.2 Risk 2 (HIGH) — JHSC Data Mandate vs. Sovereignty Act Clauses 6–8

LEGAL CONFLICT — JHSC ACTIVITIES MAY REQUIRE CABINET APPROVAL

The JHSC's mandate to direct Uganda's digital health architecture, fund implementing partners, and support system integration creates a direct tension with Clauses 6–8 of the Protection of Sovereignty Act, which require Cabinet approval before agents of foreigners carry out activities in health. US government agencies, funded organisations, CDC technical assistance providers, and NGO implementing partners operating under the JHSC's direction may all qualify as agents of foreigners. The JHSC's own launch statement acknowledged programmes must comply with 'applicable US and Ugandan laws' — this is an acknowledgement of this risk. Resolution requires: a formal legal opinion on which JHSC activities require Cabinet approval; a compliance pathway for implementing partners; and explicit exemption language in the MOU Implementation Plan.

7.3 Risk 4 (MEDIUM) — DPPA Section 19 vs. Cross-Border Data Exchange

DATA LOCALISATION COMPLIANCE — REQUIRED BEFORE EARDIP INTEGRATION

DPPA 2019 Section 19 prohibits transfer of personal data outside Uganda without either (a) adequate protection in the receiving country, or (b) explicit consent, or (c) a regulatory exemption. The PDPO's July 2025 Google ruling confirmed this is actively enforced. Cross-border health data exchange under EARDIP is currently subject to this requirement. Recommended action: MoH and PDPO jointly develop a Data Transfer Impact Assessment (DTIA) framework as a prerequisite for any EARDIP integration. This is standard practice under GDPR-equivalent frameworks. The DTIA would document the legal basis, safeguards, and justification for each class of health data transferred cross-border. Sources: DPPA 2019 Section 19; PDPO vs Google LLC, July 2025[13]; DLA Piper Privacy Matters, August 2025.[13]

7.5 Risk 5 (MEDIUM) — Sovereignty Act Clause 22 and Blended Finance Structures

BLENDED FINANCE COMPLIANCE — FOREIGN CAPITAL IN HEALTH SECTOR REQUIRES DECLARATION

Clause 22 of the Protection of Sovereignty Act (final text) changed from prior-approval to mandatory declaration for foreign funding. However, for health-sector operations (Clauses 6–8), Cabinet approval is still required before agents of foreigners operate. Private sector entities receiving foreign blended finance capital for health operations in Uganda may need Cabinet approval before deploying those funds in health activities. This must be explicitly disclosed to any investor or implementing partner considering blended finance structures for Uganda health programmes.

8 · Scenario Analysis: Three Trajectories to 2030

Stress-test programme designs and investment theses against all three scenarios. The base case reflects current trajectories. The bull case requires specific catalysts. The bear case models enforcement overreach and structural failure.

Driver	Bull Case	Base Case	Bear Case
Sovereignty Act enforcement	Guidance published Q3 2026: narrow scope, health implementing partners largely exempt via Cabinet approval blanket order. Investment resumes. JHSC digital mandate proceeds unobstructed.	Compliance uncertainty persists 12–18 months. Multi-nationals restructure Uganda entities. Some implementing partners pause operations pending legal opinions. Deal flow slows but continues.	Aggressive enforcement. Major donors suspend operations. MOU ratification fails. $2.3B programme stalls. Digital health sector loses 2–3 years of momentum.
DHIS2-UgandaEMR integration	HAPI FHIR middleware mandated by MoH under MOU Year 1 workplan. 95% data concordance achieved at Kampala Level 4 hospitals by Q4 2026. 60% of facilities online by 2028 with offline-first fallback.	Integration proceeds slowly. Kampala pilot achieves 95% concordance but rural rollout delayed by connectivity. 30% of facilities integrated by 2028. Real-time reporting remains aspirational.	JHSC paralysed by Sovereignty Act compliance uncertainty. Integration paused. Hardware transferred in March 2026 sits underutilised. $104M PEPFAR digital investment loses momentum.
PDMIS-DHIS2 health integration	Ministry of ICT adds health indicators to PDMIS Pillar 4 by Q2 2027. 10.17M profiles gain health data layer. First parish-level health-economic integrated dataset in Africa. Replicable model for continent.	MoICT-MoH coordination delays PDMIS health field additions to Q4 2027. Pilot in 2 districts by end-2027. Scale to national by 2029 if pilot successful.	Inter-ministry coordination fails. PDMIS and DHIS2 remain siloed. National ID linkage opportunity missed. Uganda's data advantage wasted.
PDPO vendor certification authority	DPPA amendment and Health IT Regulation enacted by mid-2027 under MOU Year 2 workplan. PDPO-NITA-U-MoH-NDA unified certification framework operational by 2028. Uganda becomes regional benchmark.	Legislative reform takes 24–36 months. Informal certification guidance issued but lacks statutory force. Fragmented vendor landscape persists. Integration patchy.	No legislative reform. PDPO continues to operate without health IT certification authority. Fragmentation deepens. MOU digital workplan achievements unenforceable without gatekeeper.
Regional EARDIP harmonisation	EAC adequacy standard adopted by 2028. DTIA framework agreed between Uganda PDPO and EAC partners. Cross-border disease surveillance data exchange becomes legally feasible.	Country-by-country DPPA compliance remains norm. DTIA framework in development but not agreed. EARDIP connectivity improves but data governance lags.	DPPA Section 19 used to block cross-border health data transfers. EARDIP's data governance component stalls. Uganda's contribution to regional epidemic intelligence diminished.

9 · Comparative Landscape: Uganda vs. Kenya and Rwanda

Uganda's digital health architecture is benchmarked against its East African peers to make the integration gap concrete and actionable.

Dimension	Kenya	Rwanda	Uganda
Governing agency	DHA (Digital Health Act 2023); 35 county activations; 50+ training sessions	RBC (est. 2011); direct operator of cEMR, CHWApp, RBCNet	Ministry of Health HIS Directorate; no dedicated digital health agency
Vendor certification	Mandatory under LN 76/2025; tests FHIR, functionality, data quality,	RBC approval required for CHW-level tools; RHIE integration required	No mandatory vendor certification framework; MOU workplan provides

Dimension	Kenya	Rwanda	Uganda
	security		opportunity
Interoperability standard	HL7 FHIR mandatory (LN 76/2025); CIHIS as national data warehouse	OpenHIE architecture; FHIR-aligned RHIE; OpenMRS + DHIS2 integrated	OpenHIE-compatible (UgandaEMR + HAPI FHIR + Mirth Connect); 95% concordance when implemented
Insurance integration	SHA: 29M+ enrolled; KSh 91.5B claims FY24/25; biometric mandatory L4-6	IHBS (Irembo): reimbursement 93 days → 23 days post-RHIE	US MOU + domestic health budget; no SHA-equivalent national insurance digitisation
Connectivity	92.9% smartphone; 4G: 97.3% population; 97% L4-6 internet-ready	99%+ 4G/5G coverage; all health centres to have 25+ computers	~12% facilities with stable internet; solar now at 800 facilities (Mar 2026)
Data protection	ODPC: 9,061 complaints; 357 determinations; KSh 5M fines; DPA 2019	Rwanda Law No. 058/2021; Ministry of ICT oversight	PDPO (under NITA-U): first conviction July 2025; Google ruling confirmed extraterritorial scope
UHC index (2021)	56/100	54/100	50/100
Primary regulatory risk	SHA structural deficit; DHA enforcement at L2-3	CHW coverage declining (45%, Q1 2026, vs. 60% target)	Protection of Sovereignty Act 2026: enacted, criminal penalties, no guidance yet

10 · Strategic Recommendations

Each recommendation includes responsible institution, legislative vehicle, measurable metric, estimated cost, and risk if not implemented.

10.1 For the Government of Uganda

Recommendation	Detail, Metric, Institution, Cost
01 Publish Sovereignty Act implementation guidance urgently	Responsible: Ministry of Internal Affairs. Vehicle: Statutory instrument under the Protection of Sovereignty Act 2026. Metric: Guidance published with explicit health-programme exemptions and Cabinet approval process by Q3 2026. Cost: $0 (regulatory). Risk: Every week of uncertainty costs investment capital and implementing partner operational continuity. Kenya and Rwanda are already capturing capital that should flow to Uganda.
02 Mandate inter-agency certification framework	Responsible: MoH + NITA-U + PDPO + NDA. Vehicle: Inter-agency MOU + amendment to DPPA or new Health IT Regulation under National Health Act (Cap 395). Metric: Unified vendor certification framework published by Q2 2027. Cost: Low (regulatory). Risk: Without this, fragmented vendor landscape persists and MOU digital workplan achievements remain unenforceable.
03 Embed DHIS2 reporting as a government funding condition	Responsible: MoH + Ministry of Finance. Vehicle: Amendment to Primary Health Care Conditional Grants guidelines. Metric: 80% of Level 3+ facilities reporting in real-time to DHIS2 by end-2028. Cost: $0 (regulatory). Funding: Covered by MOU Year 1-2 digital health workplan allocation.
04 Add health indicators to PDMIS Pillar 4	Responsible: Ministry of ICT (Dr. Aminah Zawedde) + MoH. Vehicle: Amendment to PDM Pillar 4 (Social Services) data collection framework. Metric: Malaria incidence, ANC attendance, immunisation rates captured for 10.17M profiled households by Q4 2027. Cost: Minimal (data field additions + training). Impact: First parish-level health-economic integrated dataset in Africa.

10.2 For Development Partners and Donors

- Align JHSC workplan with integration milestones: The MOU Implementation Plan (currently being finalised) must include measurable DHIS2 real-time reporting targets by facility level, UgandaEMR integration milestones, and PDMIS health integration objectives as performance conditions for Year 2-5 disbursements.
- Fund offline-first architecture: The ~88% of Uganda's facilities without stable internet require offline-capable FHIR clients, store-and-forward synchronisation, and cached local servers. Solar for 800 facilities has been transferred. Fund the software layer to activate these hardware assets.
- Sovereignty Act legal support: Fund legal advisory services for implementing partners assessing their Sovereignty Act exposure. This is the single most time-sensitive operational risk for every Uganda programme.
- Maintain 6-month operating reserves: For all programmes dependent on the $2.3B MOU. Parliamentary ratification review is an active process. US geopolitical continuity is a stated risk in the MOU's own framing.

10.3 For Digital Health Vendors

- Register with PDPO immediately: pdpo.go.ug (under NITA-U). Annual renewal mandatory. PDPA Section 29 and Regulation 15(1) require registration. First conviction (July 2025) and Google ruling confirm enforcement is real and extraterritorial.
- Conduct Uganda Sovereignty Act compliance assessment before any market entry: Entities receiving foreign funding or direction operating in health require Cabinet approval under Clauses 6–8. Do not proceed without Ugandan legal clearance. Counsel: Onyango & Co. Advocates, MMAKS Advocates, or ENS Africa Uganda.
- Design for offline-first: Build FHIR-compatible offline clients with store-and-forward protocols. Only ~12% of Uganda facilities have stable internet. Offline capability is not an edge case — it is the primary use case.
- Use National ID as the integration layer: Uganda's NIIMS (National Identification and Registration Authority) NID is already integrated with PDMIS. Design health data tools around NID linkage to enable cross-system patient identification without building parallel identity infrastructure.

11 · Source Notes: 33 Verified References

Every factual claim is sourced below. Sources in order of first appearance.

Footnotes

1 *Statista. Digital Health Market — Uganda. Projected market volume $208M by 2029; CAGR 9.18% (2024–2029). Accessed June 2026.*

2 *Grand View Research. Africa Digital Health Market Size, Share & Trends Analysis Report, 2030. Market valued at $3.8B in 2023; projected $16.6B by 2030, CAGR 23.4%.*

3 *US Embassy Uganda. America First Global Health Strategy – Joint Statement on the Bilateral Health Cooperation MOU. December 10, 2025. US: $1.7B; Uganda: $577M co-investment. Data systems, EMR, interoperability, national data warehouse commitments explicit.*

4 *US Embassy Uganda. Press Release: United States Government Transfers Over $100 Million in National Digital Health Infrastructure to Uganda. March 31, 2026. 725 servers; 4,700+ devices; solar for 800 facilities; connectivity for 1,300+ sites; $103M CDC/PEPFAR investment 2010–2026.*

5 *US Embassy Uganda. Launch of Joint Health Steering Committee. May 8, 2026. $410M Year 1; JHSC co-chairs US Ambassador Popp and Minister Jane Ruth Aceng Ocero.*

6 *WHO Global Health Observatory. UHC Service Coverage Index (SDG 3.8.1). Uganda: 50/100; Kenya: 56/100; Rwanda: 54/100; Africa average: 44/100; Global average: 71/100. 2021 data, latest available by country.*

7 *Kiwanuka SN, Kabwama SN, Namuhani N et al. Barriers and Facilitators of the Effective Use of DHIS2 Data to Improve Program Planning and Monitoring in Uganda. Oxford Open Digital Health. January 14, 2026. doi:10.1093/oodh/oqag002.*

8 *Lawrence MR, Fuller BP, Isabirye HK et al. Health data reporting challenges in public health facilities in the age of DHIS2: a mixed-methods study in the Teso sub-region of Uganda. BMC Health Services Research. February 20, 2026. doi:10.1186/s12913-026-14188-9.*

9 *Economic Policy Research Centre (EPRC) Uganda. Process Assessment of the PDM Programme Implementation in Uganda. February 2026. PDMIS: 10.17M individuals profiled (March 2025); UGX 3.261T disbursed; Wendi wallet: 2.3M beneficiaries.*

10 *DHIS2 / Leiden University / Kampala International University. Comparative Effectiveness of DHIS2 and FAIR Data*

Approaches for Privacy-Preserving Health Data Analytics in Uganda: A Systematic Review. November 17, 2025. 84 sources; DHIS2: ~12,000 trained users; ~12% stable internet; ~35% staff turnover; ~25% intermediate analytics literacy.

11 *Parliament of Uganda. Protection of Sovereignty Act, 2026 (Act No. 13 of 2026). Enacted May 5, 2026; Presidential Assent May 17, 2026. Criminal penalties: up to 20 years imprisonment; UGX 4B fines. Banks: UGX 4B civil penalties for non-compliance.*

12 *The Monitor (Uganda). Parish development model and its opportunities. September 17, 2021. PBMIS-DHIS2 integration recommendation for health indicators.*

13 *DLA Piper / Privacy Matters. Uganda: Data Protection Regulator Clarifies Compliance Requirements for Offshore Entities. August 6, 2025. PDPO vs Google LLC (Complaint No. 08/11/24/6683), July 18, 2025. Extraterritorial enforcement confirmed; annual registration required.*

14 *Cliffe Dekker Hofmeyr. The Ugandan Personal Data Protection Office's decision on the registration of data controllers. August 13, 2025. Analysis of PDPO vs Google ruling and cross-border transfer requirements.*

15 *Captain Compliance. Uganda's Data Protection Law: First Ever Fine. August 7, 2025. First DPPA conviction: Ronald Mugulusi, Nano Loans Microfinance (Quickloan app), July 10, 2025. Convicted for failure to register with PDPO and misuse of personal data.*

16 *ENS Africa. Uganda's Protection of Sovereignty Bill 2026: What it means for business, investors and lenders. April 2026. Clauses 6–8 Cabinet approval; banks UGX 4B civil penalty (Clause 25).*

17 *MMAKS Advocates. Legal Alert: The Protection of Sovereignty Bill, 2026 (Bill No. 13 of 2026). April 22, 2026. Scope, penalties, compliance actions for NGOs, private sector, lenders.*

18 *Onyango & Company Advocates. The Protection of Sovereignty Act, 2026: Understanding Key Legal and Regulatory Considerations. 2026. Act passed May 5, 2026; assented May 17, 2026. First law of 11th Parliament.*

19 *US Embassy Uganda. Factsheet: Health Memorandum of Understanding. December 10, 2025. Explicit data systems commitments: EMR improvements, system integration, interoperability, national data warehouse.*

20 *US Embassy Uganda. Remarks by Ambassador Popp at National Handover of Digital Health Infrastructure. March 31, 2026. MOU marks shift from parallel systems to Ugandan leadership.*

21 *New Vision Uganda. US, Uganda launch $2.3 billion health partnership. May 8, 2026. JHSC structure and Year 1 disbursement details.*

22 *The Independent Uganda. Joint US–Ugandan committee to steer multi-billion dollar health support. May 8, 2026. $410M Year 1; JHSC oversight mandate.*

23 *Zambian Observer. Uganda, US sign $2.3bn health cooperation deal. December 13, 2025. MOU programme areas and commodity transition provisions.*

24 *Ministry of ICT and National Guidance (Uganda). Parish Development Model. Programme overview, PBMIS, PDMIS, and seven pillars. Accessed June 2026. ict.go.ug/programs/parish-development-model.*

25 *Ministry of ICT and National Guidance (Uganda). Digitization driving progress in Uganda's Parish Development Model. August 21, 2025. PDMIS maintained by MoICT; first comprehensive digital beneficiary database in Uganda's history.*

26 *EPRC Uganda. How Digital Technologies Are Driving Efficiency and Transparency in Uganda's PDM. 2025. PDMIS: 10.17M profiles; Wendi wallet: 2.3M beneficiaries (53% women); IFMS: UGX 3.261T disbursed.*

27 *Uganda Ministry of Health. Health Information and Digital Strategic Plan 2020/2021–2024/2025. Mandate to institutionalise patient-level digital systems at point of care across all facility levels.*

28 *Uganda Ministry of Health. Health Data Protection, Privacy and Confidentiality Guidelines. Published on MoH Knowledge Management Portal. Aligned with DPPA 2019, Data Protection Regulations 2021, Uganda Digital Health Enterprise Architecture.*

29 *Securiti.ai. A Complete Guide on Uganda's Data Protection and Privacy Act (DPPA). July 2025. PDPO structure, registration requirements, NITA-U relationship, Section 29 mandatory registration.*

30 *ITLawCo. How to register with Uganda's Personal Data Protection Office. July 2024. Detailed registration process under DPPA Section 29 and Regulation 15(1).*

31 *Grand View Research. Africa Digital Health Market — per reference 2 above.*

32 *Kapsule Tech. Digital Health in Africa: Trends, Investment, and Impact. February 28, 2026. WHO-EU EUR 8M joint initiative Oct 2025; African Union HIE Guidelines; HL7/FHIR for cross-border standards.*

33 *WHO Global Health Observatory — per reference 6 above. Africa carries 25% of global disease burden with 3% of global health workforce.*

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