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KNOWLEDGE PLATFORM ON INCLUSIVE DEVELOPMENT POLICIES

Uganda Country Case Study

Equity in COVID-19 mitigation and policy responses

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Table of Contents

1.Introduction 6

2.Background 7

Health system 8

3.Conceptual framework 9

4.Methodology 9

Legal and policy review 9

Peer-reviewed literature searches 9

Media analysis 9

Grey literature search 10

Key informant interviews 10

5.Overview of timeline of the legal and policy response 11

Travel Restrictions and Quarantine 12

Closure of Public Spaces 13

Face masks 13

Education 13

Business and Trade 14

Fiscal Measures 14

COVID testing 14

6. Determining the legal and policy response to COVID-19 17

Where do the policy responses originate from? 17

Non-state actors' inclusion in the national COVID response 18

Inclusivity of mitigation measures and policy responses 20

Innovations in response to COVID and its mitigation responses 21

Accountability mechanisms for laws, policies and regulations 22

7. Immediate impacts of the response on COVID-19-related outcomes 25

What works and does not work for vulnerable groups? 25

Governance 26

Access to information 27

Social distancing, quarantine, self-isolation measures and travel restrictions 28

Handwashing practices 29

Gaps in implementation 30

Mapping the evolution of the pandemic in the context of this policy response 30

Uptake of COVID-related services 32

Health worker and caregiver protection and support 32

Sustainability of positive measures and potential for change of negative measures 33

8. Other immediate impacts of the response 34

Impact on different groups within society 34

Livelihoods 35

Health: Biomedical and Public Health Response 36
Impact on access to other services 42
Impact of mobility restrictions on access to services 43
Government dilemmas: resource allocation and prioritization 44
Social protection or cash transfer programmes 45
Addressing police brutality and other human rights violations in the COVID response 46
9. Longer -term changes – structural, institutional and personal – foreshadowed by the COVID-19 response 48
Impact on structures and systems of power and governance 48
Impact on corruption in the distribution of welfare benefits to the most marginalized 48
How might these disadvantages become compounded over time? 49
How is the media generating public interest discussions to benefit the policy makers and the population? 49
How might the attention brought to issues such as police brutality in the context of the COVID response be capitalized on to promote positive structural change moving forward? 49
10.Conclusions and Recommendations 50
11. Annexes 54
12. References 60

Acronyms

AfDB	African Development Bank
ANC	Antenatal care
ART	Antiretroviral therapy
BBC	British Broadcasting Corporation
CAO	Chief Administrative Officer
CBHI	Community-based health insurance
CDC	Centre for Disease Control
CHW	Community health worker
COVID	Coronavirus disease
CSO	Civil society organisation
DHO	District Health Officer
EAC	East African Community
ERP	Emergency response plan
FAO	Food and Agriculture Organization
GBV	Gender-based violence
HIV	Human immunodeficiency virus
HPV	Human Papillomavirus
ICU	Intensive care unit
KCCA	Kampala City Council Authority
KII	Key informant interview
LGBT	Lesbian, gay, bisexual and transgender
NCDs	Non-communicable diseases
NGO	Non-governmental organisation
NHIS	National Health Insurance Scheme
OECD	Organisation for Economic Co-operation and Development
PCR	Polymerase chain reaction
PPE	Personal protective equipment
RDC	Resident District Commissioners
RT-PCR	Reverse transcription polymerase chain reaction
SAGE	Social Assistance Grants for Empowerment
SMS	Short message service
UGX	Uganda shillings
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNHCR	United Nations High Commission for Refugees
UNHS	Uganda National Household Survey
UNICEF:	United Nations International Children's Emergency Fund
UN Women:	United Nations Women
UNHS:	Uganda National Household Survey
USC	University of Southern California
UVRI	Uganda Virus Research Institute
WFP	World Food Programme
WHO	World Health Organization
WRA	White Ribbon Alliance

Chapter 1. Introduction

Even prior to COVID, health and ill-health were not equitably distributed in Uganda. History has shown that public health emergencies such as COVID can have a disproportionate impact on communities that are already disadvantaged. Not paying explicit attention to existing inequalities and the particular needs of vulnerable and marginalized groups subjects them to a higher risk of infection and also undermines the broader response to COVID. It is already clear that not only does COVID disproportionately affect people who are already vulnerable due to comorbidities that are often a result of pre-existing social inequalities, but mitigation and policy responses in Africa have disproportionate negative impacts on socially marginalized or disadvantaged groups. People with underlying conditions (e.g. cancer, diabetes, being immunocompromised) are disproportionately vulnerable to severe illness from the coronavirus. Adherence to government response measures might be compromised by a range of factors, with poverty prime amongst them. The pandemic has shone a light on pre-existing societal inequalities and it is now exacerbating them.

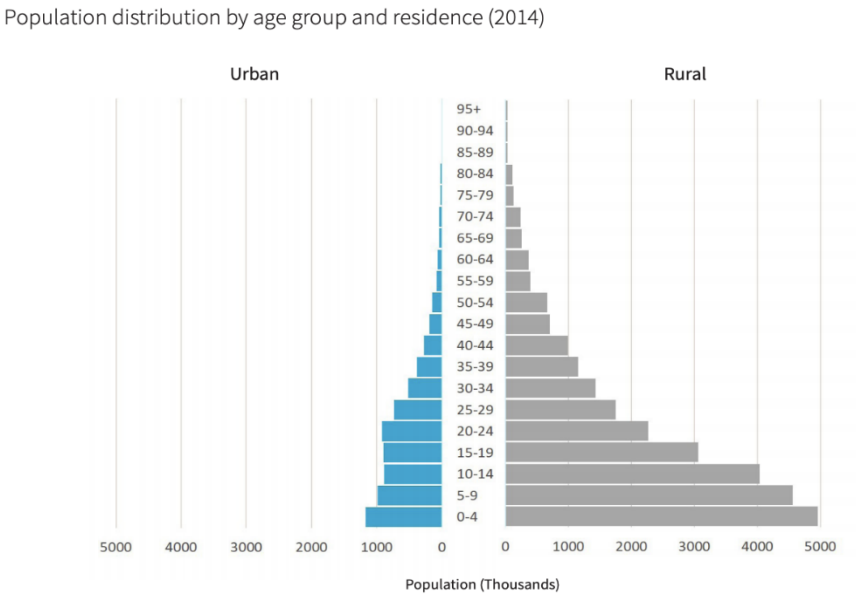
This case study explores Uganda's national legal and policy response to COVID with particular attention to human rights and equity. It encompasses issues such as civil society participation in the response as well as the unequal impact of the response on different populations.

Chapter 2. Background

Uganda has a very young population: 72% of the population is aged 24 or less while only 2% are 65 years old or older. 25% of the population lives in dense urban areas and urbanisation is rapidly occurring. Uganda has a high population growth rate at 3.3 percent according to the 2017 census.[i] Uganda's refugee population influx which is also observed to have tripled since July 2016, attributed to its open door refugee policy, allows refugees to access and enjoy social services and land.[ii] The high population is said to be overly stressing systems of service delivery particularly health and education, with the influx of refugees also straining host communities.[iii]

With the population relatively evenly distributed by sex, the population pyramid below illustrates the national population disaggregated by place of residence, showing that the vast majority of the population live in rural areas.

Figure 1. Population pyramid (Source: Uganda Census, 2014)



Source: Uganda Census 2014

Ranked 159 out of 189 countries in the Human Development Index, Uganda was still categorized as a lower middle income economy by the World Bank in early 2020 due to its high poverty level and low score in development indicators. Although the percentage of households living in poverty has decreased in recent years, the number of people living in poverty has increased in all regions except the Northern region and most people lack savings. Economic vulnerability to external shocks is high, with two out of every three people who escape poverty falling back into it. In 2016, 42% of the population was living on less than $1.90 per day.[iv] Social protection programmes are inadequate, reaching only 3% of the population.[v] Shared, multigenerational and crowded households are the norm. Moreover, only 38% of households have access to electricity and around 40% have access to improved sanitation indicating limited access to basic services. Twenty-nine percent of children under the age of five are stunted, a measure of chronic malnutrition that highlights the need for attention to food security.

High youth unemployment is reported: 700,000 young people reach working age every year but only 75,000 jobs are created annually. More than 70% of Ugandans are employed in agriculture, mainly on a subsistence basis.[vi]

More than 17.5 million people in Uganda attend either public or private school.[vii] According to UNHS 2016 findings, net enrollment in secondary education was at 27.8 percent which is much lower than in the region. A concern in terms of the quality of both primary and secondary education was observed in the survey.

Health system

In Uganda, even prior to the pandemic, the health system was overstretched, with relatively low ratios of health professionals to population, little intensive care capacity and critical shortages of medical equipment including ventilators.[viii] The health system throughout the country is chronically under-funded and fragmented. There is a shortage of health resources across the country. There is one doctor per 24,000 people, and one nurse per 11,000 people. Only 55 ICU beds are available in-country - 1.3 per million Ugandans. Of these ICU beds, 20 lack ventilatory capacity, only one-third are part of the public health system, and they are all located in major urban hubs.[ix]

Access to health services is more limited in rural than urban areas and, as socioeconomic status decreases so too does access to health services.[x] In 2018, out-of-pocket expenditure made up 38% of total health expenditure, highlighting challenges with equity in access to services.[xi] In the same year, voluntary health insurance contributions account for only 2.1% of health expenditure. In 2019, the Cabinet approved the National Health Insurance Scheme (NHIS) Bill 2019. The bill comprises three sub-schemes that will be concurrently implemented: social health insurance, community-based health insurance (CBHI), and private-commercial health insurance. The CBHI will primarily target the informal sector.[xii] It will take time for these schemes to be brought to scale.

Though communicable diseases are a huge burden in Uganda, non-communicable diseases such as hypertension and diabetes which pose significant risk to those who contract COVID-19 are on the rise. Though there is limited data, available evidence points to rising cases not only in the urban areas but also in the rural areas.[xiii] The 2014 NCD survey attributed 33% of annual deaths to NCDs. Increase of hypertension and high blood sugars was reported with many of those affected not being on medication.[xiv]

All of this has raised concerns about the ability to mount an effective biomedical response to the pandemic alongside the fear that necessary public health measures such as physical distancing, hand-washing and wearing face-masks might also be difficult to implement, particularly among certain populations including the poorest of the poor.

Chapter 3. Conceptual framework

This work was guided by a social ecological framework whereby individuals' experiences are shaped by a range of nested, inter-related factors around them, from seemingly 'distant' factors such as laws and policies down to more 'proximal' factors such as their immediate living situation. The interplay of these factors, particularly the range of laws, policies and regulations relevant to COVID-19 (both national and sub-national) and how they impact on different populations was explored.

Chapter 4. Methodology

This mixed methods study includes policy, quantitative and qualitative research as well as a joint analysis to bring together all of these different types of data.

Legal and policy review

For the purposes of the legal and policy analysis, we reviewed web-based search engines such as Google and Google Scholar. Searches were limited by date range of publication and were restricted to the year 2020. Searches included "Uganda + COVID + policy," "Uganda + COVID + law," "international + COVID + policy + tracker," "Uganda + COVID + legal + response." Data were assessed for relevance and systematically extracted based on their direct or indirect implications for vulnerable communities. The data were organized thematically and categorized according to date, issuing body, and type of measure issued to create a timeline of the national response.

Peer-reviewed literature searches

Searches were conducted on Pubmed, Google Scholar, and Scopus on October 25th using the search terms "Uganda" AND "covid". Pubmed searches were inclusive of the abstract and article while Google Scholar and Scopus searches were only inclusive of the title. The Pubmed search yielded 90 total results, with 30 articles deemed relevant after a title and abstract review, and 15 articles included in the final review. The Google Scholar search yielded 67 total results, of which 46 were unique to Google Scholar and deemed relevant after a title and abstract review. Twenty-one articles were included in the final review. The Scopus search did not yield any unique results. Thus, a total of 36 articles were included for full review.

Media analysis

Media searches were carried out between September and November focusing on articles published from March to November 2020. This entailed a two-step strategy, starting with a broad strategy where specific media houses were searched generally for articles published covering COVID news in Uganda. E.g. New Vision media group news on COVID. These searches generated 120 articles listed chronologically with about 10 articles per page. From each page only 2 to 3 were selected, based on relevance as determined by the research questions to be answered. Out of 400 articles reviewed in total for local media 59 articles were analysed for the study. The second level search was based on specific search words linked to this study's research questions keyed into Google and Bing. These searches yielded about 15 articles per media house, although some of the articles had already been captured in general searches. For

international media 234 articles were reviewed out of which 10 articles were selected for the study. The data generated was tabulated indicating the date, main issue reported and reference.

The local media houses reviewed include: New Vision, The Independent and The Monitor newspaper. Uganda media houses faced a lot of challenges at the beginning of the COVID response and New Vision was the most active media house thus had the highest number of COVID response articles. The international media articles were mostly sourced from the websites of Reuters, BBC, The Guardian, and the Washington Post. Social media searches were also included particularly from Twitter.

Grey literature search

Organizations actively engaged in the COVID response in Kenya were identified from the media analysis including UN organizations such as the WHO, UNDP, UNICEF, WFP, FAO, UN Women as well as civil society organizations including Amref Health Africa, the Red Cross, World Vision, Save the Children, Akina mama wa Afrika and the White Ribbon Alliance. Their latest reports on areas of interest were reviewed and data relevant to answering the study's research questions was systematically extracted. The information obtained was drawn from their research findings , programmatic reports and experiences on the realities encountered in their programme implementation.

Key informant interviews

Thirteen key informant interviews were carried out with a range of participants across different sectors at the national level and in Lango region in northern Uganda. Participants at national level included ministers, heads of departments, program managers, principal medical officers at the Ministry of Health. At regional/district level, these included medical superintendents, hospital administrators, Residence District Commissioners (RDCs), Chief Administrative Officers (CAO) of districts, District Health Officers (DHO). Within civil society, participants included representatives of nongovernmental organizations and an employers' union. Interviews were recorded and transcribed verbatim for analysis. Ethical approvals were secured through the MILDMAY Uganda Ethics Review Committee and the USC Institutional Review Board.

Chapter 5. Overview of timeline of the legal and policy response

Uganda has been widely lauded by the World Health Organization and the Africa Centre for Disease Control (Africa CDC) for its decisive reaction against the pandemic. The government has put in place a range of legal and policy measures since the start of the pandemic, each covering different aspects of their response.

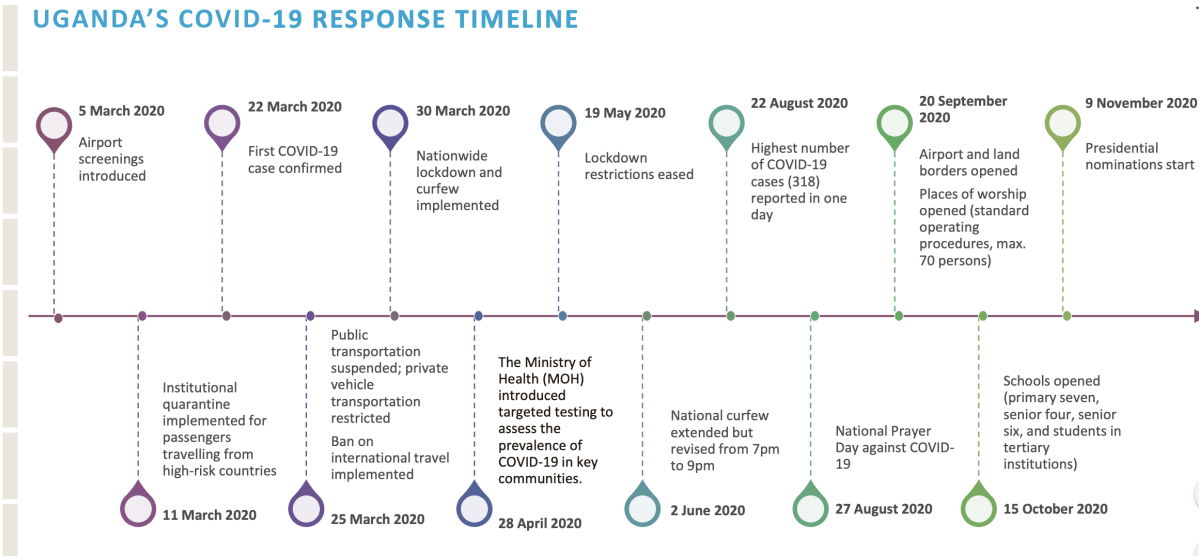
The pre-existing Public Health Act provided the overall legal framework for designing and implementing the COVID response: the Minister of Health invoked powers under this Act to issue rules and orders aimed at combating Covid-19: In the Public Health (Notification of COVID-19) Order, 2020, Covid-19 is declared a notifiable disease to which the provisions on prevention and suppression of infectious diseases under the Public Health Act (Cap. 281) apply. This includes the Minister of Health's power to make rules for control of the spread of the disease, order the quarantine of infected persons or those suspected to be infected, inspect premises of persons believed to be infected with the disease, and disinfect premises and buildings which have been covered under these rules and orders. Local government authorities are empowered to enforce such regulations and may make their own.

The national *COVID-19 Preparedness and Response Plan* was developed based on model guidance for countries published by the WHO. The Ugandan plan includes eight pillars: Leadership, Stewardship, Coordination, and Oversight; Surveillance and Laboratory; Case Management; Strategic Information, Research, and Innovation; Risk Communication and Social Mobilisation; Community Engagement and Social Protection; Logistics and Operations; and Continuity of Essential Services. This plan is designed to guide the overall national response. It is supplemented by the additional legal and policy measures that have been instituted over the course of the pandemic.

The Ministry of Gender, Labour and Social Development issued COVID-19 guidelines in which they call on employers to retain employees who are paid on a monthly basis (regardless of whether they are essential or non-essential staff) and to reach agreement with workers on who may stay home. The employees most likely to be affected by this option will be casual employees who are employees who are paid on an hourly or daily basis at the completion of each day's work. These guidelines do not, however, have the force of law.

Figure 2 below provides an overview of the national response up until November 2020. One important characteristic of the government response is the phased re-opening: rather than immediately remove all restrictions, the government has gradually loosened them, always tracking the impact on the epidemic.

Figure 2. Uganda's COVID-19 response timeline[xv]



Source: https://thinkwell.global/wp-content/uploads/2020/05/COVID-19-Uganda_August-2020-Updates-final.pdf

Further information on these measures is provided below, organized by the different sectors they are designed to impact. The section ends with an analysis of how these measures may have influenced the spread of COVID over the course of 2020. The actual impact of the measures will be explored in the subsequent sections.

In November (after the period covered in the timeline above), it was reported that a new national strategy had been launched in which community health workers (CHWs) are to be paid a monthly allowance to fight Covid-19 at the community level.[xvi]

Travel Restrictions and Quarantine

President Museveni acted quickly, closing all airports and country borders on March 25th. This included banning new refugee arrivals, which was a big change from the usual 'open door' policy for refugees.[xvii] On March 30th, the President approved lockdown measures which would restrict all movement of people for 14 days. These measures were updated on April first, when the President declared a 14-day nationwide lockdown in an effort to prevent further spread of the virus. The measures included a curfew from 7pm to 6:30am, airport and border closures (with the exception of cargo trucks), and the prohibition of private transportation. Unless individuals were transporting cargo or food and agricultural products, or they were part of the COVID response, all members of the public were instructed to stay indoors. President Museveni extended the lockdown on April the 14th for an additional 3 weeks. All businesses except those that provide essential goods and services were instructed to close and the nationwide curfew was updated to be from 7pm to 5am.

The lockdown was extended on May 4th and again on May 18, though some restrictions, such as driving in a private car with up to 3 persons, were eased. On June the 4th, public transport was reopened; regulations only allowed for half the normal passenger capacity, required the use of PPE, reduced contact between staff and passengers, and required temperature checks.

Lockdown restrictions were eased on June 29th, specifically for the Gulu district in the north. Gulu is a non-border district. Restrictions were eased by the President on July 22nd, and curfew hours were adjusted to 9pm to 5:30am. Motorcycle taxis, known as boda bodas, were allowed to begin operations on the 27th of July. New guidelines indicated that passengers must wear a mask and drivers were allowed to drive until 6pm.

The government of Uganda decided to open its borders for Ugandan nationals who had been stranded abroad in neighbouring East African Community (EAC) countries. On September 20th, land borders and airports were opened, and both tourists and citizens who were stranded abroad were allowed to enter the country. As of October 1st, Uganda's borders opened and international flights were resumed. Passengers arriving in the country must have a negative PCR test certificate within 72 hours prior to arrival in Uganda.

Closure of Public Spaces

On March 18th, the President of Uganda, Yoweri Museveni, issued a wide-sweeping directive that effectively closed schools and universities, and restricted most public gatherings (with no more than five people allowed to congregate). The directive banned large religious gatherings, and provided guidelines on social distancing, public health, and public transport. All political gatherings were prohibited for 32 days.

Face masks

The government made wearing of masks in public settings mandatory on June 9th 2020 and began distributing face masks to all households across the country the next day.[xviii] According to a key informant, at the beginning of policy introductions for mask requirements, individuals found they could not access reusable masks and only one supplier was contracted for distribution. Organizations complained and the government responded by facilitating an easier path for more suppliers to speed up a bottlenecked distribution process.[xix]

Education

Education institutions in Uganda remained closed for months after the directive issued by President Museveni. The government developed a response plan with a focus on continuity of learning during the closure of schools in the meantime. According to UNHCR, nearly 500,000 children accessed distanced learning across Uganda while schools were closed, and 1,127 children with disabilities received support.

The 2019-2020 Education Sector strategy was tailored to align with the Education Response Plan for Refugees and Host Communities in Uganda (ERP), which seeks to provide refugee and host community girls and boys with both equitable and inclusive access to education.[xx] In September, guidelines around reopening schools were issued by the President.[xxi] There has been some apprehension about moves to e-learning as certain demographics have limited access to the internet or a disability preventing them from participating fully.[xxii]

It was not until September 20th that education institutions were scheduled to be reopened to a small subset of students; candidate classes and final year students were allowed to resume studies on October the 15th.

Business and Trade

On April 1st, President Museveni ordered the closure of all non-food shops. Shops that sold food, agricultural products, veterinary products, detergents and pharmaceuticals were allowed to remain open. The President tightened measures on April 8th, maintaining that boda-bodas (motorcycle taxis) could not operate after 2pm. Provided that they adhere to strict social distancing rules, businesses such as wholesalers, hardware shops, and warehouses were allowed to open on May 4th. Insurance providers were also added to a list of essential services on this date. Restaurants were allowed to operate as well, provided that they only serve take-out. The President eased measures on May 26th by allowing general merchandise shops outside of shopping malls, arcades, and food markets to open. The President again loosened measures on July 22 by allowing salons to operate on the proviso that they adhere to public health guidelines. Some arcades and shopping centres were reopened with new features such as temperature monitors, more avenues for handwashing, and improved layouts for vendor/customer safety.

Fiscal Measures

Under the Rapid Credit Facility, Uganda was able to secure US$491.5 million in emergency financing from the IMF. This transaction, which occurred on May 6th, was intended to boost international reserves in order to bolster health spending on vulnerable populations. In June, Finance Minister Matia Kasaija announced that the Uganda budget for fiscal year 2020/21 would focus on three objectives: improving the well-being of Ugandans, boosting economic transformation, and improving peace, security, and good governance. The fiscal year lasts from July 1, 2020 to June 30th 2021 and the total fiscal budget is $US12.1bn. Tax cuts were announced in June as part of the stimulus package. The budget included an economic stimulus and growth strategy including: introduction of tax relief to businesses; expansion of social protection for the vulnerable; improvement of household incomes through work programmes and credit facilities; and reduction of mobile transaction costs to prevent the spread of the pandemic.[xxiii]

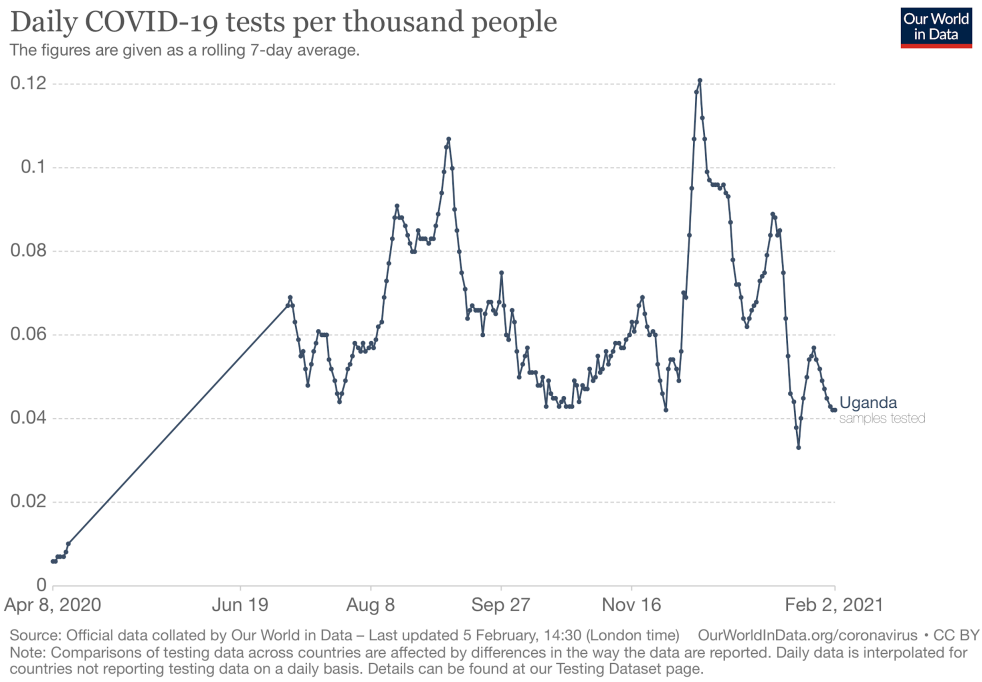
On the 29th of June, the Uganda COVID-19 Economic Crisis and Recovery Development Policy Financing received $300 million in budget support from the World Bank. The money was intended to support reforms to provide immediate relief to businesses and individuals hit hardest by the pandemic.

COVID testing

Uganda has performed better on testing than most countries on the African continent, with the government making this a priority from early in the pandemic and focusing their efforts strategically. According to the government almost 840,000 coronavirus tests had been carried out on its 45 million population by late January 2021.[xxiv] In the early phase of the pandemic, March 2020, Uganda instituted mandatory testing of travellers arriving from high-risk countries.[xxv] A region-wide system was instituted to test, track and share information about long-distance truck drivers across the EAC, Uganda being a major transit route for countries such as Burundi, Rwanda, Tanzania, South Sudan and Kenya. The Tanzanian government posed significant problems in regards to transit, as they denied the importance of the pandemic and refused to take measures against it.

In May, contact tracing and testing was instituted and community testing started. The number tested in the months following increased and has fluctuated since then, but remains too low to make inferences about infection rates (Figure 3).

Figure 3. Daily COVID-19 tests per thousand population



In August, the government instituted a cost-recovery fee of $65 for COVID-19 testing for some categories of individuals and organizations, such as truck drivers, travellers and people who wanted to know their status, which was later reduced to $50 ostensibly to make it more affordable. The move affected negatively not only the COVID-19 management and control but also businesses as it affected the truck drivers transporting goods within the East African region. All travellers into the country were tested regardless of symptoms and required to pay for the test.[xxvi]

Testing and surveillance have been prioritised with expansion over the course of the pandemic to detect community cases as well as two rapid assessment surveys to determine prevalence in specific groups and areas identified at potentially higher risk. The first survey covered specific populations and areas including: markets, truck drivers and communities along their routes; border crossing points and communities living in these areas, health workers, security forces and factories and their workers. The assessment consisted of a total sample of 10,000 people and found some evidence of community transmission of the virus with a 28 per 1000 positivity rate. The second survey sought to estimate COVID-19 infection rates in high-risk population sub-groups and areas in 10 border districts. It consisted of 12,500 tests covering healthcare workers, road law enforcement officers, commercial sex workers, community members, taxi drivers, market vendors, fishing communities, factory workers and mobile money agents. The survey found 15 positive cases or a positivity rate of 0.12% - over four times higher than the proportion of positive cases in the first survey. Market vendors comprised 40% of all the positive cases, road law enforcers 26.7%, and community households 20%. Laboratory testing of oropharyngeal and/or nasopharyngeal swabs has been done at Uganda Virus Research Institute (UVRI) using

real-time RT-PCR (Berlin protocol).[xxvii] An early bottleneck was that this was the only laboratory carrying out testing but, as the pandemic has progressed, this capacity was expanded to twelve laboratories, including two in the private sector, enabling increased case detection.[xxviii] The laboratory test results have been used to inform the COVID response including targeting of surveillance, contact tracing and community engagement efforts.[xxix]

It is important to also acknowledge the important role of community-based disease surveillance in the COVID response. Although not testing per se (and therefore not included in any published testing data), this has been an important mechanism for identifying cases, linking them to care and carrying out contact tracing. The Ugandan government established a community-based disease surveillance and contact tracing model made up of Village Health Teams (VHTs) and local councils, which has been credited for effective testing of COVID-19 cases at border districts.[xxx] [xxxi] Where positive cases are identified, they are taken to isolation facilities where they are quarantined until they have a negative result, and contact tracing teams trace all listed contacts.

Chapter 6. Determining the legal and policy response to COVID-19

Where do the policy responses originate from?

There is very little information in published literature about the origins of Uganda's policy response to COVID. One study noted that mitigative policies were modelled with high-income settings in mind but applied to the entire country, including poor and high-density communities.[xxxii] This made sense because at the beginning of the epidemic as most of the available data came from high-income countries. The government has also drawn heavily on guidance provided by the WHO, striving to adapt it to the local context.

Multiple key informants pointed out that the policies were developed at the national level and shared with the various departments and sub-national levels for implementation. They indicated that the existing laws and frameworks such as the constitution, the public health act and various sectors development plans were used for COVID-19 response.[xxxiii] Key informants suggested that there was little to no consultation by the government with NGOs in the drafting of pandemic response policies. However, key informants report that within civil society, labour unions and employers featured more prominently in the decision making process.[xxxiv]

Once it became clear that the coronavirus would indeed reach Uganda, the country activated its emergency response infrastructure. There had already been substantial investment in emergency preparedness and response due to prior outbreaks e.g. Ebola, which meant that surveillance systems already existed, thousands of health workers had been trained on infection prevention and control, and there were clear structures for managing the emergency response at all levels. This provided a strong foundation for the COVID response, for example with rapid cascading of COVID measures throughout the health workforce across the country, and the activation of village health teams to support surveillance. All of these actions were based on previous experience within Uganda and were thus tailored to the local environment.

Before the first case of COVID was diagnosed in Uganda, the COVID response structures were already put in place. A multisectoral National Task Force for public health emergency coordination (RSCM-CE) was established within the Prime Minister's Office to provide advice to the Cabinet and guide the response. Chaired by the Prime Minister, this Task Force also includes government representatives from key sectors including health, education, finance and transport as well as the private sector and has targeted viruses such as Ebola in the past. A COVID-19 Response Fund Secretariat in addition to an Inter-Agency Joint Task Force to combat COVID-19 were created specifically for this crisis. The Secretariat is composed of the Prime Minister, Health Minister, private sector representation, representatives in international development, church leaders, and other government representatives. Of its 15 members, four are female and 11 are male. At the district level, in all 134 districts, COVID Task Forces, also comprising a mix of government officials and technical appointees, were established to guide and coordinate local responses.[xxxv] The functionality of the district task forces varies by district but many are proactive in driving local response strategies through activities such as facilitating community dialogue and engagement, conducting social mobilisation activities, distributing information, education and communication materials in local languages, and increasing awareness of COVID risks and preventive measures through media and social media.[xxxvi]

At the community level, the government leveraged existing structures to assist with the COVID response. The Village Health Teams, used during the pandemic to spread health information and provide basic services, have been identified as a successful grassroots approach to healthcare that should be prioritized moving forward as they can play an important role in disease prevention.[xxxvii] They have been involved in community-based disease surveillance, which has been widely praised for its success with case identification and contact tracing, including in border communities.

A Scientific Advisory Committee comprising leading academics and scientists was established to advise the National Task Force based on research and data. A Strategic Committee was also established with the purpose of mobilising resources and providing technical and strategic guidance. This committee, led by the Minister of Health, included representatives of United Nations agencies, professional bodies and civil society.[xxxviii]

Lines of communication between and among all of these committees and task forces were clear from the outset, facilitating a coordinated response. Over the course of the pandemic, the country has generated increasing data on testing, cases and deaths among different populations, which has been used to help guide the response.[xxxix] During the lockdown period, the government worked to plan the easing of restrictions including planning the phased re-opening of schools and creating a guideline to allow the judiciary to function through Zoom.[xl]

As the pandemic evolved, so too did the government response. Having started with the aim of preventing entry of the coronavirus into the country, the emphasis then shifted onto testing, contact tracing and isolation, and when community transmission became much higher it shifted again to focus on the promotion of home-based care for non-severe infection.[xli] There were, of course, other considerations that affected decisions around response measures, including pressure from religious leaders to prioritize reopening churches.[xlii] In addition, with elections in January 2021, the ruling party was cognizant that a response that was perceived to be too harsh might have negatively impacted their performance at the polling station.[xliii]

Overall, it seems that to a large extent, the structures used for implementing the response were already designed based on prior epidemic experience in Uganda, but some of the measures implemented such as the curfew and the movement restrictions were replicated from higher income settings. The shortcomings of the latter became evident and efforts were made to adjust to the local realities but challenges remained to identify effective alternative interventions that are locally feasible.

Non-state actors' inclusion in the national COVID response

Within the government, there was cross-sectoral involvement in designing the COVID response. However, most evidence suggests that the government acted unilaterally in designing the response, restricting consultation and contributions to decision-making. While the chosen strategies were quickly deemed successful, with few reported COVID cases, this came at the cost of multi-sectoral action. Some key informants felt this approach was justified given the need for quick action and report that even community engagement came in much later.[xliv] It has fuelled growing demands from civil society and the private sector for greater involvement and accountability.

In October, the Prime Minister launched the National Community Engagement Strategy for the COVID-19 response with the objective of "ensur[ing] that all people in Uganda are aware, empowered and are participating actively in the prevention and control of the outbreak of COVID-19 as both a duty and a right, using existing structures, systems and resources as much as possible."[xlv] However, it has been suggested that additional opportunities for community involvement in the COVID response exist, including strengthening community structures such as community, political, religious and cultural leaders to engage in all aspects of the response as well as deploying community extension health workers to mobilise and engage communities in the pandemic response.[xlvi] There is also considerable room for growth in the implementation of socio-economic measures, such as social protection and cash transfers, whereby inclusion and participation of representative individuals and organizations can facilitate optimized distribution channels.

Multiple key informants noted that avenues for participation were limited in the crafting of the government response. One key informant stated that there was no deliberate avenue for citizens to actively participate, and that with the degree of misinformation being spread throughout different channels, this contributed to an erosion of public trust.[xlvii] One key informant from an NGO noted that as a whole, communities and their representatives were not involved at a level of policy formulation, nor were they consulted.[xlviii]

Overall, key informants who represented the government suggested that civil society involvement in the national response increased over time but their primary function was often described as support to the government in terms of providing financing and supplies and sensitizing communities rather than an active role in designing the COVID response.[xlix] A national-level official justified this by explaining that "the government response framework is science-based so there is no need to involve [civil society]."[l] Another key informant, however, thought that civil society could be more effectively involved in policy making, implementation and monitoring.[li] However, civil society representatives reported that even as the national strategy evolved over time, there remained a lack of consultation between government and civil society. A key informant spoke of a community engagement strategy launched later in the year which had no input from civil society groups, with another informant noting that it was around mid- to late-2020 when civil society began to be include.[lii] As a result, civil society often feels the relationship is adversarial and that to get attention and make change, these issues must be brought into a public forum.[liii]

Some inclusion of religious and cultural leaders was reported in order to ensure acceptability of and compliance with restrictions on mass gatherings. However, a key informant pointed to a lack of inclusion of community leaders whose connection to public audiences may be more impactful than hearing from the religious and popular leaders who addressed the public on television.

Civil society's different efforts to increase their involvement in the national response often met mixed results from the government. For example, a key informant stated that civil society wrote letters to the different task forces, to the prime minister and minister of health, advocating for various tweaks to measures. These petitions requested more representation from civil society to bring attention to community-level challenges, such as access to medications and health facilities ,and contribute to overcoming them. They also employed social media campaigns and engaged with key stakeholders on social media. The informant reported that through these channels they were successful in the government adopting some of their proposals.[liv]

In stark contrast to NGOs, employers and labour unions were key participants in the design of the COVID response. Workers that belong to a labour union registered less reduction in their work entitlements and/or social safety nets than their non-unionised counterparts – though 85% of Uganda's employed population is not a member of any trade union.[lv] A key informant recognized the creation of a tripartite association of government, employers and labour unions that met as a task force to address the pandemic from the perspective of employers and workers.[lvi] Among these groups were the Manufacturers Association, the Private Sector Foundation, the Chamber of Commerce and others involved in the health space. A key informant specifically points to the involvement of civil society in these meetings as well.[lvii]

Inclusivity of mitigation measures and policy responses

There is little information in the published literature about attention to different population groups in mitigation measures and policy responses. Some key informants, especially government representatives at the national level, emphasized that laws and policies apply equally to everyone in the country, thus rendering it unnecessary to accord additional attention to any sub-population.[lviii] Others stated that there was indeed attention to vulnerable populations with the elderly, children, people with disabilities and people with underlying health conditions most often mentioned even as there was acknowledgement that when the government first designed the response it was based on biomedical criteria without due attention to social factors, such as poverty, that might put some people at greater risk.[lix] Finally, some noted that attention was given to vulnerable groups at the intervention level rather than within laws and policies, such as the food relief programme that was targeted to the urban poor, the universal provision of free face masks, and permission for pregnant women to travel outside curfew to reach health facilities.[lx]

The differential impact of the policy response on different population groups will be explored in depth throughout the report but it warrants mention upfront that the government's mitigation measures and policy responses have disproportionately affected certain populations including women, the urban poor, children, people with disabilities, and people living with HIV and other chronic health conditions. As one example, the impact on women is reflected by an increase in reported domestic violence, a loss of jobs across sectors dominated by women, a rise in abortion cases, and the limitation of travel for essential health services.[lxi] [lxii] [lxiii]

Overall, it seems that there was little consideration for vulnerable populations; for example, people with disabilities such as people with hearing, speech or sight impediments were left out yet they needed communication.[lxiv] Even when vulnerabilities were considered, more of the health related challenges were in the fore leaving the socio-economically disadvantaged inadequately covered. Policy responses mainly focused on combating the spread of the infection and protecting those at high risk of COVID but did not give due considerations to the effects on the poor.[lxv]

Socioeconomic mitigation measures and policy responses reflected very little appreciation for inclusivity by the Ugandan government. A December 2020 government report on the impact of the pandemic on labour, employment, and productivity suggests that the government, the private sector and a few development partners were cognizant of the "adverse welfare effects" of the virus and resulting containment measures and drafted the following initiatives to support vulnerable groups: suspension of PAYE, a moratorium on debt, payment of VAT refund arrears, and food distribution to vulnerable urban households. However, suspending PAYE can only affect those in formal employment, a debt moratorium only applies to those with debt in official institutions, VAT arrears only affect registered businesses, and food distribution efforts suffered

from logistical errors and misidentification of households. The report notes that 69% of workers did not receive any support at all from the government which it then suggests is a function of the government targeting business enterprises rather than misappropriation of funds.[lxvi] There were flaws with both the design and the implementation of these initiatives purportedly intended to reach the most vulnerable.

The World Food Programme announced a 30% reduction in the food it distributes to refugees due to funding concerns early in the pandemic.[lxvii] Other international funders also cut support for food relief programmes, which led to those in Uganda becoming prohibitively expensive. In addition, key informants noted that these programmes were very time consuming due to difficulties in the physical transfer of food and other necessities.[lxviii]

Government efforts to draft policy around social protection have fallen short as well. A key informant representing an NGO notes that social protection measures were only drafted to include the age 80 and up population. Civil society had requested the government extend social protection to those aged 65 and up to more accurately reflect the median age in the country.[lxix]

Innovations in response to COVID and its mitigation responses

A range of innovations specific to the mitigation of the COVID pandemic have been developed since the beginning of the pandemic, covering three main areas: materials for the COVID response, technologies for improved access to health information and services and innovations in health service delivery.

The government asked specific manufacturers to produce locally designed PPE that meets infection control standards.[lxx] Although the scale of production is undocumented, a national-level key informant noted that locally manufactured masks and alcohol-based sanitizer have brought down prices of these important commodities and allowed for entrepreneurship that boosts the local economy.[lxxi] In addition, researchers at Makerere have been involved in a range of innovations to assist the COVID response. This includes designing hands-free sanitizer dispensers, biodegradable transparent face masks, a thermal imaging detection system and rapid testing kits as well as manufacturing low-cost ventilators.[lxxii] [lxxiii]

The hands-free sanitizer dispenser provides instructions in English and Luganda, and ensures an automated delivery of soap and water and a wash that lasts for the 20 seconds recommended by the World Health Organisation. By September, 15 kits had been placed at different public shared spaces such as hospitals and markets in Greater Kampala.[lxxiv] The thermal imaging system shows an image of the person whose temperature is being measured and the person's average temperature around the throat, nose, eyes and forehead, making it superior to standard temperature guns.[lxxv]

A local business, Defining Technologies, developed a contact tracing app that uses smart phone and global positioning system technologies to alert users and the Ministry of Health if someone has been in contact with someone known to have COVID. The app was donated to the National Task Force to assist with the national response, and, by May 2020, it was reported to have more than 5,000 users, perhaps limited by ownership of smartphones, which remains low. Concerns have also been raised about the compliance of this app with data privacy standards.[lxxvi]

Technology has been harnessed to increase access to health information and services in a variety of different ways. SMS has been used to distribute information on COVID by

telecommunication companies supporting the Ministry of Health.[lxxvii] Call centres are used as a health information source and a provider of triage and referral services, and several online search platforms also facilitate access to health service points.[lxxviii] An app called *Centers4Her* was created that provides sexual and reproductive health services through telecounselling and other methods, and tele-consultations with health workers are also being used to provide broader counselling and psychiatry services.[lxxix]

The Ministry of Health and Community Health Academy-Last Mile Health, in partnership with Makerere University, launched an e-learning platform to address the knowledge gap in the management of COVID-19. The platform houses a range of courses for health workers such as surveillance, case management guidelines and psychosocial support.[lxxx]

The US Embassy also developed an online toolkit that is designed to provide information and linkage to additional resources for the general public. In addition to providing information on the signs and symptoms of COVID, prevention and care, mask-wearing, social distancing, hand hygiene, and other health-related information, it also includes COVID-related audio and video public service announcements.[lxxxi]

Launched in September 2020, N*Gen, or Next Generation Television is a locally created television show focusing on Science, Technology, Engineering and Mathematics targeting 8-12 year-olds. Fronted by African women in science, episodes cover "educational segments delivered by charismatic teachers, exciting animations, fun quizzes and experiments, fitness and mindfulness exercises, as well as tips for healthy living."[lxxxii] The show has proved immensely popular in Uganda and across sub-Saharan Africa.

In health service delivery innovation, medicine delivery services have been developed that allow providers to take prescription refills to the client's home and mobile laboratory services similarly involve providers collecting samples from the client's home.[lxxxiii] In other outreach, volunteers and health professionals delivered supplies for individuals with Type 1 Diabetes throughout the period of mobility restrictions after gaining police permits that allow mobility over long distances.[lxxxiv]

In one article, several challenges with some technological innovations were identified, including the lack of documentation of telehealth consultations, language barriers in health content distributed via SMS in English only, cost of internet subscriptions and other internet-related costs, and the skills of health providers employed by telehealth services.[lxxxv] These challenges are not unique to Uganda but will require follow-up to ensure that accessibility and quality of health information and services can be maintained throughout the pandemic.

Accountability mechanisms for laws, policies and regulations

Arising from the government's unilateral response to designing the COVID response, there are growing concerns from civil society and the private sector for greater accountability.[lxxxvi] Some government officials indicate a lack of concern in this regard, noting that pre-existing accountability mechanisms are fit for purpose in the context of COVID and could be used by people if they needed them.[lxxxvii]

Civil society organisations have played an important role highlighting shortcomings in the government's response to try to pressure for change. Within the first few months of the pandemic, they had drawn attention to the preventable deaths and suffering of pregnant women

brought about by the transport ban and the challenges faced by people living with HIV in accessing treatment. They also carried out advocacy for the continuity of maternal and other essential health services.[lxxxviii] According to some key informants, it is the civil society that advocated for the rights of the vulnerable (such as pregnant women and people with chronic illnesses) who were facing great difficulties due to the lock down, which contributed to partial opening up of the economy.[lxxxix]

At the launch of the aforementioned National Community Engagement Strategy for COVID in October, the Prime Minister announced that "through the strategy, the government is handing over the responsibility of fighting COVID-19 to individuals, households and communities". It remains to be seen what effect this has, where accountability for the COVID response will lie and what mechanisms for complaint and redress will exist.[xc]

With regard to accountability for the implementation and enforcement of the government response, most key informants noted that there have been shortcomings, comprising over-zealous implementation at the beginning which contributed to a loss of trust in the government response followed by laxity in implementation months into the epidemic which contributed to lower adherence to preventive measures.[xci] Some government officials suggested that penalties for non-compliance should be harsher.[xcii] In terms of behaviour change, people complied well at first but over time became more complacent, with some understanding that, in some cases, this is because people have to continue earning a living.[xciii]

A key informant suggested that in terms of accountability, it is hard to fully blame policy makers and implementers because of the uncertainty through which COVID-19 unfolded. They reported that most decisions were based on the experiences of other countries, most of them developed countries like Europe, the US, and China with heavy death tolls witnessed on a daily basis.[xciv] However, another key informant suggested that the lack of civil society participation in government processes led to a lack of access to information, further inhibiting meaningful participation and preventing civil society from holding leaders accountable, especially in the context of implementation.[xcv] A key informant reported that private sector contributions to government efforts to fight the pandemic have been substantial – ambulances, cars, masks food and other supplies were donated to support communities. Yet the key informant noted there has been no transparency and no accountability in regards to the distribution of these resources.[xcvi]

The January 2021 presidential elections in Uganda saw the defeat of popular young opposition candidate Bobi Wine and the sixth successful term win for incumbent Yoweri Museveni. During campaigning, the national government issued guidelines requiring presidential candidates to address crowds of less than 200 people, using the pandemic as their rationale. Clashes between Ugandans and security forces resulted in loss of life, with nearly 50 Ugandans recorded dying in one day. Challenger Bobi Wine was arrested for violating the above guidelines. One key informant noted that while the opposition party may have had "200 or 300 people" at campaign rallies, the ruling party may have had 1000 people at their own rallies, often without masks or social distancing.[xcvii] According to the public The Monitor, enforcement of the COVID-19 election guidelines meant that the government was responsible for disappearances and extra-judicial killings and pointed to a "traceable direct correlation" with heightened militarization of political and civic spaces.[xcviii] The government was alleged to have undermined the democratic process through ballot stuffing, intimidation, and falsification of vote tallies in addition to leveraging anti-coronavirus measures to crackdown on opposition.[xcix]

Other key informants thought that efforts to protect people were instead politicized by opposition politicians.[c] Rather than the government giving an unfair advantage to the sitting party, one key informant representing an employers association instead suggested that they were protecting people from the virus.

Chapter 7. Immediate impacts of the response on COVID-19-related outcomes

While some government officials reported that the response had had its intended impact on COVID outcomes, others acknowledged challenges in this regard.[ci] In the first six months or so of the pandemic, Uganda was internationally lauded for a successful response but, in recent months, as community transmission has increased, concerns are rising about the ability to contain the pandemic if it continues spreading.

What works and does not work for vulnerable groups?

No publications were found that attempt to find a causal link between specific COVID response measures and COVID-related outcomes among different groups, but there is some evidence of what appears to be working well or, in some instances, not so well. A key informant reported that people with disabilities were not given due attention in the design and implementation of COVID-related measures resulting in insufficient protections for those in this population who might be particularly vulnerable.[cii] Although the financial implications of these measures are widely noted, there is rarely mention of the disproportionate impact of this on people who are already living in poverty. However, in June 2020, the UN predicted that national poverty rates could rise between approximately 2 and 8 percentage points, and, among wage earning households, by 16 percentage points. Furthermore, they noted that this would have a disproportionate impact on older persons, women, households with a high ratio of persons with specific needs in addition to those with refugee or migrant status and marginalized groups such as indigenous communities.[ciii] According to a key informant, crime rate could increase due to loss of livelihoods associated with the policy response.[49] Key informants spoke about the perceived variance in government responsiveness that appeared to shift according to population group and sense of urgency. An example of this can be seen in shelters that were opened quickly after groups complained about rising rates of GBV due to lockdown measures.[civ] Additional examples are presented below.

The level of risk of exposure to the coronavirus is not equally distributed among population groups. Figure 4 below shows the distribution of risk among different populations based on household exposure to seven risk factors: 1) levels of overcrowding; 2) population living with an older person (aged 60+); 3) population with no access to water in their dwelling or on their premises (yard/plot); 4) population that reports having to collect their own water; 5) population who have to share their sanitation facilities with others, or who lack any toilet facilities; 6) population who report not having hand washing facilities near their toilets; 7) population who have to collect fuel for cooking.[cv]

Figure 4. Number of risk factors to which people are exposed. Red indicates higher risk, yellow indicates moderate risk, and green indicates lower risk.[cvi]

		HH-EXPOSURE TO COVID19 RISK FACTORS					
		NONE		1-3 RISK FACTORS		4+ RISK FACTORS	
		COUNT	ROW N (%)	COUNT	ROW N %	COUNT	ROW N (%)
Uganda	National	869	2	13,012	31	27,587	67
Place of Residence	Rural	130	0	8,104	26	22,823	73
	Urban	739	7	4,888	47	4,764	46
Sub-region	Kampala	160	9	884	49	752	42
	Central1	374	7	2,727	50	2,324	43
	Central2	105	2	1,744	39	2,590	58
	Busoga	23	1	974	23	3,203	76
	Bukedi	19	1	322	15	1,842	84
	Bugishu	11	1	520	25	1,536	74
	Teso	2	0	381	18	1,784	82
	Karamoja	-	0	74	6	1,086	94
	Lango	27	1	619	24	1,891	75
	Acholi	-	0	256	14	1,536	86
	West Nile	12	0	539	18	2,523	82
	Bunyoro	35	1	794	32	1,677	67
	Toro	37	1	1,046	34	1,994	65
	Ankole	59	2	1,591	46	1,818	52
	Kigezi	7	0	523	34	1,030	66
Poverty status (UBOS)	Non-poor	868	3	11,902	36	20,099	61
	Poor	-	0	952	11	7,462	89
Poverty Group	Poor	4	0	3,027	16	16,433	84
	Rising	37	4	371	44	434	52
	Vulnerable	10	0	1,387	33	2,749	66
	Not poor	819	5	8,226	48	7,972	47

Source: UNHS 2016/17 (UBOS, 2018)

At the national level, almost 67% of the population has a high risk of exposure for more than four risk factors while rural areas have a higher risk exposure than urban (73% and 46% respectively). People living in poverty are also at higher risk than the non-poor, and certain sub-regions such as Karamoja, Acholi, Bukedi and West Nile are particularly affected. All of these data should help guide the national response, targeting most at risk populations.

The main population groups covered by the literature include rural populations, students, refugees, street children, sex workers and some indigenous populations. The impact of different elements of the response on these populations is outlined below.

Governance

Beyond detailing the governance structures that were very quickly put in place to guide the COVID response, very little has been published about governance of the COVID response in Uganda. However, one study noted that the centralized coordination of a national COVID-19 response could have contributed to challenges related to obtaining and distributing already produced supplies.[cvii] For example, a key informant noted that because the government did not partner with local councils to identify and distribute support to the most vulnerable, this support was often misappropriated and items like food and supplies were found to be resold in shops rather than given to the most vulnerable.[cviii] This has implications for future efforts around logistics and the potential decentralization of parts of the response.

Key informants were able to provide useful information about governance of the COVID response, with many noting the multi-sectoral nature of the government response at both national and district levels and highlighting that it is coordinated from the Prime Minister's office,

illustrating the priority it has been given.[cix] The broad engagement of development partners was also mentioned.[cx]

There were divided opinions among key informants as to the degree to which the response should be decentralized. While one participant raised concerns that the organisation at the district level might have had challenges with unclear membership and the surveillance teams getting overwhelmed by the work, most participants were supportive of a decentralized response, recognising the value of existing structures at district, local government and community levels.[cxi] It is generally agreed that response has become more decentralized over time but district level officials emphasised the need for additional efforts to bring the response to the grassroots level.[cxii]

Access to information

The Ministry of Health has held regular press conferences and used social media to share routine COVID updates, with the aim of reaching a wide audience while maintaining social distancing.[cxiii] This includes trying to counter misinformation being published about the pandemic, such as in May 2020 when the government issued a press release to counter the headline "Tobacco Offers Corona Cure Hope" that had appeared in a tabloid newspaper.[cxiv] Indeed, almost all of the key informants noted that, overall, the media did an excellent job educating the people about COVID including some media outlets providing contact information for government call centres where the general public could access information and advice.[cxv] However, in some instances they propagated myths and misconceptions.[cxvi]

In May, it was noticed the misinformation on COVID was rampant among the Pakwach population, spreading within the community and through social media. With obvious potential negative consequences on behaviours, the rumours included that the virus could not survive hot temperatures, consumption of alcohol would protect because of connections between alcoholic sanitizer and drinking alcohol, and face masks were a conspiracy to suffocate the population to death. In response, the COVID-19 task force in Pakwach assembled Village Health Teams to provide accurate health advice and dispel myths by reaching out to marketplaces through posters, informational materials, and megaphones, and creating sensitisation and awareness activities. This appears to have been successful at combating this misinformation.[cxvii]

A study published in May found that wireless media, including television, radio, and social media can be effective in spreading awareness and mass media and social media are the most used and preferred COVID-related information sources for healthcare providers and medical students.[cxviii] Another study noted that in rural communities, COVID-related information is primarily acquired through radio, highlighting the need to disseminate messages through different channels.[cxix]

However, by November, although 84% of people sampled across the country indicated that they were aware of COVID preventive measures, they also stated that they did not have enough information. Two studies highlighted populations who were not reached through these information dissemination efforts: urban refugees who face a language barrier and are therefore unable to access government directives and public health messages; and street children whose low literacy and social isolation impede their access to this information.[cxx] [cxxi] A key informant also highlighted very rural communities as having low levels of knowledge about COVID, how to prevent it, and what to do in case of a suspected infection.[cxxii]

Recognizing that sex workers might contribute to pandemic spread if they continued their work, an advertisement was broadcast starring a sex worker and "Uganda city socialite" so as to convince sex workers near the borders not to interact with truck drivers and spread COVID.[cxxiii] The impact of this has not been studied.

General suspicion of government initiatives was also reported to be an impediment with high levels of mistrust in COVID messages and a widely reported belief that COVID does not really exist but is just a political ploy. One of the challenges that faced the COVID campaign was mistrust of the government with any initiative from government being treated with suspicion; some people actually believed there was no COVID.[cxxiv]

Social distancing, quarantine, self-isolation measures and travel restrictions

Key informants underscored how the lockdown was unfeasible for many people, especially the urban poor and those working in the informal sector.[cxxv] Reliance on a daily wage to meet basic needs is simply incompatible with lockdown measures. Some participants noted that the impacts of movement restrictions on the economy, livelihoods and access to health care were largely unforeseen.[cxxvi] Other reported unforeseen impacts included increases in the costs of food, medicines and transportation.[cxxvii] These impacts have been disproportionately felt by the urban poor, many of whom have reportedly had to pack up and return to rural areas.[cxxviii] Low income earners struggled with the curfew imposed by lockdown measures as they had to travel extremely early in the day to ensure they were not on the road after curfew hours.[cxxix]

Government responsiveness to challenges arising from the pandemic response varied considerably based on the populations involved and the perceived urgency of the issue. For example, lockdown procedures made it difficult for some healthcare staff, particularly midwives, to reach their workplace.[cxxx] [cxxxi] Civil society requested that the government act on this to prevent the harassment of providers and the government responded with a sticker identification system so that HCP's can better identify themselves.[cxxxii] Although the government provided stickers to allow transport, this largely only benefited healthcare workers with cars who are the minority.[cxxxiii] Self-isolation and quarantine have also led to shortages of health workers as so many could not attend work.[cxxxiv]

The movement restrictions also impeded people living in rural areas from travelling to urban areas to access tertiary level health services. Barriers to access for health services were at the crux of several civil society calls for government to update their policies. A key informant noted that civil society was also behind a letter to the office of the prime minister to better respond to barriers in sexual and reproductive health services created by the lockdown.[cxxxv] Another key informant notes that local government task forces sometimes required lengthy approval processes for emergency situations in which patients needed to access facilities. Civil society petitions to clear obstacles to entering the facilities were, however, ultimately met with government approval.[cxxxvi]

The proliferation of gender-based violence (GBV) as a by-product of lockdown measures coincided with the shut-down of many government operated GBV shelters. A key informant noted that civil society petitioned the government to reopen shelters as women and girls could neither seek refuge at home nor at the now-closed shelters. The key informant reported that the government was responsive to the demands for shelters to be re-opened and that the government mobilized both food and services for survivors during the lockdown.[cxxxvii]

However, the government has not been responsive to all of the challenges created by their pandemic response measures. Many people reported that quarantine simply was not feasible for them due to food insecurity, meaning that they did not follow this directive.[cxxxviii] This is particularly acute for people working in the informal sector, many of whom survive on what they can earn daily, relying on this daily income to buy food for the household. In this situation, it was very difficult for people to comply with some of the restrictions that were imposed. Initially, the government did not cover the costs of quarantine, further exacerbating people's challenges to follow this directive, however after public outcry the government agreed to cover the entire cost.[cxxxix] One study found that faith groups have contributed to a lack of willingness to self-isolate or adopt other preventive behaviours such as wearing a face-mask, with implications for community transmission.[cxl]

50% of residents in the Greater Kampala Metropolitan Area live in informal settlements, comprising only 16% of total land, presenting challenges to compliance with measures such as physical distancing and self-isolation.[cxli]

While COVID testing for long-distance truck drivers at international points of entry has been widely lauded, the effectiveness of border closures has been questioned in some studies, with suggestions that this has not stopped refugees entering or other people travelling back and forth for resources, but it has discouraged COVID monitoring among these populations for fear of punishment.[cxlii] [cxliii]

Lockdowns also limited job opportunities for sex workers, which has led to them engaging in riskier behaviours that could contribute to community transmission.[cxliv] There have been only minimal, small-scale government efforts to provide support for sex workers who have lost income during the pandemic.

Overall, interview respondents representing government agencies and subsets of civil society such as employers' associations argued that the legal and policy measures implemented had their intended effect on COVID-related outcomes, including keeping mortality low, shielding the elderly from infection and improving health infrastructure. Members of NGOs paint a very different picture, indicating that measures did not protect all members of society from COVID-related outcomes and that the government response was particularly ineffective with regard to reaching vulnerable groups.

Handwashing practices

Challenges have been noted for refugees adhering to hygiene recommendations such as hand-washing or sanitizing. The United Nations and some non-governmental organisations have helped refugee communities by establishing handwashing and temperature screening facilities, distributing hygiene products, educating about hygiene, training health workers and running health facilities.[cxlv]

Street children are another population for whom it is difficult to adhere to recommendations regarding handwashing.[cxlvi] Although no literature was found documenting challenges in urban informal settlements, it is highly likely that residents in these areas also lack access to water, soap and hand sanitizers.

A reticence to use alcohol-based sanitizers has been documented among some Muslim populations, highlighting the need to promote alternative practices for this group.[cxlvii]

Despite these challenges, interview participants noted that improvements in hand hygiene due to COVID-related precautions might have contributed to a decrease in other communicable diseases - a positive side effect of this measure.[cxlviii]

Gaps in implementation

Some policies, guidelines and standard operating procedures could not be fully implemented, primarily due to lack of resources. Within the health system, this included testing kits, limited work force like staff, lack of hospital space for social distancing, and lack of PPEs for health workers. Limited capacity at the community level has impeded contact tracing, with a resulting impact on onward transmission within the community. There remains a critical gap in critical care capacity for treating people with severe COVID. More broadly it also included shortages and delays with funding, which impeded effectiveness.

A key informant noted that despite government promises to provide food and supplies, many people continued to complain to civil society that they are not able to access it or that it was simply not available. The informant reported that after civil society challenged these issues, marginal improvements were seen but that shortcomings remain.[cxlix]

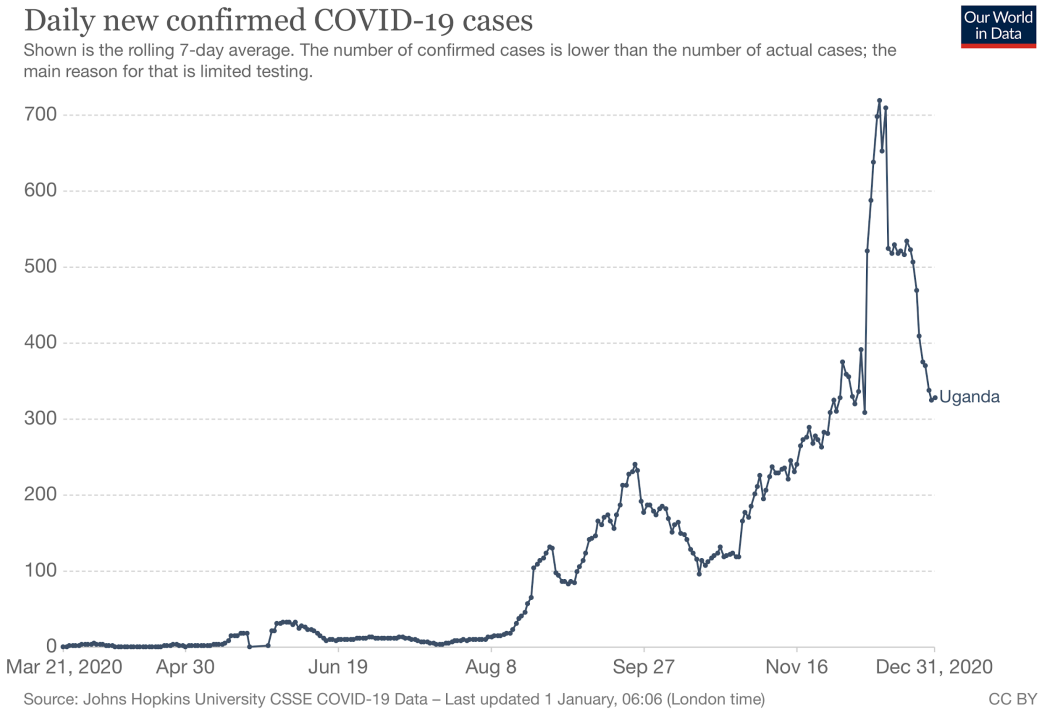
The government stimulus package, according to one key informant, was replete with barriers, which delayed implementation but it appears that this support is now available.[cl] In regards to employing people as a way of stimulus, another key informant observed that it is not very clear where this has been implemented and to what extent it has been effective, if at all.[cli]

Social protection measures taken by the government were met with some pushback from civil society, especially after requirements to access what a key informant refers to as “social justice grants” included the stipulation that individuals were at a minimum 80 years old in a country where the average life expectancy is 63 years.[clii] Civil society saw that distribution of these benefits had only been rolled out in some districts and filed a complaint against the government to change the age to 65 and up and to make them countrywide. Donors such as World Bank added their voice to this request. Per a key informant, the government ruled against the age provisions but agreed that countrywide distribution was necessary.[cliii]

Mapping the evolution of the pandemic in the context of this policy response

The COVID-19 case count in Uganda stayed extremely low until August where it rose sharply, peaking around September 27th before dipping again. It rose much more sharply in November, eventually reaching 700 new confirmed cases per day before dropping down (Figure 5).

Figure 5. Daily new confirmed COVID-19 cases (7-day rolling average)



At the more micro level, the government implemented two surveys to assess COVID infections in high risk areas such as border districts. Between the first survey in mid-April and the second one in August, there was a four-fold increase in prevalence; this trend is also reflected in the above figure. These surveys are not exactly comparable as geographic areas and populations included varied between the two rounds but these data do suggest an increase in prevalence over this period. In the second survey, market vendors comprised 40% of the positive cases, road law enforcers 27% and community households 20%.[cliv]

The government's swift initial response to COVID as well as its experience with previous pandemics are credited with maintaining infection rates low for the initial months of the pandemic. Based on this previous experience, the government was able to pinpoint factors that contribute to management of disease outbreaks across a range of areas, including infrastructure, capacity, institutional relationships and networks.[clv]

Several policy moves in late July could be tied to the initial peak in infections. For instance, on July 22, President Museveni eased and even lifted some restrictions and reduced curfew by two hours. Salons were allowed to open conditionally, some arcades and shopping centres were opened, and boda bodas (motorcycle taxis) were allowed to begin operations on July 27th. On August 10th, Uganda opened its borders for nationals stranded abroad. As cases were trending up, President Museveni allowed schools, tertiary colleges and universities to reopen for candidate classes and finalist students. Although the government had purposefully planned a phased re-opening to try to avoid a spike in infections, cases rose rapidly in the weeks following this move. In response to the fast-moving spread of infection during August, the Ugandan Ministry of Health transformed parts of a major national stadium into an auxiliary hospital. There does not appear to be data at the moment as to whether this move was a direct cause of success as new cases only trended down for a short period of time before rising considerably.

According to the World Health Organization, the most recent surge in illness in December comes from a lift of lockdown restrictions and consequent gatherings of small groups. The government of Uganda has blamed "citizen complacency" and violation of existing health protocols for the sharp rise in cases.[clvi]

People's need to keep working because they survive on daily wages, coupled with challenges faced by some workplaces, particularly in the informal sector, complying with COVID preventive measures is said to also be contributing to the disease spread. This includes people working in congested workplaces, inconsistent mask-wearing, and shortages of soap and water or hand sanitizers.[clvii]

Uptake of COVID-related services

While Uganda's response primarily depends on self-presentation to the health system for testing or disease management, this likely fails to capture populations who will not voluntarily present themselves to health services including people without proper documentation such as urban refugees, people perceived to be contravening any government policies and any other populations who are already afraid of contacting health providers.[clviii] This would include people who are non-compliant with public health regulations such as border closures and curfew.

Given the limited health system capacity to provide treatment for severe COVID, a lot of emphasis has been put on prevention, with community health workers considered the front line. However, community health workers have often been left to take the initiative to work out how best to carry out their work in the context of the pandemic. Lacking guidance from the central level, some have turned to local community leaders to help devise ways of promoting preventive measures as widely as possible while also protecting their own health.[clix] As a result, the effectiveness of community-based activities has varied widely across the country. Furthermore, as community transmission has increased, some community surveillance systems are reportedly unable to manage the volume of testing and contact tracing that is required.[clx]

Health worker and caregiver protection and support

By November 10, at least 1,070 health workers in Uganda were confirmed to have contracted COVID.[clxi] At least 17 front-line health workers have lost their lives to the pandemic.[clxii] Although some district hospital and lower-level facilities received PPE and infection prevention and control commodities that had been centrally procured, there are widespread reports of shortages and deficiencies in personal protective equipment (PPE) supply, with some reports that some health workers did not have access to basic PPE such as face masks and gloves.[clxiii clxiv clxv clxvi clxvii clxviii]According to our media analysis, reports show that health workers have been exposed to unsafe working conditions, low pay, long working hours, and violence.[clxix] Healthcare workers report being anxious, panicked, and have avoided patients with COVID-like symptoms due to concerns of being infected.[clxx clxxi clxxii] One study found that workers in non-COVID designated hospital departments are more at risk for COVID because infection prevention and control measures are inadequate.[clxxiii] In some places, UNICEF has supplied health facilities with personal protective equipment, detergents, handwashing stations and soap for infection prevention and control.[clxxiv]

Training for infection prevention and control has increased health worker knowledge and must be sustained, particularly in light of evolving guidelines.[clxxv] However, there are concerns that this training has not been sufficiently widespread, with health workers themselves expressing

concern at their lack of training.[clxxvi] Underscoring the need for more training, compliance with health measures by health workers was associated with COVID-specific training, having infection prevention and control guidelines, and perceived institutional support.[clxxvii]

With implications for their motivation and mental health, healthcare workers, particularly midwives, have reported increased workloads, frequent schedule changes, and exhaustion.[clxxviii]

Mental health has also been a challenge for some peer support workers in mental health due to the inability to meet in person and the threat to their livelihood caused by the lockdown. Peer support workers in mental health are not salaried employees and therefore have to resort to meal and transport allowances as well as other small income-generating activities in order to survive. While some peer support workers have been able to participate in weekly conference calls, mobile phones and cellular data are not affordable for others, meaning that they are unable to keep in touch with co-workers, leaving them socially isolated.[clxxix]

Although guidance for management of non-severe COVID is home-based care, there is no provision of PPE for caregivers, which, while understandable in the context of nationwide shortages, presents challenges, particularly in crowded households where true self-isolation might not be possible.

Reports of socioeconomic impacts on healthcare workers persist as well. A key informant reported that health care providers were not allocated allowances for lunches for months on end. The Ministry of Health's declaration that these allowances were "eaten by COVID-19" led to strikes among nurses, midwives, and health care providers.[clxxx]

Sustainability of positive measures and potential for change of negative measures

There is no mention of how measures might be sustained or adapted in any of the articles reviewed. Interview participants provided some insight into the government's plans moving forward: many of them stated that, recognising that the pandemic is unlikely to disappear any time soon, the government is planning to integrate COVID services into routine health services. One participant even situated the long-term response within Uganda's international commitment to Universal Health Coverage and the Sustainable Development Goals.

In terms of financial sustainability, some respondents highlighted the current moment as an opportunity to mobilise funding from development partners to invest in the COVID response in ways that would have a lasting impact on the national health infrastructure, such as equipping intensive care units and buying ambulances.[clxxxi] One respondent even highlighted the potential to use policies and guidelines as advocacy tools with which to approach development partners and request additional support.[clxxxii] One national level government official was clear that financial sustainability relies on the government, particularly the Ministry of Finance and the Prime Minister's office but, importantly, also with private sector engagement.[clxxxiii] Reminiscent of early HIV responses, some interview participants stressed the importance of continuing to coordinate the response from the Prime Minister's office to ensure prioritization and a multi-sectoral response.[clxxxiv]

Chapter 8. Other immediate impacts of the response

Given the breadth of the pandemic response, it has impacted not only COVID-related outcomes but other spheres of life too including health, nutrition, education and livelihoods. The impact of the COVID response on these other areas is explored below with particular attention to who benefits most and who is left behind.

Impact on different groups within society

The literature documenting the differential impact of the policy response focuses primarily on how women are most affected across all spheres.

There is documentation of pregnant women who have died because they had to walk long distances to get to hospitals due to the bans on public transport.[clxxxv] With regard to livelihoods, many of the industries most affected by shutdowns, including tourism, hospitality, horticulture, infant educators, petty traders, market vendors, roadside travellers, hawkers and cleaners are dominated by women.[clxxxvi] [clxxxvii] The government stated that food markets could only remain operational if workers socially distanced themselves and slept in the markets. Female vendors have an extra burden due to childcare and some resorted to either sleeping with their children in the market or leaving them at home for days.[clxxxviii] Some poor women have been unable to afford paying fees to sell in the market and have had to resort to hawking and roadside trading.[clxxxix] With school closures and isolation in homes, many women who already bore the brunt of unpaid domestic care work now have to attend to it as a full-time job.[cxc] For some this is happening alongside their full-time jobs which they are trying to fulfil from home.[cxci] Some of these chores are also falling to girls as they are not attending school, which limits their opportunities to study.[cxcii] Female refugees are also particularly affected with the additional burden of domestic responsibilities.[cxciii] Many of the interview participants recognised the impact of movement restrictions on pregnant women's access to health services but not a single one mentioned any of these gender-related factors exacerbating the pandemic's impact on women. One interview participant noted that women may have been left out of livelihood support programmes.[cxciv]

A disproportionate impact of all policy and mitigation measures on people of low socioeconomic status, particularly the urban poor many of whom work in the informal sector and rely on daily wages to meet their basic needs, has been documented both in the literature and from key informant interviews. While the government took additional measures to overcome some of these disproportionate impacts, these were selective (e.g. expanding the geographic access of social justice grants but not lowering the age threshold for access; tax benefits and debt relief for those in the formal sector but nothing to target those in the informal sector) and still insufficient to offset the hardships experienced.

In addition, key informants noted that the elderly were disproportionately affected as many of them depend on young people for care and support.[cxcv] Due to fear of infecting the elderly, the young people stopped visiting them, leaving the elderly with inadequate care with some developing depression.[cxcvi]

Stigmatized groups, including former COVID patients, refugees, migrants, travellers and other perceived potential carriers, have faced hostility including from community leaders and health workers, which has also exacerbated the negative impacts of policies.[cxcvii] [cxcviii]

Livelihoods

A recent study concluded that "the income losses from the crisis are severe, erasing poverty gains of the past 10 years, and reaching well beyond Kampala."[cxcix] The secondary effects of COVID measures and restrictions in the form of lockdowns, curfews, closures of businesses and markets, reduced business operating hours etc. have destroyed jobs, crippled incomes and devastated economies (AfDB, OECD & UNDP).[cc] The closure of businesses has had and will continue to have a severe effect on jobs which are dominated by women. There has also been a decrease in remittance from overseas, with everyone impacted by COVID worldwide. This economic contraction will impact livelihoods across the country for years to come. Interview participants generally agreed that the economic impacts of the pandemic at both individual and national levels have been severe, were largely unanticipated and were inadequately addressed by the government.

The immediate impacts of the lockdown on economic outcomes and well-being in rural Uganda indicated severe effects on households. In comparison to statistics from immediately before the lockdown, household income was shown to fall by 60%, with enterprise and wage income among the heaviest areas hit. Households reported purchasing 50% less food per capita, suggesting that they were drawing from their savings and increasing borrowing, and increasing their labour supply to farms and livestock. In the context of well-being, there was a 50% reported increase in the likelihood of missing a meal and a 25% decline in reported life satisfaction.[cci]

Women who are over-represented in the informal sector, sex workers, market vendors, hawkers, caterers etc., most of whom live hand to mouth and are the only breadwinners of their families have lost their only sources of income because they have been forced to stop working indefinitely.[ccii] Forty-six percent of workers employed in the informal sector are reported to have been pushed below the poverty line in the first months of the pandemic, with similar trends seen in the hospitality industry (43%) and trading and services (41%), all of which disproportionately affected women.[cciii] The number of households with no income earner rose by 41% in the first three weeks of the lockdown, with female-headed households, people living with disabilities and elderly people most affected.[cciv] The closure of Kaelerwe market resulted in lost livelihood for 10,000 vendors, 80% of whom are women and the vast majority of whom have no access to social safety nets.[ccv]

According to the Bureau of Labour Statistics, in Greater Kampala, over 87% of total employment is informal; during the pandemic, informal workers have experienced a high risk of loss of income and livelihood, as well as COVID infection due to trading with close person-to-person contact.[ccvi] In addition, a survey in April found that approximately 84% of the small and medium businesses in Kampala had reduced their workforce by more than half since the start of the pandemic.[ccvii] Additional layoffs, pay cuts, and terminations occurred as a result of cash flow shortages stemming from the lockdown.[ccviii] Some of these layoffs have been attributed to the ban on internal travel, which particularly affected small and medium sized businesses.[ccix]

Employees in the formal sectors that cannot work remotely or in businesses that have closed, scaled down or suspended operations have also not been spared. These aggravating factors have heightened urban livelihood vulnerabilities to the pandemic given already existing underlying high working poverty, youth unemployment, low savings, lack of alternative livelihoods and low social safety net coverage.[ccx] Urban refugees depend on both the informal market and small businesses, and have therefore been greatly affected by income insecurity and loss of livelihood.[ccxi]

A key informant explained that the employment act passed by the government protects formal sector workers over the informal sector and that, in conjunction with the lack of a meaningful stimulus package, the lack of attention paid to the informal sector has exacerbated inequalities.[ccxii] Another civil society key informant noted that stimulus money put into the Ugandan development bank has not found its way to individuals or associations formed to apply for government funds, with applications being met with shifting requirements or a lack of information on how to access funds.[ccxiii] The informal sector in particular could not access funds from the stimulus package as in some cases collateral may have been required.

Systemic barriers such as limited access to start-up or scale-up capital have been identified as persisting limits to job creation.[ccxiv] Individuals have pointed to the need for collaborative action between government, development partners and the private sector to address these barriers. In August of 2020, President Museveni, along with UNDP, Stanbic Bank Uganda and Stanbic Business Incubator launched Youth4Biz in an attempt to reduce youth unemployment. The project was designed to create 20,000 jobs for youth and provide capacity building for an additional 50,000 youth, and has already issued three rounds of calls for proposals.[ccxv]

Several individuals moved out of urban areas at the beginning of the pandemic and have experienced dwindling household resources as income-generating activities are more limited.[ccxvi] Some families have been forced to reduce expenditure on essential health items, including food and medicine.[ccxvii] [ccxviii]

There are reports that some sex workers have been driven to extreme poverty. The NGOs who usually provide free service are unable to reach them because most sex workers have had to move their work away from their usual stations.[ccxix]

The suspension of all fishing activities has affected people reliant on this industry for their livelihood, many of whom have subsequently been forcefully relocated, causing the creation of informal settlements.[ccxx] As will be further explored below, farmers have also faced logistical challenges in the production, distribution and sale of their products that has limited their income.[ccxxi] [ccxxii]Approximately 75% of Uganda's population is involved with agriculture and close to 70% are smallholder farmers cultivated less than five hectares of land who derive their livelihood from agriculture. The COVID response measures have impacted the livelihoods of all of these people.

Out of a need to generate income, some vehicle owners have been taking advantage of public transport bans and charging high sums of money to transport passengers even as this meant breaking social distancing protocols thereby entailing some risk of infection.[ccxxiii]

Health: Biomedical and Public Health Response

Gender-based violence

Women have been affected by the spike in cases of domestic violence that has occurred since the lock-down was instituted.[ccxxiv] Between March 30 and April 28, 2020 alone 3,280 cases of gender-based violence were reported to the Police. Anger and frustration due to loss of income has increased strain on relationships and aggravated emotional and physical violence.[ccxxv] [ccxxvi] Due to the isolation regulations being enforced as well as widespread loss of employment, people are spending more time at home and some women, particularly those who lack financial independence, may be unable to escape abusive partners, leaving them at risk of being severely

harmed.[ccxxvii] [ccxxviii] [ccxxix] Certain districts, including Wakiso, are more impacted than others.[ccxxx] In these situations, access to recourse with the authorities or seeking shelter elsewhere have been difficult at times due to the movement restrictions.[ccxxxi] [ccxxxii]

Walking to work, especially after curfew, poses a risk of sexual and gender-based violence.[ccxxxiii] Furthermore, sex workers have experienced increased violence and have been forced to engage in more risky behaviours as a result of the pandemic.[ccxxxiv] Informal trade closures have led to female refugees engaging in transactional sex to support their families.[ccxxxv] This same trend has been reported generally among younger people.[ccxxxvi]

In the five months of lockdown, Uganda registered more than 21,000 cases of child abuse.[ccxxxvii] A recent survey found that 60% of people said they have observed an increase in sexual violence against children since lockdown began, and 80% reported that parents are using violence against children.[ccxxxviii]

Child protection

In addition to the rise in violence and abuse against children since the outbreak began, other child protection concerns include increasing poverty and hunger, and more children being forced into harmful practices such as child labour and child marriage.[ccxxxix]

The economic impact of the epidemic, coupled with school closures and gaps in government support has led to a sharp rise in child labour. The Human Rights Watch and Initiative for Social and Economic Rights (ISER) point to a growing need for children to assist families in labour as an inevitable consequence of the pandemic, especially after parents and family members have lost jobs and income due to illness and lockdowns. A by-product of this shift is a simultaneous rise in hazardous working conditions and the presence of violence, harassment, and pay theft.[ccxl]

Girls from families of low socioeconomic status – who are being pushed further into poverty during lockdown – are increasingly trading sex for money, food and even sanitary towels.[ccxli] Early marriages for girls have increased. In some regions, this is because girls are no longer in school. In other regions, the taboos of defilement and teenage pregnancy (which has increased during the pandemic) have been cited as reasons that parents might marry off a daughter to their abuser.[ccxlii] Key informants reported increased teenage pregnancies and girls increasingly dropping out of school.[49]

One study found that approximately half of street children surveyed have been exposed to violence. In addition, the challenges associated with being on the streets during the pandemic has forced some street children to go back to their abusive families.[ccxliii]

Maternal health

The government of Uganda banned transportation, including private transport to health facilities, which is the primary means for women to reach facilities for childbirth, as public ambulances are scarce. An interview participant noted that before these restrictions were lifted they were beginning to see an increase in maternal morbidity and mortality.[ccxliv] A coalition of organizations, including WRA Uganda, urged the government to reconsider its earlier stance and ensure that women have a way to access facilities for emergency services.[ccxlv] As a result, President Museveni issued a directive on April 20 that pregnant women will no longer be banned from using transport to seek health services during the lockdown. However, although the government promised exceptions for movement restrictions, these exceptions were insufficient or not implemented and it still remained very difficult for women to travel and access services. Some

reports indicate that some mothers delivered in the regional district commissioners offices as they were waiting for transport authorization.[ccxlvi]

Mental health

The mental health implications of COVID-19 lockdowns are far ranging and affect many vulnerable populations. Social support networks for urban refugees have eroded while food insecurity, confinement, and social restrictions have caused anxiety, stress, exclusion and other psychosocial problems.[ccxlvii] Food insecurity and the secondary effects of lockdowns have bred anxiety and stress among other problems. In response, the government has agreed to send task forces to villages around Uganda to check on the wellness of households.[ccxlviii]

The inability to attend social gatherings has caused feelings of fear, uncertainty, and stress, particularly for salaried workers.[ccxlix] The lack of social interaction disproportionately affects girls who are less likely than boys to maintain social contact because of boys' greater access to mobile phones and the ability to meet in person at community gatherings.[ccl]

The suicide rate among men, including a disproportionate number of male teachers, has gone up during the pandemic, likely due to school closures which led to suspension of monthly pay.[ccli]

People with disabilities

People with disabilities have been heavily impacted by barriers to health access and were often met with violence by authority.[cclii] They have faced challenges accessing health centres and markets to seek medical attention and basic items for their families. Some good examples exist of trying to ensure that people with disabilities could be reached with preventive measures, such as the inclusion of representatives from the National Union for Disabled Persons Uganda in district level meetings in Lira.[ccliii] The government implemented a Disability Grant that in addition to persons with disabilities included children and youth. The intention of the grant was to provide revolving funds. According to the Ministry of Gender, Labour, and Social Development there have been favourable impacts however media reports that, without support from the government or others, people with disabilities are being left behind at a time when they need access to services and support more than ever.[ccliv]

Food security

Prior to the start of the pandemic, in early 2020, Uganda experienced a locust invasion that affected agricultural production. Any subsequent impact of the pandemic and the response to it on food security was layered on top of this pre-existing vulnerability. In the context of the pandemic, vulnerable populations living in urban areas were disproportionately impacted by policies that limited the distribution of food, closed large swaths of the informal economy, and drove up food prices. Additionally, populations such as refugees were left out of food distribution programs set up in response to the pandemic that only provided for Ugandan nationals. Civil society pushback on national identity card requirements for food distribution led to a government shift in policy and the inclusion of refugees in these programs.[cclv]

The lockdown has amplified existing food crises.[cclvi] It has affected the food supply chain at all stages and income shocks have further amplified food insecurity with increased prices, food shortages and the inability of supply chains to adapt.[cclvii] These changes disproportionately impact socioeconomically vulnerable households, particularly those who do not grow their own food.[cclviii]

The data are stark, coming from multiple surveys that all found a concerning situation. One survey found that, compared to a 'normal period' there were significant increases in the number of respondents during COVID who reduced the amount of food eaten (30 percentage points), were unable to eat healthy and nutritious food (35 percentage points), consumed less diverse diets (45 percentage points), or were worried about not having enough food (50 percentage points).[cclix] Another survey found that 17% of Ugandans living in Kampala are facing acute food insecurity, with six in ten families having sold productive assets such as land and livestock and begged or turned to illegal activities to find food and two in ten urban households not having enough food to eat.[cclx] Some young people have borrowed money, going into debt, to buy food and other essentials.[cclxi] A third analysis found that the lockdown pushed Ugandans in nine urban areas to crisis levels of food insecurity or worse for months leading to August, with urban areas in Gulu, Jinja and Kasese most affected: nearly one in three people reportedly struggled to find nutritious food on a regular basis.[cclxii] This was attributed to the loss of livelihoods in the informal sector, tourism, the travel and events industry and the education sector as well as reduced remittances and commercial networks due to the border closures. A decrease in the amount and variety of food consumed in urban slums has also been documented.[cclxiii] Millions of children are no longer receiving school meals due to the schools' closure.[cclxiv] [cclxv]

Transport restrictions have also had a negative impact on food security among the peri-urban and rural poor.[cclxvi] The effect is particularly pronounced for people living along the border with the DRC: these borders are normally open and fluid, but with the restrictions people were unable to reach their farms on either side where they work.[cclxvii]

Ugandans are worried about insufficient food, are unable to eat healthy food, are eating reduced portions, and now consume limited food varieties.[cclxviii] Other groups noted to have experienced increased food insecurity include street children, indigenous communities, people with disabilities, the elderly, sex workers and people with pre-existing chronic health conditions such as HIV or diabetes.[cclxix] [cclxx] [cclxxi] [cclxxii] The government has provided targeted food donations for sex workers in one district but these efforts are limited in impact and do not completely address their challenges.[cclxxiii] Diabetes associations have provided food and other support to families that have a child with Type 1 Diabetes in some areas.[cclxxiv]

In March 2020, the government recognized the severe negative impacts that the lockdown would have on household earnings, especially the urban poor and requested US$15 million to provide food for two million poor people living in urban centres.[cclxxv] This intervention was widely cited by interview participants as pro-poor and an important response to the unforeseen impact on food security caused by COVID-related restrictions.[cclxxvi] The Uganda Coronavirus Response Team has directed food distribution to the urban poor but has only targeted central urban groups living in and near Kampala.[cclxxvii] [cclxxviii] [cclxxix] In particular, women, lactating mothers, the elderly, the sick, and small business owners have benefited from this move.[cclxxx] However, urban refugees have been left out because current food distribution programs require individuals to present national identification cards that refugees do not possess.[cclxxxi] [cclxxxii] Rural populations are also excluded from food distribution programs and can also no longer access their gardens due to movement restrictions.[cclxxxiii]

Current food aid has been found to be insufficient in amount and variety to address the food insecurity crisis.[cclxxxiv] The approximation that 1.5 million people would need food assistance was an underestimation.[cclxxxv] Early in the pandemic, the World Food Programme (WFP) cut rations for refugees in the settlements by 30% due to funding shortfalls.[cclxxxvi] The government stated that they would provide food relief to vulnerable workers who have been the most impacted by the lockdown but this is yet to be seen.[cclxxxvii]

Recognising the impact of the pandemic on food security including on the ability to produce, process, distribute, obtain and consume healthy and nutritious foods, in May 2020, the government published nutritional guidance for the general population in the context of COVID. This guidance explains what a healthy diet is and why it is important, but it provides no insight into how people might overcome the challenges to adopting or maintaining a healthy diet in the context of the pandemic.[cclxxxviii]

Farmers' logistical challenges have contributed to food insecurity. Although the government expressly gave permission to farm workers to travel, they are often denied access to their farms by security personnel, they have struggled to transport their produce to markets, and many markets have closed due to social distancing procedures.[cclxxxix] [ccxc] The risk is not only that immediate rural production, food deliveries, exports, employment and incomes will collapse, but also that planting for next year's crops will be disrupted, with local businesses and supply chains likely more affected than international ones.[ccxci] Disruptions to food supply chains, caused primarily by travel restrictions and social distancing rules that slowed the loading of produce, are likely to have a sustained impact on the availability of farm inputs and labour, post-harvest losses, and thus farmers' ability to buy inputs for next year's planting.[ccxcii] The poultry, cattle and fishing industries have been similarly affected.

Education

School closures in Uganda, in response to COVID-19 have resulted in about 15 million children being out-of-school. The government has been supporting alternative learning using mass media for distance learning, mostly through community based radio as radio is the most commonly used media in Uganda (87% of households have a working radio). Radio broadcasts with short messages or communal reading are common. A key informant noted that the government promised to distribute radios in communities after complaints that learning materials were not reaching the students in time, but, even though money was disbursed for this, the radios were never distributed and nobody knows where the money went.[ccxciii] The government has set up book banks and reading clubs so that children can keep reading, and it has supported the establishment of play groups to encourage stimulating activities, interactions and creativity in safe and healthy environments.[ccxciv]

However, with schools closed, many children are still not benefiting from home learning and risk being left behind: 80% of Uganda's school-age children and youth living in rural areas characterised by a lack of basic living resources and limited educational and supporting infrastructure.[ccxcv] Location and affordability are large factors in determining ability to access online learning resources (U28, preprint, October).[ccxcvi] The rural-urban gap in participation in any education or learning activities has widened over the course of the pandemic. The most frequent reasons for children not participating in any education or learning activities were lack of learning materials, low student interest, no access to radio/tv and increased household chores. Only 16 percent of children did not face any problem while learning at home, while many children faced multiple difficulties, especially those in rural areas.[ccxcvii] Children with disabilities such as visual impairments are also not reached by these efforts.[ccxcviii]

The lost time in education will affect the poorest and most vulnerable the most. Given that education is key to reducing vulnerability to poverty, increasing household resilience to shock and improving health, this disadvantage will become compounded over time. The likelihood of vulnerable children continuing to access education or even to return to schools once they reopen is thought to be low.[ccxcix] Many students are concerned about the financial viability of returning

to education when this becomes possible. This includes concerns about exam payments, the cost of repeating the year and whether loss of income during the pandemic could affect future affordability of education.[ccc] In addition the increases in child sexual abuse, early pregnancy and child marriages create challenges for students, particularly girls, returning to school.[ccci] [cccii]

Closure of vocational training institutes has impacted students who were hoping to enter these fields.[ccciii]

As schools reopen, a key informant noted that institutions are greatly increasing their fees, including adding examination fees which has led to some students being unable to afford to take exams.[ccciv]

Sustainability of the response

It is clearly unsustainable to maintain in place measures that limit access to health services, increase food insecurity and impede education. There has already been gradual easing of many of these restrictions, with a view to minimising the negative impact they have had. Of concern is the long-term nature of the food insecurity that has arisen as it is likely that food relief will be needed for a long time on a much larger scale than has been provided to date. The availability of adequate funding to support the broad response that will be needed long into the future is unclear; some interview participants suggested that a special COVID fund should be created, to which taxes would contribute along with support from bilateral and multilateral partners.

Policy responses promoting structural changes

Building on the pre-existing village health team infrastructure, village COVID-19 task forces have been created to reach out to all households to find out how the people are. This strategy is designed to not only tackle COVID-19, but also other health-related issues which will help people improve their health by seeking medical care.[cccv] It will be important that these efforts be evaluated.

At the national and district levels, it might be hoped that multi-sectoral committees formed to address COVID might remain active with an expanded remit to promote multi-sectoral across other relevant issues.

Media messages to promote pandemic guidelines

The media, including newspapers, television, radio and social media, have played a critical role in disseminating information relating to COVID. The government used a wide range of media to disseminate public health messaging which was generally seen to be transparent, consistent and inclusive. In addition, the president held periodic press briefings to manage public perception and deliver situation reports about the pandemic.[cccvi]

Health workers have used social media and radio broadcasts by the Uganda Cancer Institute to issue advice and inform cancer patients of programs.[cccvii]

Impact on access to other services

Health

At the outset of the pandemic, two primary factors negatively impacted access to health services. First was the need to decongest facilities for fear of an influx of COVID patients, which contributed to declining access to healthcare. Maternal and newborn health outpatient and community health services were suspended and priority given to patients at high risk.[cccviii] Secondly, the movement restrictions impeded access to essential health services, which is further expanded on in the next sub-section.[cccix]

As a result, between February and March 2020 there was a decline in individuals testing for HIV (16%), linkage to HIV care (20%), antenatal care (ANC) visits, (14%), and facility-based deliveries (6%), and an increase in deliveries by Caesarean section (4%), neonatal deaths (7%), perinatal deaths (9%), maternal deaths (43%), and GBV cases (6%).[cccx] Routine health system data confirm that most maternal health indicators (e.g. pregnant women with at least 1 ANC visit, pregnant women with 4 ANC visits, health facility deliveries) worsened in the first two or three months of the pandemic but also show that they had recovered by August 2020 (the most recent data available). The number of women newly diagnosed with HIV during pregnancy and the number then linked to care are lower than in previous years.[cccxi]

Vitamin A supplementation to children under five suffered because biannual campaigns are run in April and October every year but the April 2020 campaign could not be carried out. Between May and August 2020, monthly routine Vitamin A supplementation exceeded that during the same period in 2019.[cccxii]

Sexual and reproductive health services were initially not listed as essential, impeding access for women of reproductive age who are seeking services such as contraception or abortions.[cccxiii] Patients with chronic illnesses such as diabetes, HIV, heart conditions, cancer and prostate issues were advised to wait or consult online.[cccxiv] In addition, certain conditions (diabetic patients, people living with HIV, sickle cell anaemia patients, patients with cardiac conditions) were not designated as an emergency, with negative impact on access to services.[cccxv] [cccxvi] No HPV vaccinations were given to adolescents and women during lockdown. While the Family Health Days program had previously increased access to immunisations for vaccines, this program was stopped due to the pandemic.[cccxvii]

In April 2020, cognisant of the disruption to routine health services and the heavy disease burden attributed to conditions other than COVID, a coordination mechanism was established and the Ministry of Health published the *Guidelines for Continuity of Essential Services during the COVID-19 Outbreak.*[cccxviii] [cccxix] These guidelines outline which health services can either be continued or discontinued depending on three transmission scenarios. Successes and challenges related to implementation of the guidelines will need to be assessed to inform future health services provision.[cccxx]

While these guidelines were welcome, health resources, including infrastructure, health workers and financing, continued to be reallocated from regular services to accommodate the COVID response. For example, at the Hoima Referral Hospital, a coronavirus treatment unit displaced a mental health department and its patients.[cccxxi]

Clinic closures during lockdown have prevented the linkage to care for people recently diagnosed with HIV, and concerns about compromised quality of HIV services has left clients unsure about which clinics they should attend.[cccxxii] [cccxxiii] HIV clients have reported that lack of

transportation, police violence, and insufficient money have constituted barriers to accessing care during the pandemic.[cccxxiv] While some clients have stated that adherence has improved as they are at home so can focus on this, others have noted struggles with adherence due to food insecurity and stigma from family members.[cccxxv] Recognising the difficulties that some people living with HIV faced in accessing their medication, some facilities made arrangements with partner NGOs to have the drugs delivered to the patients at the community.[cccxxvi]

Access to medication has been a challenge for patients with chronic conditions who rely on medication for survival and quality of life. Some could not access medication due to movement restrictions; others could no longer afford it due to lost livelihoods.[cccxxvii]

Cancer screening and outreach programs were suspended and patient capacity in clinics was limited. Health workers who previously delivered cancer services were transferred to work in COVID facilities.[cccxxviii] All of this disrupted sensitization campaigns on screening as well as access to treatment services. This has a negative impact on the ability to detect cancer early, loss to follow up of patients after diagnosis, delays in accessing care post-diagnosis, adherence to treatment schedules, and survival rates for patients. It has also negatively impacted patients' mental health with increased anxiety due to lack of access to these services.[cccxxix]

Restricted access to healthcare disproportionately impacts women, as they have a higher HIV burden and also predominantly care for the sick.[cccxxx]

Individuals fear catching COVID at health facilities, which has reduced demand for services including antenatal care and HIV care and treatment services.[cccxxxi] [cccxxxii] [cccxxxiii] [cccxxxiv] [cccxxxv]

Access to justice

The closure of courts and the prioritization of criminal matters has impacted women who want to file charges related to sexual and gender based violence, which are often considered civil matters and have therefore been deprioritized.[cccxxxvi] A key informant also noted that lawyers were not considered to be essential workers, which has limited access to justice across multiple scenarios. For example, if there was an urgent application, lawyers were less willing to take on the case. The state was arresting people for violating regulations but lawyers were not permitted to be move around during lockdown.[cccxxxvii] Another key informant pointed to a lack of magistrate courts close to communities as a barrier. Instead courts require transport and neither the lockdown measures nor the budget reflect this reality.[cccxxxviii]

Impact of mobility restrictions on access to services

The transportation ban included private transport to health facilities, leading to difficulties for both women and healthcare providers to access healthcare facilities.[cccxxxix] Delays have been reported in seeking care, delays in reaching the appropriate facility, and in receiving care at facilities due to cessation of public transport.[cccxl] [cccxli] Telephone communication and telemedicine have been promoted as ways to ensure continuity of care but telemedicine is poorly developed in more income constrained settings and available primarily to people of higher socioeconomic status.[cccxlii]

Restrictions on movement also meant people were unable to access health services. For example, several people living with HIV were unable to get vital life-saving drugs because they could not travel to clinics. In addition, initiatives to test vulnerable groups, including workplace testing, mobile mass testing campaigns, self-testing among fishermen, sex workers, and male

partners of women in antenatal care, have all been disrupted.[cccxliii] Border closures and restriction of movement may have disrupted the antiretroviral therapy (ART) supply chain, with potential implications for treatment adherence.[cccxliv] For fear of HIV-related stigma, some HIV patients have reported being afraid to disclose their health status in order to obtain special permission to travel and access HIV health services.[cccxlv] In order to cope with movement restrictions impacting HIV care, patients have sent taxis to obtain drug refills or have moved in with relatives closer to the clinic.[cccxlvi] Some facilities made arrangements with the implementing partners to have the HIV drugs delivered to the patients in the community.[cccxlvii]

The increased cost of transport also amplifies inequalities in health care. Due to movement restrictions, the government promised to provide alternative transport for health emergencies. However, access is limited given the large district sizes (geographically and population-wise). It was difficult to seek out these vehicles to ask for permission to use or access transport. Many elderly and chronically ill have missed their routine medical treatment as a result of the lockdown.[cccxlviii] Pregnant women have not been adequately protected: they too have to seek permission from their Resident District Commissioner to access medical assistance. This is not feasible in an emergency and puts both mother and child at risk.[cccxlix] The curfew has also limited women's ability to access delivery services at night.

The lockdown has been attributed as the cause of the great increase in abortion cases (in some cases by 100%), as it impeded access to family planning and reproductive health information and services. Health workers have reported that the number of pregnant women reporting with incomplete abortions, or requesting an abortion, peaked in June, exactly three months after the lockdown was imposed.[cccl]

While civil society organisations (CSOs) provide many of Uganda's reproductive and psychosocial services, they were not designated as an essential service. CSOs did not receive special travel permits, and therefore access to these services was limited.[cccli]

Government dilemmas: resource allocation and prioritization

Key informants allude to the government's dilemma early in the pandemic, in prioritizing between measures believed to control the spread of infections and balancing with the resulting negative economic outcomes. Initially, interventions to prevent the spread of infection took centre stage, however as the negative effects on the social and economic aspects were experienced and with advocacy from the civil society, the government relaxed those interventions.[ccclii] Thus the socio-economic effects got more recognition. A key informant noted that there was positive feedback from the government, employers, and labour unions in terms of the response to economic submissions, noting that requests were made on the issue of deferment of tax, deferment of social security, and stimulus packages for employers who were having difficulties, flexibility to allow businesses to operate on a reduced scale; all of which were met with support.[ccliii] However, the shortcomings of all of these measures have already been noted.

Key informants also reported the government and development partners diverting health resources (including funding, health workers and supplies) away from other health services to support the COVID response.[ccliv]

Social protection or cash transfer programmes

A World Bank report early in the pandemic indicated that the coverage and design of social protection programs were insufficient to meaningfully address the range and scope of vulnerabilities to shocks in Uganda. It noted that only 3% of the population was being reached with any direct income support and recommended prioritizing future social protection interventions in areas with the highest levels of vulnerability and risk.[ccclv] A key informant reports that the government responded to civil society demands for social protection positively, however implementation challenges remained surrounding access to these funds and many individuals in need had no access at all.[ccclvi]

The Social Assistance Grants for Empowerment (SAGE) program pre-dates COVID and was designed as a cash transfer for senior citizens. In early March, prior to the pandemic, the President announced the national scale-up of the program. Pandemic restrictions then meant that the distribution mechanism had to be re-visited, which led to severe delays in payments with payments recommencing in June. This Senior Citizen Grant is UGX25,000 per month and was provided in arrears so as to mitigate the negative impacts of the pandemic.[ccclvii] To access these grants, people must present a national identification document, which can be a challenge for some.[ccclviii]

The GirlsEmpoweringGirls Program, implemented by Kampala City Council Authority (KCCA), has three components: empowering girls through a network of peer mentors; engaging them through education, training, and referrals to support services; and enabling them to pursue better opportunities for their future through a small cash transfer.[ccclix] While the program has continued through the pandemic, its reach and impact are unclear.

In April, once the lockdown was instituted, the government began providing food distribution to vulnerable people affected by the pandemic in Kampala, Wakiso and Mukono districts. Within the first 37 days of this intervention the government had distributed food to 1,385,000 people covering 372,397 households but the program has since been discontinued.[ccclx] The reasons for discontinuation are unclear but might include logistical challenges, increasing food prices and criticisms about the very small geographic coverage of the program. Questions have been raised about the decision to provide food relief rather than cash transfers to the urban poor, which have been promoted by many global agencies and countries as the most effective mechanism to expand access to health and other social services.[ccclxi] In another effort to support food security, the government reported that farmers would be supported to access high quality agricultural inputs, seeds and fertilizers using e-vouchers. A survey in 2019 found that, prior to the pandemic, 49% of farmers surveyed reported using the e-Voucher system.[ccclxii] The World Bank $300 million contribution to Uganda's pandemic response included some funding for this system.[ccclxiii] Even a key informant working in the field of agriculture did not feel well positioned to comment on the extent to which this has been implemented.

Another scheme that pre-dates the pandemic is the Ministry of Gender Labour and Social Development's National Special Grant for Persons with Disabilities. Although the amounts disbursed are unclear, the Ministry decided to make payments during the pandemic. That said, one study found that social protection programs have not been accessible for people with disabilities because they fall into a category that requires special emotional, financial, and social assistance and they depend on a third person to access benefits, which may have impeded access during this time.[ccclxiv]

Uninterrupted access to essential utilities like electricity, water and sanitation services has been guaranteed through subsidies, and tax exemption extended to supplies and equipment used in treatment of COVID-19.[cccLxv]

The US government had reportedly planned a $10 million direct cash transfer programme to support people affected by the pandemic but this plan was dropped in October, ostensibly due to obstacles put in place by the Ugandan government.[cccLxvi]

A key informant notes that after civil society pressured government for a social protection programme and stimulus package the government responded, however the administration of the programmes was problematic. Instead of consulting with civil society on modalities of implementation, government was seen to have mostly focused their efforts on operating through the Ugandan Development Bank. The key informant states that there is a disconnect between the Ugandan Development Bank and small and medium enterprises in dire need of the funds – especially those who may not be able to offer collateral.[cccLxvii]

Overall, there have been very few cash transfer or social protection programmes put in place in response to COVID. Those that have been implemented are all pre-existing programmes targeted to very specific populations. Only a tiny proportion of the population has benefitted.

Addressing police brutality and other human rights violations in the COVID response

During the lockdown, beatings, canings and killings by security officials tasked with enforcing lockdown restrictions were reported across the country. This violence has decreased the trust of young people in public authorities.[cccLxviii] After incidents where security personnel beat up women sleeping in the market, Uganda People's Defence Force officials apologized publicly but no further actions were taken.[cccLxix] The Uganda Human Rights Commission in West Nile issued a warning to the police to desist from violence in enforcing the night curfew.[cccLxx]

A number of people were arrested and imprisoned for violating night curfews and social distancing rules (AfDB, OECD & UNDP, 2016). If the aim of curfews and social distancing is to prevent disease transmission, imprisoning people who do not comply risks having the opposite effect.

Some have accused the government of using COVID-related regulations to impose the strong arm of force on its citizens.[cccLxxi] Police charged 20 LGBT people with disobeying rules on physical distancing and risking the spread of coronavirus, in what campaigners say is a clear case of authorities abusing newly imposed restrictions to target sexual minorities.[cccLxxii] Campaigners say enforcement measures to prevent COVID-19 have led to a surge in violations of human rights and knock-on effects on other health services.

While several articles and key informants mentioned the issue of police brutality, none stated how policy makers are addressing this issue or how law enforcement has been explicitly trained to handle people.

Some key informants felt it was important to enforce policies and guidelines even if it meant penalties for the offenders or some degree of infringing on the rights to control the pandemic.[cccLxxiii] There was no discussion of how such penalties would undoubtedly be disproportionately imposed on vulnerable populations, particularly those of low socioeconomic status, thus further exacerbating inequalities without necessarily supporting public health objectives. Other key informants felt rather than imposing penalties it is best to do more of behaviour change communication to have individuals take responsibility.[cccLxxiv]

Chapter 9. Longer -term changes – structural, institutional and personal – foreshadowed by the COVID-19 response

Very little was published about longer-term changes arising from the COVID response, nor did this come out strongly in the interviews. The focus to date, given the urgency of the situation, appears to have been on the immediate impacts.

According to a UN Socioeconomic Impact Report on COVID-19 in Uganda, there has been a reduction in progress towards several Sustainable Development Goals (SDGs) including SDG 1 (no poverty), SDG 8 (decent work and economic growth) and SDG 10 (reducing inequalities). The report states that nearly 60% of informal micro, small, and medium enterprises (MSMEs) are expected to go out of business, 46% of workers have been pushed below the poverty line (with the informal sector, hospitality, trading and services most affected), 1.9 million people fell into poverty after the first eight weeks of national lockdown (from May to June 2020), poverty is expected to increase between 2-8 percent, and tourism is projected to lose nearly USD$5 billion over the next 5 years.[ccclxxv] The Uganda Revenue Authority estimates that revenue losses totalled nearly USD$170m in the January to March 2020 quarter alone.[ccclxxvi]

Impact on structures and systems of power and governance

The government leveraged existing structures at community and grassroots level in their COVID response. The health system strengthening by increasing the capacity of facilities to care for the very sick by availing intensive care units and oxygen will positively impact the quality of care.[ccclxxvii] There have also been improved hand washing infrastructure in different points.[50] Different lessons have been learnt such as the need to be better prepared for emergencies, cost-effective use of technology and the need for involving all stakeholders in responses.[ccclxxviii] If these lessons are implemented, they offer an opportunity to further improve and build the resilience of the health system and to improve the quality of care and future responses.

As mentioned above, the multi-sectoral and multi-stakeholder committees established at national and district levels could be useful structures to maintain with a remit that goes beyond the COVID response. Keeping the national level committees situated under the Prime Minister's office might help prioritize their mandate.

Impact on corruption in the distribution of welfare benefits to the most marginalized

There is no discussion of corruption in welfare benefits in any of the articles. However, some key informants raised the issue of transparency noting that there is poor accountability and yet it is difficult to demand transparency.[ccclxxix] One key informant representing an NGO noted the presence of corruption in food distribution programs, suggesting that in many cases food and supplies intended for the most vulnerable ended up being resold in businesses and shops across the country.[ccclxxx] Additional evaluation of these efforts will be important to document their strengths, weaknesses and impacts.

How might these disadvantages become compounded over time?

It has been noted that the COVID pandemic and response to it have exacerbated pre-existing inequalities and will continue to do so. This means that those who were previously living in, or close to, poverty will be hardest hit economically into the future. If children do not return to school, which is a particular risk for those who have become married or involved in child labour activities, their earning potential will be compromised, destining them (and their children) to harder life.

South Sudanese refugees in Ugandan settlements were singled out in one study as a population for whom the stress, anxiety and depression caused by COVID will compound their already challenging mental health situation.[ccclxxxi]

The long-term effects of malnutrition are a particular concern given the levels of food insecurity that have been widely reported. Affecting those who are already vulnerable, malnutrition among children impacts their physical and mental development, future years of schooling and earning potential, all of which compound pre-existing disadvantages.

How is the media generating public interest discussions to benefit the policy makers and the population?

One publication reported that the media has been an important factor in reporting corruption during the pandemic. In particular, the media reported on the non-compliance towards quarantine of government authorities and the associated allegations of bribery towards quarantine officials. Later, in a media interview, the Health Minister stated that he regretted the bad example set and that this led to difficulties enforcing the measure.[ccclxxxii]

How might the attention brought to issues such as police brutality in the context of the COVID response be capitalized on to promote positive structural change moving forward?

No articles discussed how attention brought to certain issues could be capitalized on to promote structural change. Few interview participants touched on this theme but one noted that greater community engagement in the COVID response might have helped mitigate against the policy brutality, suggesting that community engagement might be a useful component in any efforts to build the capacity of law enforcement officers to carry out their function to promote public health and maintain order while avoiding excessive force and fully respecting human rights.[ccclxxxiii]

Chapter 10. Conclusions and Recommendations

Lessons learned for maximising benefit and minimizing harm of the current COVID-19 response

The pre-existing epidemic response structures were an important foundation for the national response to COVID: they allowed the government to act quickly and decisively, which undoubtedly helped slow the spread of disease. Over time, there has been increasing engagement of community partners in these structures but this still remains limited and, overall, trust of the government has been eroded over the course of the epidemic. People's trust in the government is an important influence on adherence to preventive measures: the more that communities are involved in the response (with appropriate remuneration), the more they will trust it. Furthermore, they can help ensure that any measures put in place are appropriate to the local context. It is troubling that one government official's justification for lack of civil society involvement in the response was that it was 'science-based', which suggests both a lack of appreciation for civil society's understanding of and contribution to science as well as an under-appreciation of the importance of the sociocultural aspects of effective pandemic response.

Initially health funding focused on case management in high-level facilities. This may be understandable given the very low availability of intensive care beds and oxygen, which were, at the beginning of the pandemic, thought to be what was needed for COVID treatment (and still is although more treatment options are emerging). The lack of autonomy in budget allocation at district and health facility levels has been an impediment to efficient spending throughout the pandemic.

There were very few social protection programs put in place in response to COVID and even those that were implemented faced logistical challenges and failed to reach many of those who needed them most. While epidemiological data are key to informing national pandemic responses, so too is ensuring that people's basic needs are met. Without this, adherence to pandemic control measures may be impossible for some people, endangering themselves as well as the effectiveness of the broader response.

The media has been a very powerful tool for data dissemination throughout the pandemic. There have also been various instances of misinformation highlighting the need for trusted communications channels that can combat this.

Provide evidence for different stakeholders to hold the duty bearers accountable

Documented evidence of police brutality already exists and is widely known. The important question is how this evidence will be used: will individual police officers be held accountable for their actions? Will mass training be instituted? Will the role of the police in any future pandemics be different? The government itself could take on these issues or it might fall to civil society to exert pressure where they feel most important. In addition, the government's actions in the run-up to the elections were unacceptable to many citizens, leading to civil unrest and no avenues for accountability.

There is strong evidence of the economic impact of the pandemic response as well as the impact on nutrition, including how vulnerable populations have been disproportionately affected. There is little evidence to date of the government using these data to direct resources and augment efforts to reach those who are being left behind.

Lessons learned for informing future responses to infectious disease outbreaks

Many of the lessons learned for maximising benefit and minimising harm of the current COVID-19 response are also applicable to future infectious disease outbreaks. However, additional measures, which it will take longer to institute, will also be useful.

It is clear that lockdown measures are not viable given the reliance on daily wages for meeting basic needs, unless a cash transfer programme could be instituted that could reach all those who needed assistance very quickly. It will be important to consider what policy options might exist in the context of a future airborne pandemic that might be viable across all the different contexts of Uganda and to put in place structures to facilitate this as soon as possible.

Particularly in its early stages, the national COVID response was very much a unilateral government response. Some civil society actors, primarily those key to economic interests, were involved but engagement of broader civil society was minimal and has only improved slightly over time. Even when civil society organization raised shortcomings in the response to the government, there was a mixed response, with relatively little effective redirection of efforts. This is particular true with regard to reaching vulnerable groups, who have, to a large extent, still not been adequately reached with support.

The regional system for COVID testing of long-distance truck drivers is an example of a successful intervention that should be documented as a means of informing future pandemic responses in East Africa and other regions. It reduced the burden and cost of testing at points of entry, enabled mutual recognition of COVID-19 test results among EAC states; ensured faster clearance of cargo, better cross-border communication and sharing of test results; and resulted in stronger collaboration of law enforcement, customs and immigration at border crossings.

Recommendations

Early engagement with communities and the private sector is critical to an effective disease response. Even in an emergency situation where time pressure is immense, involving these partners from the outset will help promote trust in government and a cohesive response to which all stakeholders can commit. The importance of public trust in the government during an infectious disease outbreak cannot be overestimated: it is critical to compliance with government directives and willingness to collaborate in the disease response. Establishing protocols and mechanisms for how this should be done and where responsibility lies might help facilitate this for future disease outbreaks.

The government should continue to capitalize on the strength of the media for information dissemination with particular attention to how to reach the grassroots level where fewer media may be available. This feels particularly pertinent in the current context of reduced compliance with preventive measures. A non-punitive approach to implementation would be recommended as this will only exacerbate inequalities and it is unlikely to positively impact the pandemic.

Capacity building of civil society organisations will be important to expand their ability to engage in and advocate for appropriate responses to future pandemics. They can also play a useful watchdog role, helping to hold duty bearers to account.

Advocacy for governmental action might also be needed over the coming months and years to promote the use of data to direct the national pandemic response. The impacts of poverty and malnutrition will be felt for months and, in the context of their international human rights obligations, the government is responsible for helping to mitigate against them. Efforts could be made to hold the government accountable for its actions (or inaction) to date but the impact of this should be balanced against a more forward-looking approach to government engagement. The same argument might be made for addressing the disruptions to access to medications, particularly for those with chronic illnesses: some people may want accountability for damage already caused while others might use these data to try to rectify the situation as soon as possible.

The data on the impact of the pandemic on nutrition are striking and a warning of worse to come. An emergency feeding programme will likely be needed to mitigate against the immediate and long-term effects of under-nutrition at both the personal and national level.

Instituting targeted social protection programmes, for example to people aged 65 and over, to those working in the informal sector and to those of lowest socioeconomic status, could help mitigate against the impact of the pandemic on livelihoods. These have been shown to be very effective in other locations and could be equally valuable in this context. For example, payments to households whose income is derived solely from informal work would allow greater compliance with any future movement restrictions or lockdown measures allowing families to survive with dignity. Existing data on exposure to socioeconomic risk factors in the context of COVID could be used, along with input from local leaders and civil society organizations, to help target social protection efforts. As schools reopen it will be important to track pupils' re-enrolment to see which groups are most likely to have dropped out or had to repeat a year: additional support might be needed to help these children return to school and complete their education. A fully costed social protection plan to support vulnerable and marginalised populations and includes mitigation measures for unexpected financial shocks could help cushion the impacts of lost livelihoods during any future disease outbreak. Governance structures, implementation modalities and resource mobilisation will all be needed to ensure appropriate preparedness before the next outbreak strikes. Long-term investment in women's economic empowerment and creating employment opportunities will also be a useful strategy for helping promote self-sufficiency and provide more of a cushion for communities in the event of future outbreaks.

The need for investment in the food supply chain has also been highlighted. Investment in infrastructure to create resilience in domestic food production, storage and distribution can help mitigate food insecurity and ensure a timely government response if food distribution is needed.[cccIxxxiv] In addition, the creation of a strategic food reserve could facilitate a rapid government response to sudden shocks to food and nutrition security among vulnerable and marginalised households. During future disease outbreaks, if schools are closed again, it would be useful to have in place alternative mechanisms through which school feeding programmes might be sustained.

Greater investment in community structures and primary health care is needed to focus on preventive measures, contact tracing and isolation in a bid to reduce the number of overall and severe cases of disease. This includes not only investments in infrastructure but also expansion

of the health workforce, strengthening of supply chains and upgrading of health management information systems to efficiently capture and link data at all levels from the community to the national. A national stockpile of PPE would be an asset. This will have the corollary benefit of improving access to a wide range of other services, thus better meeting community needs and helping the country move towards its universal health coverage targets. That community structures became overwhelmed with the volume of COVID testing and contact tracing that was required suggests a need to expand the cadre who can carry out these functions - speed is truly of the essence in this area of pandemic response.

Allowing some latitude in the allocation of resources at district level, i.e. deviating from existing standards around budget allocation could be introduced for the duration of the pandemic to allow district and health facility leadership to allocate resources to their areas of greatest need. In the longer-term, alternative guidelines for budget and staff allocation during infectious disease outbreaks might be developed to provide a framework within which this could be done.

Building on learning around streamlining work process through digitization, investment might useful be made in ensuring an appropriate infrastructure for ongoing virtual meetings and communication, and digital financial transactions.

Moving forward it will be important to ensure access to functional mechanisms for accountability and redress. Civil society will likely have to advocate for such structures to be put in place, using informal means to exert pressures on the government to demand change.

Before any future pandemic, it will be important to dispel the idea, very prevalent among leaders in the response, that a law that covers everyone affects everyone equally. Capacity building of the differential impacts of laws and policies on different populations will help ensure a more targeted response in future that is responsive to the needs of different groups.

Future research directions

The existing evidence base draws attention to which population groups have been most negatively affected by the current pandemic and the government's policy response to it. This will need to continue as the impacts continue to be felt. Much less evidence exists documenting the impact of programmes instituted to lessen these impacts such as social protection measures, emergency food supplies and provision of inputs to farmers. Operational research to better understand the reach and impact of these programmes on different populations will be critical moving forward. This should include documentation of programmes that have not performed well in addition to the success stories so as to maximise learning from all experience.

Comparative research of districts that have responded differently might be useful. For example, in districts with greater community engagement in the response, is there greater adherence to preventive measures? While some inter-district variability is to be expected, understanding how district level responses are shaped and implemented could help inform governance mechanisms for health and development.

Qualitative research with people who have been on the frontlines of the COVID response whether at national policy level, district planning and coordination, health services management and delivery or community responses would be useful to understand the challenges that all of these stakeholders have faced during the pandemic response, what has worked well for them and what lessons they want to ensure are learned from this experience to inform future actions.

Annexes

Notes

a. The data request is based on the need for a comparative pre-corona context analysis and the three core objectives of the project, namely the influence of COVID-19 policies and measures on:

- Work and income
- Access to basic services, notably education
- Political empowerment

b. Depending on the availability of data, we are interested in disaggregation by the following major axes of inequality that INCLUDE is particularly interested in (gender, rural/urban, expenditure quintiles (esp. the 20% poorest), age (youth and elderly), disability (where available) and regional inequalities- where relevant).

A. Tables which provide context for country comparisons

Table 1. Selected Country Indicators

Indicator	Value	Year
1. Country Status a) Least Developed Country (LDC) b) Low Income Country (LIC) c) Low Middle Income Country (LMIC) d) Middle Income (MC)	Low income	2020 https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-group
2. GDP	34.39 USD Billion in **2019**	2019
3. Sectoral composition of		2019

GDP in percentage a) Agriculture b) Manufacturing c) Services NB. Informal sector Formal sector Self-employed	21.92 27.07 43.32	https://www.statista.com/statistics/447716/uganda-gdp-distribution-across-economic-sectors/
4. Sectoral composition of employment in percentage a) Agriculture b) Manufacturing c) Services	41.2 16.4 42.4	
5. Income Poverty levels National Poverty headcount disaggregated by a) Region b) Rural and urban	87.8 21.4	
6. Gini index a) Income disparities in percentage	42.8	2016 World bank
7. Food security: Under five malnutrition	Stunting; 28.9%	https://globalnutritionreport.org/resources/nutrition-profiles/africa/eastern-
8. Violence against women	30%	UDHS

9. Attitude to violence against women		
10. Adult literacy rates (male vs female)	67 female 81male	2018 UDHS
11. Doctor-patient ratio	1 to 23700	2019 Health Sector Performance Report 2018/19
12. Nurse -patient ratio	1 to 2967	2019 Health Sector Performance Report 2018/19

Table 2. Employment structure: Currently Employed Population 15 years (%)

Indicators	Total	Women	Men	Rural	Urban	Disabilit	Age (till age	Age (60 and above)	Expenditure quintile	Total
Type of work										
Wage employment-Public sector	842,900									
Wage employment-Private sector	192,000									
Self-employed with employees a) Non-agricultural b) Agricultural										
Self-employed without employees a) Non-agricultural b) Agricultural	45 68									
Contributing family worker a) Non-Agricultural b) Agricultural	35.03 14.25	47.18	29.97							
Casual worker										
Unpaid apprentice										
Domestic worker										
Labour force participation, 15 years and older (%)	74.006	77.37	72.51	73.2	69.4					
Vulnerable employment, 15 years and above (%)	51.3	68	39							
Time spent on unpaid domestic work, 10 years and older in minutes		99	38							
Other										
Total										

Table 3. Access to Health Care Services

Indicator	Total (% of population)	Sex		Location		Age (till age 35)	Age (60 and above)	Expenditure Quintile (poorest 20 percent)	Disability
		Female	Male	Rural	Urban				
Access to health facility									
Registered with Health Insurance	20%	34.4		27.9	53.2			13.6	

Socio-Economic-Impact-COVID-19-Uganda-Brief-1-UNDP-Uganda-April-2020%20(2).pdf

Table 4. Proportion of Individuals aged 12years and older who own, or use computers by region, locality, sex, and age group, disability, and expenditure quintile

Indicators	Total(%)	Female	Male	Urban	Rural	Age (till 35 years)	Age (60 years and above)	Disability (where available)	Expenditure Quintile (poorest 20%)
Own Laptop (Working)	9.5								
Own Desktop/laptop									
Working desktop									
Own Tablet									
Own any one of the devices									
Used a computer									
ICT skills (basic knowledge)									
Mobile phone ownership and use	68.2								
TV ownership	47.8								
Radio ownership	79.1								

Electricity connectivity	**28.6**			**59.1**	**18.1**				

2016/17 UNHS

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