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COVID-19 IN UGANDA:
TOWARD A NATIONAL STRATEGY ON COMPLEX PUBLIC HEALTH EMERGENCIES

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This paper analyses the relationship between Coronavirus (Covid-19) in Uganda, on one hand, and the development and operationalization of a National Strategy on Complex Public Health Emergencies. Attention centres on:(i) State preparedness following outbreak and global transmission of Covid-19;(ii) State Responses tosubsequent importation to, and transmission of the disease within, Uganda; (iii) State-Society Relations occasioned by intra-country morbidity and transmissions; and (iv) the implications of (i)-(iii) for Uganda's national strategy for CPHEs.The paper underscores the State's central role in developing and operationalising a CPHE Strategy. The Strategy, though a multi-stakeholder effort, ought to prioritise preparedness, response, and post-CPHE socioeconomic recovery in order to cushion society against immediate and long-term impacts of CPHEs. Severally,Covid-19 has revealed the need to alter Uganda's approach to public health governance. The conclusion sums up main lessons and makes recommendations for developing a National CPHE Strategy.

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Introduction

The novel coronavirus reportedly erupted in Wuhan City, Hubei Province, in People's Republic of China (hereinafter, "PRC"), causing severe respiratory illnesses. Detected late 2019, the disease it causes was named "2019-nCov", or "Covid-19" or "SARSCoV-2".[1]On 30 January 2020, one month after discovery, the World Health Organisation (WHO) declared that the Covid-19 outbreak was a Public Health Emergency of International Concern (PHEIC) following advice from the Emergency Committee on the novel coronavirus[2]. A PHEIC is, according to International Health Regulations (IHR, 2005), "an extraordinary event", of a public health nature, with potential to spread internationally and require coordinated international response.[3] 2019-nCov apparently belongs to the family of other coronaviruses that previously afflicted humanity causing diseases like Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). But 2019-nCov has demonstrated unprecedented rapidity of infection, virulence, deadliness, and global spread.

Save for mortality rate, Covid-19 rivals the Ebola Virus Disease (EVD) that afflicted the Mano River Union (MRU) of West Africa during 2013-2016 in terms of absolute numbers of the dead; by 11 April 2020 it had infected 1,610,909 and killed 99,690 people globally, from 282 infections and 06 deaths by 20 January 2020.[4]

The rapid globalisation of Covid-19 has been unprecedented. While previous complex public health emergencies (CPHEs) like Ebola, Marburg, Cholera, MERS-COV and SARS-COV, have been confined in specific sub-regions, countries, subnational regions or locales within affected countries, 2019-nCov has spread to all continents on earth, mainly through air travel, and has affected millions within 100 days. Uganda confirmed her first case of Covid-19 on 21 March 2020[5]. By 11 April 2020, a total of 53 Ugandans had been infected. No death has been reported.

Why Covid-19, and why the National Strategy on CPHEs? Three answers are sufficient here. First, while Uganda has suffered previous epidemics like Ebola and Marburg, no such epidemic was fearsome enough to cause a nation-wide lockdown.

[1]World Health Organization (hereinafter, "WHO), 2020 (21 Jan.), Novel Coronavirus (2019-nCoV) Situation Report – 1, 21 January 2020, Geneva: WHO

[2]WHO, 2020 (31 Jan.), Novel Coronavirus (2019-nCoV) Situation Report – 11, Geneva: WHO

[3] Robert L. Cubeta, et al., 2020, 'New Models for a New Disease: Simulating the 2019 Novel Coronavirus',Alexandria, VA: Institute for Defence Analysis

[4]WHO, 2015, 'Ebola Virus Disease': Fact sheet N°103 (Aug. 2015). (see: https://www.who.int/features/ebola/storymap/en/, accessed 11 April 2020); WHO, 2020 (11 April),Coronavirus disease 2019 (COVID-19) Situation Report – 82, Geneva: WHO; WHO, 2020 (2o Jan.), Novel Coronavirus (2019-nCoV) Situation Report – 1, 21 January 2020, Geneva: WHO

[5]The Independent, 2020 (22 March), "President Museveni to address nation again today", Kampala: The Independent (from https://www.independent.co.ug/president-museveni-to-address-nation-againtoday/, 11 April 2020)

Previous lock-downs have been restricted to specific districts (Kibaale and Gulu, during Ebola) or sub-regions within the country. Non-disease lock-downs, such as restrictions occasioned by civil wars (in northern Uganda during the early-to-mid-2000s; and the cut-off of south-western Uganda between September 1985 and January 1986), were either regional or sub-regional. Thus, 2019-nCov engendered more profound national paralysis than previous emergencies. Second, previous epidemics like Ebola and Marburg, and national disasters like mudslides and landslides, provoked national disaster awareness and learning whose efficacy tests materialise with 2019-nCov. Finally, the above reasons help in considering Uganda's possible strategy on CPHEs, and this crisis provides sufficient ground for assessing progress on policy and technical focus on such a Strategy. In several respects, Covid-19 revealed the need to alter Uganda's approach to public health governance.

The paper proceeds in three sections. Section one outlines state preparedness for 2019-nCov, outlining the publicly-known measures undertaken to control the importation and spread of Covid-19. The second section examines state response to actual 2019-nCov in Uganda. Section three presents novel ideas about relations between the state and the broad Ugandan society in respect of anti-2019-nCov interventions. Section four outlines the implications of response-measures and state-society relations for Uganda's possible National Strategy on CPHEs. The conclusion sums up the main lessons and makes recommendations for developing a National CPHE Strategy. Limited attention is paid to societal reactions to the disease, and predictions about its possible socioeconomic and political impact. While 2019-nCov may seriously affect governance, the economy, social well-being and psycho-social resilience, this is reserved for another effort.

State Preparedness

By "state" is meant organised and coordinated institutions that wield a country's coercive and functional powers, and inform authority structures through which governmental rule is operationalised. Thus, government (the ruling and decision-making executives at different levels) operates through the state. Government depends on the state, that is, on the country's coercive and technical structures, for its functionality. Weak state institutions can cause daunting failures to even the most determined of leaders.

Strong state institutions can prevent even the most obstinate of leaders from doing certain things – especially where the state is autonomous from societal forces and interests[6]. And while non-state actors playa key role in managing CPHEs, the intricate link between 2019-nCov and international travel, international trade, and inter-state regulation of global linkages, renders the anti-state logics of previous decades almost stale; Covid-19 demonstrated that those who thought globalisation meant "the end of the state" now demand its restoration or re-capacitation. The once-touted "no government", but global exchanges networks and interactions, now turned to "good government" as an "urgently required" [7] mechanism for managing PHEICs. This became clearer with global spread of Covid-19.

State preparedness implies the measures the State put in place to respond to 2019-nCov. These include: preventive measures, mobilisation of state capabilities for response, and preparation of the public to avoid becoming victims of Covid-19. It is these measures that define whether State preparedness is anchored in the National Strategy on CPHEs or scattered in the broad governance ecology on disaster management or public health. [8]

Preventive measures in Uganda consisted in: monitoring international developments on Covid-19, intensifying health screening at border points, definition and designation of countries into categories, and public awareness. On monitoring developments of 2019-nCov, the state emphasized collating reports from Asia, Europe, Australia and Americas, and determining coronavirus's main transmission channels. Ongoing research efforts were also monitored. The Ministry of Heath worked closely with WHO to enrich the country's understanding of the 2019-nCov crisis. This enabled Uganda to determine the urgency of health screening at points of entry to arrest possible importation Covid-19.

Health screening is common at entry-points. Border-point health checks became more pronounced when countries started experiencing disease transmissions via immigration and transits, such as Ebola during the 2013-2016 MRU crisis. However, screening was intensified following the 2019-nCov crisis in Asia and Europe because by end of January 2020, there had been 9,826 globally-confirmed cases of Covid-19, 106 outside of PRC and strewn in 19 countries in all continents but Africa.

[6]Samuel P. Huntington, 1968, Political Order in Changing Societies, New Haven: Yale University Press
[7]Christopher Hird, 1997, 'The capable state', Index on Censorship 3:59-66
[8]See: Uganda Protectorate, 1935, The Public Health Act (Cap. 281),Commencement: 15 October, 1935

The first two out-of-PRC cases were reported in Italy on 31 January 2020. Both had travelled to Wuhan. This informed the expectation "that further international exportation of cases may appear in any country." Therefore, Uganda needed preparation "for containment, including active surveillance, early detection, isolation and case management, contact tracing and prevention of onward spread of 2019-nCoV infection", among other measures.[9]

Uganda used thermos-scanners at Entebbe International Airport. These scanners can pick a person's temperature, within a crowd, in a range of 4–20 meters, identify persons with raised (above normal) temperatures, and photograph the person with finer details on a different screen from which appropriate decisions are made. Diverse other internal measures were put in place, including: equipping the Uganda Virus Research Institute (UVRI),; developing and sharing information sheets with travelers; appeals for self-isolation by travelers from Covid-19-affected countries; multi-media public engagement on appropriate behaviors; risk mapping and assessment of vulnerable areas, to ensure disease surveillance; and strengthening of Entebbe and Naguru hospitals.[10]

Uganda carefully studied morbidity in other countries, to determine levels of potentially-imported risk. In early March 2020, the designation of countries into categories included:

(i) Category One countries – those that had more than one hundred (100) confirmed cases of Covid-19, such as PRC, Spain, France, Italy, Iran, Germany and South Korea, as of 7th March 2020;
(ii) Category Two countries, with less than 100 cases, such as the UK, Netherlands, Norway,Switzerland, Sweden, Belgium, India and USA as of 8th March; and
(iii) Category Three countries, those without confirmed/reported cases. Travellers from Category One countries were subjected to compulsory 14 days' quarantine.

Those from Category Two countries were observed "very closely". Those from "Category 3" countries would undergo routine screening upon arrival, were advised to prevent possible spread of coronavirus, and encouraged to report immediately they sense Covid-19-related symptoms. Uganda, then, undertook phased restrictions on travels from these different categories. By 8th March 2020, the State had banned international conferences, and advised travellers from Category 1 countries to postpone travels to Uganda or suffer 14-days' compulsory quarantine. [11]

[9]WHO, 2020 (31 January 2020), Novel Coronavirus(2019-nCoV) Situation Report – 11, Geneva: WHO
[10]Republic of Uganda, 2020 (11th February), Status of Uganda's Preparedness on the 2019-Coronavirus Outbreak. Update #02, Kampala: Ministry of Health
[11]Nobert Atukunda, 2020 (8th March),
Coronavirus: Gov't to quarantine all travellers from worst hit countries', Kampala: Daily Monitor (from https://www.monitor.co.ug/News/National/CoronavirusGovt-quarantine-travellers-worst-hit-countries/688334-5483052-u7fqclz/index.html, 14 Apr. 20)

Soon Category 2 countries became Category 1, and on, as virulence worsened globally. By 11 April 2020, global infection was "very high." Within four days the world reported 1,844,863 infections (10,787 of them in Africa) and 117,021 deaths (501 of them in Africa).[12] The categorisation of countries, while informative of how to direct state efforts, was to prove inadequate for several reasons: first, Uganda possibly lacked information on the magnitude (numbers, categories, of travellers) and regularity of travels between countries. This implied that the Ugandan State was not able to determine the rapidity of spread, infection and virulence among countries with which Uganda has travel relations.

Second, the 2019-nCoV was a new virus about which little scientific information was yet known. Despite close genetic relations with SARS and MERS coronaviruses (its genetic sequence showed more than 80% identity to SARS-CoV and 50% to MERS-CoV, both originating in bats)[13], the methods of spread (by air, sexually, oral-fecal, or just through 'in-take' of micro-droplets) remain less well understood. Its incubation period amongst different peoples remains to be fully grasped. Thence, asymptomatic cases might traverse the world un-noticed, possibly infecting other peoples through then-unknown channels, and consequently putting Uganda at risk of travel-related infections. [14]

Third, coronaviruses, have worldwide distribution, are highly infectious, exceedingly difficult to control, owing to their extensive genetic diversity, short generation times, high genetic mutation rates and recombination at a rate similar to that of influenza viruses.[15]

The SARS-CoV-2 might have acquired antibody dependent enhancement (ADE) due to prior exposure to other coronaviruses, possibly explaining discrepancies between "the severity of cases observed in the Hubei province of China and those occurring elsewhere in the world."[16] While facts remain obscure, this likelihood demanded more scientific analysis and understanding beyond mere geospatial categorisation of affected countries or regions. This and similar changes in the virus's biochemistry might have rendered 2019-nCov already altered, recombinated, mutated, and difficult of detection and management using methods already tested in other countries. A country with weak health systems and low levels of social development, such as Uganda, might face exceedingly difficult times coping with the highly-mutative and rapidly-spreading virus.

[12]WHO, 2020 (14 April), Coronavirus disease 2019 (COVID-19) Situation Report – 85, Geneva: WHO

[13]Hussin A. Rothana, et al., 2020, 'The epidemiology and pathogenesis of coronavirus disease (COVID-19) outbreak', Journal of Autoimunology 109 (2020) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7127067/pdf/main.pdf, 15 April 2020)

[14]Lso see: Ron A. M. Fouchier, et al., 2004, 'Previously Undescribed Coronavirus Associated with Respiratory Disease in Humans', Proceedings of the National Academy of Sciences of the USA, 101 (16):6212-6216; Chih-Cheng Lai, et al.,2020, 'Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and coronavirus disease-2019 (COVID-19): The epidemic and the challenges', International Journal of Antimicrobial Agents, 55 (3):X-XXX

[15]Mark W. Jack, 2006, 'The Relationship of Severe Acute Respiratory Syndrome Coronavirus with Avian and Other Coronaviruses', Avian Diseases 50:315-320

[16]Jason A. Tetro, 2020, 'Is COVID-19 receiving ADE from other coronaviruses?', Microbes and Infection 22:72-73

Fourth, various and multi-source rumors and fake news accompanied the Covid-19 pandemic, seeking to increase fear about it, assign blame for its outbreak and spread. Meshed into these exchanges were state actors, conspiracy theorists, civilians and the wildly online media. [17] This affected public awareness and weakened states' efforts at claiming legitimacy about their information shared with publics.

Finally, with porous borders, weak border and immigration controls remain problematic for Uganda. Consequently, the country isa source, transit, and destination for victims of Trafficking in Persons (TIP), some of whom are trafficked via "unmanaged borders."[18] By 2019, Uganda remained on Tier 2 Watch List in the Trafficking in Persons Report, because "Government of Uganda does not fully meet the minimum standards for the elimination of trafficking" despite efforts to do so.[19] Given these reasons, it is difficult to determine whether Uganda benefited much in categorising countries and differentiating travel restrictions or whether she needed blanked travel bans as later happened given the unusually rapid internationalisation of Covid-19.

It is not unreasonable to surmise carriers might cross Ugandan borders, both manned and unmanned, and transmit Covid-19 into the country. This possibly explains why and how a Ugandan returning from western Kenya infected his daughter in Iganga, western Uganda. By 23rd March 2020, the country had nine (09) confirmed Covid-19 cases, eight (08) of them Ugandans with travel history to United Arab Emirates (UAE). Uganda had fifty-four (54) confirmed cases, 1,302 direct contacts of those cases, 18,000 "High risk travellers" since 07 March, 231 under institutional quarantine, seven (07) recoveries, and zero deaths, by 14th April 2020[20]. State response started with the first case.

State Responses

While incoming travel restrictions, screening, quarantining and isolation had constituted some forms of responses, they were more preventive than reactive. Reactive responses followed the actual presence of Covid-19 in Uganda. Thousands of Ugandan and non-Ugandan travellers underwent quarantine (compulsory-institutional and self) over these months.

[17]Roy Schulman and David Siman-Tov, 2020 (March 18), 'From Biological Weapons to Miracle Drugs: Fake News about the Coronavirus Pandemic', INSS Insight No. 1275, pp. 1-5

[18]Republic of Uganda, Undated, National Action Plan For Prevention of Trafficking in Persons In Uganda, Kampala: MoIA (from-https://www.mia.go.ug/sites/default/files/PTIP-National%20Action%20Plan%20revised1.pdf, 14 April 2020)

[19]Department of State, 2019, Trafficking in Persons Report 2019 – Uganda: Tier 2, Washington DC: DoS, pp. 472-475

[20]Republic of Uganda, 2020 (23rd March), Update on the Covid-19 Outbreak in Uganda, Kampala: Ministry of Health (MoH); 2020 (14th April), MoH Uganda: COVID-19 Information Portal, Online: MoH (available https://covid19.gou.go.ug/#FileManager, accessed 14 Apr. 20)

Thousands underwent medical examination at the UVRI, following intense tracing and testing of individuals who returned from abroad between 7th and 22nd March 2020. [21] Uganda also apparently established100 health hubs for collecting samples and transporting them to the UVRI offices, in Entebbe, for testing. But following global intensification of Covid-19, Uganda's cabinet, chaired by President Yoweri Museveni, sat on Monday, 16th March 2020, and appreciated the country's vulnerability to Covd-19.

Cabinet recognised a high sense of vulnerability based on millions of unhealthy Ugandans: 1.4 million living with HIV/AIDS; 800,000 suffering from diabetes; 4.8 million afflicted with hypertension; 100,000 Ugandans battling tuberculosis (TB) per year; and these are supplanted with malnutrition. Accordingly, Cabinet decided that Uganda "must do everything possible to ensure that this enemy does not come here, does not find plenty of dry grass piled up and ready for flaming."[22] This flammable, piled, "dry grass," implied "big masses of people, gathered together and in close proximity", such as schools, social and non-social public gatherings and religio-spiritual congregations.

The decisions taken included: closure of all education institutions "even before the occurrence of a single corona incident" in the country; and suspension of prayer-related religious gatherings "for a month with immediate effect",and of various public events, travels and processes, such as political and/or cultural rallies, conferences, elections, for 32 days; out-bound movement by Ugandans to or through Category One countries were banned "with immediate effect", while foreigners going to those countries would do so provided they do not intend to return within 32 days; and provision of Standard Operating Procedures (SOPs) for areas not stopped from operating, such as factories and food markets. Equally suspended were large-group weddings with attendants' numbers exceeding 10; large-gathering funeral rituals and ceremonies; and monthly livestock markets. Ugandans coming from Category One countries were subjected to mandatory quarantine, in designated places (institutional quarantine), at their own cost unless they "sit out the storm in the country of their temporary abode." The providers of public transport were cautioned, and a one-month suspension made to merry making spaces like discos, the dances, bars, sports, music shows, cinemas and concerts. Government also provided advice on hygiene, feeding/nutrition, and other behavioural adjustments. [23]

[21] Ibid

[22] Republic of Uganda, 2020 (18th March), President Museveni statement on COVID-19, Entebbe: State House

[23] President Museveni's Statement on COVID-19, The Independent, March 18, 2020 (available at https://www.independent.co.ug/live-president-museveni-statement-on-covid-19/2/, 15 April 2020)

Eight days later, on 26th March 2020, government suspended public transport for 14 days, "with immediate effect", to minimise movement and person-to-person contacts. While private transport was spared, cars were not allowed carry more than three passengers, including the driver. Markets were restricted to selling foodstuffs, and non-food items suspended. Public offices were closed, and "only essential staff" were allowed to "report for duty in the offices", closing virtually most governmental operations. While the 100 hubs might have capacity to collect samples, transportation for these test samples might become problematic. Accordingly, the president directed "that all government vehicles at the district be surrendered to a pool to be overseen by the district health officer with support of the police and army", bringing armed forces in the limelight of Covid-19 responses and creating a semblance of civil-military cooperation in the country's anti-2019-nCov efforts. The "stay at home" pronouncement or curfew had been prepared. [24]

Four days later, on 31st March 2020, private cars were suspended when the president prohibited "all people-to-people movement by everybody including those using their private vehicles, boda bodas, tuk-tuks, etc"; a 14-days' curfew imposed; opening of shopping malls, arcades, hardware shops, salons and garages suspended; and all borders closed to passengers coming into Uganda by air, land or water, including in-coming planes, trains, buses, taxis, boats, and pedestrians (people walking on foot) from neighbouring countries. Telecommunication companies, banks, factories, and private security companies, remained in operation as long as they, alongside other essential state services[25] like revenue collection and migration controls, provided transport tags for their personnel.[26] Construction sites would continue operating only if they would encamp their workers. Gatherings of more than 5 people were banned. Before using private cars to take sick persons to health centres, one had to seek permission from Resident District Commissioners (RDCs): "In order to deal with other health emergencies, permission can be sought from the RDC to use private transport to take a sick person to hospital." [27]

Other measures were forward looking. Besides mobilisation of support from non-state sources, the President promised to purchase vehicles for the Ministry of Health using the UGX 3.2 billion donated by 15th April 2020. There was mobilisation of machinery (mainly used to manufacture Covid-19-related protective gear from India) and local companies to produce products needed for effective Covid-19 management.[28] Perhaps personal-hygiene and pharmaceutical companies will receive appropriate state support.

[24]Republic of Uganda, 2020 (26th March), President Museveni's 5th COVID-19 address(from https://www.independent.co.ug/-full-speech-president-musevenis-5th-covid-19-address/, 14 April 2020)

[25]Essential services are: medical, veterinary, telephones, door-to-door delivery, Banks, Private Security companies, cleaning services, garbage collection, fire-brigade, petrol stations, water departments, private security companies, and KCCA. The URA was not to close tax-defaulting businesses in the 14 days.

[26]Daily Nation, 2020 (Tuesday, March 31), 'Museveni bans use of private cars, imposes 14-day curfew', Nairobi: Daily Nation (from https://www.nation.co.ke/news/africa/Uganda-placed-under-curfew-over-Covid-19/1066-5509546-y6jh2d/index.html, 14 April 2020)

[27]President's 4th Speech on Covid-19, Tuesday, 14th April 2020

[28]Ibid

The state also upped the management of institutional quarantines, followed up recent travellers believed to have interacted with the public,and appealed to them to voluntarily report to hubs for testing. Escapees from quarantines were arrested. In a word, Uganda's raft of responses included capacitating the health infrastructureandscattering Ugandans to prevent mass transmissions. This helped to avoid large gatherings that are susceptible to infection. The president personally appealed for assistance from Ugandan companies, organisations and individuals,to the country's anti-Covid-19 efforts. He would publicly read out donations by different organisations, groups and individuals. Beyond preventing mobility-driventransmission,the State supplied food items toselected urban poorbelieved to have lost daily income due to Covid-19 shut-down.

By 15th April, Uganda claimed to have reasonably avoided rapid spread. The president, nevertheless, warned against laxity. He stressed prolongation of restrictive responses, and extended these measures for another 21 days until 5th May 2020.[29] While the public had generally cooperated until 15 April 2020, there had been instances of civilians attacking state actors enforcing government's stay-homeand other orders. This sends signals on the evolving state-society relations in the context of Covid-19.

State-Society Relations

By "society" is meant the broad and diverse Ugandan communities scattered around the country's rural, peri-urban and urban landscapes. This society depends on diverse state and non-state institutions for its everyday functioning. Most-times, the Ugandan society relates with the state only when facing difficult situations. Otherwise, society chiefly relies on extended family systems, clannetworks, religio-spiritual communities, professional and business associations, neighbourhood communities and collaborations, old students' associations, community self-help groups, and traditional authority structures for its functioning. But none of these social formations was capable, let alone prepared, to respond to Covid-19 without depending on the state. This state centrality in the epidemic implies several issues related to state-society relations: cooperation and conflict; trust and mistrust; voluntary support; and collaborative capacity building.

Cooperation and conflict relates to pubic response to the measures announced by the state. The state has coercive capabilities. But societal resistance can render even the most well-meaning of sate measures futile.

[29]John Kizza, 2020 (14th April), 'Uganda extends coronavirus lockdown until May 5', Kampala: The New Vision (from https://www.newvision.co.ug/new_vision/news/1517866/-live-coronavirus-situation-uganda, 15 April 2020); Yoweri K. Museveni, 2020 (14th April), Fourth address on COVID19, Online: YK Museveni (From https://www.yowerikmuseveni.com/fourth-address-covid19, 15 Apr 20)

Along cooperation between civilian officials and armed forces, society supported the state's multi-agency measures implemented under National and District Task Forces. Perhaps Ugandans had appreciated the virulence, rapidity of spread, morbidity and mortality of Covid-19 by the president Museveni announce a raft of response measures. Given previous experience with Ebola, Marburg, Measles, Cholera and other outbreaks, the society cooperated with the state in effecting the lock-down, ban on social activities, public transport, and suspension of income-generating activities. Society also helped in identifying and tracing recent travellers as well as keeping social distance and personal hygiene despite the socio-economic challenges of acquiring such products and services. Different forms of improvisation in this respect were observed in neighbourhoods and repeatedly shared on social media.

State-society cooperation was not without instances of conflicts, of attacks and counter-attacks between state actors and members of society. In some instances, state actors behaved unprofessionally[30], excessively harassing civilians, shooting others[31], beating pregnant women under the guise of implementing presidential directives on Covid-19.[32] Some state actors were insensitive to the impact of these measures on key issues like seeking maternal health services, and were inattentive of whether presidential orders issued prior to declaration of a state of emergency were suitable for blanket enforcement without contradicting the country's constitutional and legal rules. To avoid societal backlash, the state punished its own personnel who overstepped their mandates. In other instances, civilians attacked armed personnel: in Bibia Municipality, Amuru District, Pte. Alex Niwanyine, of the Uganda People's Defence Forces (UPDF) lost his eye when he was attacked enforcing Covid-19-related directives. Sgt Paul Kyandiya had also been attacked trying to enforce Covid-19 measures in Mityana District.[33]

Trust and mistrust relates to experiences and the nature of the state. Uganda's is a patrimonial state, in which corruption-political and bureaucratic, petty and grand, official and non-official-gnaws at the marrow of the moral fabric. While many Ugandans trusted the professionalism and commitment of frontline health and security personnel confronting Covid-19, they were wary about corruption and its impact on service delivery.

[30]Chares Wanyoro, 2020 (March 29th), 'Another journalist attacked by police during implementation of Covid-19 orders', Nairobi: NNews; Business Day, 2020 (27 March), 'Uganda shoots and beats those breaking Covid-19 restrictions', Johannesburg: BusinessDay (from https://www.businesslive.co.za/bd/world/af rica/2020-03-27-uganda-shoots-and-beats-thosebreaking-covid-19-restrictions/, 15 April 2020)

[31] Jessica Sabano, 2020 (Friday, 27 March), 'COVID-19: Two shot for defying presidential directives', Kampala: Daily Monitor (fromhttps://www.monitor.co.ug/News/National/Two-shot-Muko no-defyingpresidential-directives/688334-550644-aro68b/index.html, 15 April 2020)

[32] Maurice Muhwezi, 2020 (April 4), 'Two policemen arrested for clobbering pregnant woman', Kampala: The Red Pepper (from https://www.redpepper.co.ug/2020/04/two-policemen-arrested-for-clobberingpregnant-woman/, 15 Apr. 20)

[33]Daily Monitor, 2020 (Sunday, April 12), COVID19: UPDF Soldier Loses Eye while Enforcing Night Curfew', Kampala: Daily Monitor (fromhttps://www.monitor.co.ug/News/National/UPDF-soldier-eyeloses-enforcing-Covid19-curfew-Bibia/688334-5522234-cvslsi/index.html, 15 Apr. 20)

Some questioned the wisdom of quarantining arriving-travellers in expensive hotels instead of schools whose occupants had left after Covid-19-driven closure of education institutions. The question of who owns those hotels, costs of quarantining persons, and satisfaction with services vis-à-vis costs charged by some of the government-recommended hotels, left a lot of questions. Eventually, some took to social media complaining against quarantine fees, delayed attention by medical personnel, and fear of infections they might suffer from hotel workers operating in night and day shifts.[34] Covid-19-related corruption requires further investigation. But the president's regular practice of reading out donations from different sources possibly ensured a degree of openness and transparency hitherto uncommon in Uganda's governmental operations.

Voluntary support to the state consisted in working with enforcers of restrictions, which forced urban dwellers to resort to waking unusually long distances to shopping spaces, plus provision of various donations. On some occasions, the President, possibly after appreciating that foreign donations related to Covid-19 from traditional donors were unlikely because western societies were equally suffering untold virulence and mortality, appealed to Ugandans for donations. He requested for vehicles to enable him "build a fleet" of health-related transport, and promised, on 14th April 2020, to use the UGX 3.2 billion so far donated to buy more vehicles for the Ministry of Health. Assessments of donations read out by the President reveals that most donations amounting to or exceeding UGX 100 million were donated by foreign investors.

The relatively low-level donations from indigenous sources reveals several possibilities. First, Uganda lacks a strong indigenous capitalist class, in terms of rich individuals, families, and companies, which can generously donate to a national emergency. Second, rich Ugandans and indigenous companies preferred anonymousdonating, or are hardly enthusiastic about corporate social giving. Third, Ugandans actually did not donate for fear that corrupt state officials might appropriate their donations for selfish benefits at the expense of those for whom donations would have been meant, or believed the state had capacity or responsibility to look after its citizens from whom it has been extracting taxes and natural resources with limited transformation to show for it. Fourth, Ugandans are not rich enough, in terms of material possession or psychological self-awareness, to donate to national emergencies.

[34] The Independent, 2020 (March 20), 'Quarantined COVID-19 travellers protest against Uganda restrictions', Kampala: The Independent (from https://www.independent.co.ug/quarantined-covid-19-travelers-protest-against-uganda-restrictions/, 14 April 2020)

While not expecting grand donations, such as those from Jack Ma and Alibaba Foundations, from Ugandans, indigenous Ugandans donated dismally. Whatever be the explanation, Uganda indisputably needs a strong indigenous capitalist class capable of supporting national emergency responses.

Finally, collaborative capacity building was strewn across the Ugandan social space. By 14th April 2020, President Museveni was still telling the country in future tense, that "The health workers dealing with the corona-virus patients will be given the necessary masks (surgical, N-95, etc.) and the other protective gear. Many of these will be manufactured here. We shall only import a few."[35] The country had not mustered enough capacity. Donations should leave the health sector strengthened enough to handle similar emergencies in future. Researchers in state and non-state spaces started sharing ideas on what forms of interventions to undertake. For instance, an independent group of early career and senior academic researchers, called Network for Education and Multidisciplinary Research Africa (NEMRA), constituted an online group for raising donations on masks for security and medical personnel. Members co-opted medical doctors and members of the National Task Force and regularly challenged one another to conduct online research and inform their respective networks on possible protective measures and management of Covid-19 related ailments. Wellcare Centre, under Dr. Paul Kasenene, also used social media and intensified regular sharing of information on nutrition, laying emphasis on those feeding habits and lifestyle behaviours which, the Centre claims, would strengthen a person's body immunity against Covid-19. Ugandan scientists started "inventing new products for testing" Covid-19, Ugandan factories produced alcohol-based sanitizers, and the state encouraged industries to produce masks and other related products.[36]

The foregoing syntheses on preparedness, response, and State-Society relations, reveal a progressive take that reflects on the national CPHE response and management strategy. The country relies on a 1935 Pubic Health Act, but despite weak health infrastructure, Uganda placed its health personnel on high alert and ably contained Covid-19 to below 100 confirmed infections for more than 45 days, effected social awareness measures, and ***learnt this bitter lesson: no Ugandan should fly out of the country to seek medical services; instead everything should be done to make the country self-sufficient in terms of health services.***

[35]Museveni, Speech on Covid-19, 14th April 2020
[36]Museveni, Speech on Covid-19, 14th April 2020

This lesson was hitherto signaled by Ebola and Marburg. Charles Onyango-Obbo mused that "when epidemics visit, Uganda becomes a different country", because epidemics provoke political will to use meritocratic interventions and reverse emergencies that threaten power centres. During "the country's worst Ebola outbreak in 2000 in northern Uganda, even if the region was still at war, it was contained fairly quickly in the north, hardly crossing the Karuma."[37] Thus, political will and bureaucratic commitment are key to managing politically-sensitive national crises viameritocracy and scientific processes.

The strengthening of our health infrastructure and systems, though tested by previous epidemics, remains a priority area underlined by Covid-19. Global virulence made it impossible for rich Ugandans and senior public officials to seek healthcare from the global north. Simultaneously, the need to mobilize local support underscored the value of strengthening Ugandans' capacity, or ensuring mass wealth creation amongst Ugandans, as a means of forestalling any future need for external assistance in Covid-19-like crises. These realities highlight the importance of a National Strategy on CPHEs.

Implications for National Strategy on CPHEs

By "National Strategy on CPHEs" is meant coordinated and interlined institutional measures and structures, "on paper" and "on the ground", which are established to help the country respond to possible epidemics outbreaks. The notion of the strategy is rooted in observations of, and awareness about, Uganda's experience with epidemics since the HIV/AIDS crisis during the 1980s-1990s. Since then, Cholera, Marburg, Ebola, and now Covid-19 have afflicted the country. The CPHE Strategy may be a component of, but is distinct from, disaster preparedness strategy in one respect: it focuses on public health.

A critical aspect of the CPHEs Strategy is the fusion between national security and public health. The rapid spread of Covid-19 sparked global panic. Countries took unprecedented drastic measures to deal with the pandemic, closing borders, quarantining travelers, banning domestic public transport, closing socioeconomic activities and causing national paralysis.[38] Many local and international investors have closed shop. In all previous national security crises, Uganda has never experienced nation-wide lock-downs. The fact that viruses can cause more paralysis than war indicates that the National Strategy on CPHEs ought to be construed in the context of national security.

[37]Charles Onyango Obbo, 2020 (March 18), 'When Epidemics Visit, Uganda becomes a different Country', Kampala: Daily Monitor (from https://www.monitor.co.ug/OpEd/columnists/CharlesOnyangoObb o/When-epidemics-visit-Uganda-becomes-different-country/878504-5495234-5p5qh6z/index.html, 15 Apr. 20)

[38]See,: Thirumalaisamy P. Velavan and Christian G. Meyer, 2020 'The COVID-19 epidemic', Tropical Medicine and International Health, volume 00 no 00. doi:10.1111/tmi.13383; Tomer Fadlon and Galia Lavi, 2020 (27 Feb.), 'The Coronavirus and Israel', INSS Insight No. 1265:1-4

Elements of this Strategy obtain in Uganda's disaster preparedness and management policy.[39] The policy defines an epidemic as reflecting more morbidity, "more cases of that disease than normal", which becomes a pandemic when it goes worldwide. As though prognosticating, by 2010, the drafters of the policy feared the possibility of an influenza-like pandemic that Covid-19 is. They forewarned: "[A]n influenza pandemic may occur when a new influenza virus appears against which the human population has no immunity. With the increase in global transport, as well as urbanization and overcrowded conditions in some areas, epidemics due to a new influenza virus are likely to take hold around the world, and become a pandemic faster than before."[40] Previous influenza pandemics, such as the 1918-1919 pandemic, resulted in an estimated 40-50 million deaths, and great social disruption. Projections, a decade ago, pointed to between two and 7.4 million deaths globally. This indicated the known relationship between an influenza pandemic, such as Covid-19, and global interconnectedness enabled by international travels.[41] Two major policy responses are listed:

(i) strengthen entomological, epidemiological and disease surveillance; and
(ii) develop appropriate preparedness and response plans, through different institutions.

Ten years now, Covid-19 found the proposed interventions adequate.The second national health policy, 2010, makes similar observations[42], but it seems epidemics can elude policy statements not followed by concrete actions.

This study proposes a National Strategy on Complex Public Health Emergencies consisting of multi-level teams and interventions. Unlike Covid-19, which might sneak into Uganda through border posts, other CPHEs may erupt from anywhere. Remote places may be severely affected if there are no lowest-level teams to attend to emergencies, contain their impacts in specific locales, and seek higher-level assistance. These and similar measures need timeliness and coordinated. Therefore, the strategy should specify actors and their roles at different levels, and establish country-wide emergency-response capabilities at appropriate and accessible points.

[39]Republic of Uganda, 2010, The National Policy For Disaster Preparedness and Management, Kampala: Office of the Prime Minister.
[40]Ibid, p. 13-14
[41]Ibid
[42]Republic of Uganda, 2010, Second National Health Policy (NHP II), Kampala: Ministry of Health

The lowest level of implementing the National Strategy on CPHEs can entail equivalents of today's Village Health Teams (VHTs) in Uganda. These teams work on an ad hoc basis, lack basic equipment, are not trained to quickly arrest and respond to emergencies, and are beholden to local political structures. Yet, at VHT level, local councils and service systems should be fused but held accountable and responsible: VHT members drawn from LCI executive councils ought to be trained in emergency responses. Village/Cell Public Health Emergency Teams (ViPHETs) should also have basic but durable supplies like gloves and clinical thermometers, and trained in their use.

A functional mechanism should enable ViPHETs get equipment and supplies, whenever needed, from district level teams. These structures should, through sub-county-level teams, make weekly reports in case of normal health conditions and daily reports in instances of uncommon ailments.[43] Cell/village residents should constitute ViPHETs, indicating the importance of availability, commitment, lowest-cost aspects of this strategy, and the importance of having trained personnel at the lowest possible level.

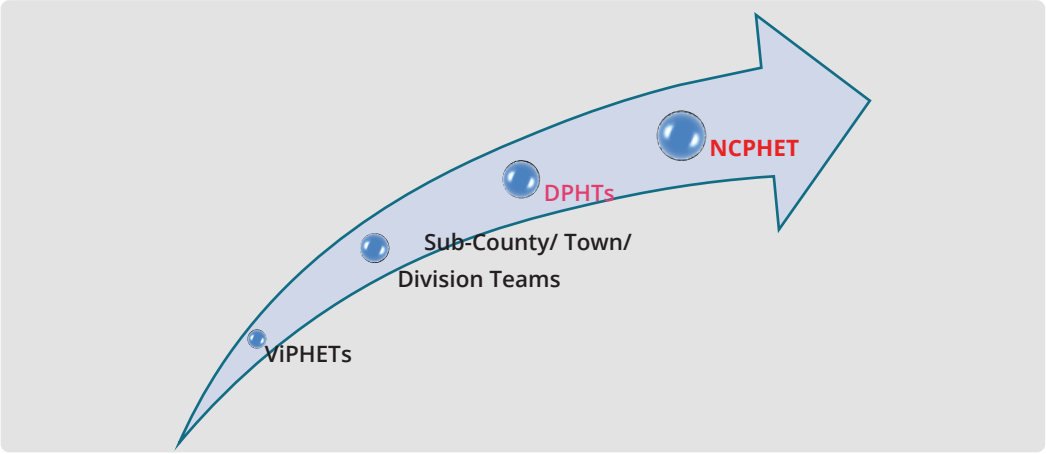
At sub-county, Town, or Division level, more technical teams (3-5 in number) consisting of Health Centre III personnel, Sub-County/Town/Division Executives, and internal security personnel, should be constituted, trained, equipped, and given responsibility for weekly public health updates in their areas. These teams should coordinate and monitor the operations of ViPHETs, visiting every ViPHET within their jurisdiction once in a quarter using resources of the Community Development Office (CDO) or Health Centre III. These teams should, under normal public-health conditions promote hygiene, sanitation, good/proper feeding and nutrition, address health-threatening behaviors like alcohol and substance abuse, and conduct simple local-level research. They should keep records of morbidity from different ailments, and manage local communities' maternal health service needs. National health statistics would be acquired from this level.

Above the sub-county/town/division, should be District and/or City Public Health Teams (DPHTs; Fig. 1) headed by technical personnel and members drawn from political executives, technical leadership, and internal security.

[43]Reports may include mere phone calls or SMMs, which are integrated at sub-county level and sent up

The teams, approximating District Task Forces during Uganda's Covid-19 response, should be equipped, capacitated, and mandated to manage pubic-heath emergencies within their districts through Heath Centre V/District Hospital systems. DPHTs need not reflect our political-administrative districts, but should be constituted in such a way that they can coordinate with and integrate data from sub-counties, towns and divisions, within their areas. Where CPHEs erupt, the DPHTs should use their ambulance systems, communication channels, data management systems, and technical knowhow, to collect samples, test them, confine cases, declare intra-district curfews and inform the National CPHE Taskforce.

Figure 1: Operational Processes of the Multi-Level National CPHE Strategy



The National CPHE Team (NCPHET, Fig. 1) ought to work separately from (but may coordinate and collaborate with) national security and disaster management structures. Its major task should entail coordination and facilitation of DPHTs: monitoring and quality control; coordination and collaboration with universities and other research institutions; budgeting and provision of equipment and supplies to DPHTs and lower-level structures; intensive research on virological, bacteriological, and micro-biological changes; supporting national security structures on biosecurity; collaborations with the external world; and investing in pharmacological, pharmaceutical, and ethnobotanical developments.

While answerable to the Minister of Health and Parliamentary Committee on Health, the NCPHET should have technical autonomy regarding the country's public health future. During emergencies, such as Covid-19, the NCPHET ought to be the lead agency in terms of ensuring national preparedness, responses, and post-CPHE recovery. Its technical input to policy decisions should take center-stage.

These structures need not be separate governance formations or levels of a new national agency. The starting point is to legislate their creation, draw personnel from relevant structures and levels, and specify mandates of role holders. Where an agency like a National CPHE Agency is created, it ought to be given more research roles during normal public health conditions, its non-core personnel absorbed in preexisting structures only to be called upon immediately when an emergency creates such necessity. The absence of a stand-alone strategy and relevant legislation means that Uganda relied on politically-crafted task forces that included non-technical personnel like RDCs whose activities led to collision with preexisting political and technical structures.

The National CPHE Strategy operationalized in a multi-level process has several benefits. It enhances the country'sCPHEs-response capability: CPHES have become a common feature since 2000, and may remain so. The Covid-19 experience exposed inadequate ambulance services at sub-national levels: addressing these gaps requires functional subnational structures proposed in this strategy. Third, mass education and legitimation of state actions during emergencies becomes is easier with skilled and informed multi-level teams. Fourth, intervention resources areeasily channeled through well-stablished teams compared to haphazard reliance on LDUs and other armed forces for food supplies to the near neglect of civilian state structures. Fifth, the presence of trained persons at all levels makes the country more capable of responding to public-health emergencies and managing biosecurity threats.

Finally, ongoing research and capacity building may, in the medium term, enable the country to produce CPHE-related systems and products, such as testing kits, protective gear, medication products, and even vaccines. Moreover, the multi-level strategy strengthens national public health via continuous mass education, monitoring, and enforcement on public health standards.

Conclusion and Recommendations

The Covid-19 crisis is a strong and strange wakeup call upon Uganda, Africa, the world. Consistent with previous pandemics since 2000, SARS-Cov-2 indicates a future riddled with more complex pandemics afflicting humanity. Countries need not wait for the WHO's declaration of PHEICbefore acting with rapidity and certitude.[44]

[44]WHO, 2019-nCoV Situation Report – 11.

Whether or not an epidemic has potential to spread globally and/or require coordinated international response[45], countries need to care about potentially unprecedented rapidity of infection, virulence, deadliness, and global spread. Confining outbreaks in specific areas like Wuhan enables the international community to rescue the affected country more rapidly: Covid-19 has rendered mostcountries too helpless to assist relatively fragile polities like Uganda. Though by 20th April 2020 Uganda had only 56 infections and zero deaths, and despite experience managing epidemics, the future remains dangerously unpredictable.

The proposed National Strategy on CPHEs provides analytic perspectives and novel insights on operationalising the provisions of the disaster preparedness and management and health policies by crafting an operational CPHEs Strategy. The proposed multi-level processes reflect awareness that CPHEs may erupt anywhere, not though international airports but porous borders or sudden eruptions in remote areas. Response and testing capacity should be accessible and available at district if not lower levels. Uganda's preparedness and response to Covid-19 was possible because the CPHE first appeared as a Chinese problem, then non-African international problem, until it became inclusively global and specifically Ugandan too. The state-society relations that continue to unfold in the wake of Covid-19 also indicate the urgency of a National CPHE Strategy.

None of Uganda's previous epidemics has been spine-chilling enough to cause nation-wide lockdown. But previous emergencies provoked national disaster awareness and learning whose efficacy 2019-nCov is testing. This crisis, therefore, provides justification for prioritising a national strategy, because, in many respects Covid-19 has revealed the need to augment Uganda's approach to public health governance to avoid future lock-downs. The strategy should be multi-stakeholder, prioritising preparedness, response, and post-CPHE recovery. Process-based, multi-actor strategies tend to cushion society against negative impacts of CPHEs like Covid-19.

[45]Robert L. Cubeta, et al., 2020, 'New Models for a New Disease: Simulating the 2019 Novel Coronavirus', Alexandria, VA: Institute for Defence Analysis

From the foregoing, we come to the following recommendations:

1. ***Draw from Relevant Policies to Develop National Strategy on CPHEs:*** The Ministry of Health, working with the Department of Disaster Preparedness in the Office of the Prime Minister and the National Security Council, should draw from the provisions of the national heath and disaster preparedness and management policies to develop a National Strategy on CPHEs.

2. ***Constitute multi-level Teams to execute the Strategy:*** The office of the prime minister should supervise the creation of multi-level teams constituting the operational nodes of the strategy, and ensure that the National Strategy on CPHEs is multi-level, technically competent, given specific mandate, well facilitated, functional, and operates outside of the local political squabbles.

3. ***Undertake consultations on possible development of the Strategy:*** The Office of the Prime Minister, Ministry of Health, and members of National and District Covid-19 Task Forces should start online multi-stakeholder consultations on the development and operationalization of the National Strategy on CPHEs.

4. ***Legislation on the Strategy:*** Ministry of Health and Office of the Prime Minister, should, in an effort to legislatively operationalise the national health policy and disaster preparedness and management policy, ensure that provisions are made on the establishment and operationalisation of the National Strategy on CPHEs.

5. ***Make National Health Self-Sufficiency Central to the Strategy:*** From Covid-19 lessons, the Office of the President, Office of the Prime Minister, and Ministry of Health, should make central to the National Strategy on CPHEs to ensure that Uganda's health systems and structures are strengthened to world class standards in order to forestall future dependence on foreign health services and supplies.

6. ***Draw upon Current Personnel in the Anti-Covid-19 effort to constitute Multi-Level Teams:*** Drawing on the current personnel involved in the national response to Covid-19, measures should be put in place to identify competent, committed, patriotic, and motivated Ugandans who can serve as members of multi-level teams implementing the National Strategy on CPHEs.

About the Author

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