



THE PERFORMANCE OF THE COVID-19 DISTRICT TASK FORCES IN UGANDA

Understanding the Dynamics and Functionality

Wilson Winstons Muhwezi | Jonas Mbabazi
Fred Kasalirwe | Phoebe Atukunda
Eugene Gerald Ssemakula | Oscord Mark Otile
Rebecca Nalwoga Mukwaya | Walter Akena

ACODE Policy Research Paper Series No. 101, 2020

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Acronyms and abbreviations

ACODE	Advocates Coalition for Development and Environment
CAO	Chief Administrative Officer
CDMTC	City Disaster Management Technical Committee
CDPC	City Disaster Policy Committee
COVID-19	Coronavirus Disease of 2019
CSOs	Civil Society Organisations
DDPC	District Disaster Policy Committee
DDPMC	District Disaster Preparedness and Management Committee
DDMCs	District Disaster Management Committees
DECOC	District Emergency Coordination and Operations Centre
DGF	Democratic Governance Facility
DHO	District Health Officer
DTFs	District Task Forces
IATC	Inter-Agency Technical Committee
IGAD	Inter-Governmental Authority on Development
IMPC	Inter-Ministerial Policy Committee
IPCC	Inter-Governmental Panel on Climate Change
LC	Local Council
LGCSCI	Local Government Councils Scorecard Initiative
LGs	Local Governments
MGLSD	Ministry of Gender Labour and Social Development
MLHUD	Ministry of Lands Housing and Urban Development
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MPC	Ministerial Policy Committee
NARO	National Agricultural Research Organisation
NDPMC	National Disaster Preparedness Management Committee
NECOC	National Emergency Coordination and Operations Centre
NGO	Non-Governmental Organisations
NIC	National Incident Commander
OPM	Office of the Prime Minister
RDC	Resident District Commissioner
SCDMC	Sub County Disaster Preparedness and Management Committee
SOPs	Standard Operating Procedures
VHT	Village Health Team

Executive Summary

As the world is faced with the unprecedented challenges from COVID-19, the strain on many governments is extreme, and the impact on people all over the world continues to grow. Indeed, the COVID-19 pandemic has disrupted the social and economic structures of service delivery with significant consequences on lives, livelihoods and general economic development. As part of the response mechanism to contain and manage the COVID-19 pandemic, the Government of Uganda (GoU) instituted national and sub-national COVID-19 task forces to implement and manage the COVID-19 pandemic containment and recovery measures. The Presidential Decree on COVID-19 recognizes the Central Government's role in the provision of healthcare and security. District Taskforces (DTFs) were put in place to support Central Government's containment of COVID-19 and implementation of the GoU COVID-19 containment strategies of case management, surveillance, health promotion, resource mobilization, enforcement of standard operating procedures (SOPs) and continued delivery of basic services.

This report is an important assessment of the performance of the DTFs in implementing the COVID-19 pandemic containment plan.

The main objective of the study is to identify the determinants and level of performance of District Covid-19 Task Forces to enhance their effectiveness. The specific objectives of this study were:

- a) To assess the level of effectiveness, efficiency and functionality of the district task forces;
- b) To explain the role of Central Government Support to District Task Forces and identify success stories for replication.
- c) To establish the level of participation of civil society organizations in the activities of the District Task Forces.
- d) To provide appropriate policy recommendations for building resilient, accountable and effective disaster response structures at the Local Government levels.

The study employed a mixed-methods approach for data collection. The methods included a cross-sectional survey of community members and an appreciative inquiry with key informants. The quantitative approach was adopted to explore the awareness, perceptions and experiences of the community individuals who were beneficiaries of the interventions of the established COVID-19 district task forces. The key informants, on the other hand, were Core Team Members of the DTF and other partners including the Private Sector, Civil Society Organizations, Religious Leaders, Opinion Leaders, Lower Local Council Leaders and Media.

This study was done in 31 districts the choice of which was informed by the previous activities of the Local Government Councils Scorecard Initiative (LGCSCI), a social accountability intervention, implemented in 35 districts across the country. Kampala

District which is not covered by LGCSCI was included in this study because it was the epi-centre of the interventions on COVID-19. The number of community members who participated in the quantitative survey in each of the districts was random while the key informants were purposively selected. The quantitative data collection was based on a scientifically determined sample size proportional to the district's total population provided by the Uganda Bureau of Statistics. A total of 1,415 community members were chosen for a quantitative survey and a total of 744 key informant interviews were conducted.

Quantitative data was collected electronically using Open Data Kit (ODK) with the Computer-Assisted Programme Interviewer (CAPI), while qualitative data was captured using recorders and was transcribed verbatim, into text format. After data collection, the quantitative data was downloaded from the server and exported to STATA for cleaning and analysis. STATA computer Programme was also used to analyze collected quantitative data and to provide useful insights. The analysis of qualitative data also relied on the memos drawn by the researchers and enumerators in the field to put together the responses and make sense of the emerging arguments. The analysis was conducted using Atlas-ti qualitative data analysis software after conducting the data coding processes.

Key Findings

The key findings cover the broad analysis areas that included the context and the regulatory framework in which epidemics and other disasters were being addressed and managed in Uganda, the operational guidelines for the DTFs, DTF structures and processes, the structural capacity of the DTFs, outcomes of the DTF interventions, successes and challenges of the DTFs in Uganda and the perceptions of the community members on the performance and operations of the DTFs in Uganda.

- The findings indicate that much as there were provisions for the guidelines and / or Terms of Reference to the District Task Forces in Uganda, the implementation of these guidelines varied from district to district. These guidelines were passed on to the Local Governments from Central Government Ministries to guide districts on how to handle operational issues like utilization of resources, activating task forces, maintaining a lean staff structure, and conducting the business of councils among others. In many districts, the guidelines were very instrumental and helpful in the implementation of the activities of the DTFs.
- The Local Governments responded very fast to activate an institutional infrastructure to respond to COVID-19. The results showed that there were committees and sub-committees formed both at the districts, Municipalities, Town Councils, Sub-counties and Villages in all districts to contain the spread of COVID-19. These committees were mainly formed along with the existing local government structure. The major sub-committees running were: security, surveillance and burial committees which were mainly



composed of the Health Technical Team. Much as different districts had varying sub-committees, generally, the Risk Communication Committee, the Psychosocial Support, the Case Management, and Testing Committees and the Logistics Committee were more prominent.

- The membership of the core DTFs in several districts ranged from 19 to 22 members. Some sub-committees supported the core team. The composition of these teams varied across the districts. In some districts, there were support mechanisms for the Sub-county committees.
- Also, the guidelines provided to the LGs on the structure of the COVID-19 District's Task Force required the Resident District Commissioner to be the Chairperson of the Taskforce. This, however, was not consistent with the *Disaster Preparedness and Management Policy (2011)* which designates the District Chairperson to head such a task forces. The distortion of this institutional structure created role conflicts in some districts which affected the performance of the Task Forces.
- The findings also showed that there was a lack of coordination of communications sent to the Local Governments from the Central Government Ministries and Agencies. The DTFs got directives from several fronts including: Ministry of Finance Planning and Economic Development (MoFPED), Minister for Presidency, Office of the Prime Minister, UPDF and each entity sent their communication to its representative on the task force to implement most times without their knowledge of the line Ministry.
- These findings revealed that the creation and structures of the national and sub-national COVID-19 Task Forces were not consistent with the National Policy on Disaster Preparedness and Management. It was also noted that the Ministerial Policy Committee and the National Emergency Coordination and Operations Centre (NECOC) which were mandated with leading a national response as well as the decentralized structures like the District Disaster Management Committees and the District Emergency Coordination and Operations Centre (DECOC) were found not to be very active during this period
- It was noted that the community, LC1s and VHTs played key roles in tracing contacts, issuing alerts and getting suspected cases of COVID-19 with the support of surveillance sub-committee. This was attributed to the sensitization of the public on COVID-19. In some districts, the Village Health Teams (VHTs) which are the lowest levels of the Health System, were trained to become instrumental in the identification of the cases.
- Use of ICTs was found to be instrumental in the performance of the DTFs. The DTFs coordinate activities with different stakeholders using different mechanisms. For instance, the National Task Force (NTF) communicated with the different DTFs through social media particularly WhatsApp, zoom meetings, emails, and phone calls. The NTF shared official communication and gave guidelines during these meetings. Similarly, the committees within

the DTF had to report weekly on the progress they had made through the reports presented during the meetings. This, therefore, presented a case for intensifying e-governance in the Local Governments.

- In terms of the role of key stakeholders, it was evident that the Central Government played a critical role in providing regular information and updates about COVID-19, especially, in the first three months after the country went on a lockdown and that this helped to contain the spread of the virus among the population. Also, the Central Government played a key role in facilitating the activities of the DTFs in the different Local Governments.
- Further, any Local Government with a strong CSO presence was able to achieve more results. The CSOs played important roles in resource mobilization to supplement the efforts of the task force. Some CSOs facilitated meetings, movement, coordination, and other efforts of the DTFs. Others sponsored radio talk shows for the DTFs to sensitize the communities in their localities. Similarly, the results revealed that other stakeholders such as media, private sector, opinion leaders and religious leaders played significant roles to support the DTFs in the fight against COVID-19.
- The results of the study showed that there was a coordinated structure from the district to the lowest level of the community. The utilisation of the Local Council structure as mirrored in the health care structure with support from the security personnel was instrumental in reporting and tracing of contacts across the districts.
- The results show that different districts had different strategies for inclusion targeting the vulnerable in their jurisdictions. Also, the categorisation of the vulnerable people seemed to vary by district. Most districts, however, targeted women, children and PWDs as vulnerable categories and provided minimal support to these groups.
- In terms of preparedness by DTFs, the findings revealed that most districts did not have response plans and budgets in place. It was mainly those districts that had experienced epidemics like Ebola, Marburg that had such response plans. Even when most of the districts had a resource mobilization committee in place, they lacked any mechanism or clear strategy for resource mobilization. It was also revealed that most districts had not been able to equip the health facilities with hand washing equipment, personal protective gear, creating isolation and quarantine centres. However; where districts had made efforts to create the isolation and quarantine centres, the level of sufficiency of the resources needed in these units was lacking.
- The measures to respond to COVID-19 seemed to be ad hoc. In districts where the response plans existed, they were not adequately financed. Further, it was established that there was no direct funding to LGs to take care of emergencies like the pandemic, epidemics, and natural disasters among others in the Local Government budgets. Even when the Local Governments were at the forefront of dealing with disasters, prevention



and preparedness, the LGs lacked funding directed towards disaster management, preparedness and prevention which had rendered the implementation of the District Response Plans difficult. Those that had some available local revenue often allocated this to respond to disasters, however, since these resources were meagre, the LGs often found themselves reaching out to development partners and OPM for assistance. There were significant responses that indicated lack of coordination and awareness about contingency planning and activities. This should be strengthened as a cross-cutting issue in Local Government activities.

- Most Local Governments appreciated the Central Government for allocating some resources for LGs to respond to COVID-19. While Parliament allocated UGX 165 million in the supplementary budget to Local Governments in April 2020, there were concerns that these monies were not released in time.
- Whereas there were such mechanisms in ensuring accountability and transparency within the DTFs, many key informants raised concerns about how the resources were used. Most of these concerns rotate around; failure by the DTF members to provide accountability for resources received and nepotism in identifying beneficiaries of food items.
- Concerning community perceptions on the performance of the DTFs, first, it is established that majority of the respondents (67%) were aware of the existence and activities of the DTFs in Uganda with Resident District Commissioner (RDC), the District Health Officer (DHO), and the Police Officers were the most popular categories of the members of the COVID-19 District Task Forces. Most of the respondents did not know that the District Chairperson was a member of the DTF.
- The results also revealed that Lower Local Council leaders were commonly contacted by the community members in case of any emergency or need. Among the most common services which community members reported about included: information sharing/sensitization by the DTF team (74%), and enforcement of the Ministry of Health guidelines (54%). Also, 33 per cent of the respondents reported that they were aware of the testing and quarantine/isolation centres in their respective districts.
- In terms of experiences, the results indicated that overall, 58 per cent of the respondents reported that they had benefited from the different services offered by their respective COVID-19 District Task Forces. It was also revealed that mobile phones (54 per cent) and word of mouth (54%) were the most commonly used communication platforms by the DTF to pass on information to the members of the community.
- Regarding the interface between the community members and the members of the DTFs, the results revealed that 18 per cent of the respondents reported that they had interfaced with a member of the DTF team directly compared to 82 per cent who had not. Exploring the circumstances under which the community members interfaced with the DTF core team members, it

was reported that majority of the community members (48%) interfaced with the DTF core team through receiving food items and other forms of donations. In terms of their experiences, the majority (85%) reported that the DTF officials were friendly and happily offered assistance to the people. Concerning experiences of the community members who managed to get services within the testing and isolation centres, the majority (68%) reported that they experienced good services.

- From the regional perspective, the results showed that Teso (31%) and Acholi (22%) sub-regions had the highest proportions of community members that reported the DTF to have offered services to be the community members in their jurisdiction
- Concerning access to information, overall; 91 per cent of the community members reported being sensitized on COVID-19 pandemic related issues from a wide range of relevant agencies and individuals. In terms of frequency of sensitization, 57 per cent of the respondents reported that they received daily messages on prevention and containment of COVID-19 while 18 per cent received sensitization once a week. The results also revealed that the majority of the respondents (99%) reported that COVID-19 communication adverts contained information on preventive measures against COVID-19 while 17 per cent reported that the COVID-19 adverts contained messages on the emergency response by the health officials.
- In terms of satisfaction, results showed that 27 per cent of the respondents were highly satisfied with the community sensitization provided by the District task forces, 32 per cent were moderately satisfied, and 28 per cent had low satisfaction while 12 per cent were not satisfied at all.
- Relating to the readiness of the DTFs to address COVID-19 emergencies, the study revealed that 43 per cent of the respondents reporting that their satisfaction with the level of readiness of the DTF was low. Also, concerning enforcement, 30 per cent of the respondents reported that they were highly satisfied with the DTFs, 35 per cent were moderately satisfied while 26 per cent reported low rates of satisfaction with the enforcement of the SOPs.
- Also, majority of the respondents were not satisfied with the level of accountability by the DTFs. Specifically, results showed that 47 per cent of the respondents were never satisfied with the level of accountability while 44 per cent rated it low. On food distribution, 20 per cent of the total number of respondents reported receiving this form of social assistance from the government. Out of these, 21 per cent were highly satisfied while 40 per cent were moderately satisfied.
- On the issuance of the travel permits, it was made evident that the majority (61%) were not satisfied with the efficiency and timeliness of issuance of travel permits in their localities. Also, 22 per cent of the respondents reported that the level of satisfaction with this service was low.

- About the efficiency of the DTFs in executing their mandate, 61% of the members of the public did not receive any information or communication on how the resources, supplies and other items in the hands of the DTF were utilised. Also, it was reported that 20 per cent of the respondents were able to easily and timely have access to services from the DTFs while 56 per cent were not. The services easily and timely delivered to the community were information and sensitization on COVID-19 as reported by 64% of those members of the community that received services from the DTF. Also, 50 per cent of the community revealed that food distribution was inefficiently handled and that 72 per cent of the respondents reported receiving food that was being distributed in their communities.
- Relating to effectiveness in the DTF service delivery and operations, 33 per cent of community members reported that the COVID-19 District Task Forces achieved their objectives in managing and containing COVID-19 in their communities while 45 per cent reported that DTF objectives were not achieved. The largest proportion of the community members (69%) reported that education or sensitization on COVID-19 was the most significant benefit from the COVID-19 District Taskforce.
- The level of education was observed as the most significant driver of the community members' awareness and satisfaction levels towards COVID-19 DTF activities. It is evident that as one's education levels increase, one is more likely to be knowledgeable and aware of the DTF services compared to one with less or no education. There is no other significant factor that influences the satisfaction of the community members but there is quite a number that influences awareness. Gender positively and significantly influences one's levels of awareness whereby, male respondents were more likely to be knowledgeable and aware of the DTF activities and services compared to their female counterparts. On the other hand, the main source of income, age, and location are all significant drivers of one's knowledge and awareness of the COVID-19 DTF activities and services. Also, as one moves out of the central region, one becomes more likely to be knowledgeable, aware of and satisfied with the DTF activities and services.

Recommendations

Response strategies on handling

1. Local Governments should improve road and other communication infrastructure to facilitate timely access and response. Findings indicated that delayed response led to the loss of life.
2. DTFs/ DDMCs should develop effective coordination system with clear procedures for the entire response phase by strengthening the capacity of corresponding DECOCs and DDPCs.
3. District Disaster Management Committees (DDMCs) should establish

rapid response teams under the DRR platform. A coordination mechanism involving all disaster responders (Governments, CSOs and local community members) should be strengthened and should have standards against which accountability should be based.

4. DDMCs/DTFs should carry out training programs for local communities to actively respond to pandemics, epidemics and other disasters. Empirical evidence showed that local communities were usually the first responders and were less empowered to intervene in case of need. It is, therefore, necessary to empower local communities to be more effective in supporting efforts for containing such pandemics.
5. There is need to utilise the existing local government structure to implement interventions for containment and recovery from COVID-19. The local government structure should be utilized in implementing interventions to respond to COVID-19. There is the great capacity and potential within the existing Local Government structure including LC I, LC II, LC III, and LC V. The utilization of this structure has not been optimal. There is, however, no doubt that resources both in terms of capacities and funding are needed to implement the disaster management plans.

Recommendations for the Office of the Prime Minister

1. The study recommends that government makes use of the institutional framework established by the National Policy on Disaster Preparedness and Management in its disaster response programs. Structures like the National Platform for Disaster Risk Reduction, NECOC, Ministerial Policy Committee, District Disaster Committees, DECOC among others should be relied upon to provide disaster mitigation, aversion and management guidance as they are established with the right technical expertise, competencies and capabilities. Disaster management should not be ad hoc in nature as usually seen through the establishment of ad hoc structures like the National Taskforce on Coronavirus to the detriment of institutional response.
2. OPM should ensure that National Disaster Management Policies and Frameworks are prepared and communicated by districts to all stakeholders since they have a direct bearing upon recovery. This will enable awareness creation and preparations against disasters including pandemics like the COVID-19.
3. OPM and DDMCs should create and provide disaster contingency funds to ensure quick response to landslides disasters. Funding is a key resource in disaster management. Therefore, funds should be made readily available for ease of managing disasters.
4. DTFs should encourage and empower local communities to actively participate in COVID-19 containment measures and all other processes. Local communities especially Local Councils have developed surveillance



systems that can help in the dissemination of information, locating alerts and contacts and mobilizing communities. The DTFs can draw upon this capital to be more effective in implementing COVID-19 containment measures.

5. DDMCs should ensure adequate manpower with technical competences in managing disaster is in place well in advance before landslides disaster occurrence. Findings indicated that technical officers in land management did not assist local communities on housing construction and agricultural practices as necessary mitigation measures in landslides disasters prone areas. Technical competencies are vital in helping people militate against landslides related disasters.
6. Interaction between the national and district level is one of the most important issues in ensuring the establishment of a well-functioning DDMR system. The study has observed a huge commitment and enthusiasm within many of the DTF members interviewed. The study also establishes that there are variations in the levels of capacity among the DTFs. In some districts like Mbale, and Bududa there were reports of regular meetings for planning and response. This could be explained by their previous experience in handling disasters like landslides in their jurisdictions. In other districts capacity is more limited and DTFs rarely meet. Strengthening the capacity of the DTFs should be a priority task for OPM, MOLG and MOH. This has to include clear ToR for DTFs.
7. COVID-19 has affected all districts in Uganda. In this case, the issue of inter-district coordination is critical. Therefore, coordinating with several DTFs/DDMCs, each carrying out their parallel planning exercises and requesting the same resources from the national level will be a complex task. This issue can be addressed by cooperation, collaboration and coordination between districts at regional levels. Establishment of regional response teams may register more successes for regional cooperation of the districts.
8. There is need to follow the established for responding to pandemics and disasters. The OPM, who has the mandate to coordinate and manage disaster preparedness and planning response activities, is currently unable to fulfill its responsibilities as it lacks the full support of all key players, including resources. The absence of clear TOR/ legal framework and adequate resources has led to a lack of a unified and coherent system in the districts, resulting in the establishment of ad-hoc and personalized arrangements during disasters. The GoU should ensure that a single institution at the central government level maintains the mandate and responsibility to manage disaster response. The chain of command at every level should be identified and complied with.
9. There is need for a law to govern disaster risk reduction and management: Currently, Uganda does not have a national law governing disaster risk reduction and management, and its alignment with international thinking

although a National Policy for Disaster Preparedness and Management exists. The Uganda National Disaster Preparedness and Management Act, draft Bill should be fast tracked and enacted into law.

10. There is a need to operationalize the Disaster Preparedness and Management Commission. Uganda's Constitution (Article 249) also provides for the establishment of a Disaster Preparedness and Management Commission "to deal with both natural and man-made disasters", which is yet to be operationalized. Without a law to govern government's work on disasters, the composition of the Disaster Preparedness and Management Commission and its duties, response to disasters will remain ad hoc and impractical.

Ministry of Finance, Planning and Economic Development

11. There is need to operationalize the Contingency Fund provided for under Section 26 of the 2015 Public Finance Management Act so that the both the Central Government and the Local Governments are empowered to effectively respond to pandemics, disasters and other risks adequately. This would also boost financing Uganda's Disaster response as detailed in the National Policy on Disaster Preparedness and Management.
12. There is a need to increase health sector financing for emergencies. Inadequate funding was reported as a major challenge affecting the functioning of the District Task Forces. It was evident that the country was not adequately prepared to handle the pandemic. Most DTFs relied on contributions from individuals, the private sector and civil society to finance its response activities. It is recommended that Government of Uganda through the Ministry of Finance, Planning and Economic Development should increase health financing by increasing the share of Budget allocation to the health sector from the current 5.1 per cent to at least 15 per cent as it committed to during the Abuja Declaration in 2001. Uganda's health sector has to be well funded to quickly deal with such health pandemic. Regional testing labs should be put in place.
13. Establish a Pandemic Response Plan and Contingency Fund. There is need to operationalize the Contingency Fund as provided for in Section 26 of the 2015 Public Finance Management (PFM) Act so that government efforts to avert risk and manage disasters are adequately funded.

Ministry of Health

14. Mainstreaming pandemic preparedness and response within the broader context of health systems.¹ Epidemics could be addressed through making contingency plans and structuring emergency health services. It is also important to establish develop early warning systems through routine

¹ <https://blogs.worldbank.org/health/what-can-we-learn-uganda-fighting-deadly-disease-outbreaks>

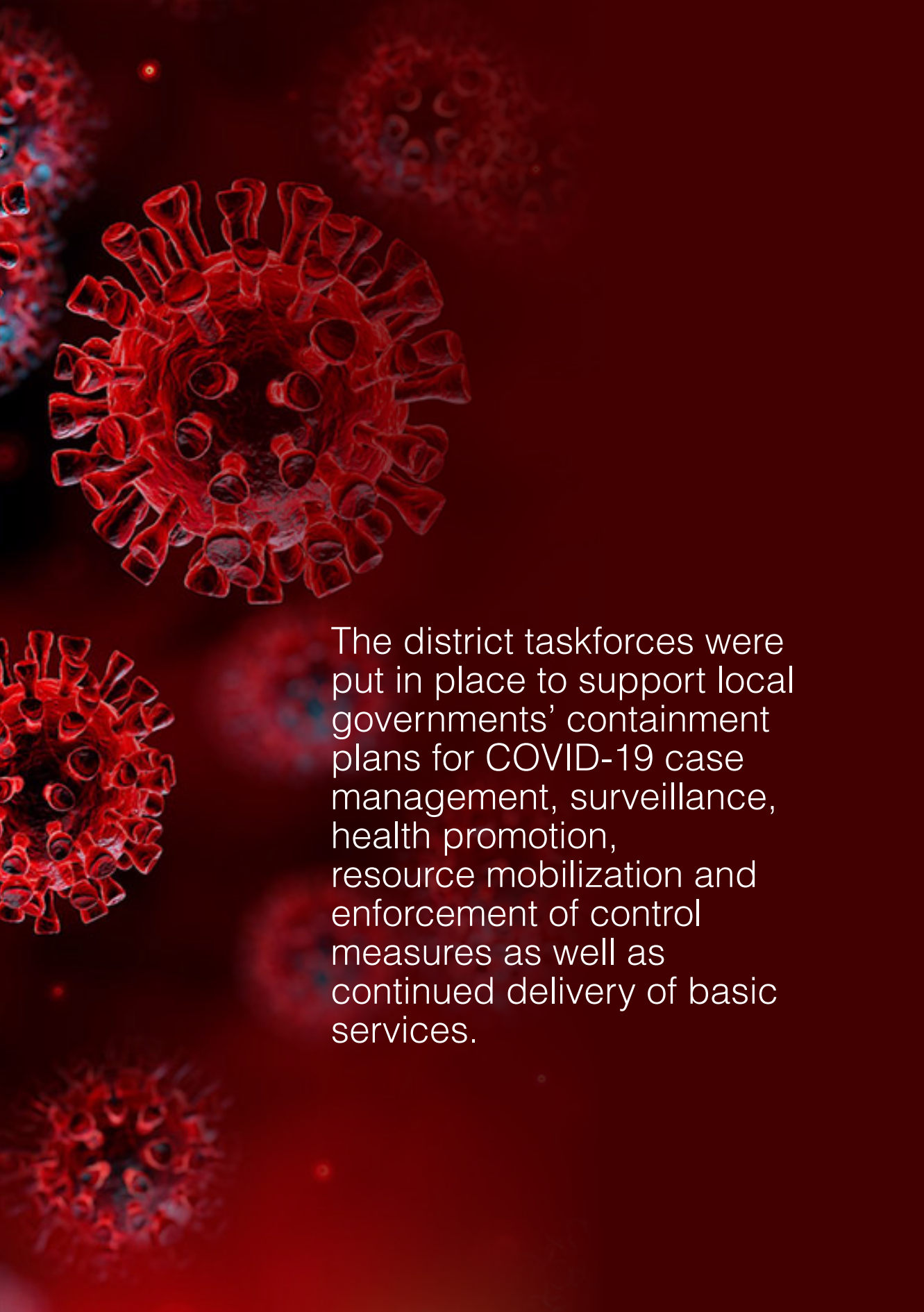
surveillance and training in emergency operations. Success of this will depend on creation of an inventory of required resources. There is need to have establishment of emergency units at the district levels like disaster preparedness strategies. Have a permanent task response team in place for any emergency which should be well facilitated in terms of allowances and resources to use. This task force should have planning and accountability mechanisms in place. The lockdown magnified the need for local content and the need to develop local capacity.

15. Emergency funds like in the case of COVID-19 should be decentralized across the various levels of Local Governments to enhance response by all actors.
16. To achieve and sustain Universal Health Care (UHC) gains requires resilient health systems that are better prepared and can recover from public health crises. Pandemic preparedness protects people from health threats and UHC reforms ensure that everyone has access to quality health services without suffering financial hardship.

Ministry of Local Government

1. Revitalise District Disaster Management Committees. The National Policy for Disaster Preparedness and Management 2011 provides for the District Disaster Management Committee in the district. The committee is chaired by the CAO and comprises of heads of departments, DPC, army representatives and representatives of other relevant government agencies and Partners within the district including Uganda Red Cross Society and relevant NGOs. However, findings revealed that these are largely inactive and in some cases non-existent. It is recommended that these committees be revived and supported to remain functional to coordinate local government responses to future disasters.
2. There is a need for the MoLG to mainstream e-governance in Local Governments. The Ministry of Local Government needs to work hand in hand with the Ministry of ICT to expand the ICT infrastructure across the country. This also calls for investment in the expansion of access and provision of low-cost internet services.
3. Compliance to accountability is often compromised in a bid to attend to emergencies during pandemics that arise now and then as expedient disbursements and procurements are made. To curb this, there is need to create multi-disciplinary teams that give oversight to the core team, especially, of the resource mobilisation /logistics committee.
4. Training law enforcement on human rights. The study also revealed that there were reports of human rights violations during the enforcement of the guidelines. This, therefore, calls sensitisation of the police and the military on human rights issues during such operations.

5. The DTFs should operationalize preparedness mechanisms to empower local communities to handle pandemics, epidemics and other disasters.
6. There is a need to establish a single and unified preparedness framework by integrating preparedness and management of pandemics and disasters into respective sector plans of government at the local level. Many of the responses indicated a lack of coordination and awareness about contingency plans and activities. This should be strengthened as a cross-cutting issue in local government activities.
7. There is a need for clear coordination systems. The Ministry of Local Government needs to set up effective coordination systems with clear procedures governing the entire response cycle. Results showed inadequate coordination mechanisms within and among DTFs, other organizations involved in response activities and affected communities. Coordination is a vital aspect in managing emergencies and needs improvement for maximum effect in handling epidemics, pandemics, landslides, floods and other emergencies.
8. The Ministry of Local Government should ensure that facilitation and implementation of emergency response or plans is geared towards mitigating their consequences by strengthening resource capacity at the local level. This would be instrumental in providing emergency equipment and materials for handling pandemics, epidemics and other disasters. Empirical evidence revealed inadequate emergency materials and equipment necessary in handling pandemics like COVID-19.



The district taskforces were put in place to support local governments' containment plans for COVID-19 case management, surveillance, health promotion, resource mobilization and enforcement of control measures as well as continued delivery of basic services.



Chapter 1

Introduction and Background

1.1 Introduction

This is a report of the study on the performance of the COVID-19 District Task Forces (DTFs) conducted during the months of August and September 2020. As countries face the unprecedented challenges from COVID-19 the strain on the governments' coffers is extreme, and the impact on people all over the world continues to grow.² Coronavirus (COVID-19) was declared a pandemic on 11 March 2020 by the World Health Organization. Cases of this virus have been recorded in most countries around the world. According to WHO's COVID-19 dashboard as of December 18, 2020, there have been 72,851,747 confirmed cases of COVID-19, including 1,643,339 deaths reported to WHO. In Africa alone, COVID-19 cases were reported at 2,469,446 with 58,329 deaths.³ As of December 17, 2020, the COVID-19 situation in Uganda was as follows: new cases were 710, new deaths were 2, new recoveries were 0, cumulative cases were 30,071, cumulative deaths were 230, cumulative recoveries were 10,251, new tests were 702,198.⁴ The COVID-19 pandemic has disrupted the social and economic structures of service delivery with significant consequences on many lives, livelihoods and on the national economy. To restrain the spread of COVID-19 pandemic, the Government of Uganda instituted measures such as partial lockdown on movement of people and closure of places that involved close public interactions. This resulted into disruptions in social services and economic development structures, especially, the Local Government systems of service delivery with severe consequences on health, livelihoods and general economic development. (UNCDF, COBAMS, 2020).

As part of the response to contain and manage the COVID-19 pandemic, the Government of Uganda instituted national and sub-national COVID-19 task forces to implement containment measures and manage recovery out of the pandemic. The national-level COVID-19 task force, is headed by the president while the ones at the Local Governments' levels are headed by the Resident District Commissioners who are the representatives of the president at the district levels. The Presidential decree on COVID-19 recognizes Local Governments as essential services that must continue along with healthcare and security.⁵ This is in line with the Local Government Act (1997) and the National Policy for Disaster Preparedness and Management that places Local Governments among the responsible institutions to handle disasters (GoU, 2011).

The district taskforces were put in place to support local governments' containment plan for COVID-19 case management, surveillance, health promotion, resource mobilization and enforcement of control measures as well as continued delivery of

² <https://www.opengovpartnership.org/collecting-open-government-approaches-to-covid-19/>

³ https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200618-covid-19-sitrep-150.pdf?sfvrsn=aa9fe9cf_2

⁴ <https://covid19.gou.go.ug/statistics.html>

⁵ <https://www.uncdf.org/article/5507/ugandan-local-governments-the-driving-force-behind-the-covid-19-response>

basic services. Local Governments the world over are at the core of the COVID-19 crisis to ensure that the services that keep communities functioning continue to be delivered to the best standards.⁶

Since 2009, ACODE has been implementing an accountability and capacity building initiative in 35 Local Governments across the country with support from the Democratic Governance Facility (DGF). The Local Government Scorecard Initiative (LGCSCI) is a strategic social accountability initiative that enables citizens to demand excellence of their local governments and enables the Local Governments to respond effectively and efficiently to those demands. The LGCSCI methodology, described in ACODE's annual scorecard reports is grounded in an action research methodology. It combines capacity-building with an evidence-based assessment of the ability of elected political leaders to fulfil their mandate (Bainomugisha et al. 2014), as defined in Uganda's Local Government Act 1997 (as amended). The assessment of the performance of the COVID-19 District Task Forces, therefore, is one of the interventions aimed at stimulating the supply side. The study also cross-examines the level of involvement and participation of citizens in the containment of COVID-19 by means of the existing structures with a view of generating issues for informing policy processes and re-engineering the existing structures to deliver the necessary services to the ordinary citizens at the Local Government level. The study further seeks to establish the best practices, and achievements of the district task forces for scale-up across the Local Governments in Uganda.

1.2 Objectives of the study

The main objective of the study is to identify the determinants and level of performance of District Covid-19 Task Forces to enhance their effectiveness.

1.2.1 Specific Objective

- a) To assess the level of effectiveness, efficiency and functionality of the district task forces;
- b) To explain the role of Central Government Support to District Task Forces and identify success stories for replication.
- c) To establish the level of participation of civil society organizations in the activities of the District Task Forces.
- d) To provide appropriate policy recommendations for building resilient, accountable and effective disaster response structures at the Local Government levels.

⁶ <https://www.clgf.org.uk/whats-new/local-government-action-on-covid-19/>

1.3 Background

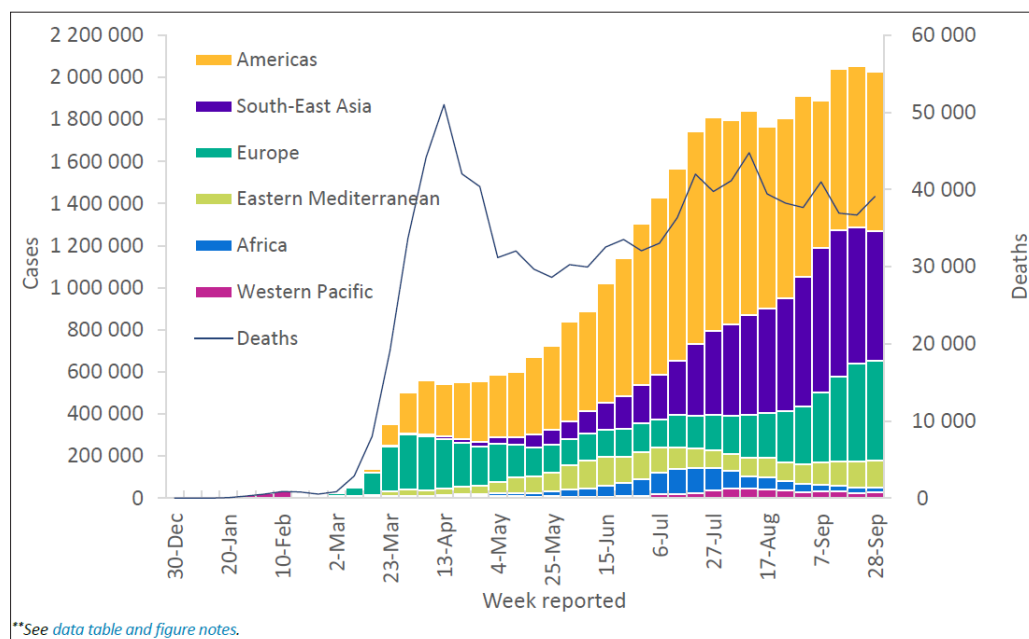
Corona viruses cause diseases in mammals and birds. They mainly circulate among animals but can evolve to infect humans. In humans, the viruses cause respiratory illnesses which are typically mild including the common cold but severe forms can be fatal. In animals, these viruses may cause diarrhoea, while in chicken they cause upper respiratory disease. All corona viruses that infect humans have been shown to have human to human spread. There are no vaccines or antiviral drugs approved for the prevention or treatment of corona viruses. There have been two large outbreaks of Coronavirus in the last 2 decades namely: (a) Severe Acute Respiratory Syndrome (SARS) between 2002- 2003 that affected over 8,000 people with 800 deaths in 29 countries; and (b) Middle Eastern Respiratory Syndrome (MERS) in 2012 with over 1,700 cases and 670 deaths in 27 countries.

COVID-19 was first detected in Wuhan city, Central China, in December 2019. It is believed to have originated from wild animals, passing to humans due to the wildlife trade and wet markets. The virus spread to other Chinese provinces in early and mid-January 2020. This was due to the increased mobility of the population during the Chinese New Year celebration. Cases were detected in other countries among international travellers from Wuhan to various countries. By 1st of March 2020, the following countries had been affected: Thailand, Japan, South Korea, Taiwan, the United States, Hong Kong, Macau, Singapore, France, Nepal, Vietnam, Australia, Malaysia, Canada, Cambodia, Germany, Finland, Sri Lanka, the United Arab Emirates, India, Italy, Philippines, Russia, United Kingdom, and Sweden.

After confirming the onset of the pandemic, the World Health Organisation (WHO) released operational planning guidelines to support country-specific preparedness and response. The global appreciation of these guidelines was varied with some Asian, European, South American and African countries responding in diverse ways. The consequences of the COVID-19 pandemic have since stretched far beyond the spread of the disease. Efforts to contain transmission triggered the worst global economic crisis in the century, devastating the livelihoods of millions of people. In the developing world, reduced incomes, food insecurity, inadequate education, and increased domestic violence, child-marriages and teenage pregnancies are all contributing to the worsening in welfare and increasing poverty. Around 40 to 60 million additional people could fall into extreme poverty in 2020 compared to 2019. Poverty is expected to increase for the first time since 1998, erasing the progress made in the past five years and threatening the goal of eradicating extreme poverty by 2030, particularly in fragile states where most of the global extreme poor will reside⁷. The increase in poverty is driven by large and sustained falls in income, leading to the depletion of savings and food insecurity. On top of that, welfare is being further eroded from the impact of widespread school closures and higher incidences of domestic violence. The global economic downturn, extensive containment measures, and inadequate social protection have meant significant drops in income for many in the developing world.

⁷ <https://www.worldbank.org/en/topic/poverty/publication/fragility-conflict-on-the-front-lines-fight-against-poverty>

Figure 1: Number of COVID-19 cases reported weekly by WHO region and global deaths, 30 December 2019 through 04 October 2020



Source: WHO 2020

In the wake of this pandemic, the Government of Uganda (GoU) was jolted into action to provide policy and strategic direction for the epidemic response. Since March 2020, the GoU has been implementing a series of vulnerability reduction and containment measures to curtail transmission of COVID-19. When Uganda registered the first case, the GoU declared that from midnight of Sunday 22nd March 2020, all passenger flights entering and leaving Uganda were banned. Only cargo planes were allowed in and out of Entebbe International Airport. Also banned were entries into Uganda by anyone other than truck drivers, by land or water. Pedestrians were also prohibited from entry into the country from the neighbouring countries⁸. On 25th March 2020, all public passenger transport was suspended, non-food stuff vending in public markets were closed to the general public save for food vendors who were cautioned against making unnecessary trips to and from home. Private vehicles were allowed to move but with restrictions to carrying a maximum of 3 people per vehicle including the driver. However, on 30th March 2020, authorities discovered that unregulated private car owners were using their cars to ferry passengers at exorbitant rates. The GoU announced a lockdown for 14 days starting 1st April 2020 and prohibited all people to people movement, gatherings of more than five (5) people and closed all shopping malls, arcades, and shops selling non-food items. Only factories, farms, supermarkets, food stores selling agricultural products, veterinary products, detergents, and pharmaceuticals were allowed to remain open but with clear SOPs observing social distancing.


⁸ <https://www.mediacentre.go.ug/media/president-musevenis-8th-address-covid-19-and-lockdown-relaxation>

E-commerce and home deliveries for essential goods and services were encouraged. Factories and construction sites were also allowed to continue but with restricted movements of all workers who had to be encamped at their places of work for the period of the lockdown. Uganda also recognized essential services as being: medical & veterinary, telecom & internet, couriers & door-to-door delivery, banks, private security companies, cleaning services, garbage collection, fire-brigade, petrol stations, water departments and key government offices such as Uganda Revenue Authority and Uganda National Roads Authority. The GoU also announced a countrywide curfew starting 1900 hours and ending 0630 hours on every day. Uganda also recognized that a disadvantaged section of its population would still require access to certain services. Consequently, individuals with pre-existing medical conditions, pregnant women requiring ante-natal visits, mothers with newborn babies, and the sick were allowed to access health centres but with written permission and clearance from the respective Resident District Commissioner, as district representative of the President of the Republic of Uganda. In addition, the government announced that it would collect any government vehicles that did not belong to Uganda's security forces and Uganda Wildlife Authority for use by the District Task Force teams.

Some of the the Presidential directives on COVID-19 recognized Local Governments as epicentres of essential services that had to continue along with healthcare and security.⁹ This is in line with the Local Government Act (1997) and the National Policy for Disaster Preparedness and Management that places the Central Government among the responsible institutions to handle disasters (GoU, 2011). The District taskforces were put in place to help Central Government contain COVID-19 and implement GoU COVID-19 containment approaches like case management, surveillance, health promotion, resource mobilization and enforcement of control measures and continued delivery of basic services. It should be noted that Local Governments throughout the world were and are still at the core of the COVID-19 crisis response to ensure that the services that keep communities functioning continue to be delivered in the best standards possible.¹⁰ It is against this background that ACODE, with the support from Democratic Governance Facility (DGF) commissioned this study to better understand the dynamics that informed the performance and functionality of managing COVID-19 and its effects on the operations of Central and Local Governments in Uganda.

⁹ <https://www.uncdf.org/article/5507/ugandan-local-governments-the-driving-force-behind-the-covid-19-response>

¹⁰ <https://www.clgf.org.uk/whats-new/local-government-action-on-covid-19/>



Chapter 2

Conceptual Framework

In this chapter, a conceptual framework for the study is presented. The conceptual framework adopted in this study highly draws from the work of Handler, A., Issel, M., & Turnock, B. (2001)¹¹ that proposes 5 key elements in the assessment of public health systems. The conceptual framework posits that any analysis of public health system interventions has to pay attention to the macro context, the set mission, structural capacity, processes and outcomes.

The functionality of a District COVID 19 Task force in Uganda shall be assessed basing on the assumption that:

... the mission, structural capacity, processes, and outcomes of the public health system ... affected by the social, economic, and political milieu in which the system operates. If the mission and functions of the public health system are to be achieved, the appropriate. structural capacity (e.g., human and information resources) must be in place. The resources and relationships that constitute this capacity are used to carry out the processes of public health, those that identify and prioritize population health needs and determine how they will be addressed, as well as those that represent the outputs of these more fundamental processes, public health services, policies, and interventions. These system processes constitute public health practice. The ultimate results of public health practice are system outcomes, typically measured as improvements in population health status.¹²

These concepts are applied in this study on the functionality of a District Task Force is as follows:

The context for the DTF: The context of a DTF performance is informed by the COVID-19 situation at Global National and sub-national level. This context demonstrates the interaction between the DTF and the ever-changing environment and realities of the pandemic with global, national and subnational ramifications. It also comprises the social, economic and political realities the DTF has to contend with.

Set mission for the DTF: The mission defines the goals that have been set for the district task force. In this particular pandemic, the time element of the realisation of the set mission for the countrywide response by each DTF is paramount.

¹¹ A conceptual framework to measure performance of the public health system. American Journal of Public Health, 91(8), 1235-1239.

¹² Ibid

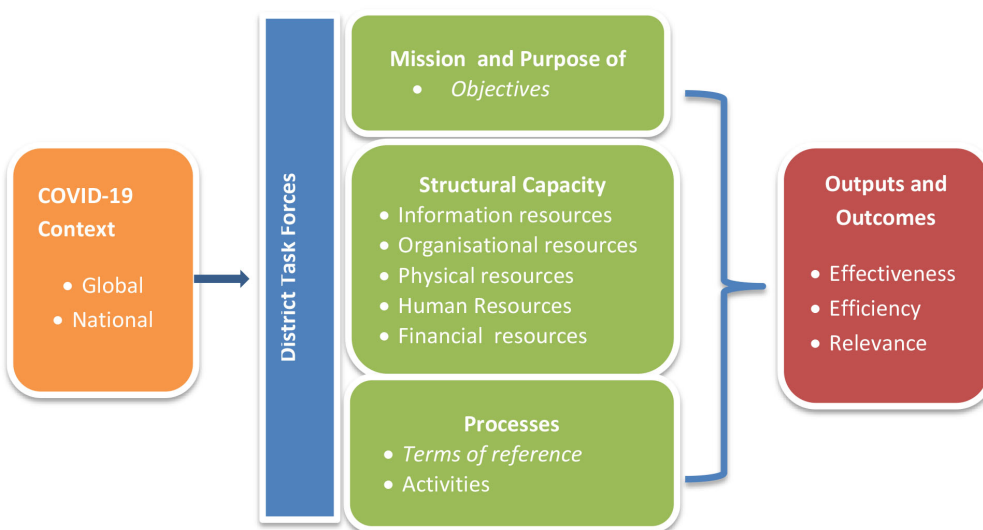
Structural Capacity: Conceptually, the structural capacity is the cumulative resources and relationships necessary to carry out the important processes set for the District Task Force. These resources include information resources, organizational resources, physical resources, human resources, and financial resources. The interaction of these elements is a key focus in this study.

Processes: In the context of this study, the processes refer to the key interventions that are being undertaken by the District Task Force. These are mainly drawn from the Terms of Reference provided to the DTF. This concept also covers the hierarchical and cyclical nature of these processes in addition to their coordination, guidelines and timeliness of response.

Outcomes: The ultimate measure of functionality lies in the ability to show results. These results are both immediate and long terms in nature. The measurement of these outcomes focuses on effectiveness (achievement of the set targets), efficiency (resource utilisation) and relevance (meeting needs and expectations, especially, of the various stakeholders).

The interaction of these variables is illustrated in Fig. 1

Figure 2: Conceptual Framework for Analysis of the Functionality of Task forces



Adapted from Handler, A., Issel, M., & Turnock, B. (2001)



Chapter 3

Methodology and Study Design

This chapter presents the study design which highlights the districts selected for the study, sample size and sampling procedures, data collection techniques, fieldwork processes, data management and analysis, and ethical considerations.

3.1 The COVID-19 DTF Study Assessment Design and Methods

3.1.1 Categories of the Study Participants

The study employed a mixed-methods approach for data collection. The methods included a cross-sectional survey of community members and an appreciative inquiry with key informants. The community members included individuals from the community who were drawn from their respective areas of aboard. The quantitative approach was adopted to explore the awareness, perceptions and experiences of the community individuals who are beneficiaries of the interventions of the established COVID-19 district task forces. The key informants, on the other hand, were core team members of the DTF and other partners including the private sector, Civil Society Organizations, Religious Leaders, Opinion Leaders, Lower Local Council leaders and media. A qualitative approach was adopted to explore the functionality and dynamics in which the DTFs operate and to understand the coordination mechanisms within a specific DTF and with the national and LLC levels as well as collaboration with any other stakeholders in the containment of COVID-19 spread in the districts and Uganda in general.

3.1.2 Sample Determination of the Selected Participants

The number of community members who participated in the quantitative survey in each of the selected district was done randomly while the key informants were selected purposively. The quantitative data collection was based on a scientifically determined sample of the district-specific total population derived from the available sample frames obtained from the Uganda Bureau of Statistics. A rural-urban divide was considered to capture the varying experience of individuals who reside in the rural areas to those residing in the urban areas. In a district, two sub-counties were selected, that is, an urban sub-county (Town Council, Division or Municipal Council) and another rural.

To determine the sample size for the quantitative survey, we used the standard formula for sample size determination where the population size is known, given by:

$$n = Z\alpha^2 * \rho(1 - \rho)/E^2, n = N/(1 + N * E^2)$$

Where n is the sample selected from a particular district, $Z_{\alpha/2}$ is the critical value of the Normal distribution. We assumed a confidence level of 95%, and $\alpha = 0.05$ giving a critical value of 1.96. E is the margin of error score, p is the sample proportion, and N is the population size.

Sample proportion for each district is the ratio of the number of individuals aged 18 years and above in the district to the total number of individuals in the 31 districts. A total of 1,415 community members was determined and distributed as reflected in table 1.

Table 1: Sample distribution among the selected districts

S/N	District	District Population Size	Sample Proportion	Study Sample Size
1	Amuru	93,900	0.013	19
2	Apac	100,600	0.014	21
3	Arua	337,230	0.046	67
4	Bududa	119,080	0.016	24
5	Buliisa	68,890	0.009	14
6	Gulu	154,560	0.021	31
7	Hoima	178,110	0.024	36
8	Jinja	244,140	0.033	49
9	Kabale	125,670	0.017	26
10	Kabarole	166,780	0.023	34
11	Kaliro	123,060	0.017	25
12	Kampala	993,710	0.135	179
13	Kamuli	240,760	0.033	48
14	Kanungu	127,970	0.017	26
15	Kisoro	143,660	0.019	29
16	Lira	223,120	0.030	45
17	Luwero	245,410	0.033	49
18	Masindi	162,960	0.022	33
19	Mbale	290,020	0.039	58
20	Mbarara	206,800	0.028	42
21	Moroto	55,250	0.007	11
22	Mpigi	135,490	0.018	28
23	Mukono	350,950	0.048	70
24	Nakapiripirit	53,430	0.007	11
25	Nebbi	122,220	0.017	25
26	Nwoya	99,570	0.013	20
27	Rukungiri	156,860	0.021	32

S/N	District	District Population Size	Sample Proportion	Study Sample Size
28	Sheema	108,130	0.015	22
29	Soroti	168,170	0.023	34
30	Tororo	259,460	0.035	52
31	Wakiso	1,526,100	0.207	252
	Total	7,382,060	1	1,415

Similarly, the sample for the key informants that constituted the qualitative section of this study was determined purposively amongst all the categories and a total of 744 key informant interviews were conducted. The interviews with the DTF core team were aimed at understanding the dynamics in the implementation of the containment mechanisms of the pandemic in the districts and compare variations across different districts and assess the reasons for variations in the outcomes. This was intended to understand what works better and what does not. The distribution of the Key Informant interviews by category is reported in Table 2.

Table 2: Categories of Key Informants that were targeted for interviews

S/N	Type of Key Informants	# of Interviews per District	# of Districts	Total	Notes
1	DTF Officials	6	31	186	Any 6 officials of the DTF. Ensure at least each one comes from a different department e.g. security, political wing, Presidential representative (RDC), Technical wing (CAO), Health wing (DHO), etc, as per the structural composition of the DTF.
2	CSO	3	31	93	Target mainly the E.Ds of the CSOs or any other person knowledgeable of the operations of the CSO.
3	Media Houses	2	31	62	Any person knowledgeable of the operations of the media house on issues of COVID sensitization
4	Private Sector	5	31	155	Target mainly the E.D of the Institution or any other person knowledgeable of its operations of the CSO.
5	In-Charge of HC IV	1	31	31	In-Charge for a health facility relevant for COVID-19 suspects and patients.
6	Religious leaders	2	31	62	Any relevant religious leader in the district.
7	Local Council leaders	3	31	93	Could be LC 1 or LC 2, LC3.
8	Opinion Leaders	2	31	62	
	Total	24	31	744	

3.1.3 Selection Criteria of the sampled Districts and Sub-counties

The determination of a sample followed the national approach with particular emphasis on the districts covered by the Local Government Councils Scorecard initiative (LGCSCI) and those covered by other DGF interventions, and Kampala as the central hub for COVID-19 management in Uganda. The study covered 31 districts including Amuru, Apac, Arua, Bududa, Buliisa, Gulu, Hoima, Jinja, Kabale, Kabarole, Kaliro, Kampala, Kamuli, Kanungu, Kisoro, Lira, Luwero, Masindi, Mbale, Mbarara, Moroto, Mpigi, Mukono, Nakapiripirit, Nebbi, Nwoya, Rukungiri, Sheema,

Soroti, Tororo and Wakiso. This implies that the 10 main regions of the country (Central, Busoga-Bukedi, Teso, Ankore-Kigezi, Bunyoro-Tooro, Lango, Acholi, West Nile, and Elgon) were all represented

3.2. Data Collection Procedures and Management of COVID-19 SOPs

At the inception stage, the ACODE team met virtually with the team from DGF and other stakeholders to discuss and agree on the research strategy to use in the survey. Similarly, it met with the Ministry of Local Government (MoLG), discussed and agreed on the scope of the study, the approach and methodology, key deliverables and reporting targets and strategies for dissemination.

After close discussion with MoLG and DGF, approval was granted by DGF and an advert was made for interested qualified research assistants to apply to participate in the activity of data collection. Preference was made of those candidates who were residents in the respective targeted districts. This was intended to minimize movements from one district to another thus preventing the spread and or contracting of the disease by the research assistants. After the selection of the research assistants, a virtual training via ZOOM was organized and the research assistants were fully introduced to the background and objectives of the study. The researchers were also taken through the categories of the targeted study participants, and the ethical considerations while conducting data collection including observing the Standard Operating Procedures for observing and containing COVID-19 pandemic while in the field. The researchers were also taken through the qualitative study guides and quantitative questionnaire and a session on the question and answer as well that on role-plays were conducted. They were also trained in the use and application of data collection methods for conducting of interviews including note-taking, maintaining non-judgmental approaches, listening skills, balancing discussions and picking up on emerging themes for follow-up-discussions. Introductory letters to the district authorities, that is, a letter to the District Chief Administrative Officers (CAOs) from ACODE and request letter from the Ministry to the Resident District Commissioners (RDCs) were provided to the research assistants to notify and seek authorization from the leaders beforehand.

3.3. Quality Control Measures in the Data Collection Processes

After approval of the data collection tools, the survey tool for community members was programmed in Open Data Kit (ODK) software and installed on the researchers' mobile smartphones via a link. The research assistants recruited were trained for 2 days.

To ensure the quality of data, close supervision of the research teams in the field and communication at all times was ensured. The Team Leader at ACODE ensured that the expectations and deliverables of the assignment were followed consistently by the research assistants. Field teams were required to provide timely feedback to

the Team Leader who ensured that appropriate actions were taken for any emerging issues.

3.4. Instruments for Data Collection

There were mainly 3 categories of data collection instruments used for this study. The first study instrument targeted the community members and was exploring their experiences and perceptions on the functionality of the DTF. The second tool was targeting the core DTF members and sought to explore the dynamics of how a DTF operates, its efficiency and effectiveness. The third study tool was targeting other partners in the struggle against the COVID-19 pandemic within the district.

The tools were designed in a manner that addresses the study objectives exhaustively. The mixed approach helped in triangulating the data collected using different methods.

3.5. Data Management and Analysis

The collected qualitative data was organized under the major themes drawn from the study objectives and then subjected to further analysis. The analysis focused on the indicators that the thematic areas generated during the discussions with DGF and other stakeholders. Some verbatim extractions were made from the transcriptions analyzed and inserted into this report.

Data management processes were facilitated by both digitalized and analogue methods. The digitalized process involved subscription to online managed servers to store some data and analogue involved use of hardcopy questionnaire and then transferring data to excel and other data management software for easy manipulation and transcription.

Completed questionnaires were submitted daily through the data processing centre since data was captured using computerized gadgets. The data processing personnel included the Online Server and office staff responsible for data cleaning.

After data collection, the quantitative data was downloaded from the server and exported to STATA for cleaning and analysis. STATA computer Programme was also used to analyze collected quantitative data and to provide useful insights.

On the other hand, qualitative data was captured using recorders and was transcribed verbatim, into text format. The analysis of qualitative data also relied on the memos drawn by the researchers and enumerators in the field to put together the responses and make sense of the emerging arguments. The analysis was conducted using Atlas-Ti qualitative data analysis software after conducting the data coding processes. The findings from the qualitative phase were then used to complement those from the quantitative approaches particularly to add more insights and explanations to quantitative statistical findings.

3.6 Ethics, Challenges and Mitigation Measures

As earlier stated, the research team made sure that they worked closely with the DGF, ULGA and Ministry of Local Government to secure the introductory letters and have easy entry into the districts. Upon reaching the district headquarters, before doing any activity, the data collection team reported to the district officers and sought permission to operate within the district and to engage some district officials, community members and some other partners in the study. On top of the above, the team ensured that it abides by the ethical considerations during data collection:

- (i) Consent was sought and confirmed from respondents. Research Assistants made an emphasis to the respondents that participation was fully voluntary.
- (ii) A statement of confidentiality for the beneficiary was bolded in all the tools, explaining the purpose of the survey and committing not to divulge individual respondent details but rather report on them as an aggregate thus protecting them.
- (iii) Observing the COVID-19 SOPs by the Ministry of Health through social distancing while conducting interviews, regular hand washing and wearing their face masks at all time while in the field.

3.7 Limitations of the Study

Although the study endeavoured to capture data and collect views of stakeholders from various districts across the country, it may not have a complete picture of COVID-19 response from all Local Governments in Uganda. This is because of the following:

- a) Geographical Scope: The study did not cover the entire country; it was limited to selected districts covered by the Local Government Councils Scorecard Initiative and Kampala which has been the epicentre of COVID-19 response activities.
- b) Availability of some Core COVID-19 District Task Force members: In some Districts, some core DTF members were not available. Some had been quarantined while others were not available for interviews due to their busy schedules. The research team thus resorted to a convenient method of interviewing members who were readily available for the interviews.
- c) The findings were limited to only district-level stakeholders in the response to COVID-19. The study therefore does not report on national-level actors to further give other dimensions that could explain the circumstances at the district and other Lower Local Government levels.



Chapter 4

Presentation of Findings of the DTF Study

This Chapter presents the findings of the study and focuses on the dynamics and functionality of the DTFs; communication and coordination mechanisms of the DTFs; efficiency and effectiveness of the DTFs; and stakeholder involvement in COVID-19 response.

4.1 Context for COVID-19 Response

Over the years, Uganda has handled several epidemics namely leprosy, plague, cholera, meningitis, Ebola, Marburg fever, Polio, Hepatitis E and the nodding disease among other that have claimed lives of Ugandans (New Vision, 2012). Furthermore, Uganda has also been faced with emergencies such as the recent locust invasion, landslides and refugee influx among others. Uganda has been able to handle these emergencies with support from international bodies like Uganda Red Cross Society (URCS) (Monitor Newspaper, 2020), World Health Organization (WHO), United Nations' Children's Fund (UNICEF) and the United States Agency for International Development (USAID), United Nations Development Programme (UNDP), United Nations High Commissioner for Refugees and World Food Programme (WFP) among others (Lacken, 2013). In all these emergencies Local Governments have played a key role though with varying levels of engagement.

4.1.1 Institutional and Legal Framework for Disaster Management in Uganda

The 1995 Constitution of Uganda in the sixth schedule (Number 29) points out that the primary responsibility for disaster preparedness and management rests with the state, while Objective 23 of the Constitution states that, the State shall institute effective machinery for dealing with any hazard or disaster arising out of natural calamities or any situation resulting in the general displacement of people or serious disruption of their normal life. The National Policy for Disaster Preparedness and Management (2011) aims to create an effective framework through which disaster preparedness and management is entrenched in all aspects of development processes, including planning, saving lives, protecting livelihoods and the country's resources (GOU, 2016). Uganda recognizes the importance of District-level Contingency Planning as a key element of emergency preparedness, which is a mandatory requirement under the Constitution of Uganda. In addition, the National Policy for DPM further puts in place structures and mechanisms through which this policy will be implemented at both the Central and Local Government

levels such as the Inter-Agency Technical Committee, District Disaster Management Committees and Sub-County Disaster Management Committees. It also states that these structures shall develop contingency and disaster preparedness plans and update data annually.

One of the major components that were decentralized to the Lower Local Governments was planning (Local Government Act 1997 (5)). The technical units follow well-set guidelines when undertaking planning with a strong degree of independence. The plans are then passed on to the policy-making organs -the District Councils of elected legislators - who ratify the implementation plans. The districts can utilize this opportunity to plan for emergencies and disasters, as each of these can have localized dimensions (Uganda, n/d, p.71).

a) ***The National Disaster Policy***

The National Disaster policy categorizes pandemics and epidemics as disaster incidents. The National Policy for Disaster Preparedness and Management (GOU , 2010) provides for containment of epidemics include avian influenza (bird flu), Ebola hemorrhagic fever, malaria, meningitis, cholera, HIV/AIDS and Ebola, plague and jiggers among others. The policy further notes that epidemics could be addressed by making contingency plans and structuring emergency health services. The policy underscores the need to develop early warning systems through routine surveillance and training in emergency operations. This policy recognizes Local Governments as one of the key institutions responsible for containing and managing epidemics/pandemics. It provides for responsibilities that include: improving sanitation and hygiene practices; ensure vaccination, immunisation of the affected population and treatment of the sick; Ensuring staffing of all health centres with qualified personnel; strengthening entomological services and disease surveillance and creating public awareness¹³.

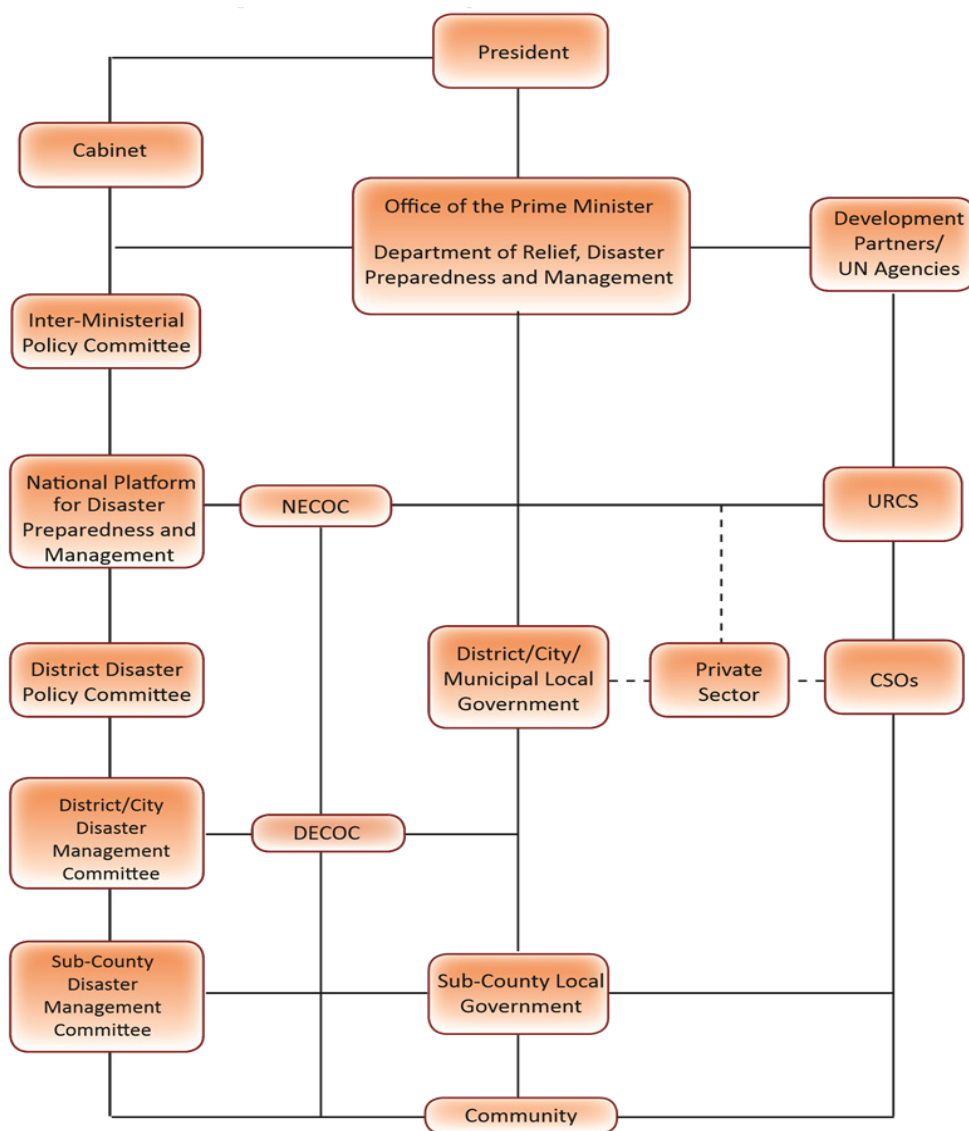
b) ***Institutional Framework for Disaster Response***

The implementation of the National Disaster Preparedness and Management Policy provides for a multi-sectoral and multidisciplinary process for response and management of pandemics and epidemics alike. The process involves all government ministries in collaboration with humanitarian and development partners, the private sector, Local Governments and the community. The Office of the Prime Minister is the lead agency in co-coordinating all stakeholders on disaster preparedness and management in the country. Disaster preparedness and management shall be a shared responsibility between the state and all citizens

c) ***Disaster Management Structure at the National Level***

The national Disaster management structure provided for under the National Preparedness and Management Policy (2011) includes The President; The Cabinet; The Ministerial Policy Committee (MPC); The Inter-Agency Technical Committee; National Emergency Coordination and Operations Centre (NECOC); City Disaster Policy Committee (CDPC); and City Disaster Management Technical Committee (CDMTC). This structure is further presented in Figure 3.

Figure 3: Institutional Setup of the National Disaster Preparedness and Management



Gaps:

1. The biggest challenge at the moment is in the coordination of response efforts. The country seems to be more attuned to response than to preparedness. There is a lot of confusion on the layering of interventions – different actors do different interventions in their ways leading to un-coordinated response, confusion, in-fighting and duplication.
2. The other challenge noted is the distinction between the roles of the Ministry of Health and those of the Office of the Prime Minister, MoLG and other actors

3. The operationalization of the Disaster Response Policy and empowerment of the different lower levels has not yet been done
4. Despite the policy, there is no uniform disaster response plan that connects the agencies. The available plans are sector-based, running within line ministries (health, agriculture and animal husbandry, office of the prime minister- for refugees and IDPs, etc). Some ministries therefore do not have comprehensive disaster prevention plans.
5. The Ministry of Local Government (MoLG) that is supposed to be at the centre of coordinating response seems to be sidelined. The MoLG has an elaborate structure from the district to the village level but its involvement in the COVID-19 response is minimal.
6. The MoLG did not receive any COVID-19 response funds. The MoLG was not involved in the design and the monitoring of interventions at the LGs and is expected to ensure accountability and monitoring of interventions whose design they did not participate in.
7. In terms of financing Local Governments to respond to COVID-19, the border districts received the same amount of money like other districts, yet they have more unique needs to attend to like patrolling the porous border, receiving and resettling refugees, dealing with cross border trade and markets among others.
8. The LC system was not financed to conduct surveillance at the lower levels.

d) ***District Disaster Policy Committee (DDPC)***

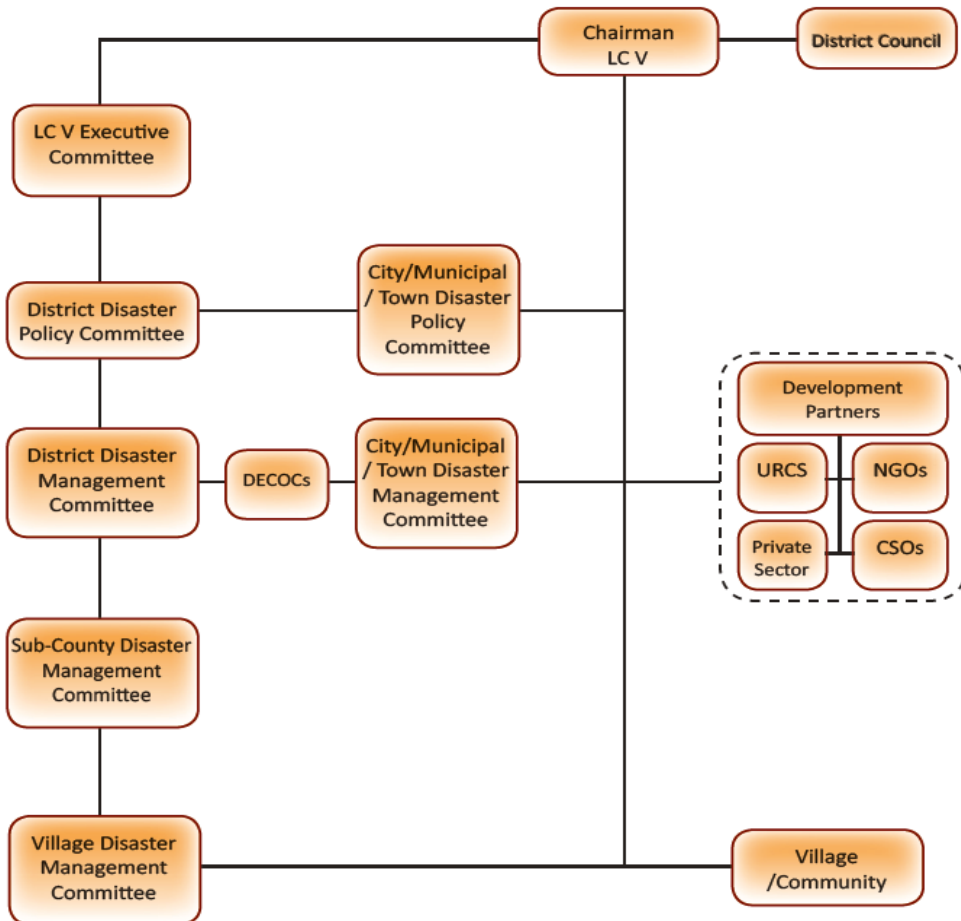
According to Uganda's disaster policy statement (NPDPMP, 2011), the Disaster Preparedness and Management Policy provide for a DDPC¹⁴. DDMCs are crucial in the framework of working towards mitigating disasters of all kinds in vulnerable communities. It is argued that they influence preparedness, response, recovery, prevention and mitigation phases through several approaches and dimensions. The DPMP requires that the District Chairperson chairs the committee while the Chief Administrative Officer is the secretary. The Committee is supposed to be composed of the District Executive Committee, RDC, RPC, DMC, DPC, DISO, a representative of the army and the Mayors / L.C3, Urban Chairpersons of town councils. The roles of the committees are to:

- a) Give policy direction to the District Disaster Preparedness and Management Technical Committee.
- b) Inform Council about the nature and effects of disasters in the district
- c) Provide a link between National Disaster Preparedness and Management Committee and the Local Government structures responsible for disaster preparedness and management
- d) Identify district priorities for disaster preparedness
- e) Monitor the implementation of disaster response activities in the district.
- f) Ensure and authorise expenditure for disaster-related activities in the district

¹⁴ See p 12

DDMCs have a significant effect on containing the spread of COVID-19 in Uganda. Whereas they aim at reducing potential losses from spread, morbidity and fatalities from COVID-19, the level of intervention was found to be a challenge. Hence, the justification for this study to establish the level of performance of the COVID-19 District Taskforces in the interventions for containing the spread of COVID-19. The District Disaster Preparedness and Management Institutional Structure provided for under the policy is presented in Figure 4.

Figure 4: District Disaster Preparedness and Management Institutional Structure



Source: Disaster Preparedness and Management Policy, 2011.

e) ***Disaster Management Structures at the Local Government Level***

The National Policy also provides for the establishment of the Disaster Management Structures at the Local Government Level that includes the following:

- a) District Disaster Management Technical Committee
- b) District Emergency Coordination and Operations Centre
- c) Municipal / Town Disaster Policy Committee
- d) Municipal / Town Disaster Management Technical Committee
- e) Sub-County Disaster Management Committees (SDMC)
- f) Village Disaster Management Committee

Gaps:

- The National Task Force directed that the RDC chairs the COVID-19 District Task Force which conflicted with the structure established by the policy that requires the District Chairperson to be head of such a response committee at the district level.
- Most districts do not have adequate capacity to plan for pandemics or disasters. The districts have not received adequate training to respond to this deficit.
- Disaster committees or sub-committees in most districts have not yet been composed or trained
- While there has been a lot of focus on the District Task Forces of District Committees, there has been little or no focus on the committees at the Municipality and sub-county levels.
- The implementations of these plans were constrained by lack of resources and poor understanding of their responsibility.
- The response to COVID-19 on the DHO and not the health structure at the Local Government level. "The health system at the district level doesn't stop with the DHO but runs up to the Village Health Teams (VHTs). The HC IIs and IIIs are not part of the COVID-19 response. The HC IIIs are the facilities that take care of other cases like diabetes, giving out ARVs, Primary Health Care, maternal health, immunisation and these seem to have been ignored.
- The LG Structure at LC III, LC II and LC I were ignored in the response to COVID-19. Yet these are very important structures whose relevance is emphasized by the policy.
- The VHTs have been ignored in COVID-19 response yet they are the ones with the capacity to reach every household and mobilise communities against COVID-19.
- COVID has other elements of communal existence beyond health issues. It should be a multi-stakeholder. However, the response to COVID-19 has been limited to the health and security sectors.

d) **Strengths of the Policy**

The biggest strength of the National Policy on Disaster Preparedness and Management is its recognition of the conventional *ad hoc* nature of disaster response and management. The conventional *ad hoc* nature of disaster response and management negates the aspect that disaster is a normal occurrence in life and must be prepared for. Because of its *ad hoc* nature, countries have always been behind disasters in timing, preparation, mitigation and risk aversion which has led to massive loss of resources, time and human life. A 2015 UNDP commissioned report by the Office of the Prime Minister states in clear and succinct terms that the conventional focus has been on “preparedness for response”.¹⁵ This is an approach that the policy, at least on paper, seeks to change and adopt a proactive multi-sectoral and interdisciplinary disaster preparedness, management and response system.

As such, the Policy rides on the already existing administrative structures of the country to integrate disaster preparedness and management systems into planning and government programming. For instance, the policy seeks to make use of administrative structures created by the Local Government Act such as the District Councils and administrative wings to generate composition of the membership of the District Disaster Management Committees as well as the District Emergency Coordination and Operations Centre (DECOC). This is best for institutionalizing risk aversion and disaster response programs as well as executing early warning systems for disaster¹⁶.

Even before Uganda registered the first COVID-19 case, the Government had been jolted into action to provide strategic oversight for the COVID-19 response using this structure. The GoU implemented a series of vulnerability reduction and containment measures to curtail COVID-19 transmission countrywide. Some of the measures that were instituted in February 2020 included: closure of international airport and ground crossing points for passengers; closure of schools and other high congregation points like places of worship; freeze of public and private transport; outlawing all mass gathering events, including funerals and marriage events; overnight curfew; and a nationwide lockdown. The rationale for the plan for National Coronavirus Disease (COVID-19) preparedness and response in Uganda was informed by the fact that COVID-19 was fast spreading and had over 10,000 cases reported globally with 20,000 others under investigation in only one week after the outbreak (26th January and 1st February 2020). This number rose rapidly, spreading the infection amidst the absence of available treatment. There were substantial numbers of passengers who travelled between Uganda and China as well as other affected countries for various reasons during that time. Like in the rest of the world, this risk of importation of COVID-19 into Uganda was elevated by the increased mobility due to trade, education and travel for leisure and/or work.

¹⁵ Office of the Prime Minister and the United Nations Development Programme (2015). Governance of disaster risk reduction and management in Uganda: A literature review.

¹⁶ Mubangizi, P (2020). A Critical Review of the National Policy on Disaster Preparedness and Management: Scenario modeling from the COVID-19 Pandemic in Uganda. CEPA Policy Series Papers Number 20 of 2020. Kampala.

It is pertinent to note that Uganda remained on high alert and invested massively in the COVID-19 preparedness and response.

4.1.2 National response mechanisms for COVID-19

The Ugandan response to the COVID-19 pandemic was laid out in the National Coronavirus Disease (COVID-19) Preparedness and Response Plan (June 2020)¹⁷. The key principles for preparedness and response to COVID-19 encompassed utilization of ICT innovations, community-led approaches and a 24-hour surge capacity. The plan was arranged according to different scenarios. Scenario 1 was for the best-case situation where no case had been identified in Uganda and activities were focused on preparedness. Scenario 2 was when a single case was identified in Uganda, and response activities were initiated, and the command and control structure shifted to the NTF under the Office of the Prime Minister. Scenario 3 was the worst-case situation where multiple cases were identified. Case activities of scenario 2 were enhanced and COVID-19 business continuity plans per sector were activated. The Plan outlined the steps and resources necessary for Uganda to respond to different scenarios. In doing so, Uganda had created the necessary capacities to allow the country to respond to other scenarios sparked off by the evolving threat(s). The Ugandan COVID-19 response plan is hinged on eight (8) cardinal pillars.

Pillar 1: Leadership, Stewardship, Coordination and Oversight: Leadership and stewardship during epidemic response situations is deemed to be very crucial to providing strategic direction and mobilizing resources. Coordination is known to facilitate speedy implementation; generate economies of scale; avoid fragmentation of interventions; create synergies; and, catalyse processes. Coordinated responses, timely inter-agency assessments and information sharing reduce the burden on affected communities who may be subjected to demands for the same information from the different stakeholders. The oversight function is necessary at all levels to ensure transparency and real-time accountability. This calls for the involvement of Parliament within its constitutional mandate to provide oversight and ensure the whole of Government approach to the COVID-19 response. The Parliamentary oversight activities are overseen by the Office of the Speaker through established parliamentary structures. Another key leadership function is to ensure that the response goals are met. This helps to highlight the resources required by the workers for the proper performance of the tasks in terms of timeliness, quantity and quality. This calls for proper forecasting, quantification and timely procurement of all inputs for the response.

Pillar 2: Case Management: In the majority of COVID-19 cases, the affected individuals tend to contract a mild disease (this may be in up to 80% of infected

¹⁷ https://covid19.gou.go.ug/uploads/document_repository/authors/ministry_of_health/document/COVID19_PreparednessResponse_Plan_Signed_Vers_July20201.pdf

individuals) but the remaining 20% of individuals infected may have moderate to severe disease necessitating hospitalization in a designated COVID-19 facility, and 5% will have very severe and critical disease. Certain conditions put the patients at risk of severe disease and poor treatment outcomes. These include: advanced age, hypertension, diabetes, cardiovascular disease, chronic respiratory diseases and immunosuppressive conditions like cancer. Since there is no effective cure or vaccine for COVID-19, emphasis needs to be put on prevention of transmission from person to person at the community level and points of the congregation including churches, mosques, schools, workplaces, etc. The focus must also be on strengthening infection prevention and control (IPC); including water, sanitation and hygiene (WASH) in health facilities, institutions and communities. Treatment is mainly supportive. Coronavirus infection may cause psychosocial stress because of the nature of the disease and may also cause social disruption to the infected, affected, including responders and their families. Targeted response interventions by health including physical isolation may impact on COVID-19 affected communities' mental health and therefore there is need to provide quality and culturally appropriate treatment and protection interventions through planning, implementing, coordinating, and monitoring psychosocial care and protection for people who are affected by Coronavirus. All confirmed cases of COVID-19 depending on their severity are managed in designated isolation facilities - including homes across the country. Mildly ill or asymptomatic patients are isolated at homes, non-traditional facilities, General Hospitals or Health Centre IVs. Moderately to severely ill patients are hospitalized in designated COVID-19 treatment centres which have a capacity for High Dependence Units (HDU) and ICUs.

Pillar 3: Continuity of Essential Health Service: Uganda's health system resilience is being tested by the COVID-19 pandemic. This calls for a dual response to mitigate the impact on the Uganda population and maintain uninterrupted essential health services. This includes a sustained response to outbreaks including Ebola, Yellow fever and Cholera, among others. Also, the need to maintain responses to communicable and non-communicable conditions is important to avoid increased morbidity and mortality in the population. Government is committed to sustaining the delivery of essential health services through existing networks while Ugandan continued to respond to COVID-19. Strategic actions are therefore required to harmonize and maintain essential health services within the context of COVID-19 pandemic. This is to assure the residents in Uganda to continue to receive the essential care they needed.

Pillar 4: Strategic Information, Research and Innovation (SIRI): The novel coronavirus is fast evolving and provision of strategic information guides on what is currently happening and what interventions should be put in place to mitigate and control the spread of the disease. Real-time data utilization is known to inform the decision making of the incident command. It is important to provide the population with real-time information and knowledge as the disease evolves. There is need to

understand the current situation and stimulate innovation, especially, where there is global demand for commodities essential for the COVID-19 response like test kits, Personal Protective Equipment (PPEs), vaccines and therapeutic interventions. Through the Presidential Directives, several innovations have been initiated by Ugandan-based local factories to produce commodities to support the COVID-19 interventions like the local production of surgical masks, face shields, coveralls and aprons. Conducting research is critical to understand the novel Coronavirus and the social-economic aspects that the virus poses on the population of Uganda. There is currently no known cure for COVID-19 and thus the need to explore research and innovations in prevention, diagnosis and treatment including traditional medicine. There is also a need for innovative approaches to managing the COVID-19 response. Implementation of the data management and analytics rides on the existing frameworks in the health sector and the key stakeholders for managing the epidemics. Due to the evolving nature of the COVID-19 pandemic, use and adaptation of technology are expected to support timely and appropriate response, sharing and use information.

Pillar 5: Community Engagement and Social Protection: A distinct Community Engagement and Social Protection pillar is essential for targeting the delivery of health services and addressing the social needs of the population, especially, the most at risk and vulnerable. Beyond the immediate public health aspects of the COVID-19 pandemic, the disease also has humanitarian and socio-economic consequences, as already seen in the global economic slowdown. Given the high degree of vulnerability for the bottom 40 per cent of the population, particularly in rural areas and refugee-host communities, the COVID-19 pandemic is bound to disrupt essential health and social services and exacerbate gender-based violence (GBV). The GoU has to take several measures to minimize the multi-faceted impacts of this rapidly evolving situation.

Communities are an integral platform for the delivery of key basic services and essential public health functions. Community engagement - in planning, research, financing and implementation, and empowerment - is critical to ensure ownership and uptake of targeted interventions. There is need to increase close to community cross-sectoral, catalytic and synergistic actions, for example, environmental sanitation and hygiene, nutrition, family planning, reproduction and child health, sexual and gender-based violence, and social protection, including health financing, social security measures, among others. The MoH in collaboration with key stakeholders is meant to engage all communities' physical and virtual-social networks. Physical communities include households; villages; schools; places of worship; cultural and professional groups; and, workspace spaces, factories, workplaces, markets, health facilities; and others, to take charge of community-based interventions. The key stakeholders will include: Central Government (MoGLSD, MoLG, MoE&S, MoICT&NG, MoW&E, MoT&I, MoFPED, MoIA, MoD and MAAIF), Religious and Cultural Institutions, Private Sector, Development and Implementing partners, and CSOs. They all work through existing Local Government (LG) and

community structures and self-help programmes to build voluntary actions at the community level. The same community system is supported to intensify social protection mechanisms.

Pillar 6: Surveillance and Laboratory: There is a need for sustained surveillance to facilitate early detection, reporting, verification, investigation, confirmation, and response to alerts and suspected cases. The enhanced surveillance strategic areas focus on: Alert management and active case search, laboratory-based surveillance, community-based disease surveillance, health facility-based surveillance, quarantine, point of entry surveillance and contact tracing. This is based on regular risk assessments and prioritization of districts. COVID-19 surveillance activities conducted within the integrated disease surveillance and response framework to allow detection of other epidemic-prone diseases e.g. Measles, Acute Flaccid Paralysis, Ebola and Viral Haemorrhagic Fevers and continuity of services. Weekly and monthly Health Management Information System (HMIS) reports are continuously submitted to the Ministry of Health (MoH). The MoH mobilizes the partnerships needed for activation of all surveillance systems in the country as mentioned above.

Pillar 7: Risk Communication and Social Mobilization (RCSM): The COVID-19 virus is new and, globally there is limited knowledge about this virus. There is evidence that the provision of information to the general public about COVID-19 contributes to the prevention and control of the disease outbreak. The MoH, therefore, implements RCSM interventions to raise awareness and build partnerships in preparedness and response phase of new coronavirus throughout the country. Information generation is through the strategic information & research pillar to ensure evidence-driven communication. Key messages on the status of the epidemic concerning the status of surveillance, number of cases, prevention measures and community engagement for prevention and social protection is given through Presidential directives and the MoH. Dissemination to reach all residents by key stakeholders with and through the MoH.

Pillar 8: Logistics Operations: Timely provision of supplies of both medical and non-medical nature is critical in the COVID-19 response. The purpose of this pillar is to ensure proper storage, distribution and tracking of both medical and nonmedical logistics for the COVID-19 response.

4.1.3 Subnational Response mechanisms

To operationalize the subnational response plan to manage the COVID-19 epidemic, the GoU went ahead to activate the National Task Force (NTF), Incident Management Team (IMT), District Task Forces (DTFs) and their sub-committees. Various guidelines, Standard Operating Procedures (SOPs) and public awareness

messages were developed and widely disseminated. Capacity building of the health workforce and re-organization of service delivery points were undertaken to prepare for COVID-19 management; while ensuring continuity of essential services. Surveillance and laboratory services were strengthened since they were very critical to the effectiveness of the response to the pandemic. In a best-case scenario of having no cases reported in Uganda, district categorization and preparedness was focused in high-risk districts. In a scenario where there were confirmed cases in a geographical location in a district, there was enhanced preparedness across the country. District categorization and preparedness were meant to be focused on high-risk districts and the response in affected areas. In a SWOT analysis, the decentralised health services that provided country-wide coverage; the previously activated district preparedness and response teams were appreciated strength. In strategies for leadership, stewardship, coordination and oversight; the plan remains on strengthening coordination and leadership for the COVID-19 response at national, regional and district level.

4.2 Operational Guidelines for the DTFs

According to the Coronavirus 2019 (COVID-19), preparedness and response plan (March 2020 – June 2021) of Uganda, the district COVID-19 Task Forces are supposed to plan the local response and establish/revitalize and orient the regional response. The District Task Force Roles/ToRs include:

- a) Developing District COVID-19 Response Plans and Budget by the District Health Office (DHO)
- b) Strengthening coordination and leadership for COVID-19 response at national, regional and district level.
- c) Orienting of the District Task Force on its roles and responsibilities in Incident Management (IM).
- d) Ensuring coordination, population safety and security at the national and district level by all other MDAs.
- e) Holding quarterly multi-sectoral accountability forum for the district response under the guidance of the Prime Minister (PM) and Resident District Commissioner (RDC) of the respective district.
- f) Building district-level capacity on COVID-19 surveillance and reporting to National Task Force (NTF), Incident Management Teams (IMT), District Task Forces (DTF), Health workers, Points of Entry (PoE), responders and selected Village Health Teams (VHTs).
- g) Orienting district-level staff to COVID-19 surveillance and reporting (NTF, IMT, DTF, Health workers, PoE, responders and selected VHTs).
- h) Mapping partners and mobilize resources for the implementation of COVID-19 surveillance at district and community level.

- i) Conducting quarterly district level risk assessments - IM (Incident Management) and DHO (District Health Office).
- j) Establishing an alert management desk in each district (airtime, data, phone sets, computer systems, etc.). This is the role of the CAO and DHO.
- k) Training on specimen collection and packaging - National, district, laboratory staff, clinical staff and surveillance officers by CHS NPHLS.
- l) Conducting training/orientation of district staff on data analysis for COVID-19 by Assistant Commissioner of Health Services (ACHS) Division of Health Information (DHI).
- m) Building the human resource capacity ready for a surge to support the areas of Communication for development, Risk Communication and Social Mobilization (RCSM) at both national and the district level through Health Professions' Education (HPE) and the District Health Education (DHE).
- n) Monitoring and evaluate of RCSM-CE (Risk Communication and Social Mobilization-Community Engagement) activities at the district levels.
- o) Developing, printing and disseminating quarantine guidelines and SOPs to all national and district stakeholders by CHS IES&PHE.
- p) Liaising with OPM, District COVID-19 Task Forces and Managers of Reception/Remand Homes and Gender-Based Violence (GBV) shelters to provide GBV and VAC Survivors with age-appropriate protection case management services, material support and other direct assistance based on needs identified by MoGLSD.
- q) Conducting capacity building at national and district level on emergency medical services including pre-hospital care by CHS EMS.
- r) Strengthening the occupational health and safety programme in health facilities.
- s) Orienting IPC committees/focal persons at all levels on COVID-19 (national, regional, district) by CHS CS, Hospital Directors, DHOs.
- t) Compiling and disseminating district and health facility dashboards for key performance indicators by ACHS DHI, Programme managers, DHOs.

The appreciation and implementation of these guidelines however differs from district to district as indicated in the voices from various stakeholders:

The guidelines were not given in hard copies although, like any other pandemic, we used the guidelines as were provided by the ministry of health on EBOLA which has been well utilized and explained to the members of the district task force and other stakeholders. These guidelines have helped us to always track out working with the different stakeholders and how we can measure our successes but also avoid a collision while executing our work. Some of the issues embedded in the guidelines are the formation of the committees, having regular meetings, reporting, separate roles and



ensuring transparency. It stipulates that the task force should sensitize the community on the pandemic, ensure resources are mobilized, liaise and collaborate with the other stakeholders, liaise with the national level governments and do any other issue as directed by the Central Government from time to time. **District Task Force Member, Masindi District**

The guidelines are those that have been developed in times of crisis, so it is assumed that they had already been developed.

Those things are also, not necessarily for COVID. We are talking about a task force in case of an epidemic. Those guidelines are there because we realized COVID was detected last year in December 2019 in the whole world. So, by then, guidelines for the formation of the district task force, me I do not remember seeing them. But we were using the guidance of formation of a district task force in response to any epidemic let it be Ebola or let it be cholera. For the sub-committees, there were no guidelines. We got this because we had pressure and we had a lot of work, the DHO and the RDC. So, we discussed and came up with a decision of forming the sub-committees so that we nominate heads who can help us move the system, to keep the system moving. But we did not have any guidance for the formation of the sub-committees. But after that, I think around May, we received a communication from the Ministry of Health where they were guiding us to form about 7 sub-committees. There we got a document; I think from Doctor Kisakye who works with the World Health Organization. She came and told us “You need to form about 7 sub-committees. **District Task Force member, Mukono district.**

The guidelines were helpful to the committees because they helped to streamline several issues. A core team member applauds the guidelines as stated below:

Yes, the Chairperson of the DTF has a copy. The guidelines have been immensely helpful; each stakeholder has indicated roles, no need to do other stakeholders' work. However, this was not been the case at the beginning of the Covid-19 pandemic. The reporting mechanism was not clear at the beginning because many people thought COVID-19 was a police case. There was tension in the population about this disease and the government as well. Now, the DTF is responding better to issues of COVID-19. **District Task Force member, Arua district.**

The guidelines required that all cash funds collected at the district local government will be deposited to the national response fund to the COVID-19 bank account. The guidelines further required that Local Government accounting officers (CAO) should receive and acknowledge all bank deposits from donors for onwards submission to the OPM Accounting Officer for reconciliation and updating the national response fund. The local Government accounting officers shall update the district task force with a record of all cash deposits. However, the reports from several districts indicate that most of these guidelines were not received by the members of the DTFs. In Masindi District for instance, it was reported that:

The guidelines were not given in hard copies although, like any other pandemic, we used the guidelines as were provided by the Ministry of health on EBOLA which has been well utilized and explained to the members of the district task force and other stakeholders. These guidelines have helped us to always track out working with the different stakeholders and how we can measure our successes but also avoid a collision while executing our work. Some of the issues embedded in the guidelines are the formation of the committees, having regular meetings, reporting, separate roles and ensuring transparency. It stipulates that the task force should sensitize the community on the pandemic, ensure resources are mobilized, liaise and collaborate with the other stakeholders, liaise with the national level governments and do any other issue as directed by the Central Government from time to time. **District Task Force member, Masindi district.**

Some of the members of the DTF were not so sure of the guidelines and not aware of where the guidelines.

I am not very sure of the guidelines on the composition of the task force because I came on board later. Being a deputy CAO, the CAO called me after the task force had been formed. He called me to come and represent him. So, I am not very sure whether there were guidelines. But it could be that there are guidelines. There could be guidelines because for the mere fact that it was mandatorily made, that the RDC is the chairperson and then others follow the team then it implies that there are some guidelines that were followed. Otherwise, the chairperson LCV would have come and say, I am the chairman of the task force or the CAO would come up and say, I'm the chairperson, but because it was strict that the RDC is the chairperson of the task force, it makes me believe that there are guidelines that were followed. **District Task Force member, Mukono district.**

The task force members are aware of the guidelines on which they operated however, the guidelines seemed to be in the custody of the core team that is RDC and his secretary. The guidelines were provided by the centre that is MoH.

We followed the guidelines for epidemic preparedness and response, but enforcement was added later by the task force yeah, we thought it was important to have coordination I mean the enforcement committee. **District Task Force member, Nwoya district.**

I am the Chairperson of the District Task Force. This means that my roles and responsibilities include: Chairing of DTF meetings; Receiving and Commissioning of relief aid; Co-ordination of COVID-19 activities; Causing the implementation of COVID-19 Rapid Response team activities; Monitoring of the junior surveillance team at least once a month; Planning, Controlling and decision making for the District Task Force; and Sensitisation of the public to stop the stigmatization of COVID-19 suspects and recoveries. **District Task Force member, Wakiso district.**

4.3 DTF Structures and processes

4.3.1 Structure of the District Task Forces

Following a presidential directive to fight COVID-19 crisis at the local level, a DTF was put in place comprising of the Resident District Commissioner – Chair; District Health Officer - Vice Chairperson; District Internal Security Officer - Secretary; Chief Administrative Officer - member of the executive committee; Regional Police Commander; District Police Commander; COVID-19 Enforcement Officer; UPDF representative at the rank of a Colonel; Special directives - Brigadier General COVID 19 taskforce and Civil Society Organizations representatives. However, the constitution of the task force was not uniform across all districts, especially, concerning the involvement of the political leadership. In some districts, for example, District LCV Chairpersons and Speakers of Council were co-opted on the team while others were not.

The district taskforces constituted sub-committees to deal with specific issues. These sub-committees also differed from district to district. Generic committees included the following:

- a) Security committee headed by the Deputy RDC was tasked with general security in the area.
- b) Resource mobilisation committee headed by CAO but also had CSO membership was charged with the task of pooling resources for the taskforce.
- c) Business fraternity committee implemented guidelines in the business sector e.g. social distancing, in the market, place handwashing facilities in business areas, market allocation of stalls, and resource mobilisation amongst the business fraternity. This committee was headed by the Director Chamber of Commerce.
- d) Health response committee was headed by the technical personnel in the health department but also had CSO membership. Its task is to deal with any health issues that arise.
- e) Welfare committee - looks after people in quarantine and oversees the distribution of food. It is headed by the deputy RDC.

The taskforce gets directives from several fronts, such as, MoFPED, Minister of Presidency, Office of the Prime Minister, UPDF and each office sends a communication to its representatives on the task force to implement. The membership of the core DTFs in several districts ranged from 19 to 22 members. Some sub-committees are in place to support the core team. The composition of these teams varies across the districts. In some districts, there are sub-county support committees. The following are the responses about the DTF composition:

The RDC is the Chairperson, Co-Chairperson is the CAO, DHO, DHI, Logistics Officer, WHO Representative, DPC, UPDF Representative, DISO and Arua City Health Inspector from the core team. The DTF has 21 members.

*There are committees (9) nine in number. They hold meetings and provide feedback to the DTF. There is a Business Committee, Security Committee, and others. The Committees respond to a need, for example, the Security Committee has the Police, UOPDF, DISO, Surveillance and Intelligence to enforce all Covid-19 guidelines. In summary, each Committee has a role to play on the DTF in containing the spread of Covid-19 in Arua. **District Task Force member, Arua district.***

In Bududa District it was reported that:

*The task force structure is composed of several members and we have the RDC as the chairperson of the Taskforce, we have the DHO who is the secretary of the task force, we have the CAO being accounting officer for the district and is part of the district task force, We have DPC and DISO who are also part of the security, we have assistant DHO maternal and child health and is part of the health team, we have Assistant District Health Officer Environment is also part of the DTF, then we also have the disease surveillance person who is also a member of the team and she gives reports to the DTF pertaining the health situation about the district then we have the medical superintendent who represents the hospital, we have the principal nursing officer from the district, we have the senior administrators of the hospital and we have the Biostatistician who is part of the task force. We also have the DCDO (District Community Development Officer) who is also part of the district task force, the commercial officer who is responsible for receiving and giving out donations and so many other members. **District Task Force member, Bududa district.***

a) **Sub-committees**

The districts used the guidelines to inform the formation of the sub-committees that form part of the DTF. The District Taskforce was the core team but there were sub-committees which were charged with different roles. Clarke et. al. (2020) advocate for a multisectoral approach to emergencies. The adoption of a multi-stakeholder and multi-sectoral oversight body, involving governments, civil society, academia, and anti-corruption, audit and oversight institutions, helps to raise awareness, and to bridge the health and anti-corruption communities, promoting dialogue and cooperation to mitigate corruption risks and make the most of available resources (Clarke, Wierzynska, DiBiase, & Timilsina, 2020). The major subcommittees running were; security, surveillance and burial committee which is mainly composed of the health technical team, system organisation, As it is different districts had varying subcommittees but generally, the risk communication committee, psychosocial support, case management and testing committee, logistics committee,

A respondent on the DTF expounds on the roles of the subcommittees as follows:

The sub-committee is the one am telling you about, surveillance is a sub-committee. For surveillance, there work is to look for people who are

*suspects, contacts, cases okay these are what they are looking for. So, when they get them, they either test them or they recommend quarantine as they find them. And those confirmed because now the surveillance team has been lab sector and then the clinical people. So, when they identify those people they can now advise accordingly, for treatment, for quarantine, surveillance in their homes whatever they are. So that is a sub-committee there. There are infection control and prevention that is where we fall but with that, there is health education and environmental health that is of course in public health law. so that is our role but under me, we have health educators those who happen to communicate to the community on how to observe the guidelines. So, we work together as a committee. Then there is in enforcement that is why I told you about the DPC to enforce the public health guidelines. The other sub-committee is the procurement committee; we have a procurement officer as part of that committee. **District Task Force member, Jinja district.***

b) Roles of sub-committees

The resource mobilisation committee also called the coordination/logistics committee is charged with the mobilising of resources for the DTF. This committee is headed by the chairperson DTF the RDC.

*The coordination committee is the one in charge of resource mobilisation we normally identify what we need and task the coordination committee to identify prospective people who can support us in the needs that we have, they write to them and them make a follow-up. And many of them have given us support especially at the beginning of the lockdown. **District Task Force member, Hoima district.***

*Leadership and coordination, case management and treatment, surveillance, laboratory do the testing, communication for awareness, psychosocial do counselling, resource mobilization management, WASH do sanitation and hygiene, ambulance services, Essential services, security and enforcement see to it that people are safe and they also track those that are arrogant; those are the committees that we have. **District Task Force member, Gulu district.***

It was reported that the surveillance team was charged with the responsibility of responding to all the alerts that were coming in from all different corners of the district, undertaking follow-up and contact tracing. They also conducted evacuation of the cases that had been confirmed positive for COVID-19; community-based disease surveillance in collaboration with other stake-holders like VHTs and LCI chairpersons and collected samples from those suspected to have COVID-19.

Respondents further reported that on the DTF, there was the District Health Educator, whose work was communication on the risk and social mobilisation and ensuring that information reached all people in the district through using different strategies like radio talk shows and community dialogues.

c) Sub-County Committees

Most of the districts indicated that they had sub-county committees. They reported that:

*We have sub-county committees. The sub-county committee includes the sub-county chief, the parish chief, VHTs, Lower Local Leaders and Community-Based Organisations. **District Task Force member, Rukungiri District.***

*The sub-committee at sub-county level is sub-county task force and they do exist. They are composed of 9 or 10 that is, the LC3 Chairperson, the GISO (Gombolola Internal Security Organization), the Assistant Community Development Officer (ACDO), in charge of the health facility, surveillance focal person of the sub-county, health assistant at least those are the numbers. **District Task Force member, Buliisa district.***

*We have COVID-19 committees at the sub-counties. There is the LC3 chairman, sub-county security officer (GISO), representative of the VHT, health facility in-charge, and health inspector. There are 5 members at the sub-county level. Health facility level we have the in-charge of COVID-19, Surveillance person, 2 health workers and members of the VHT. **District Task Force member, Mpigi District.***

The Chairperson of LCIII was reported to be the Chairperson of the committees at the sub-county level while the Senior Assistant Secretary (Sub-county Chief), is the accounting officer for the committee. The Health Assistant was reported to be the technical person for the committee with the responsibility of advising the sub-committee on health issues, dealing with alerts and suspected cases. The Health III facility in-charge was reported to be the one working on the COVID-19 suspected cases while the GISO ensured the enforcement of guidelines for isolation and quarantine. The CDO on the other hand was charged with community mobilisation in cases where the sub-county committee needed to interface with the community members. The findings further revealed that most of the sub-county committees were not very active or fully functional due to limited or lack of facilitation.

These findings revealed that the creation and structures of the national and sub-national COVID-19 Task Forces were not consistent with the National Policy on Disaster Preparedness and Management. It was also noted that the Ministerial Policy Committee and the National Emergency Coordination and Operations Centre (NECOC) which were mandated with leading the national response and the decentralized structures like the District Disaster Management Committees and the District Emergency Coordination and Operations Centre (DECOC) but were found not be active during the period of the study.

4.3.2 Contact Tracing Mechanisms

The DTFs had mechanisms for identifying and tracing COVID-19 suspected cases, alerts or contacts. The community members also participated in identifying victims and were charged with the responsibility of informing the authorities immediately.

*... it is a chain because immediately the village identifies that person, that person is reported to the authorities. The authority is either the sub-county chairperson, the LC 111 or the DISO immediately that is got they report to me before the RDC and if there is no response they keep on pressing us until the surveillance team picks that person. The high level of awareness is that if you risk you may even lose your level in the village the awareness is too strong. **District Task Force Member, Mbale District.***

This role on the DTF was played by the surveillance sub-committee that was assisted by the community members, the Local Council structure and Village Health Teams (VHTs). It was reported in various districts thus:

*We have a good surveillance team which has worked together with the case management team to follow up all contacts in the communities and the contacts of the contacts. We have also used the local council leaders at the grass root in the communities to trace for the contacts. We have allocated some resources to the surveillance and case management team including fuel and allowances to follow-up on these suspects. We have also ensured that the people in the community are vigilant enough. They have been given telephone contacts of responsible officers so that they can call and report suspected cases in their communities. **District Task Force member, Masindi District.***

In Masindi, the community members and the Local Council I Chairpersons took it upon themselves to report suspects.

*The LCIs has been extremely helpful in helping the tracing of the contacts. Also, I the members of the community were very vigilant and would call the district task force members in case they came across contacts or suspected cases. **District Task Force member, Masindi District.***

In some other districts, emergency call lines were placed and anyone would get in touch with the surveillance teams. In Rukungiri, for example, they have placed a call centre number that is available 24 hours a day:

*The CAO and RDC numbers are also available as emergency hotlines and a pool of about six ambulances on standby which combines both bought by the MPs and the hospital. **District Task Force member, Rukungiri District.***

A clear system was put in place, especially, in instances where the person suspected to have COVID-19 goes to a health centre. In Mukono District, for instance, it was reported that:

*When suspected COVID-19 patient goes to like Mukono government hospital, we take off the sample. But during the process of taking off the sample, a lot of contact information from the suspected case captured. The sample is transported to Kampala. Normally, we get results after 2 days. The District has been having four health sub-districts but due to COVID-19, I have created a fifth health sub-district specifically to cater for Koome Island which is usually underserved due to its peculiar location and the geographical barriers to access care. We have also designated Koome Island as a health sub-district. In each health sub-district, we have surveillance teams, 3 members each. Depending on where the patient is coming from, we call the surveillance team there to locate the suspected patient. Where we fail to locate the patients, we involve the office of the RDC and the DISO. The DISO has been incredibly supportive to us because there is a time when we had failed to locate the patient in Katosi. So, we involved intelligence and the police, and that man was arrested when he was trying to board the boat to go to Congo. **District Task Force Member, Mukono District.***

Other districts like Buliisa have carried out the capacity building for their teams to enhance their capacity in tracing suspected cases, alerts and contacts. A member of the district task force from Bullisa District reported that:

*We have brought on board the LCIs at the village task force and they have done a good job. Most of the calls about suspected cases have been coming from LCIs. We also trained the community surveillance people in each parish that is why if any case is reported the surveillance team goes there to verify if the case is real or not. We trained all the sub-county task force members, that is around 9 members per sub-county. We have also gone ahead to train all VHT's per village. Trained social workers. We brought on-board other community structures like religious leaders / Business community, boda-boda riders, fishing communities, and opinion leaders. We have tried to bring everybody on board to help us report on any suspected cases. **District Task Force member, Buliisa District.***

The Village Health Teams (VHTs) which is the lowest level of health workers at the community level were trained in some districts. These have been instrumental in the identification of the suspected cases. Other members of the district task force were also involved to help in the process. It was reported in Nwoya by a member of the task force, thus:

*Like I told you we have a team right from the village level to the district. For example, we have trained VHTs, then we have involved the LCI's, GISO, and SAS. The community has also been sensitized to be on alert and report any case suspected to have COVID-19. These people have our contacts and have responded positively by reporting any suspected cases. **District Task Force Member, Nwoya District.***

The results of the study show that there is a coordinated structure from the district to the lowest level of the community. The utilisation of the Local Council structure that is

also mirrored in the Health Care structure, with support from the security personnel, was instrumental in reporting and tracing of contacts across the districts.

4.3.3 Coordination mechanisms

The study endeavoured to establish the existing coordination mechanisms in place for collaboration of technical support and activities to ensure that all resources were used efficiently and effectively to contain the COVID-19 outbreak. This was intended to further establish whether key stakeholders and partners operated as a unified team, consolidated resources, minimised duplication and disruption. This included joint decision making, planning of activities and frequent information sharing at all levels.

a) **Coordination between the National Task Force (NTF) and District Task Force (DTF)**

The NTF has an oversight role over the DTF so the DTF reports directly to the NTF. The results revealed that the NTF communicated with the different DTF through social media particularly WhatsApp, Zoom meetings, emails. Other forms of communication included circulars and telephone calls. The NTF shared official communication and gave guidelines through these means. For instance, it was reported:

*We communicate through zoom meetings, then we also schedule appointments with the different stakeholders, the other way is through correspondences where several issues are addressed. We also created a WhatsApp group for the fight against COVID-19 so that we can track our daily activities. **District Task Force Member, Nwoya District.***

In Masindi District, a member of the District Task Force further reported that:

We normally communicate using phones and we endeavour to get the contacts of all the members during the meetings. We use the contacts to ensure that they are informed of the status of the pandemic related information and activities and the next course of action. We also communicate by e-mail especially with the Central Government.

b) **Coordination within DTF**

It was learnt that the committees within the DTF reported weekly on the progress of their activities through reports presented during their meetings.

All the committees under the DTF report through the weekly DTF meetings. Emergency cases are reported directly the chairperson of the DTF to the RDC. The CAO writes to the departments about the resolutions made from the DTFs' weekly meetings. The CAO also writes to the Central Government

line ministries or Office of the Prime Minister whenever there is a need.
District Task Force member, Rukungiri district.

In case where there were new guidelines, the Chairperson of DTF invited members to inform them of the changes that had been made.

Whenever we get directives from the Central Government, we share the information during task force committee meetings and we act accordingly. This information is then passed on downwards the local government structure. We report about the implementation of the guidelines in the next meeting of the DTF. **District Task Force member, Mbale District.**

However, in some cases, there were contradictions within the DTFs on issuing travel permits. These were common in Mpigi, Lwengo, Luwero, Arua and Mukono. In Mpigi District, for instance, it was reported that:

We had issues on contradictory directives. They would say the RDC permits have expired when people would continue to come for permits to move. So, we would work with the respective security personnel manning roadblocks. We would call and request them to allow so and so to pass. But we had a lot of contradictory directives. **District Task Force member, Mpigi district.**

c) **Coordination with LLC**

Results show that in most of the districts, the DTFs worked in coordination with the Lower Local Councils through the sub-committees. They also involved the leadership of the Lower Local Councils in their meetings. In Masindi District, a member of the District Task Force reported that:

The District task force has worked together with the LCs right from LC, to Municipality levels. They have all been involved in the activities of DTF. We have involved them in some meetings and work with them in tracing for the contacts and other issues. They normally report to us on any issues that take place in their localities. ...The District task force also formed sub-county committees /task forces on COVID-19 which comprise of the chairperson, CDO, GISO, Assistant health officer, Agriculture officer and any other who was deemed necessary. They were encouraged to meet regularly, although the sub-county task force members have not been able to meet due to inadequacies in resources.

In other districts, this coordination seemed not to exist. There were reports that some sub-committees were not activated or brought on board, or were formed later than expected. Therefore, in some areas sub-committees at the sub-county level did not exist. In Arua District for instance,

Sub County committees exist but that came late because, in the beginning, the DTF was handling all issues related to containing the spread of COVID-19. Now, these committees exist but are not empowered. **District Task Force member, Arua District.**

These results demonstrate that the formation or activation of the sub-county committees to contain the spread of COVID-19 was not done uniformly across all the districts across the board.

d) **Coordination with other stakeholders**

Other stakeholders play a complementary role of community sensitisation which is one of the core tasks of the DTF:

*Am on the district task force under WASH. The role we play in that sub-committee is to sensitize the community on how to prevent the spread of COVI19. Sometimes we use door-door strategy; sometimes we use radio talk shows. **CSO member, Mbale district.***

e) **Coordination with the community**

Communication between the DTF and community was anchored in public sensitisation. Public sensitisation was mainly carried out on radio stations and that was, in some districts, done at least twice a week. In Masindi, a core team member noted that:

*The district task force has majorly used the radio stations in the district and all the 3 stations have helped in giving airtime for the sensitization to take place. We have had several talk shows on all these stations and sometimes the radios could call the task force members and we have been always available for the space provided. Sometime back we also had driven with the public address system in most trading centres and I think it was Masindi miracle centre that provided us with this mechanism, and it worked very well. **District Task Force member, Masindi district.***

In other districts, the presence of community radios was quite instrumental, as these were used to sensitise the communities about COVID-19. In Rukungiri District, it was revealed by DTF Member that:

Mobile radios going through the community with personnel reminding them of the SOPs, Radio talk shows are broadcast on Radio Boona and circular system distributed by politicians.

In other districts, mobile vans were used to sensitise the public about the pandemic as was the case in Mukono.

*The sensitization was happening almost every day around Mukono with the trucks, and over the radio especially our radio Dunamis. It would be done at least once or twice a week. And maybe even the enforcers would enforce every day. **District Task Force member, Mukono District.***

All these communication avenues notwithstanding some of these public communications would not be understood.

The community needs to be allowed to also explore and contribute to solutions to contain COVID-19. The most affected should be at the forefront. It needs to be an inclusive approach to the containment of the disease. The government and other bodies during the EBOLA epidemic, they emphasized communication, with COVID 19, the community does not understand the language used. For example, wash your hands without explaining to them well why they are washing. **Member of CSO in Masindi District.**

It should be noted that public health emergency communication interventions ought to rely on an in-depth understanding of needs, people and situations. This communication also requires solid planning.

4.3.4 Collaboration Mechanisms

These mechanisms describe arrangements between one or more public agencies that collaborate with non-state actors in a collective decision-making process aimed at implementing public policy or managing public programs or assets. The DTF is expected to engage in consensus-oriented decision making, fostering mutual trust, resource sharing, and responsibility. These collaborations between that DTFs and other actors may be formal or informal and may include multiple levels of government, businesses, non-profit and philanthropic organizations, communities, and the public (Ansell & Gash, 2008). Collaboration in this study is how the DTF in its different activities that is the Lower Local Governments, CSOs and the community. Results reveal that the DTF in most of the districts covered by the study the DTF collaborated with the CSOs, private sector, religious leaders, Local Council Structures, Health Centres and Health workers among other stakeholders.

In Lira District, it was reported that by a representative of the CSO representative that,

We also played a role in bringing in the CSO perspective, e.g. CDO's, CBO that were not included in the task force at first. When we were brought on board, we advocated that CSOs be involved at all levels of operations of the DTF.

The results also revealed that through these collaborations the private sector and CSOs were mobilised to donate supplies like food, money, household items, soap, detergents, and medical supplies. In Rukungiri District, a member of the CSO fraternity revealed that,

We voluntarily contributed five hundred kilograms (500) of maize flour to the DTF and received a certificate of appreciation and participation as a reward.

Some of these stakeholders sponsored radio talk shows, hand washing facilities in public places and health centres and provided non-food items to the task force and needy members of the community. For instance, another member of the CSO in Nwoya District remarked:



We are members of the taskforce, we sit in the meeting and implement what is agreed, we distributed 6 inferred thermometers, masks, bar soap, liquid soap hand washing buckets, t-shirts with COVID 19 prevention messages, we sponsored radio talk shows and radiospot messages in two radio stations among other support.

Interviews with the representatives of the media further revealed that Media houses provided airtime to the district task forces to communicate to the public. These findings demonstrate that in the districts where such collaborations existed, the DTFs enjoyed a lot of support from various stakeholders. Such support enabled some DTFs to respond to different needs of the sub-committees and communities such as sensitisation, food, hand washing equipment, and health supplies among others.

4.3.5 Public Participation

Public participation is also known as citizen participation is crucial in any matter while dealing with communities. Public participation is the cornerstone of sound, democratic decision-making, improved policy development, increased government responsiveness, and strengthening citizen trust (Kraft, 2020) in the activities of the DTF. The citizens were expected to play their part in containing the spread of COVID-19 – whether on a voluntary or obligatory basis and whether acting alone or as part of a group. Therefore, In Arua District, it was found that,

The public is engaged in the activities of the DTFs by observing the standard operating procedures put in place by the president and ministry of health by putting on masks, hand-washing and keeping social distance in public places.

Further, the public acted as the “eyes and ears” of the District Task Force. *For instance*, in Hoima a member of the DTF noted that,

The public provides feedback to the DTF like when we go for community dialogue; they give us feedback, from Radio talk shows. There is a talk show that was created and the RDC attends on every Wednesday, which is a question and answers session, so the public gets involved by asking questions about the DTF and how they are moving.

Also, the community is very instrumental in tracing contacts of those that have tested positive for COVID 19 as reported in Masindi District:

The public has been pivotal in helping to trace for the contacts since they know their people in the communities. They have also helped to make calls on the radio on the community members not adhering to the SoPs and those not respecting the directives of the president. The public needs to be made to appreciate the disease and how they can be involved through outreaches by the health workers and the district task force. **Member of the District Task Force.**

The public participated in designing effective COVID-19 sensitisation messages. In Lira District particularly, the community was involved in DTF activities and they were part of the process of designing IEC materials. It was revealed by a DTF member in Lira District that:

When the civil society organizations were brought on board, they really demanded for the public to be engaged in the DTF activities and as a result they were given a chance to air out their opinions for example the leadership of Lira main market asked for permission and they bought a flier written on "Covid-19 preventive measures", these plus the hand washing facilities were put in front of the main market and the message went on to the different trading centres, shops and homes where the hand washing facilities were put in place for customers to wash before being served but since sustainability is the issue the habit is disappearing now days, I think there is need to continue with the community massive sensitization as well as leaders and also support the communities in the best way possible especially with liquid soap, at the sub-county level there should be facilitation to see that the SOP's are being followed especially in areas with many people.

Furthermore, the community has been donating items to the DTF to facilitate its work in almost all the districts covered by the study. Incorporating insights and ideas from diverse communities is central for positive outcomes. Pandemic responses, by contrast, have largely involved governments telling communities what to do, seemingly with minimal community input. Yet communities, including vulnerable and marginalised groups, can identify solutions: they know what knowledge and rumours are circulating; they can provide insight into the stigma and structural barriers, and they are well placed to work with others from their communities to devise collective responses. Such community participation matters because unpopular measures risk low compliance.

4.4 Stakeholder Engagement in COVID-19-Response

Stakeholder engagement is not a new strategy especially regarding mitigating the effects of pandemics in the world and we see this emphasized in the pandemic influenza preparedness and response: a WHO guidance document which adopted a "whole-of-society" approach to pandemic influenza preparedness emphasizes the significant roles played by all sectors of society. Mitigating the effects of a pandemic such as COVID-19 should be a role not only played by the Health Sector but also by other sectors, individuals, families and communities (WHO, 2009). Stakeholder engagement is a commitment to understanding and interacting with stakeholders, taking their views into account when making key decisions. This section presents the findings on the DTF engagement of stakeholders and the roles played by different stakeholders such as the Central Government, Local Governments, CSOs, the private sector, media, religious leaders and the public in the COVID-19 response.

4.4.1 Role of the Central Government

While all sectors of society are involved in pandemic preparedness and response, the Central Government is the natural leader for overall coordination and communication efforts. In its leadership role, the Central Government should: identify, appoint, and lead the coordinating body for pandemic preparedness and response; enact or modify legislation and policies required to sustain and optimize pandemic preparedness, capacity development, and response efforts across all sectors; prioritize and guide the allocation and targeting of resources to achieve the goals as outlined in the country's pandemic preparedness plan; provide additional resources for national pandemic preparedness, capacity development, and response measures; and consider providing resources and technical assistance to countries experiencing outbreaks of influenza with pandemic potential (World Health Organization, 2009).

Local Governments featured prominently in the overall national preparedness plan as the government of Uganda prepared to counter the threat of COVID-19 and the Central Government played a key role in facilitating the activities of the DTFs in the different Local Governments. A supplementary budget of UGX 304.5 billion (approximately US \$ 80 million) to combat the COVID-19 pandemic was approved by the Ugandan Parliament, with Central Government Ministries and the Kampala City Council Authority (KCCA) receiving UGX 66 billion (approximately US \$ 16 million) (Zhang, 2020).

In April 2020, the MoFPED released 165 million to all districts to intensify the campaign against the COVID-19 pandemic. This money was meant for surveillance, coordination, the establishment of isolation centres and fuel allowance for the task force members among other activities¹⁸. The mixed responses from core DTF team members of the different districts is an indicator that the work that the resources were supposed to do was not clearly understood. In some cases, they were not even sure of the actual amount of funds from the Central Government. Members of the Taskforces also reported varying amounts of money received from the Central Government. Also, the members of the DTF did not know what the resources were. In Kaliro District, it was reported by a Member of the DTF that:

The Central Government played an important role, first, they came up with the guidelines which we are following, they allocated to us UGX 165 million in the budget; as the DTF we ensured that these funds were provided to the health team as was stated in the guidelines issued by the Central Government. Part of the health team that was allocated money were those who were moving around the community to take samples for testing; as DTF we are very happy with them because they did a commendable job as they worked hand-in-hand with the District Health Officer. Lastly, the committee of parliament visited us and we moved with them to the isolation centre, so the Central Government played an important role.

¹⁸ See The Independent , 2020

In Kaliro District still, another member of the DTF reported that,

Initially we thought that when the money came it was going to be shared among the members of the DTF; for instance, we thought that the RDC and DPC would take their share, and so would other members. However, this was not the case as guidelines were later sent by the Central Government on how this money should be spent. For example, the guide spelt out that part of the money was for mobilization and communication. Each time that we attended the DTF meeting we would be given UGX 20,000 per person to cater for our lunch. But we were suspicious that this facilitation could have intended to cater for our sitting allowance and transport allowance.

The Central Government also played a critical role in providing regular information and updates about COVID-19 especially in the first three months after the country went on a lockdown; this helped to contain the spread of the virus among the population. The Ministry of Health sent out official public health guidelines for the prevention and management of COVID-19. Lack of harmonisation of communications from the Central Government to the Local Governments notwithstanding, responses from the districts where this study was conducted revealed that directives and guidelines that are often issued out by the Central Government were effectively communicated were coordinated within the Local government structures and widely popularized among the population through the use of radios which helped to create awareness and strengthened the fight against COVID-19 in the communities as confirmed by members of the task force who were interviewed from Rukungiri and Buliisa districts.

Directives and guidelines from the Central Government are coordinated through weekly meetings of the district taskforce. Guidelines received from the national level are always printed and shared with the different departments. During the enforcement of the guidelines, when challenges are met a report is compiled and shared in the DTF meeting where different resolutions are raised to mitigate the challenges. During the weekly radio programmes, the community also get to learn about the new guidelines or any information regarding COVID – 19 and because of the way we popularised the guidelines we managed to reduce infections in the community. DTF Member of Rukungiri District.

4.4.2 Civil Society Organisations

Groups that have a close and direct relationship with communities are often well placed to raise awareness, communicate accurate information, counter rumours, provide needed services, and liaise with the government during an emergency. Such groups were expected to identify their strengths and potential roles and in partnership with Local Governments and other local organizations, plan for the actions they will take during a pandemic.

The study revealed that in Local Governments with a strong CSO presence, the CSOs played an important role in resource mobilization to supplement the efforts of the task force. In Lira district for example there were meetings of CSOs in the Lango Sub-region that were held every Monday where ideas of resource mobilization were discussed. The resource mobilization committee of the District Task Force that constituted the District Chairperson LC 5, the CAO, the Director and Chairperson Chamber of Commerce would also be in attendance.

These regular meetings provided a platform for identification and sharing of roles to avoid duplication of activities. The meetings are held in the district council hall and clearance for them is always obtained. Through these meetings, CSOs have been able to mobilize resources to procure fuel for the health workers as well as purchase personal protective equipment (PPEs) for them. CSOs resolved to open up a commercial bank account for purposes of pulling resources together – CSO members were uncomfortable with contributing funds to the district taskforce which according to the guidelines issued by the MoFPED should have its funds deposited into the national consolidated fund account. In their view, the funds would end up not being directed to their areas of operation thus the decision to open an account for this cause. This account is run by the CSOs and is managed by Lira NGO forum. **CSO representative in the Lira DTF.**

We collaborated with the District Task Force in terms of Material support such as tents to put up an Isolation Centre at the District, we have provided relevant materials like the hand washing materials, face masks, protective gears to the technical team and also facilitation of knowledge acquisition for the technical team, health workers and the lower local councils in the community. **CSO representative from Buliisa district.**

From the onset, we had a meeting with the head of the DTF in the district (RDC) and had discussions to identify areas and seek guidance on how the CSOs and NGOs would support the DTF; the RDC guided that CSOs and NGOs should continue providing services to communities in the district while observing the Ministry of Health guidelines of containing COVID-19. But as CSOs we also agreed that whatever interventions they would be undertaking in the district regarding COVID-19 should be after they have been engaged by the DTF. And for sure this is happening for all our activities in the communities. We have for instance been working with the DTF to disseminate information in different communities in Luwero, as well as delivery of services. **CSO respondent from Luwero.**

The study also revealed that some CSOs had made significant contributions in the fight against COVID-19, however, these contributions were not made in collaboration with the DTFs as expected and this was attributed to failure on the part of particular DTFs to engage all stakeholders.

We have not been in touch with the COVID-19 District Task Force. In our approach, we resorted to working with LC 1 chairpersons because they are more entrenched in the communities where we do our work as an

organisation in Jinja and Kamuli districts. You know the challenges we get as organisations is that there is a lot of bureaucracy involved in engaging leaders at the District. Even if you are undertaking research - I have ever done research here in Jinja and I faced challenges with the bureaucratic system. **CSO respondent from Jinja district.**

We have not been involved in the meetings of the district task force; first, because we don't know when they sit and second, they might already have set schedule for their meetings that we are not aware of as an organization or maybe they are quite busy. We have only collaborated with the DTF during community mobilization through radio. However, as far as food distribution by the taskforce were concerned, we were automatically kept out since we were not part of the meeting. Although we overheard that it was a messy activity in the district. Many people complained and were left wondering what criteria was used to select the names of people to benefit from the food distribution exercise. I also interacted with a member of the district task force and he told me that the food was not enough which caused challenges for the DTF. **CSO respondent from Masindi district.**

We did not go through the district task force when we were distributing our food contribution to our clients who are living positively with HIV because we did not want to expose our clients to possible stigma from the society. As an organization, we were concerned that if channelled our food contribution through the district task force, some of our clients would shy away. **CSO respondent from Mbale district.**

4.4.3 The Media

The study results revealed that various Media Houses, especially, radios provided free airtime to the district leaders to pass-on information to the public. As shown in Section 5, radio has been the most common channel of communication used by the DTFs across the country. Also, the media has been acting as a watchdog to protect public interest against malpractice, abuse of office, corruption creating public awareness on the status of COVID-19 spread in their localities. In Masindi for instance, a respondent from the reported that the media played a critical role in calming down the community, particularly when the district had registered its first COVID-19 case. A journalist in Masindi reiterated that,

I have worked with the district task force. I have attended their meetings and covered all the events of the task force in the media. I have also been producing news features to ensure that there is good coverage of issues. For example, I worked with the district task force in to return normalcy in the community that had gone rowdy and stigmatised contacts of the first conformed COVID-19 case in Masindi.

Another respondent from the media in Masindi District reported that

... my role is to disseminate information to the population on both radio and social media which I have done perfectly well. I have tried to always post information on my social media platforms for the benefit of the people in the district and beyond. My media round table on radio Kitara every Saturday has also been a forum of disseminating information to the community. I have also covered a lot of events on COVID 19 in the district and presented them in monitor and NBS Television for airing. I also tried to cover the events of the district task force especially on the items and funds given to them by the well-wishers especially those where the media was invited. **Media respondent in Masindi District.**

The media played a critical role in amplifying news and features of the vulnerable groups to attract the attention of the different stakeholders to appropriately respond and address their needs. It was reported in Masindi and Nwoya Districts that there were deliberate decisions to broadcast feature stories of vulnerable groups which included PWDs, albinos, children and women. A journalist in Nwoya District stated that,

I wrote a story about the children who have become victims of COVID-19. They were sick and suffering without any help. I was able to highlight their plight during this time of COVID 19 pandemic. Currently, different organizations have intervened to support them.

4.4.4 Private Sector

Businesses are naturally vulnerable during pandemics such as COVID-19, however, despite this vulnerability, the private sector in Uganda played a key role especially regarding resource mobilization at both the national level and the local government level. The Ministry of Health received an array of donations from the Private Sector as part of their efforts to support the COVID-19 response in Uganda. As members of the task force, the private sector donated food, non-food items and money to the task force, ensured that the SOPs were adhered to at their premises among others. In Masindi District, it was noted that:

The business community has been at the forefront of contributing donations to the district task force. They have also provided a slot for the private sector on the membership of the taskforce. We have also encouraged each one of us to ensure standard operating procedures are well respected by the business owners and their clients. **Private Sector member from Masindi district.**

In Buliisa District, a business operator reported that,

First, we follow the standard operating procedures by making sure that there is a hand washing facility, sanitizer, and that there is social distancing at our establishment to avoid contracting the virus. Second, Adonai as a company and a hotel observed that the community at the lakeshore lacked

food and were starving, Boda bodas were also not working. We donated 500 kilograms of posho, which we delivered and was received by the office of the RDC to be distributed to the needy families.

In addition, a member of the private sector from Mbale District reiterated that:

The district task force approached me requesting for donations and I responded by donating ten tonnes of maize flour, ten tonnes of beans, and I also donated soap and cooking oil and other materials. I also gave financial support to the DTF team on top of material donations.

Furthermore, the Indian Association in Uganda also made similar contributions to the taskforce. It was reported thus:

As Indian association in Uganda, Jinja branch we mobilised some companies and individuals within the business community and requested them to donate to the cause. With the funds collected, we distributed 5 kilograms of posho, two kilograms of beans and sugar targeting each family in Jinja. We were able to reach out to approximately 50 per cent of Jinja's urban dwellers and 50 per cent households in the rural areas of Jinja.

From the above observations, it is clear that the private sector played a key role in mobilising and contributing financial resources, food items, medical supplies handwashing facilities to the DTF for distribution to the needy members of the community and government facilities, especially, health centres.

4.4.5 Lower Local Councils

Local Governments are the driving force to shape and deliver local response measures. The Presidential decree on COVID-19 recognized them as essential services that must continue along with healthcare and security (Zhang, 2020). The Local Council elected leaders to play an important role in communities by creating a bridge between the communities and the service providers at the district and national levels. They provide information from the relevant authorities at the districts and national levels and provide information to the authorities concerning the community needs. During the COVID-19 lockdown, the Local Council leaders played a critical role in community mobilisation, providing community sensitization and assistance in bringing the services of the government closer to the community. The Local Council elected leaders also helped with resource mobilisation and food distribution and were acting as the first contacts in case the community members need any help from the government. Similarly, the government officials use the Local Council elected leaders as a springboard to understand the needs of the community and through them, the services are provided to the communities.

We have a Sub-county task force which is headed by me the chairperson and other members being the technical people like the in-charge for Kimengo Health Centre III, the community development officer, Gombolola Internal Security Officer (GISO) and others. We work together to ensure that any issue regarding COVID-19 is well detected and reported. We



have managed to meet only a few times since the district task force did not give us good financial support. Therefore, as a chairperson, I have tried to spread the messages on COVID-19 during my meetings and maybe during the burial. **Chairperson LC 1 from Masindi district.**

We have been sensitizing our communities about the severity of the disease, with a message that if it can badly impact on those rich countries, the situation is expected to be worse for a country like Uganda. That has been the bottom line for our sensitization efforts in a bid to reduce contraction chances for our people. **Chairperson LC 1 from Mukono district.**

In Nwoya District an LCI chairperson for Okora Village stated that,

I am the chairperson in charge of LC 1 chairpersons' task force committee in the 8 villages of Alero Sub-county. I work with seven other LC1 Chairpersons to ensure that sensitization on COVID-19 guidelines has reached every household. We have also been enforcing the provision and proper use of handwashing facilities in every home; ensuring that standard operating procedures and guidelines are followed in every public place such as markets, funeral places and places of worship. Visitors who come to the community are first interrogated and screened before acceptance.

We have earmarked some funds from local revenue of over 2 million to help in mobilization and sensitization of community members. The Municipal Town Clerk also directed that we only maintain essential staff which we have done. We have also updated our Whatsapp group for the Municipality and the Division where information of COVID 19 is circulated and shared.

Division Chairperson, Masindi Municipality.

Further, in Rukungiri District, a DTF member recounted that,

The District Task Force established Sub-county COVID-19 task forces that comprised of the Sub-county Chief, Health Assistant, Gombolola Internal Security Officer (GISO), Community Development Officer (CDO) and Officer in charge of the police station (O/C) The Sub-county Chief delegates Lower Local Councils to follow up some identified cases. The Health Assistant on the other hand implements the COVID-19 preventive measures, GISO and O/C carry out enforcement activities at the community level. The CDO implements measures at household and community levels. The Lower Local Governments (LLG) work with the district taskforce and not the Central Government and it is at the front line of fighting against the spread of COVID-19. All measures and directives are implemented by Lower Local Government.

Furthermore, there were committees formed at the lower Local Governments to respond to COVID-19. In Kanungu District, for instance, a member of the DTF stated that,

The Sub-County chief is the chairperson of the task force at the Sub-County level, while in the town council the task force is headed by the town clerk.

Then the LC III Chairperson or Mayor is Vice-chairpersons of the task force at that level. The Health Inspectors and the CDOs are also members of the Sub-committee. In the discharge of their activities, the DTF has been relying on the technical support of local government staff; for instance, recently when the Central Government was planning to partially re-open schools, guidelines were issued, the District Task Force engaged the District Education Officer who was asked to keep updating the District Task Force daily regarding the level of preparations on the part of the schools and also the enforcement of SOPs.

4.4.6 Opinion Leaders

Opinion leaders are people of great standing within the society they live in and quite often when they speak and give an opinion on an issue, they can influence how people behave. Regarding COVID-19, Opinion leaders were very influential in information dissemination, encouraging communities to adhere to SoPs, volunteering to distribute food, among others. In Nwoya District, a village chief sensitised people about guidelines to prevent the spread of COVID-19. He reported that,

As the Rwot Kweri (Village Chief), am sensitizing the community to follow the guidelines by the ministry of health on COVID-19. Secondly, my area stretches to the main road, so I ensure that truck drivers do not mingle with the villagers.

Opinion Leader from Nwoya District.

Also, in Mukono District, some opinion leaders participated in sensitising their communities through designing messages. An opinion leader from Mukono District stated:

At first, we put up signs telling people what to do to prevent the outbreak of the pandemic in the district. These had messages like washing hands with soap, using masks, and maintaining social distances. The problem with Ugandans is that they do not have a culture of reading. When the pandemic was announced we emphasized social distancing and handwashing with soap.

4.4.7 Religious Leaders

Religious leaders command a huge following and are a great communication channel of government important directives and programmes that impact the common man. During the pandemic lockdown, religious leaders provided positive messages to their followers and complied well with the government directives of closing all places of worship and continued encouraging their followers to continue to pray and avoid moving in public where they would contract the disease.

4.5 Inclusiveness

Women, the elderly, adolescents, youth, and children, persons with disabilities, indigenous populations, refugees, migrants, and minorities experience the highest degree of socio-economic marginalization. Marginalized people become even more vulnerable in emergencies¹⁹. In terms of this study, inclusion was viewed in the lens of the vulnerable communities. How were they catered for as the programming was being carried out for COVID-19? Inclusion is vital in the COVID-19 response to ensure that resources reach the neediest, not the most powerful. We need openness in decision-making and oversight over implementation to empower all voices, especially those of the most vulnerable (Pradhan, 2020).

During the total lockdown when transport had become cumbersome, pregnant mothers in some districts were given special consideration for easy movement to the health facilities; there was the distribution of food and non-food items to needy families; establishment of emergence call for expectant mothers who need to move to health centres. In Nwoya, Mukono, Gulu, Nebbi, Kamuli, Masindi, Rukungiri, Buliisa, Masindi, and Hoima Districts among others, while giving out relief items, the DTF gave priority to the vulnerable groups. They were given food as well as non-food items. A member of the District Task Force in Nwoya District stated that:

...we tried to cater for the vulnerable groups. For example, we gave them relief items which included food, hand washing facilities and involved others in our radio talk shows so they can speak in the language that their colleagues in these vulnerable groups understand.

In Mukono District, a member of the task force recounted that:

During the distribution of relief items, we gave the vulnerable groups priority. We have been looking out for the elderly, the orphans, the children and the veterans. We also formed another committee, what we called Continuity of Care Committee and this one is to foresee the implementation of other activities alongside COVID-19 related activities to prevent deaths resulting from other conditions. So this committee is currently addressing issues of the vulnerable groups and other services beyond COVID-19.

Also, in Nwoya District, a representative of persons with special needs was co-opted on the DTF to cater for their special needs in, especially, communication for the deaf. To effectively communicate with the members of the community that were deaf, the DTF co-opted a health educator who knew sign language interpretation. This person moved with the DTF team to interpret for the deaf members of the community.

The results showed that different districts had different strategies for inclusion targeting the vulnerable in their jurisdictions. Also, the categorisation of the vulnerable people seemed to vary from district to district. Most districts, however, targeted women, children and PWDs as vulnerable categories and provided minimal support to these groups.

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<https://idpjournal.biomedcentral.com/articles/10.1186/s40249-017-0375-2>

4.6 Structural Capacity of DTFs

As discussed in section 2, structural capacity is the cumulative resources and relationships necessary to carry out the significant functions for the District Task Forces. These resources included information, organizational, human, and physical.

4.6.1 District response plan and budget

The Initiative for Social and Economic Rights emphasises the need for a response plan that is coherent and comprehensive with details of the measures that need to be taken to respond to the pandemic. The study findings indicate that most districts had response plans in place with Kabale, Bullisa, Nakapiripirit, Wakiso District having the most developed. It was noted that very few districts which had experienced epidemics like Ebola, Marburg, Congo haemorrhage fever among others had response plans in place. In Buliisa District, for instance, a member of the district task force revealed that:

*We have a response plan for every disease outbreak. On developing a plan we have focused pillars we follow. These pillars include Co-ordination pillar fully funded to co-ordinate activities; strong surveillance and laboratory pillar which is working to follow up cases and taking samples; risk communication pillar; Strong communication in terms of ICT; a strong monitoring committee pillar; risk management pillar and Psycho-social support system pillar. So, this is how our response plans are designed along the above seven pillars... **District Task Force Member, Buliisa District.***

Also, it is important to note that, much as Wakiso District Local Government had not dealt with an epidemic or pandemic of this nature, the it had a clear and well thought through response plan and budget in place. A member of the district task force also reported that:

*We have a response plan for the COVID-19. It is organised along these pillars: surveillance, response to alerts, contact tracing, testing, and transportation of samples, risk communication, infection prevention and control, case management- the evacuation of positive cases. We have budgeted for mobilization, meetings, rapid response team, communication, monitoring and surveillance, support supervision, co-ordination, training of health workers, isolation centres, Psychosocial support for confirmed cases, distribution of logistics and operations. Requisitions, distribution of logistics to health sub-units, mentorship. In the beginning, we thought of transportation our health workers because we know that some of them could be infected using public means. We also planned for WASH committees at the lower Local Governments. **District Task Force member, Wakiso district.***

Other aspects of the district response plan reported in other districts include the utilisation and accountability, oversight, supervision, and reporting. Another

member of the DTF from Nakapiripirit reported that the district has a response plan and budget. He further reported that:

The plan includes activity implementation strategies like overseeing, supervision monitoring and reporting whereas budget includes resource allocation, utilization and accountability mechanisms in response to isolation Centre, the office reported that the district has isolation Centre in Tokora but with insufficient equipment's and that's why cases of covid-19 are referred to Moroto Referral Hospital. They also have quarantine Centre in Namalu where they keep suspects and their contacts. The testing Centre is not in the district, they only collect samples and take to Entebbe.

Other districts present other aspects like capacity building:

*The district response plan entails Capacity building on COVID-19 in terms of emergency response, and health system strengthening through buying sanitizers and personal protective services(PPS) as well as training of the medical workers in the aspects of Surveillance and Enforcement. **District Task Force member, Rukungiri District.***

Aspects of the roles of the different committees were also included in the district response plans:

*Yes, we do have one specifically for COVID 19. This shows the different committees with their different roles and responsibilities. Committees include relief committee, psychosocial support committee and technical committee. This response plan is being followed to a larger extent. All COVID activities are guided by COVID 19 response plan. As for the budget its quite hard to budget for an emergency. Issues are handled the way they come in. **District Task Force, Rukungiri district.***

Some districts had plans which were outdated and not tailored to the current pandemic (COVID-19).

*The district has a response plan although it is outdated and seems to have been expired. It seems it was put in place to last for five years up to F/Y 2016/17 or something. Surely, am not so much aware of what is embedded in this plan and for the budget, there is no budget for this at all. However, the district developed a specific COVID 19 response plan for six months with a budget of over 800million and the key issues in the plan are surveillance, case management, sensitization, among others. **District Task Force, Masindi district.***

Some districts had developed a short plan given the duration of the pandemic.

We have a preparedness plan for COVID-19 which was for three months, I think. We try as much as possible to follow our plan but at times some of the things come unexpectedly and we make some adjustments and modification, for example, we had not planned to repair the laboratory at Ishasha but we had to hire the team to repair it because of the need. We activities under different fields, the first theme is the coordination, where

*we have meetings, monitoring, the second theme is case management where we look at if we have a case or we have a suspect because to us suspects are also cases since you need health support, equipment to use and everything to look after that suspect until that suspect turns out to be either positive or negative and so many other themes. **District Task Force member, Kanungu district.***

A few respondents from some districts indicated that they were not aware of the presence of a district response plan neither its contents.

*No, we do not because first, we do not have the resources as budgeted out, so we keep on using the meagre things that we get here and there. **District Task Force member, Kaliro district.***

Like the famous adage 'not planning is also planning to fail.' Some districts had a plan although it did not seem functional. They called it a 'paper':

*The paper is there...It is there as a skeleton, if it cannot be funded then we cannot follow it without funds, if money comes we create a new budget within the same, if you have a budget of one billion and then they bring you one hundred thousand shillings only, then you have to prioritize what is important, like the sub-committee activities. **District Task Force Member, Gulu district.***

So far, the measures seem to be ad hoc and lack adequate financing. Further, it was established that there was no direct funding to LGs to take care of emergencies like the break out of pandemic, epidemics, and natural disasters among others. Even when the Local Governments are at the forefront of dealing with disasters, prevention and preparedness, they lack of funding directed towards disaster management, preparedness and prevention which has rendered the implementation of the District Response Plans impossible. Those that have some available local revenue often allocate this to respond to disasters, however, since these resources are meager and the LGs often find themselves reaching out to development partners and OPM for assistance. There were significant responses that indicated a lack of coordination and awareness about contingency plans and activities. This should be strengthened as a cross-cutting issue in local government activities.

4.6.2 Physical resources

Preparedness of the health facilities

Overall, the majority of the districts have been able to equip the health centres, create isolation and quarantine centres.

The health facilities, quarantine and isolation centres are well equipped to receive the COVID-19 suspects and patients in the beginning but due to the increase in community infection, the facilities are being overwhelmed by the increasing number of suspects and patients at the moment. At the regional referral hospital treatment centre we have 40 beds which are all occupied



*already, there is food which is only sufficient enough for the patients already under treatment in the treatment centre, the drugs and protective gears are available for the health workers. **District Task Force Member, Arua District.***

While Bududa district had made efforts to create the isolation and quarantine centres, the level of sufficiency of the resources needed in these units is lacking. As explained by a member of the DTF.

*The facility is there as a structure, personnel are there, the facilitation is not there right now as I speak. There is no food for people at the quarantine centre because the funds provided to us by the government got finished, the personal protective equipment are few just like other districts and even transportation of the suspects to isolation centres in terms of fuel and vehicle we don't have, protective gears. **District Task Force member, Bududa District.***

4.6.3 Financial Resources

a) Resource Mobilisation

This, according to Seltzer (2014) involves activities to secure new and additional resources for Local Governments to be able to appropriately respond to containing the spread of COVID-19. It also involves making better use of, and maximizing, existing resources (Seltzer, 2015). Several districts like Hoima, Arua, Nwoya, Rukungiri, Masindi, Kanungu, Kampala, Jinja, and Wakiso among others formed a sub-committee on resource mobilisation for purposes of mobilising stakeholders to donate items, money and other resources to enable Local Governments to prevent the spread of COVID-19 in their jurisdictions. For instance in Hoima District, it was reported by the DTF Members that:

*We have a resource mobilization committee chaired by the mayor. We reach out to the partners and other people to make donations but these activities ended in April. Since then, people have not brought in more donations. Of course, most of them though we were defeating COVID-19 in 2-3months, they did not foresee that it could go up to now, so that is how it ended. Every donation is always brought in the DTF to have recognised and registered. There are usually people to witness these. We received more of food donations and these were distributed to our quarantine centre, quarantined people's families, PWDs, Pregnant mothers at the hospital and health centre IV then babies' home which didn't close and people with HIV. **District Task Force member, Hoima district***

Other districts did not have clear sub-committees for resource mobilisation but used the DTF to mobilise resources. A case in point was Sheema District Local Government, where a member of the DTF reported that:

I may say honestly in Sheema we didn't have subcommittees, we would mobilise resources, we could even write to ask for contributions, to fuel, food but we

didn't have a food subcommittee, finance subcommittee.

b) Resource mobilisation methods

Resources were mainly raised through meetings with various stakeholders. Some stakeholders were brought on board to be part of the DTFs and this was used as an avenue for resource mobilisation. For example, in Arua District, a DTF member reported that,

We involved the stakeholders like CSOs private sector and the business community representatives in the DTF meetings. On Thursdays, we would lobby for support from them in terms of finance, supplies and equipment to help boost the DTF team in the implementation of activities to fight COVID-19.

There were transfers from the Central Government. These were releases made from the Central Government to the district as well as equipment. A respondent from the Masindi DTF alludes to this, “

The district task force receives much of the resources from the Central Government, especially, the money and other equipment which has been an arrangement of the government. However, the district has also been in the drive to ensure that the resources are also got from the local people through involving the business community and the media in the process. There is a resource mobilization committee which is part of the bigger district task force and is responsible for ensuring that resources are available. We ensure that all the resources brought to the district task force are well documented and receipts issued. While spending, the task force ensures that there is proper documentation and the media is used to give an account of what has happened and we endeavour to give full accountability to the people who have contributed specifically.

The use of Media platforms was very instrumental for some districts as they mobilised for resources. In the case of Nwoya district, a WhatsApp group was created where funds were solicited from different stakeholders. Rukungiri on the other hand appealed to the public for donations through the radio programs.

*... we created a WhatsApp group for resource mobilization where we solicit for funding from different stakeholders. We displayed our budget on the platform for everyone to see and support where possible and after receiving the donations we make it public and even show accountability for whichever coin we use. In being transparent we were able to attract resources as people saw our honesty, we got support from ZOA, Malaria consortium, Total E&P, Handle Uganda, Delta Education Initiative etc. **District Task Force Member, Nwoya district.***

*Appealing to community and individuals to support the DTF through letter-writing by the CAO and RDC. Appealing to the public through our weekly radio programmes...Soliciting for funding by showing the budget line and items. **District Task Force Member, Rukungiri district.***

Apart from contributions from the Central Government, the DTFs have been receiving voluntary contributions from the public and especially those in the private sector.

*Put aside the official government food, some people have been bringing food here and sometimes we could receive it as a community, as a team, sometimes they come to me directly, we have not apart from Pastor Kakande who gave us 2 million in cash, we have not received any cash from anybody else. Pastor Kakande gave me 2 million and I gave Wandegaya DPC 500,000 shillings from the 2 million, I gave DPC Kawempe also 500,000 shillings, then the office of the DISO, the 2 million that is how it went. The Salvation Army gave us soap almost 500 boxes and that soap and that soap reached all the zones in Kawempe division, so I gave the mayor to distribute some soap and I told him to ensure that he calls all the village chairpersons and each of them got some boxes, I gave some boxes to police in Wandegaya, police Kira, police Kawempe. **District Task Force member, Kampala district.***

Some districts did not mobilise for resources because this role was played by the centre and felt that they would not want to be tied up in the controversies of resource mobilisation. Wakiso and Jinja were cases in point.

*No, at district level we felt... someone had brought it up as a suggestion, but we decided that if National is collecting let us not collect because things to do with funding are not easy. So, as a district, we distanced ourselves from that. we would receive from those who would give us, but we did not mobilize. **District Task Force member, Wakiso district.***

*It is there but we discouraged it because it was bringing suspicion. But now when somebody brings something, we endorse it. I sign. **District Task Force member, Jinja district.***

4.6.4 Accountability and Transparency Structures, Mechanisms and Measures

Accountability means holders of public offices can be held responsible for their actions and decisions. It also includes responsibility for financial and other resources entrusted with such public officers. Transparency on the other hand refers to unfettered access by the public to timely and reliable information on decisions and performance in the public sector (Stefano & Clay , 2011). Respondents attested to the existent of robust accountability mechanisms within the DTFs; some of which include among others; documenting and communicating about donations and financial resources received and in some cases field visits to carry out physical checks. In Districts such as Masindi, Rukungiri and Nwoya among others, resources received were well documented and communicated to members during DTF meetings as noted by a member of the DTF in Masindi:

All the resources are received are well documented and receipts issued and in all the meetings, accountability is made clear. We have also

provided individual accountabilities to specific donors and well-wishers. The accountability issues are always handled right from the procurement time and the whole task force is involved. After the procurement is done, the whole task force is given the accountability to which they critique and agree as a team. It is also clear that the accountabilities will also undergo the internal audit processes of the district.

In Nwoya, like in Masindi, a member of the DTF Core Team noted that:

How we have been managing it whenever we receive any supply maybe from the partners or maybe well-wishers to support the task force, we normally present them to the task force and good receive note is written it is also the auditor has to verify that the asset is there or it is recorded.

While in Jinja, the DTF members went an extra mile to carry out field monitoring to verify claims of purchases made by the procurement committee as noted by a member of the District Task Force:

*In case of the health department is delegated to procure an item or items, the committee moves and physically inspect or monitor such things to confirm whether what was budgeted and what was discussed in the meeting were purchased. Additionally, the district task force carries out some tours in the isolation and quarantine centres to find out whether what we discussed in meetings are being implemented. **DTF Member, Jinja District.***

It was also noted that the Task Forces in most districts relied on the traditional accountability structures and measures of the Local Government. In districts like Gulu, Hoima, Nwoya, Masindi, Mbale and Jinja among others, procurement and audit functions for the task force were carried out by the procurement and audit departments respectively. In Hoima, a member of the task force noted that,

There are financial rules of regulations that are provided in line with the general accepted accountably by the accounting principles of the Local Government. And we also have auditing both internal and external auditing. All this helps in enduring transparency.

Similarly in Gulu, the task force relied on the Local Government structure to handle cases in which accountability procedures have been flouted as noted by a member of the task force:

*If there is any mess or report from the committee or public, we handle it from the district. **DTF Member- Gulu.***

Whereas there were such mechanisms in ensuring accountability and transparency within the DTFs, many key informants raised concerns about how the resources were used. Most of these concerns rotate around; failure by the DTF members to provide accountability for resources received and nepotism in identifying beneficiaries of food items. For instance, a Local Council Chairman in Luwero noted that,

There are a lot of factors. To me personally, I see there's some kind of corruption, nepotism and political issues whereby people divert the funds that have been given to the localities to other areas or personal interests.

Similarly, a religious leader in Rukungiri noted that there was corruption in the distribution of food relief and extortion of money by enforcers.

Corruption was witnessed among DTF members in the distribution of relief donated food items. The enforcers also participated in extorting money from the community members. Relief food donated and received from the government at times was not given to the rightful targeted beneficiaries.

In Apac, an LCI Chairperson noted during an interview that the DTF had failed to provide information about the monies released by the Central Government and the Food items contributed by well-wishers. The Local Council One Chairman noted that;

The one which is not done well is the transparency, we just hear that Apac received 165 million, and we were not given guidelines on how the money would be spent. They should have given to the LCs even the LC II I don't know where LC III knew. Next time it should be given to the administrative units at least they would have given to LC II if LC Is are too many.

In Arua District, a member of the CSO attested that while they received information about receipt of the monies sent by the Central Government, the DTF had failed to account for how the UGX 165 million was used.

In the beginning, the DTF lacked transparency on the usage of money received. For example, UGX. 165 Million has a breakdown but not what the money was spent on and if there was any balance. This can be attributed to lack of honesty of the DTF and corruption.

4.7 Outcomes of DTF interventions

The ultimate measure of functionality lies in the ability to show results. These results are both immediate and long terms in nature. The measurement of these outcomes focuses on effectiveness (achievement of the set targets), efficiency (resource utilisation) and relevance (meeting needs and expectations especially of the various stakeholders). The discussion of these outcomes as discussed in this section highlights the views of the key informants. The community perspective on the same issue is discussed in section 5.

4.7.1 The efficiency of the DTFs

Efficiency is often viewed as maximising output with the least amount of resources invested (Mihaiu, Opreana, & Cristescu, 2010). In this study, due to the scarcity of records on financial issues, we focused on analysing resource sufficiency and utilisation.

a) **Resource Sufficiency**

For countries to detect, manage and respond to emerging or epidemic-prone diseases, adequate financial resources and investment in public health systems is paramount (Ben , et al., 2019). To mitigate the impact of epidemics, protect the health workforce and ensure continuity of health services during and after them, investments in stronger health systems are needed. The study revealed a huge deficiency in resources available to the District Task Forces to facilitate their activities.

In Kanungu, a member of the task force noted:

Resources have never been enough but we try as much as possible to manage what is available. For example facilitation, fuel for the District Task Force vehicles. And in most cases, you find that there too much constraint.

This was also reinforced by a DTF member in Mbale district who noted that such resource constraint impacted on the efficiency of the task force,

The constraint is the inadequate fuel for the surveillance team, non-compliance by the community especially the boda-bodas, market vendors' garages.

Similarly, in Nwoya District, planned activities of the District Task Force like contact tracing, surveillance were affected. This is because the morale of members of the district task force had been affected by lack of facilitation as noted by a member of the DTF:

The resources are meagre and we financially constrained. Our staff can't move from one location to another because we do not have fuel. Besides, there is no money to motivate the people who have offered themselves to work.

A similar situation was noted in Kampala where several members had resigned their positions within the District Task Force citing lack of facilitation as was noted by a member of the task force in Kampala District:

The biggest issue has been inadequate transport because the vehicles are still not enough. Members of the Task Force have worked from May without facilitation, no transport refund so the morale is low, so they keep dropping off yet they are needed.

While Parliament allocated UGX 165 million in the supplementary budget to Local Governments in April 2020, there were concerns that these monies were not released in time. Wakiso District, for instance, received the money 3 months later. During this period, the District had already incurred over UGX 90 million costs in COVID-19 related activities. This was revealed by a member of the DTF Core Team who noted that:

We were given 165 million shillings for 3 months yet in one month (March), we had already used 90 million shillings. So, most people stayed demanding their money, mostly the workers (drivers and health workers).

b) ***Expenditure of availed Resources***

Resources available for the district task forces were majorly donations from private sectors, civil society organisations, faith-based organisations and the Central Government. These were; food items, PPEs, Masks, hand washing facilities, financial resources, and logistics among others. The Task Forces had sub-committees on resource mobilisation which also spearheaded the utilisation of such resources as noted by a member of the district task force in Nwoya:

To ensure transparency, there was a committee set that was chaired by the RDC which was in charge of the allocation of resources, which resources would be released in bits with the clear consent of the DTF CORE members and thereafter accountability was required from the different officers in charge like the Records officer.

It was reported from responses across the districts that in addition to the resource mobilisation committees, most task forces had a response plan and budgets which was the framework for resource expenditure. For example, a member of the district task force core team in Nwoya noted that:

Resources were spent in line with the planned activities like I told you we have a budget line and that is what we have been following. The team sits down and agrees on how the donations and resources should be utilized to reach the targeted beneficiaries. **DTF Core Team Member-Nwoya.**

Besides the district plans and budgets, donations especially from the Central Government came with clear guidelines on usage. This provided a further framework for resource expenditure as noted by a DTF member in Rukungiri District:

The resources come with specific guidelines of it should be spent like 4% on allowances, 10% on monitoring and 20% on maintenance.

Suffice to note the resources were mainly invested in; sensitisation and creating awareness, contact tracing and surveillance, food distribution, weekly meetings and support to quarantine and isolation centers among others. In Kaliro, for instance, the District Task Force invested the resources in facilitating health workers to sensitise the community on preventive measures and buying food for vulnerable groups like Boda Bodas. A member of the Kaliro District Task Force noted that:

Yes, there are things we have been doing within our budget for example sensitization was within our budget, buying other few items like food to the bodabodas, other people who were striking because they were stopped for a very long time so they were in our budget. **DTF Core Team Member-Kaliro.**

In addition to sensitization and purchase of food relief, the district task forces also spent monies on equipment for the quarantine centres and logistics for the task force as noted by a member of the District Task Force in Kanungu District.

*At least we were able to procure 20 mattresses, some items to use in quarantine centres, repaired 5 vehicles but I think they are more than that but the noticeable one is the one of Mpungu Health Center which was down completely and that of the community and chairperson LC5 which we were using in our operations, ambulances, managed to personalize our screening points at Ishasha, Kyeshero and Butogota. We have also repaired an emergency laboratory at Ishaha and we have been feeding people but that is not tangible. **DTF Core Team Member-Kanungu.***

4.7.2 Effectiveness of the DTFs

Effectiveness relates to the extent to which such investment is successful in producing the desired result; success. The discussion covered herein particularly focuses on key services provided, the functionality of isolation centres and community awareness.

a) Services provided effectively

Interaction with Key informant respondents revealed a mixed perception in the level of satisfaction about the effectiveness of the district task forces. While some respondents said they were satisfied with how the DTFs have performed their functions, others expressed reservations. Most respondents who said they were satisfied with the performance of the DTFs credited the task forces for; sensitisation, surveillance and case management, food and mask distributions.

In Masindi for instance, a journalist noted that the DTF had done exceptionally well in surveillance and case management. He said,

The DTF has done excellently well on issues of surveillance on the cases and the team is always in the field on the same drive. Case management has also been well undertaken where the suspects have been always rushed to Hoima referral hospital and others where necessary. For the surveillance still, it was always easy for the contacts to be traced by the team in most places and others would just bring themselves as contacts or contacts of the contacts.

The Journalist also noted that the task force had also played a big role in as far as the sensitization of the masses is the concern on radio especially for the rural people and today they are much aware of the ways of avoiding the pandemic. Another journalist in Kaliro District credited the DTF for distributing food relief to the citizens during the lockdown. He said:

The task force has done something good because, during the food distribution, the team was doing it efficiently I noticed that one although they never thought of a media person, that one they scored.

However, some respondents expressed reservations about the performance of the DTFs. They faulted the task forces for; leaving out the most vulnerable groups

during food distribution, leaving out Lower Local Governments in the activities of the DTF. According to some respondents, several vulnerable groups of people like Bodaboda riders, elderly and persons with a disability were neglected during the food distribution:

In food distribution, some vulnerable groups were neglected and those who were called like Boda men were called at the same time and didn't observe social distancing and most of them didn't have face masks. They have also failed to distribute face masks as promised by the government. There has also been a lot of extortion of money by the police from the public and the RDC being the Chairperson of security at district level didn't say anything about it. Media Rukungiri.

This was re-echoed by an opinion leader from Rukungiri District who faulted the government for failing to fulfil its promise to distribute food to people in upcountry and that the food distribution was politically motivated:

The government didn't honour its pledge of bringing food to all village people; the distribution campaign was segregate in nature in that they would look at your prior capacity to COVID-19. They allowed some politicians to use food relief donations as a way of gaining popular vote because you would find many people gathered waiting for a political leader to give them food hence ignoring the MOH and Presidential directives on COVID-19. They a lot failed to provide personal protective equipment to health workers yet it was budgeted for hence exposing health.

A Local Council Three Chairman in Buliisa District noted that there was no facilitation for leaders at the Sub-counties and this rendered the DTF ineffective because of lack of presence on the ground:

Facilitation for the lower local councils has not been done better. There should be a provision for Lower Local Councils with facilitation. The government should provide us with an ambulance in lower Buliisa like for Butiaba, Kihungya and Biiso, it would reduce expenses on fuel for a vehicle to move from upper to lower Buliisa and also hiring of Private vehicles by patients. This has affected service delivery because you have to look for the vehicle.

b) The functionality of Isolation and Quarantine Centres

As part of the measures to combat COVID-19, the Ministry of Health established Isolation and Quarantine Centres around the country to protect the public by preventing exposure to contacts, suspected and confirmed cases of COVID-19. Isolation Centres which were majorly in Regional Referral Hospitals were used to manage positive cases of the virus while the quarantine centres were established to hold suspected cases and those who had contacts with previous cases. Many of the respondents interviewed reported that there were issues regarding the functionality of these isolation and quarantine centres. Most respondents in

districts like Arua, Amuru, Gulu, Bududa, and Kisoro among others noted that the isolation and quarantine centres lacked basic equipment, were overwhelmed with the overflowing number of cases and did not have enough food to support those admitted at the centres. In Arua for instance, a member of the DTF Core Team noted that the 40-bed capacity isolation centre had become overwhelmed with the rising positive cases admitted.

The health facilities, quarantine and isolation centres are well equipped to receive the COVID-19 suspects and patients in the beginning but due to the increase in community infection, the facilities are being overwhelmed by the increasing number of suspects and patients at the moment. At the regional referral hospital treatment centre we have 40 beds which are all occupied already, there is food which is only sufficient enough for the patients already under treatment in the treatment centre, the drugs and protective gears are available for the health workers. **DTF member, Arua DLG.**

Besides the overwhelming number of cases at the isolation and quarantine centres, there were also concerns about the shortage of equipment at the facilities. In Buliisa District, it was reported by a member of the DTF that the quarantine centre lacked adequate blankets and mattresses and toilets among others.

I can say they are still ill-equipped, beds are not adequate, even mattresses, no separate toilets for the Covid suspects. **DTF Core Team Member-Buliisa**

The same was reported in Rukungiri where a member of the DTF noted that the quarantine centre also lacked Personal Protection Equipment (PPEs) for the health workers at the centre.

We still lack enough blankets and mattresses at the quarantine centre given the increasing number of infections. The few trained personnel at the district level do not have all the necessary protective equipment when handling Covid 19 suspects and patients. **DTF Team Member, Rukungiri District.**

There were also concerns about the availability of food for people admitted at the quarantine centres. This was noted in districts like Buliisa and Bududa. In Bududa District, for instance, it was reported that there was a shortage of food and lighting in the quarantine centre

No, they were not well equipped because many things were not available, there was no food, no drugs, the manpower was a problem, security for example beddings, people were encouraged to use their own, there was no facilitation for anyone so generally the place was so much lacking, even lights was another problem, can you imagine people were encouraged to use their lights. **DTF Member, Bududa District.**



c) **Community Awareness**

Risk communication is an essential intervention in any response to disease outbreaks and is equally necessary to manage infodemics. Communicating risk in epidemics involves two-way communication that is dynamic and evolving as the outbreak develops (World Health Organisation, 2018). Community engagement and sensitisation have been found to address knowledge gaps related to disease outbreak and discourage discrimination and stigmatisation towards community health workers. (Soumyadeep , Sandeep , Jyoti , Devaki , & Misimi , 2020).

The study reveals a high level of awareness about the pandemic amongst the communities. The study further reveals that citizens were aware of the risk factors and preventive measures for containment of Covid 19 as issued by the Ministry of Health. It was found that the District Taskforces invested heavily in carrying out community sensitisation. A representative of the CSO in Masindi District said that:

the district task force has actually done their best on sensitization of the community on COVID 19 and actually if I was a teacher, I should have given them a distinction. These people have been on all radio stations in the district and sometimes using different languages given that the district is cosmopolitan.

Another representative of the CSO in Luwero noted that,

the DTF have tried to alert people saying; they (the DTF) deserve credit on that. Alertness has been 90%. At least people know about the disease.

In Masindi District, for instance, the District Task Force and Civil Society partners carried out a daily community sensitisation as noted by a key informant respondent:

The District Task Force has worked tirelessly to sensitize the community of Masindi through radio talk shows both provided by the radio stations themselves, the district task force, CSOs among others. In fact, at the beginning of the pandemic, the sensitization would be almost every day since the air time on radio was readily available. The district task force has also used the public address system and drives have been made in the different trading centre which was also very successful. We take the opportunity to thank all the three media stations of Masindi for the airtime provided and other stakeholders for the support rendered. **Key Informant Respondent- Masindi.**

Radios were the major mechanism for community awareness creation by the different district Task Forces. Because of the restrictive nature of the guidelines for the prevention of Covid 19, Radios was the most viable option for community sensitisation. In Nwoya District, for instance, a key informant respondent noted that,

we are using radios to do talk shows and run spot messages, music systems mounted on cars, we also have community forums where health personnel speak to the community. Meanwhile, in Rukungiri, Mukono and Luwero Districts, mobile radios mounted on vehicles moved from village to village to carry out community sensitization.

The Speaker of Mukono District Council noted that,

The sensitization was happening almost every day around Mukono with the trucks, and over the radio especially our radio Dunamis. It would be done at least once or twice a week. And maybe even the enforcers would enforce every day. But as for now, there is no sensitization.

In Districts like Buliisa, the Village Health Team (VHT) and the Local Councils were relied upon by the District Task Force to create awareness at the village level to supplement the radio messages and talk shows according to the Resident District Commissioner and Chairman of the District Task Force. In an interview, the RDC noted that,

*We have used radios and also me as the chairman of the task force I have moved and met the LC'S we try to move around and educate the people on how to wash their hands and their preventive measures against COVID-19. Also, we meet weekly with the LC'S to do the sensitization that is every Thursdays and after meeting the LC'S I go to the radio.***Resident District Commissioner-Buliisa.**

Suffice to note that the investment in media campaigns by the district task forces of Covid 19 have been instrumental in creating awareness in the community. Through the campaign, citizens have been able to appreciate the need to adhere to the preventive measures and observe the Standard Operating Procedures (SOPs). In Nwoya District, a Radio Station Manager noted that,

We normally receive positive messages from the community. We have questionnaires that we have developed as a tool in our morning programs, we allow our presenters to interact with the community on if the measures put in place are being followed in their respective area. The answers are always positive. But largely our work is to create awareness.

The observed adherence to the guidelines and SOPs within the community can largely be attributed to the massive media campaign by the District Task Forces. In Nwoya, a member of the DTF noted that,

The public response is quite good because when you go to the market you will discover that the citizens are following the standard operating procedures, for instance, people are keeping a social distance of 2 meters apart, hand washing facilities have been put in place and people wash their hands with water and soap frequently although some people are operating bars illegally and flouting the Presidential directives.

In Masindi District, just like in Nwoya, there was observed improvement in the observance of SOPs as noted by a member of the District Task Force:

The DTF has done well on sensitization of the community on COVID 19 where everyone is now aware of the disease and what to do to contain it. Many people used to complain at the market square-main market on washing hands, today they do it willingly.

Also, during an interview, a journalist in Luwero noted that:

...at least majority of the people in the community have tried to observe the SOPs through this continuous sensitization via our different talk shows. At least the majority of people can put on their masks, can wash their hands, people can sanitize and so on.

4.7.3 Human rights violations

In the course of handling the pandemic in the districts, there were instances of reported human rights violation. Human rights violations are those acts that deny individuals the enjoyment of their rights. This study documented human rights violations perpetrated by the state actors and the non-state actors.

a) Violations from state actors/authorities

Some of the victims were persons with disability who had failed to comply with the directives because of their impairments. Some of these were assaulted by the police or the army while enforcing the guidelines, especially on the curfew. by the army and he lost his life. A Member of the DTF in Lira reported that:

Yes, there was one case, where the RDC asked his men to assault him yet he had a hearing impairment. These people beat the deaf man and when he was rushed to the hospital, he lost his life. But after that incident, the RDC stopped giving orders for people to be beaten. But now it's better, the cases of human right violations have greatly reduced.

A related incident of human rights violation of the persons with disabilities was also reported in Mukono District by a respondent from the CSOs. The respondent noted that:

There have indeed been human rights violations. For example, there is a deaf and mute youth who was beaten by an officer of the law, but the boy could not defend himself because he could not talk. He just did not know what the officer was saying. He was savagely beaten but we took the responsibility to ensure he receives medical attention. As PWDs, we felt bad about this. Secondly, the RDC had given PWDs permission to move and access medical care but this was not understood by the LDUs who would beat these people and the boda-bodas they used to move. Others could not access ARVs and mental illness tabs because of the lockdown.

The Health workers, mothers and children who move past the curfew time have regularly been assaulted by the security personnel the enforcing curfew. In Jinja District it was reported by a member of the DTF that:

... we have seen mothers who are going to the labour ward. We have seen mothers carrying children with asthma, malaria being beaten because they are travelling on the boda-boda past curfew time.

The LDUs who had been put in place to enforce the curfew had handled people roughly. And they could not listen to complaints of the DTF given that they were getting their instructions from the military and the police. In Lira District, a member of the DTF noted that,

We had a lot of complaints when the Local defence unit was brought on board, but as I told you earlier, for us as the DTF we follow the guidelines sent from the Ministry of Health. The LDU's were sent the UPDF and so we had no say on what they were doing, yet these are people trained to fight wars but not to police the community. They were very violent while handling people without observing any human rights. As a result, many people were beaten, motorcycles impounded, money robbed from the arrested peoples' pockets.

Some people were denied access to healthcare services which was a denial of the right to health care. This was during the total lockdown when transport was closed, and people could not move by any means. This affected the right to reproductive health care by the women in reproductive age. A member of the CSO in Masindi District reported that,

Denied access to health care services was a great violation especially among the women, girls, the mothers who used to walk long distances to Masindi main hospital. This prompted the go on radio talk shows that were sponsored by RDP Uganda and pronounced that the police officers should allow pregnant women going to health centres to move freely.

b) Violations from the non-state actors

Violence against children took several forms it included corporal punishment, early marriages, neglect, rape /defilement and the like. Many parents were failing to fulfil their obligations for their children and instead began getting violent with them. Cases in Kabale and Kabarole were reported.

*Yeah! Because our structures are working but we have seen some cases of domestic violence, child neglect, teenage pregnancies, early marriages because of failure by parents to carry out their roles, not carrying out proper parenting, our girls are getting impregnated, poverty issues somebody wants to be paid dowry/ bride price, what! So, he marries the daughter at an early age but if those cases are thoroughly investigated, I think the law takes its course. **DTF Member, Kabale District.***

*Many of the girls that we support with school fees through the sexual reproduction health programme once school opens, they will not be in a position to go back to school because some of them are pregnant and that is as a result of child molestation and defilement and also these children have been engaged in certain work because parents think their children should learn how to work during the lockdown which government would call child labour. **CSO Representative, Nwoya District.***

There were reports of sexual violence in some districts. Some women had their sexual rights violated when they were forced to have sex by unknown persons during curfew time.

*Yeah, I will just tell you one, in Mutundwe, we had a young lady who was raped during curfew time, that is during the time of lockdown. **DTF Member, Kampala District***

The stigmatisation of COVID 19 victims or suspects. When communities suspect a person or homestead is infected, they completely close them off from society.

*I have heard people saying for example that they locked up the suspected person in the house for three days without food, no bath not even allowing them to use a toilet. So, I think there was some kind of violation of human rights but I didn't see physically, but we also would receive phone calls and we would send our team to respond to them. **Health Worker at HCIV, Lira District***

Gender-based violence where men would batter their wives because of misunderstandings between them and the financial constraints that families faced.

*Yea, maybe we can talk about how this pandemic has caused several issues mostly domestic violence, may be caused by poverty. People have nothing to eat. People have no money, so there is stress and because of that, cases of domestic violence have increased. There is a need for psychosocial programs to be conducted in communities because now the numbers are overwhelming and you find the district task force or those departments in connection with that cannot handle the issues. **CSO Representative, Mukono District.***

Other respondents felt that the word violation had been overrated and some acts such as beating someone into complying was not a violation of rights. A respondent on the DTF in Kampala noted that,

*You see now you are talking about acts of violations, that is the problem with you people in CSOs. You tend to misinterpret situations. Now you are talking about acts of violations but if I am forcing/ beating someone to put on a mask, am I violating your right? Instead, it is you are violating my right because am coming out of my home to force you to be alive. So, I do not think that's a violation of rights. Some people even look in rooms and they drink until morning yet there is curfew. Curfew was put there for a reason and now for you people activists, you call that violation of human rights. Then who is violating the rights of each other? **DTF, Kampala District.***

While other respondents declined to respond to the question of whether there existed human rights violations in their communities because it is against organisational policies to do that.

*That is against our core values as Red Cross we do not comment on such issues it is ours. **CSO representative, Kampala.***

According to these findings, Human Rights violations did not exist in all the districts covered by the study. The reports indicate that these violations were not registered in Districts like Kamuli.

c) Mitigation of human rights violation

Among other interventions, the CSOs identified the perpetrators violence and informed the DTF to stop the human rights violation abuse that were being inflicted on the community by security personnel. A position paper was written by a CSO in Luweero condemning these acts.

*Originally it was a big challenge during implementation of the guidelines and particularly to do with the curfew there was a lot of human rights violation because the police were beating people anyhow without any mercy to think of consideration of their human rights. And as Luwero NGO Forum we made a paper which we shared with the office of the RDC, Chairperson of DTF, and we had to bring this openly to them and requested that there should be the observance of human rights while they enforce COVID-19 guidelines particularly to do with the Boda-boda cyclists who were not properly handled from the start. There was a lot of violations of human rights because many of them were being beaten others were being, their boda-bodas were confiscated by police they were being made to pay a lot of money. But now at least I think the situation is different. **CSO Representative, Luwero District.***

CSOs engaged with the head of security Regional Police Commander (RPC) and the DTF and informed them of what violations were taking place in the communities and the RPC counselled his team:

*Yes, personally not really, but We got information from the Communities about the violation e.g. women that used to sell bananas along the roadside were Chased away, beating people at night because of failing to observe the curfew hour became the order of the day, and all these would come from specific places so all this information we shared with the security team during the DTF' meeting and since the RPC has ever worked with NGO's, he understood this properly, put on a human face and talked to the security team, I greatly appreciate him for that, since then, we have seen that those things greatly reduced. **CSO Representative, Lira District.***

Use of media to speak to the community, district task force and security operatives condemning the acts. This was done especially by religious leaders who did not have membership on the district task force.

well, everyone talked condemned that acts, many people could call on the radio to report and talk against the brutality of the community members by the security. I took the advantage of my radio programme and talked to the DTF and the security themselves to stop beating people and others were

entering into people's houses and picking household items, we called upon the RDC to address the security, which she did on the RDC and at least it reduced. **Religious Leader, Apac District.**

Helped the community in requesting for transport for the pregnant mothers to ease their movement. A member of the private sector noted that,


Partly by the district, yes because when I would call the district health officer and they would send me a vehicle to transport the mothers always but of course that depended on me calling, because the community may not access the DHO's then, on the other hand, it would be dependent on like our donor foreigners aid like my organisation is foreign-funded like food for my HIV clients was funded and then also accessing those clients at home who never managed to reach the facility, they funded the motorcycle for our service delivery, so those are some of the factors that contributed to our success and my role. **Private Sector Representative, Bududa District.**

The media houses design programmes around sexual violence to sensitise communities and raise awareness about these issues and avenues for addressing them. This was well articulated by media personnel in Jinja.

Yeah, we are running programmes on GBV. We are working with the police, local government and the civil society and we are running these programs on GBV to see how we can reduce you know our community not only our community but the world over; there has been an increase on GBV. ... We are trying to reduce that and how people can go and solve their issues without getting violent. So, we are running several programs on the radio. **Media Representative, Jinja District.**

Security personnel were invited for the meetings of the sub-county committees and advised on how to handle the community.

Whenever we held town council meetings, we addressed issues arising because there was always a police officer present. We requested him sometimes to avoid exposing someone to make an accident. Already they are scared. Do not chase them, they have understood their mistakes. So, we put in place mechanisms to handle situations appropriately. It was a concerted effort, and the officers understood our concerns. We used to meet twice a week or when the need arises or following the Presidential address. We would meet to implement what was communicated. **LC 3 Chairperson, Mpigi District.**



Chapter 5

Community Perceptions on the Performance of the COVID-19 DTF

This section presents both qualitative and quantitative findings on the functionality of the COVID-19 District Task Forces Study.

5.1 Demographic Statistics

As was described in the methodology section, the study was conducted in 31 districts covering 11 sub-regions across Uganda as presented in table 3. The Central Region (Buganda sub-region) had the biggest portion of the respondents who participated in the study constituting 40.2 per cent, followed by the Western Region at 12.2 per cent. The results also show that 54 per cent of the respondents interviewed resided in urban areas compared to 46 from rural areas. A total number of 1,507 community members were interviewed, and 1,499 provided full information constituting 99 per cent response rate.

Table 3: Distribution of the Sample Size by Region and District

Region	District	District Level		Regional Level	
		Freq	%age	Freq	%age
Acholi	Amuru	20	1.3	71	4.7
	Gulu	31	2.1		
	Nwoya	20	1.3		
Lango	Apac	19	1.3	70	4.7
	Lira	51	3.4		
Karamoja	Moroto	28	1.9	35	2.3
	Nakapiripiriti	7	0.5		
West Nile	Arua	71	4.7	96	4.4
	Nebbi	25	1.7		
Teso	Soroti	43	2.9	98	6.5
	Tororo	55	3.7		
Bugisu	Bududa	24	1.6	82	5.5
	Mbale	58	3.9		
Busoga	Jinja	57	3.8	131	8.7
	Kaliro	25	1.7		
	Kamuli	49	3.3		

Region	District	District Level		Regional Level	
		Freq	%age	Freq	%age
Buganda	Kampala	185	12.3	603	40.2
	Luwero	54	3.6		
	Mpigi	29	1.9		
	Mukono	72	4.8		
	Wakiso	263	17.6		
Mid-Western	Buliisa	15	1.0	130	8.7
	Hoima	36	2.4		
	Masindi	40	2.7		
	Kabarole	39	2.6		
Western	Kabale	28	1.9	183	21.2
	Kisoro	31	2.1		
	Kanungu	26	1.7		
	Mbarara	39	2.6		
	Rukungiri	35	2.3		
	Sheema	24	1.6		
	Total	1,499	100	1,499	100

The gender disaggregation of the respondents comprised 51 per cent females and 49 per cent males while the average age of the respondents was 36 years. The results also show that majority of the respondents (63%) were married and that most of them (34.6%) have 4 to 6 persons who directly depend on them for survival. More details are shown in Table 4 below:

Table 4: Social Demographic Characteristics of the Respondents

Variable	Options	Freq.	Per cent
Gender	Female	767	51
	Male	732	49
Marital Status	Divorced/Separated	145	10
	Married/Cohabiting	950	63
	Never/Married	327	22
	Widowed	77	5
Main Source of income	Crop Farming	400	26.7
	Labour Employment	210	14.0
	Livestock	21	1.4
	Other (Specify)	124	8.3
	Petty Trade	179	11.9
	Remittance	62	4.1
	Self-Employed (Business)	503	33.6

Variable	Options	Freq.	Per cent
Age	15-24	237	16.3
	25-35	558	38.3
	36-45	325	22.3
	46-60	253	17.4
	Above 60	85	5.8
Number dependents	1-3 People	447	29.8
	4-6 People	519	34.6
	7-9 People	237	15.8
	10 And Above	148	9.9
	None	148	9.9

According to Table 4, results further revealed that the main source of income was self-employment as reported by 33.6 per cent of the respondents. Also, 26.7 per cent of the respondents reported that their source of livelihood was crop farming. The results also revealed that 16 per cent of the respondents had at least one member of their households having a functional disability.

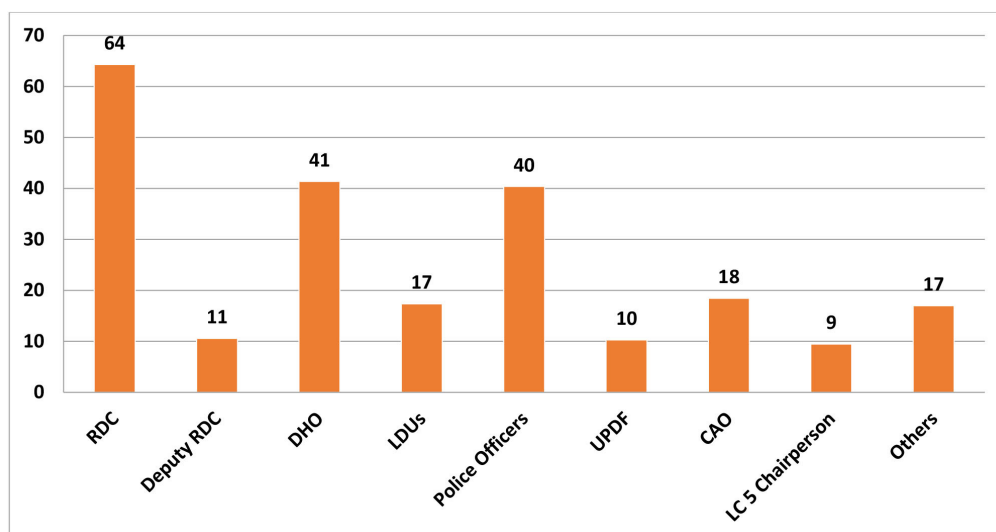
Therefore, these observations show some sort of vulnerability of the community members interviewed and points to greater challenges and difficulties that are likely to be ahead of them while coping with the COVID-19 Pandemic.

5.2 Level of Awareness

5.2.1 Community Members' Awareness of the COVID-19 DTFs and Officials in their respective Districts

The respondents were asked about their awareness of the existence of the COVID-19 District Task Forces and their operations in the communities. It was established that 67 per cent of the respondents were aware of the existence of the District Task Forces in their respective districts. The respondents were also asked about their awareness of the members on the COVID-19 district task force. The study results established that the Resident District Commissioner (RDC), the District Health Officer (DHO), and the Police Officers were the most popular categories of the members of the COVID-19 District Task as reported by 64 per cent, 41 per cent and 40 per cent respectively. More details are presented in Figure 5.

Figure 5: Category of COVID-19 DTF Officials known by Members of the Community



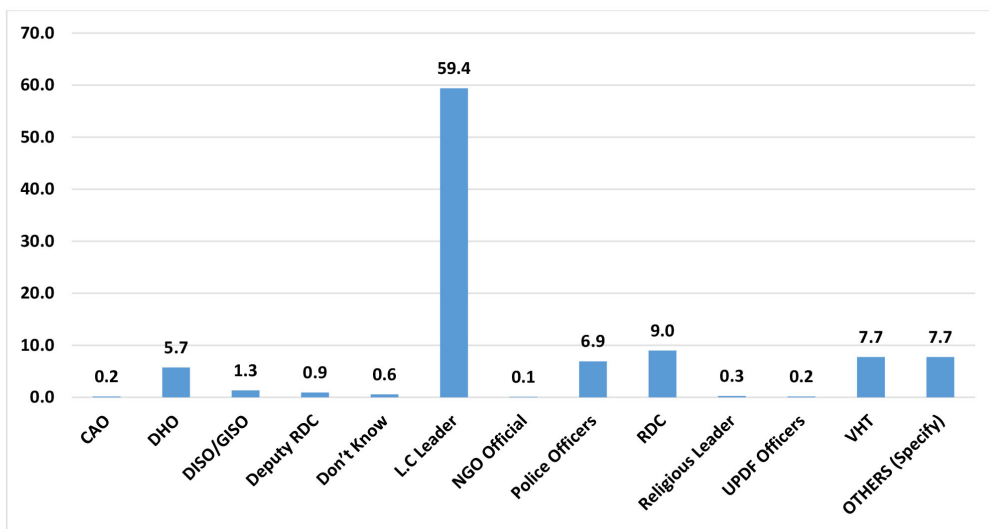
The district Chairpersons who are the Chairpersons of the District Task Force as provided for under the National Disaster Preparedness and Management Policy (2011) are the least known members of the District Task Forces. This could be explained by the fact that the National Task Force headed by the President gives more powers to the RDCs to Chair as Head the District Task Forces on COVID-19 thus conflicting with the policy. This has had serious ramifications in some districts leading to conflicts as a result of power struggles between Chairpersons and RDCs. In some Districts like Bunyangabo, there was an open confrontation between the RDC and the District Chairperson over control of resources and vehicles meant for COVID-19 containment activities²⁰.

5.2.2 Community Awareness of DTF Activities

The members of the community in the study areas were asked about their awareness of the COVID-19 District Task Forces' activities in their localities. The findings revealed that 80 per cent of the respondents reported that they knew and were aware of the concerned offices or contact persons to run to in case of any need. Figure 6 presents more details of the findings.

The results presented in Figure 5 also reveal that majority (59%) of the community members reported that they would run to their Local Council leaders while just 9 per cent, 8 per cent and 6 per cent reported that they would contact either the RDC, VHT or DHO respectively. Also, 52 per cent of these respondents reported that they do have the contacts of these officials and in case of an emergency; it is easy to communicate with them. These findings further underscore the relevance of the Local Council structure in the containment of the COVID-19. They demonstrate that the success of the interventions to contain COVID-19 would largely depend on

²⁰ See story in the media <https://www.monitor.co.ug/uganda/news/national/district-boss-as-saults-rdc-for-enforcing-government-directives-1883420>

Figure 6: Awareness Offices or Structures to be contacted in case of need during COVID-19 Pandemic

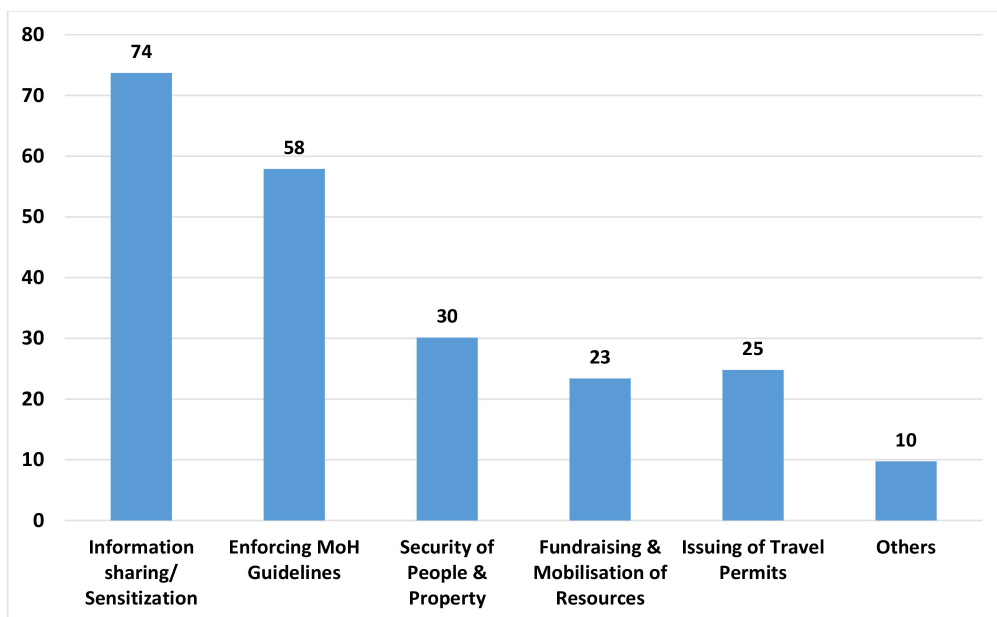
how well the local council structures are utilized in the mobilization, sensitization, surveillance and containment of COVID-19 in Uganda. This is mainly because LCs have an elaborate structure that runs from the district to the village/cell level and the leaders of these structures are usually well known to the community members.

5.2.3 Awareness of the Services of the DTF

The members of the community were also asked about their awareness about the services provided by DTF in their communities. The results show that the majority of the community members (71%) reported that they were aware of the services provided by the district task forces in their respective districts. Among the most common services which community members reported about included: information sharing/sensitization by the DTF team (74%), enforcement of the Ministry of Health guidelines (54%), provision of security for people and their property (30%) and issuance of temporary travel permits for in-country travels (23%). Figure 7 presents more details of the findings.

In terms of regional distribution, the results show that awareness of information sharing or sensitization is the most popular form of service provided by the DTFs among the members of the community in both Karamoja and Teso sub-regions as reported by 96 per cent. The results also show that knowledge about this responsibility of the DTF on sharing information/sensitization reduced as one moved towards Central or Buganda region (54%). Results indicate that slightly a larger percentage of the respondents that reside in rural areas (77%) reported being aware of the DTFs' responsibility of information sharing/sensitization compared to 71 per cent in the urban areas.

Figure 7: Common Services of the DTF

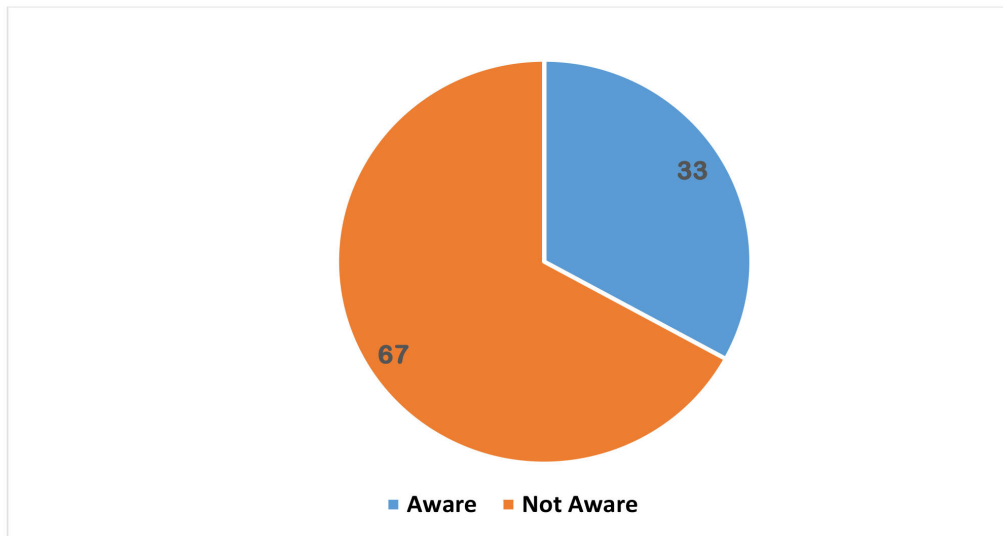


Similarly, community members' awareness of the responsibility of enforcement of the Ministry of Health COVID-19 guidelines was highly reported in the Bugisu sub-region (90%) and Lango sub-region (77%) and least reported in the West Nile sub-region (13%).

5.2.4 Awareness of Testing and Isolation Centres

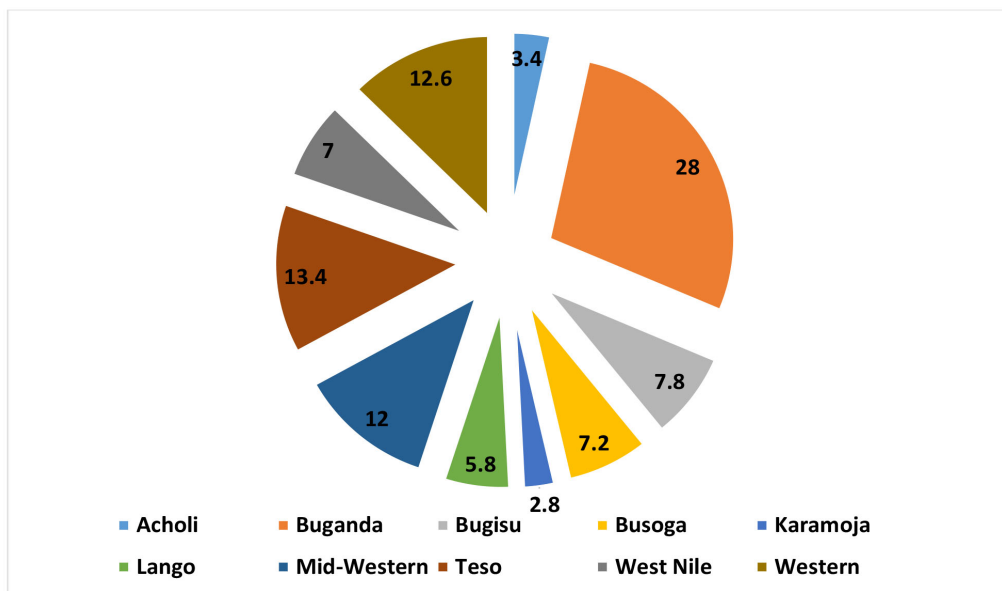
About community awareness of the availability of COVID-19 testing and isolation centres in their respective districts, the results revealed that 33 per cent of the respondents reported that they were aware of the COVID-19 testing and isolation centres. Also, 22 per cent of the respondents reported having received services from these centres. The results are presented in Figure 8.

Figure 8: Community Awareness of the Testing Centres



It was further observed that at the regional level, community members from Teso sub-region represented the highest percentage of respondents (58%) aware of location of the COVID-19 testing centres followed by community members from Bugisu sub-region (48 %). On the other hand, in the central region (districts of Wakiso, Kampala and Mukono), the study findings established that 77 per cent of the community members were not aware of the location of the testing and isolation centres in their community. Further details are presented in Figure 9.

Figure 9: Community Awareness of COVID-19 Testing Centres by Region



In terms of the rural-urban dimension, the results show that 58 per cent of the urban residents compared to 42 per cent of their rural counterparts reported that they were aware of the COVID-19 testing and isolation centres. This could partly be attributed to the fact that most of the centres were located in urban areas. In terms of gender, the results show that 35 per cent of male respondents as compared to 31 per cent of their female counterparts reporting that they were aware of these testing centres. Further, there were more male respondents (26%) than females (18%) who reported that they knew someone who has ever received a service or they had ever received services from these centres.

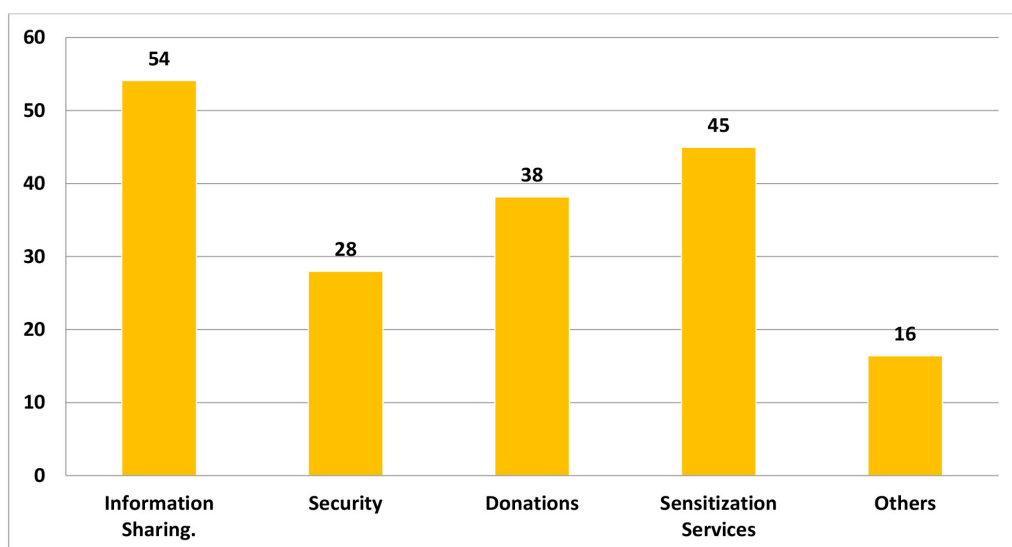
5.3 Community Members' Experiences with the COVID-19 District Taskforces

The community members were asked about their experiences while receiving support services from the District Task Force teams in their respective districts and communities. This section presents findings from respondents who received services or directly interfaced with the District Task Force Teams in their respective districts.

5.3.1 Community Members' Benefits from DTFs

The results indicate that overall, 58 per cent of the respondents reported that they have benefited from the different services offered by their respective COVID-19 District Task Forces. The findings are presented in Figure 10.

Figure 10: Community Benefits or Services from the DTF

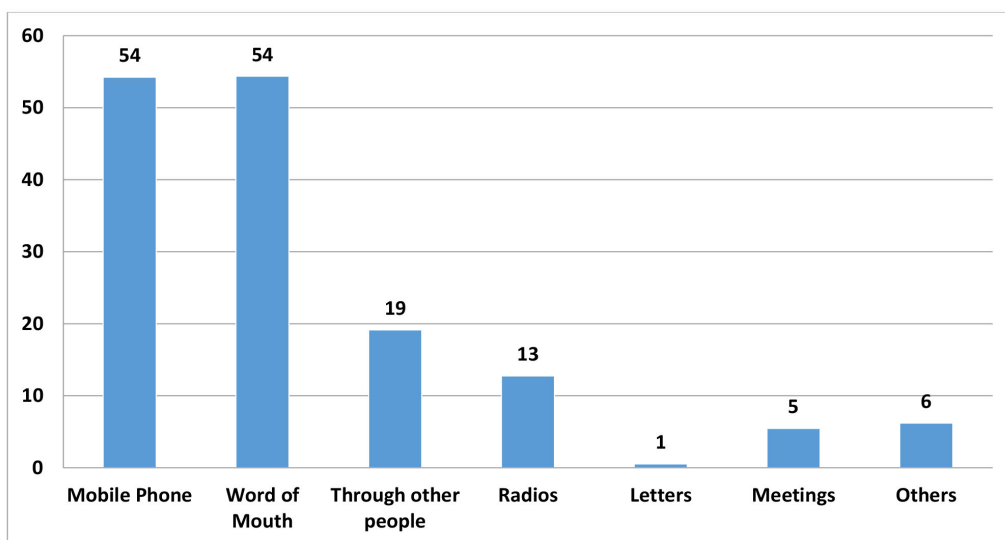


The study has established that 54 per cent, 45 per cent, 38 per cent and 28 per cent of the respondents had benefited from the information about prevention of COVID-19, sensitisation, donations and security respectively.

5.3.2 Modes of Communication used by DTFs

Further, the study sought to establish the most common modes of communication being used by District Task Forces. Thus, the results reveal that the modes of communication used by the DTFs included mobile Phones (54 per cent) and word of mouth (54%) were the most commonly used by the DTF to pass on information to the members of the community. Other reported modes of communication included word of mouth (19%), radios (13%) and meetings (5%). Figure 11 presents the details of the findings.

Figure 11: Modes of Communication used by the DTF to Communicate with Members of the Community



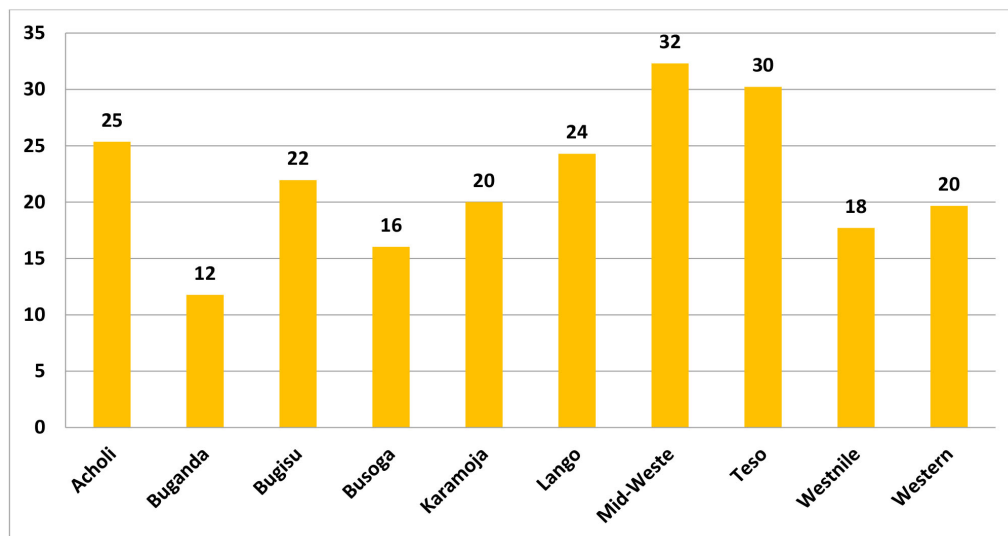
These findings show that radios which were the most common or popular mode of communication were not so well utilized by the COVID-19 District Task Forces to pass on information about containment of COVID-19 to the public.

5.4 The interface of the Community with the DTF Officials

Concerning the interface between the community members and the members of the DTFs, the results have revealed that 18 per cent of the respondents reported that they had interfaced with a member of the DTF team directly compared to 82 per cent who had not. Exploring the circumstances under which the community members interfaced with the DTF core team members, it was reported that the majority of the community members (48%) interfaced with the DTF core team through receiving food items and other forms of donations. Also, 34 per cent of

these reported that they had interfaced with the DTF core team member through requesting for the temporary travel permits, while 16 per cent reported that their interface was through seeking healthcare services. Community members from Mid-Western and Teso sub-regions represented the highest proportions of community members who had directly interfaced with at least DTF members at 32 per cent and 30 per cent respectively. Figure 12 presents an interface with the DTFs per region.

Figure 12: Interface between the DTF and Community Members by region.

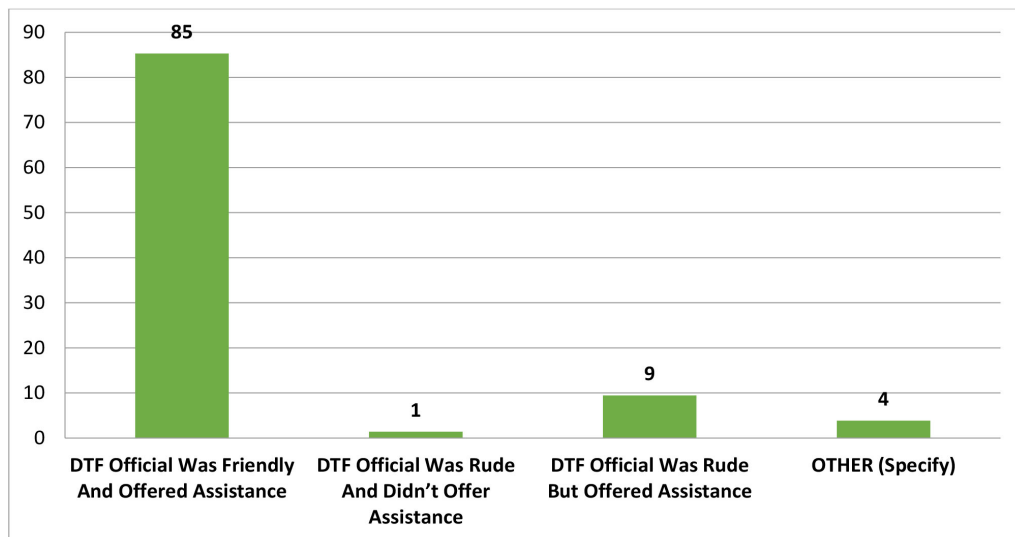


In terms of the urban-rural divide, it was revealed that community members who resided in urban areas interfaced more with the DTF members (22%) compared to those in rural areas (16%). Also, in terms of gender, the results show that more male respondents interfaced with DTF members (24%) than their female counterparts (14%). This implied that there were differences in access to services between males and females in society.

5.4.1 Community experiences interfacing with DTF

In terms of community members' experiences, while interfacing with the DTF members, the majority (85%) reported that the DTF officials were friendly and happily offered assistance to the people. Figure 13 shows more details about the community experiences with the DTFs.

Figure 13: Community Experiences with DTF Officials



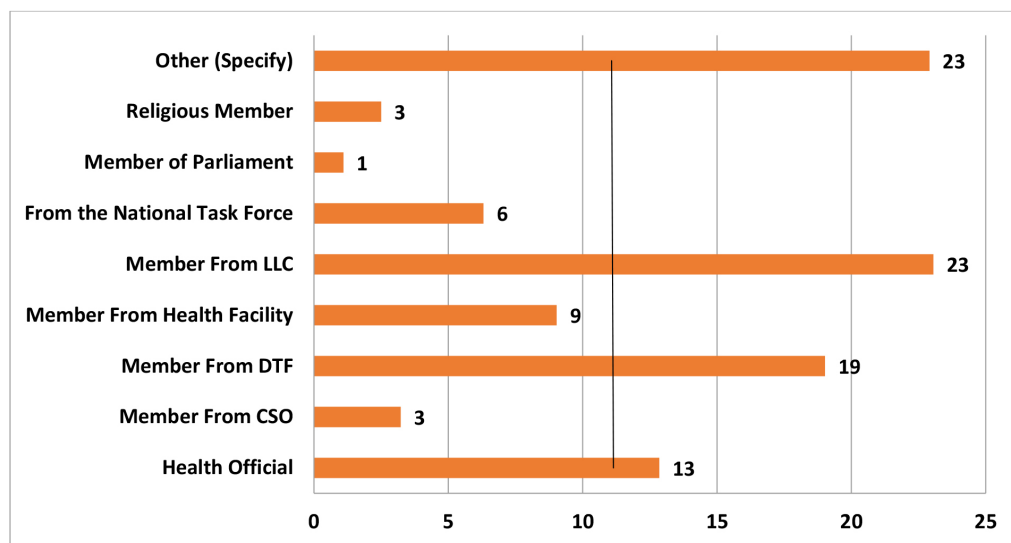
The findings from Figure 10 imply that overall, community members were largely happy with the conduct of the DTFs. From the regional perspective, the results established that Teso (31%) followed by Acholi (22%) sub-regions had the highest proportions of DTFs that never offered services to the community members in their jurisdiction.

Concerning experiences of the community members who managed to get services with the testing and isolation centres, the majority (68%) reported that they had experienced good services. However, only 26 per cent of these reported that there were some delays in service delivery, especially, in releasing test results.

5.4.2 Communication between DTF and Community members

Concerning access to sensitization information, overall, 91 per cent of the community members reported that they had been sensitized on COVID-19 pandemic related issues from a wide range of relevant agencies and individuals. Figure 14 presents the details of the findings.

Figure 14: Officials from Members of Community Received Sensitisation Messages

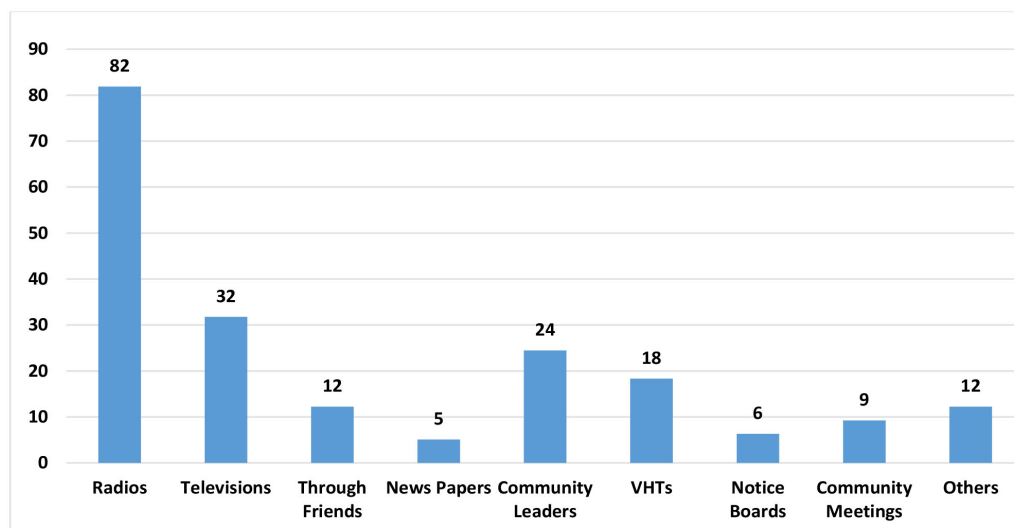


According to Figure 14, the results show that the sensitization information had been received from mainly Local Council Leaders (23 %), Health Officials (22%), DTF officials (19%), and National Task Force on COVID-19 (6%).

5.4.3 Communication Channels through which COVID-19 Messages were delivered.

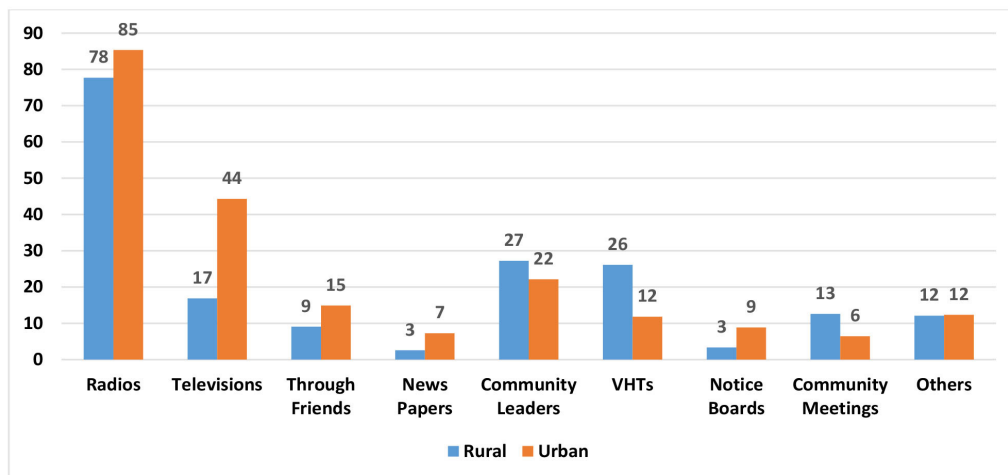
The communication channels through which most of the sensitization messages were delivered were also explored. Figure 15 presents the findings.

Figure 15: Communication Channels through which COVID-19 Messages were delivered



According to Figure 15, the results show that majority of the respondents (82%) reported that they had received COVID-19 sensitization messages through radios. In terms of the urban/rural divide, radio remained the main channel of communication as shown by 78 per cent and 85 per cent of the respondents in the rural and urban areas respectively. Figure 16 presents the details of the findings.

Figure 16: Communication Channels by the Rural and Urban Divide



5.4.4 Frequency of Sensitization

The study also sought to establish the frequency of the sensitization conducted by the DTF. The results are presented in Figure 17.

Figure 17: Frequency of the Sensitization Messages from the DTF

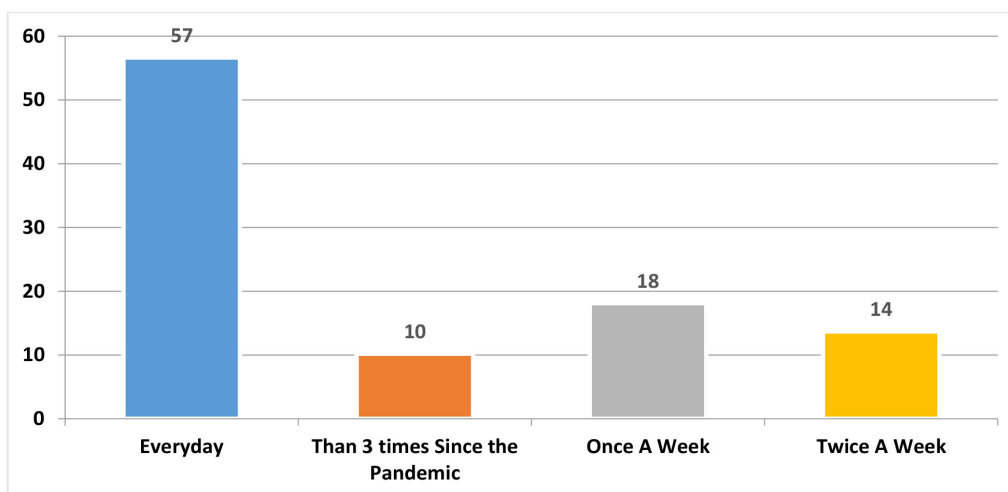
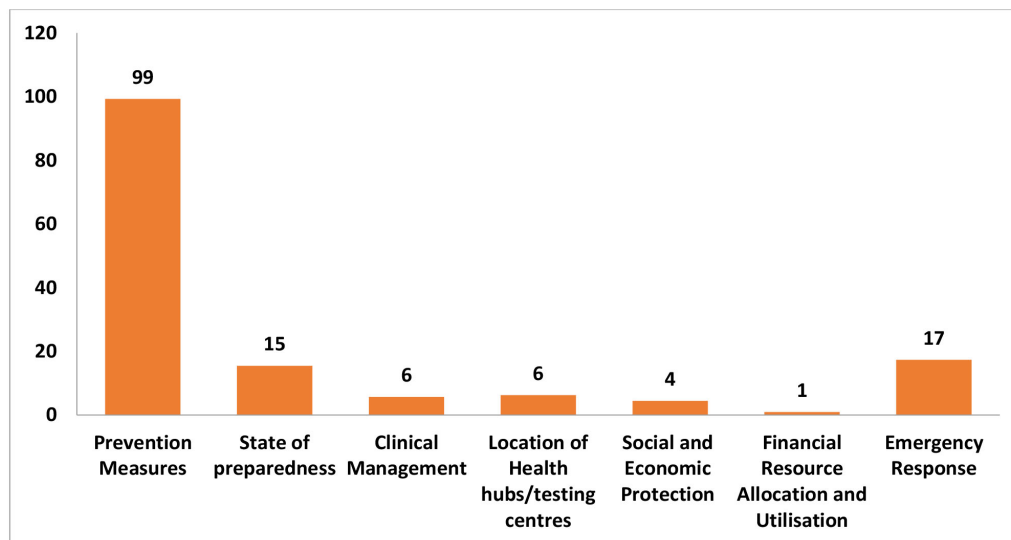


Figure 17 indicates that 57 per cent of the respondents reported that they were receiving messages daily while 18 per cent received sensitization messages on prevention and containment of COVID-19 once a week.

5.4.5 Nature of Information Shared

The study further sought to establish the nature of the information embedded in the sensitization messages for COVID-19. Figure 18 presents the findings.

Figure 18: Nature of Information in Sensitization Messages



The results revealed that majority of the respondents (99%) reported that COVID-19 communication adverts contained information on preventive measures against COVID-19 while 17 per cent reported that the COVID-19 adverts contained messages on the emergency response by the health officials.

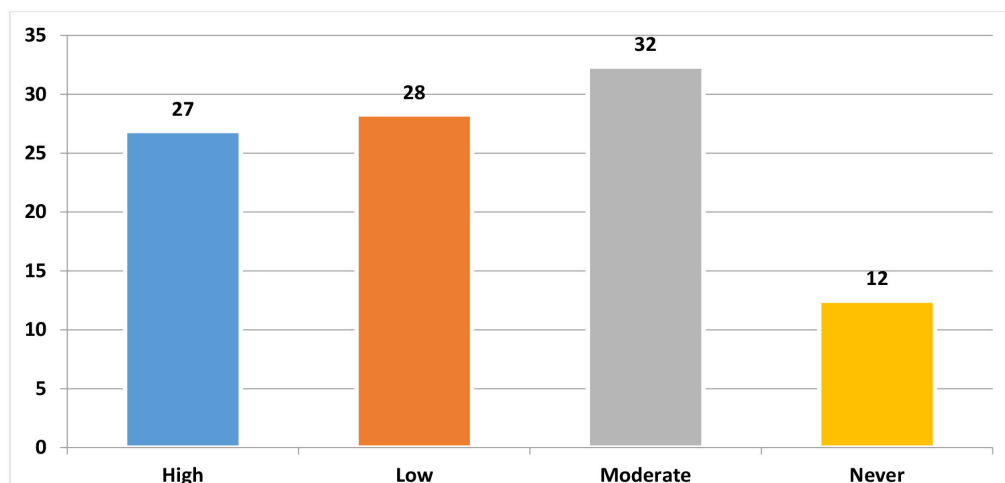
5.5 Community Members' Satisfaction with the Services of the DTFs

Further, members of the community in the districts covered by the study were asked about the level of satisfaction with the performance of the District task Forces on several parameters. To measure the level of their satisfaction, the study used a scale in terms of "high", "moderate", "low" and "never satisfied at all". The respondents were thus asked about their level of satisfaction with community sensitization; DTFs' readiness; availability of equipment to manage emergencies, enforcement of Standard Operating Procedures (SOPs), accountability for resources, food distribution and other forms of donations and issuance of the travel permits.

5.5.1 Satisfaction with Community Sensitization

The results established that 27 per cent of the respondents were highly satisfied with the community sensitization provided by the District task forces, 32 per cent were moderately satisfied, and 28 per cent had low satisfaction while 12 per cent were not satisfied at all, with the level of sensitization offered to them by their respective DTFs. These findings are further presented in Figure 19.

Figure 19: Level of Satisfaction of Sensitization Conducted by DTFs



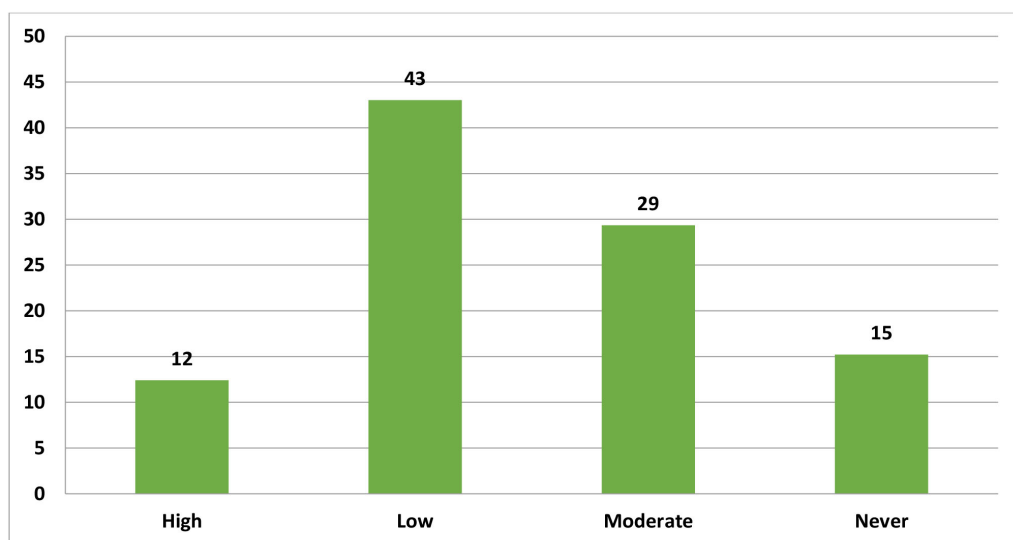
At the regional level, the results show that Lango sub-region had the highest level of appreciation of the level of sensitization by DTF as reported by 50 per cent of the respondents who reported that they were highly satisfied. On a similar measure, Mid-western and Acholi Sub-regions recorded 38 per cent and 34 per cent of their respondents highly satisfied with the sensitization messages of the DTF. On the other hand, Busoga sub-region had the highest proportion of community members who reported that they are never satisfied with the sensitization at 20 per cent.

5.5.2 Satisfaction with the Readiness of DTFs

Concerning the readiness of the DTFs to address COVID-19 emergencies, the study revealed that 43 per cent of the respondents reported that their satisfaction with the level of readiness of the DTF was low. Figure 20 presents the details of these findings.

At the regional level, the lowest levels of satisfaction of the DTFs was reported in Lango Sub-region by 23 per cent.

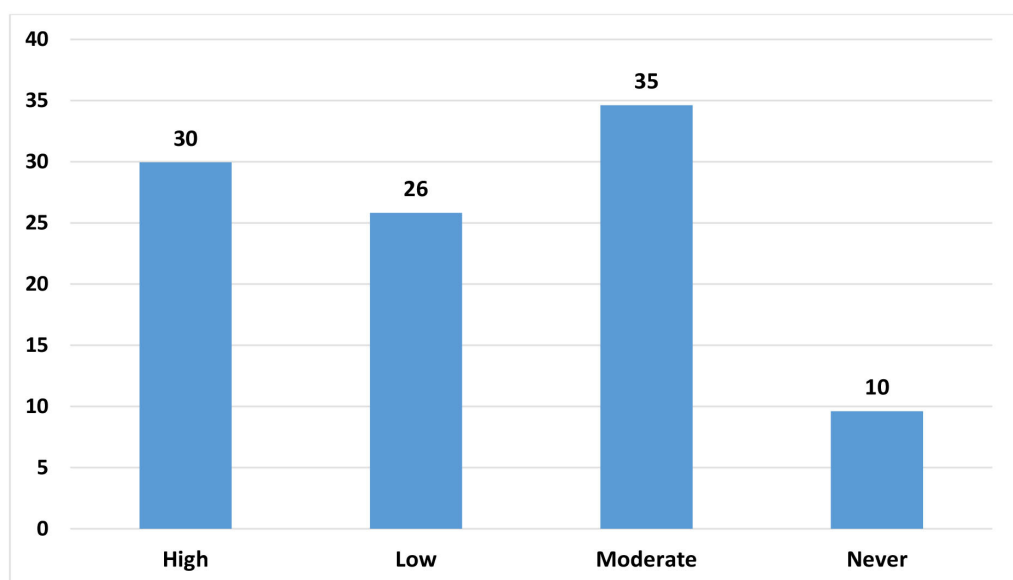
Figure 20: Satisfaction Levels with Readiness of DTFs to Address COVID-19 Emergencies



5.5.3 Satisfaction with Enforcement

One of the mandates of the DTFs was to enforce the guidelines from the Ministry of Health, Standard Operating Procedures (SOPs), and directives of containing COVID-19 from the National Task Force. The study thus intended to establish the level of satisfaction with the DTFs in fulfilling this mandate. The results show that 30 per cent of the respondents reported that they were highly satisfied with the DTFs, 35 per cent were moderately satisfied while 26 per cent reported low rates of satisfaction with the enforcement of the SOPs. Further details are presented in figure 21.

Figure 21: Satisfaction with DTFs' Enforcement of the COVID-19 SOPs

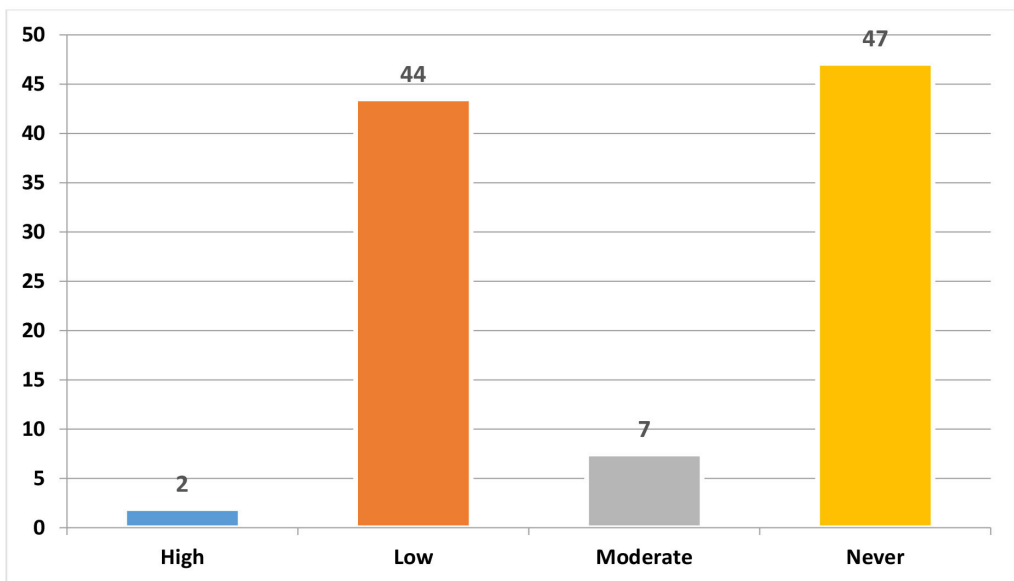


At the regional level, results from Lango Sub-region revealed that 62 % of the members of the community were highly satisfied with the enforcement of the Ministry of Health SOPs.

5.5.4 Satisfaction with Accountability

The district taskforces received resources in terms of money from Central Government, donations from the private sector, NGOs in form of money, medical, food and other supplies. The study sought to establish the levels of satisfaction of the members of the community with accountability for resources in the hands of the DTFs. The results are presented in Figure 22.

Figure 22: Satisfaction Levels with DTFs' Accountability on the COVID-19 Expenditures

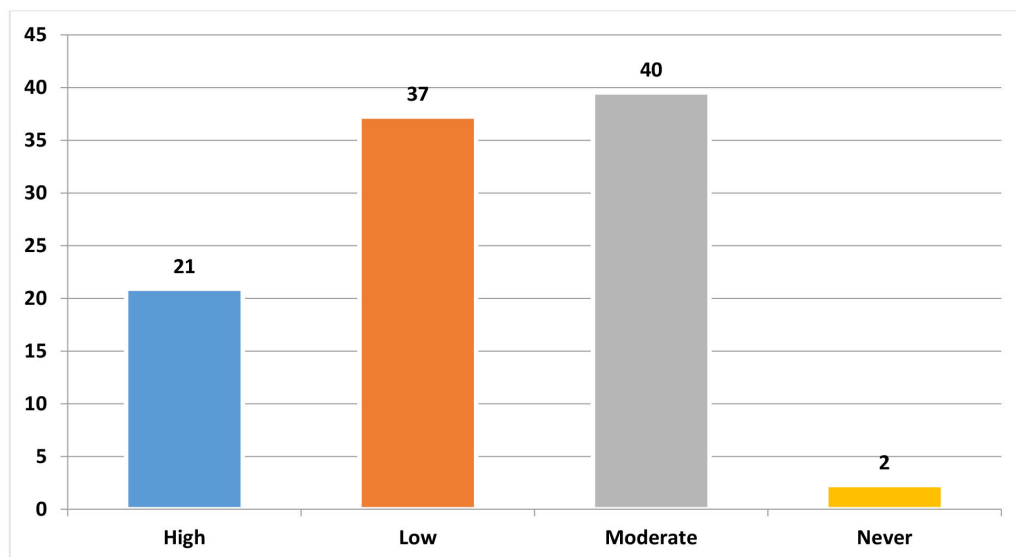


The results show that majority of the respondents were not satisfied with the level of accountability by the DTFs. Specifically, results show that 47 per cent of the respondents were never satisfied with the level of accountability while 44 per cent rated it low.

5.5.5 Satisfaction with Distribution of Food and other Supplies

During the COVID-19 induced lockdown, all non-essential services were closed down and people working in non-essential sectors were required to stay at home. Therefore, the government started a food distribution program at the household level. This was also supported by the distribution of other home supplies. The study thus sought to establish the level of satisfaction of the members of the community with regard to food distribution in their localities. Findings are presented in Figure 23.

Figure 23: Satisfaction with food Distribution



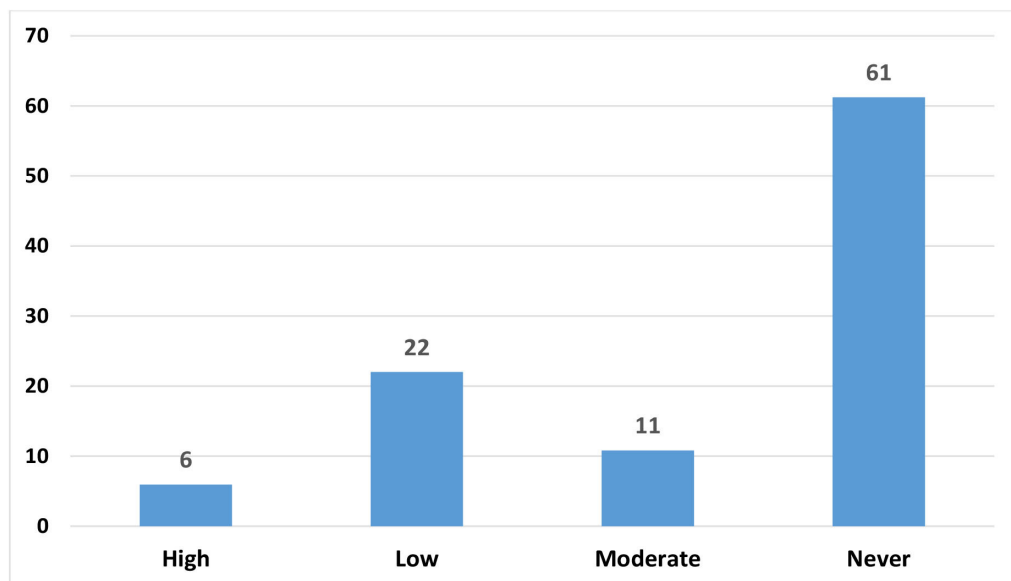
The results as presented in Figure 23 show that 20 per cent of the total number of the respondents received this form of social assistance from the government. Out of those who received food and other supplies, 21 per cent were highly satisfied while 40 per cent reported that they were moderately satisfied. Findings from Kampala, Wakiso and Mukono revealed that 44.6 per cent, 29.9 per cent and 24.8 per cent of the respondents were moderately, lowly and highly satisfied with food distribution respectively. These findings, therefore, demonstrate the DTFs performed better in other districts in food distribution than in Kampala, Wakiso and Mukono.

5.5.6 Satisfaction with the issuance of travel permits

As part of ensuring that people stay at home to control the spread of COVID-19, the national task force required that those that intended to move from their homes to distant places for any justifiable reason should acquire movement permits from the office of the RDC or at the sub-county. Figure 21 presents the findings on the level of satisfaction on the issuance of travel permits.

Results presented in figure 24 show that the majority (61%) were never satisfied with the efficiency and timeliness of issuance of travel permits in their localities. Also, 22 per cent of the respondents reported that the level of satisfaction with this service was low. In addition, findings reveal that in the districts of Wakiso, Kampala and Mukono 79.2 per cent were never satisfied with the efficiency and timeliness of issuance of travel permits while 21.4 per cent in these districts rated the performance of this service as low. The results across the study area demonstrate the poor performance of this service.

Figure 24: Satisfaction Levels with DTFs' Issuance of Travel Permits



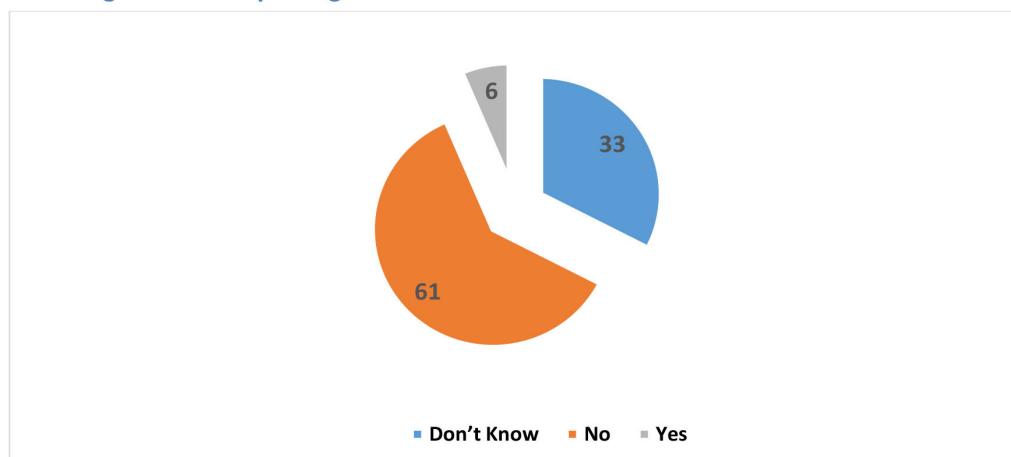
5.6 Community Perceptions on Efficiency of DTFs

To measure the efficiency of the DTFs, the study sought to establish practices of the DTFs concerning resource accountability to the community/public and the ease with which community members in need of the services were able to receive them.

5.6.1 Reporting on Resource Utilization

When asked about reporting on resource expenditure by DTFs to the public, the study revealed that 61% of the members of the public did not receive any information or communication on how the resources, supplies and other items in the hands of the DTF were utilised. Figure 25 shows more details of the findings.

Figure 25: Reporting on Utilisation of COVID-19 Resources to the Public

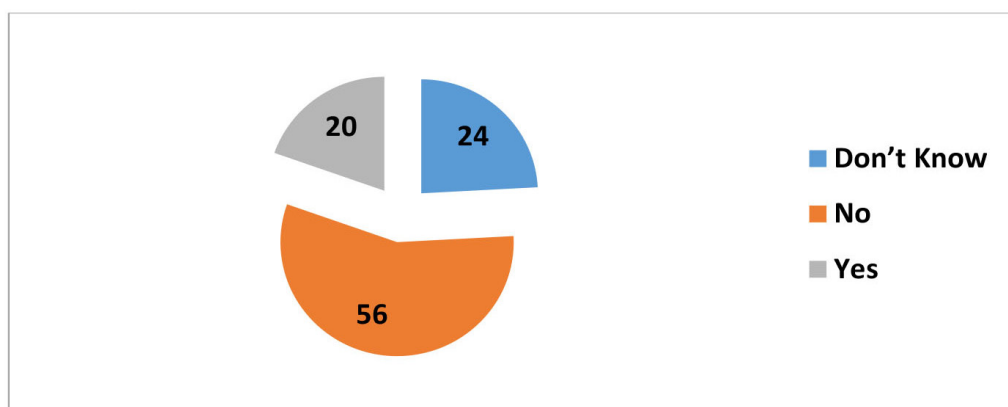


These results imply that the DTFs did not deliberately provide accountability for the money, food supplies, medical supplies and other materials received from various sources. There were reports in the media in some districts where some of the supplies meant for the response to COVID-19 were sold and ended up on the market.

5.6.2 Ease and Timeliness of Accessing Services

The study also sought to establish the ease and timeliness of accessing services provided by the DTFs. The areas of focus included information sharing, ambulatory services for the sick, food distribution, security for people and property, and sensitization among others. The respondents were asked whether those in need of services received them easily and on time. The findings are presented in figure 26.

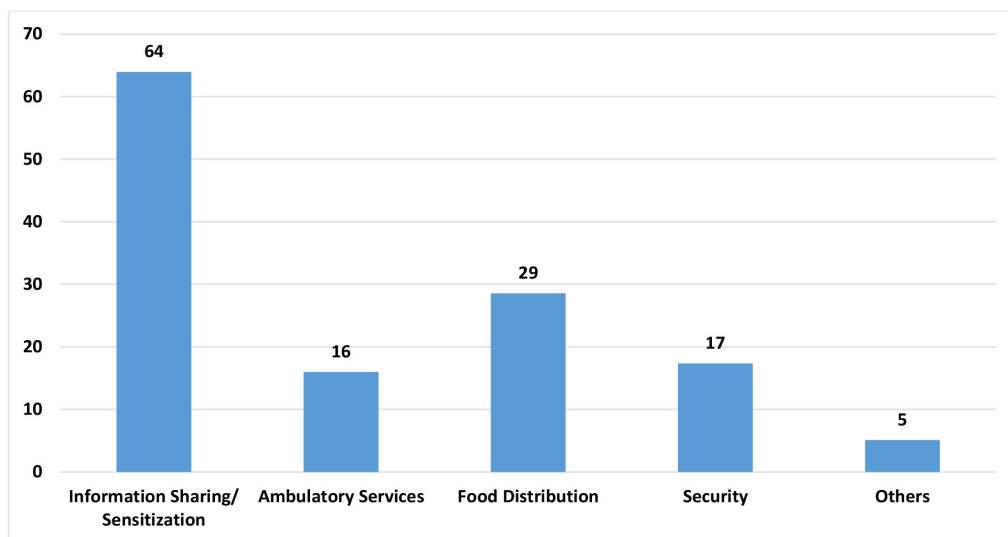
Figure 26: Ease and timeliness of access to services



According to figure 26, the results show that 20 per cent of the respondents were able to easily access services from the DTFs while 56 per cent were not. Further, results from Kampala, Mukono and Wakiso reveal that 70 per cent of the people who needed services from the DTFs were not able to receive them. It should be noted that given the high population in these districts and the relatively high demand for services, the supply side was overwhelmed.

5.6.3 Services received easily and timely

For the community members that easily received services and on-time were further asked which services they received. The details of the results are presented in figure 27.

Figure 27: Services easily provided to the community

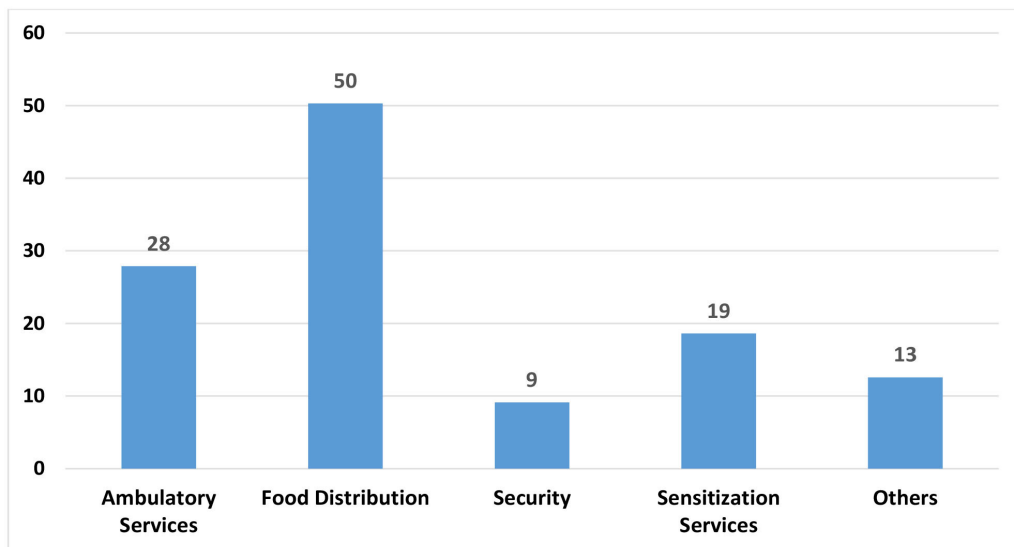
The results from figure 24 show that the results easily and timely delivered to the community were information and sensitization on COVID-19 as reported by 64% of those members of the community that received services from the DTF.

At a regional level, the DTF efficiency in service delivery concerning information sharing and sensitization was most pronounced and appreciated in West Nile Sub-region with 97 per cent of the community members interviewed reporting that they received this service easily. This was followed by Western sub-region (80%) and Acholi sub-region (77%). In terms of existence of ambulance services, Bugisu sub-region reported the highest percentage of the respondents reporting to have received this service easily (75%) followed by Karamoja (60%) and Lango sub-region at 33 per cent. In terms of food distribution, West Nile sub-region produced the highest percentage of responses reporting that they received this service without difficulty (97%), followed by Lango sub-region (81%), Mid-Western (75%) and Acholi (73%).

5.6.4 Services not received easily and timely

Concerning the services which were not provided easily and timely, 50 per cent of the community revealed that food distribution was inefficiently handled as demonstrated in Figure 28.

Figure 28: Services not received easily and timely by community members

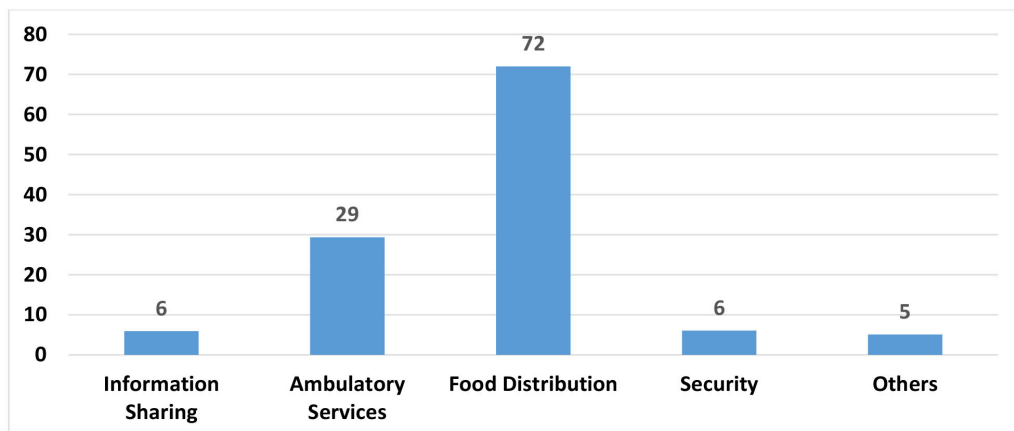


In terms of regional dimension, Mid-Western sub-region has the highest proportion of responses (80%) from community members reporting that food distribution was poorly handled and that they could not easily and timely receive it. This was followed by Teso sub-region at 78 per cent, Busoga Sub-region (63%), Lango (54%) and Western (51%).

5.6.5 Services never received at all

Furthermore, the members of the community were asked about the services they never received. The details of the results are presented in Figure 29.

Figure 29: Services not received by the Members of the Community



The results as indicated in Figure 29 indicate that 72 per cent of the respondents did not receive food that was being distributed in their communities. This was followed by ambulatory services reported by 29 per cent of the members of the community.

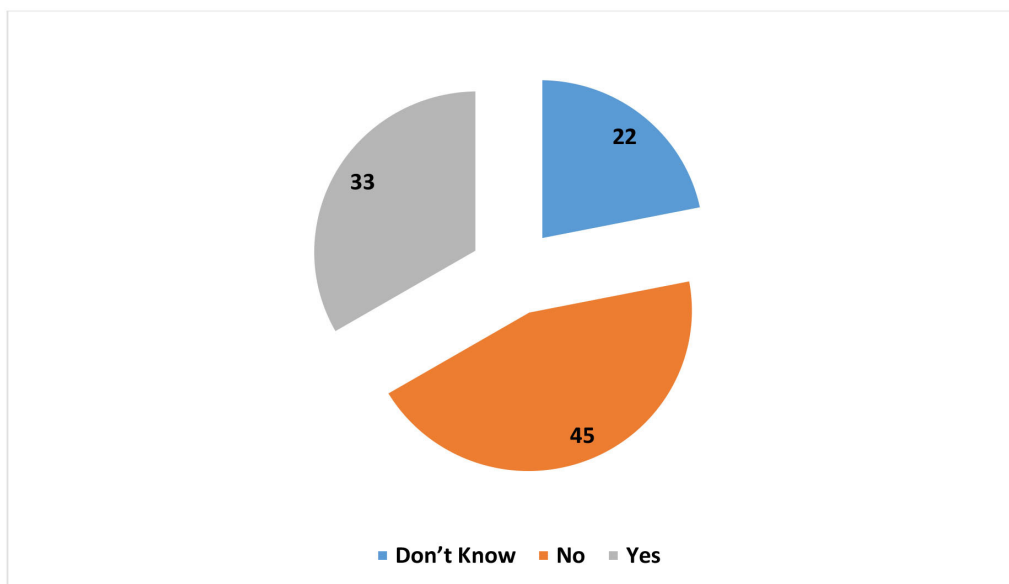
In terms of regional disaggregation, Lango sub-region constitutes the highest proportion of community members (50%) who reported that they never received ambulatory services at all when they were in need followed by mid-western sub-region (44%) and West Nile (39 %).

With regard to food distribution, Karamoja represents the highest proportion of community members reporting missing out on food distribution completely at 91 per cent, followed by Bugisu at 85 per cent, Mid-Western standing at 83 per cent, Teso and Lango both at 77 per cent. Further, in Buganda and Acholi Sub-regions 73 per cent and 72 per cent respectively did not receive any food items distributed by the COVID-19 Taskforces.

5.7 Community perception on Effectiveness of District Task Forces

The study sought to establish from the community perspective whether the DTFs were able to achieve their intended objectives in containing COVID-19 in their communities. The results are presented in Figure 30.

Figure 30: Achievement of the Objectives of COVID-19 District Task Forces



According to findings presented in Figure 30, 33 per cent of community members reported that the COVID-19 District Task Forces achieved their objectives in managing and containing COVID-19 in their communities while 45 per cent reported that their objectives were not achieved. Further disaggregation of data

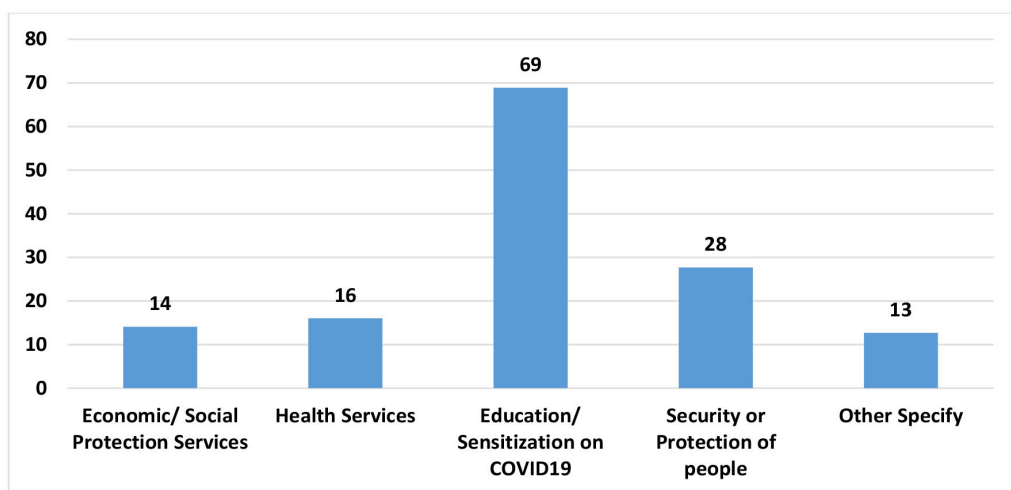
at the regional level reveals that 57 per cent and 55 per cent of the respondents from Western and West Nile sub-regions reported that the DTFs in these regions achieved their objectives. These were followed by Lango (49%), Teso (40%), Mid-west, Bugisu and Acholi both at 35 per cent.

5.7.1 Benefits from DTFs

To further establish the effectiveness of the DTFs, members of the community were asked about the benefits from the interventions of the DTFs. Figure 31 presents the details of the results.

The largest proportion of the community members (69%) reported that education or sensitization on COVID-19 was the most significant benefit from the COVID-19 district Taskforce as indicated in figure 28 above.

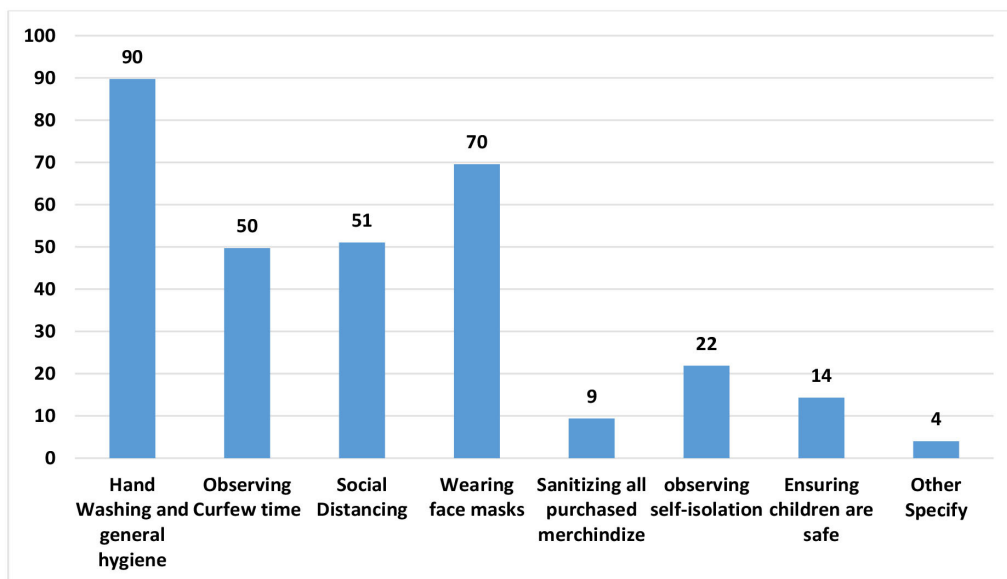
Figure 31: The Benefits derived by the Community from Interventions of DTFs



5.7.2 Behavioural Change Aspects Attributed to the DTF

As another aspect used to measure the level effectiveness of the DTFs from the perspective of the community members that were used by this study was the behaviour changes adopted by the community to contain the spread of COVID-19. The details of these findings are presented in Figure 32.

Figure 32: Behavioural Changes attributed to the DTFs interventions



The results in Figure 32 show that regular hand washing and improvement in general household hygiene was the most significant change attributed to the DTFs in the Local Governments covered by the study as reported by 90 per cent. This was followed by wearing face masks in public reported by 70 per cent. Similarly, 70 per cent of the total number of respondents reported that they were now effectively wearing their face masks as a result of the DTF work in the containment of the spread of COVID-19.

5.7.3 Drivers of the Observed Community Awareness and Satisfaction Rates

This section presents an extended analysis that explores the factors that were likely to influence the awareness and satisfaction levels by community members concerning the existence and activities of the DTFs in Uganda.

To guide this analysis, *Awareness* variable was constructed using three (3) indicators that included:

- (i) Community members' knowledge and awareness of the existence of the DTF team,
- (ii) Community knowledge and awareness of the activities of the DTF team in their community and
- (iii) Community members' knowledge and awareness of the testing, isolation and quarantine centres in their respective districts.

Therefore, a respondent was considered knowledgeable or aware, if s/he responded "Yes" to any of the above indicators and is coded 1, and 0 if otherwise – thus the *Awareness* variable is a binary.

Similarly, the variable for *Satisfaction* was measured using the satisfaction indicators across some parameters that include:

- (i) Community Members' satisfaction about the DTF sensitization activities,
- (ii) Community Members' satisfaction about how ready and equipped DTFs are in addressing the community's needs,
- (iii) Community Members' Satisfaction about DTF's security enforcement concerning the observation of the SOPs and curfew time,
- (iv) Community Members' satisfaction with the DTFs' accountability of the resources advanced to them to manage COVID-19 in their respective districts of operation,
- (v) Community Members' satisfaction about the food distribution activities done by the DTFs and
- (vi) Community Members' satisfaction about the issuance of temporary travel permits during the lockdown.

A respondent was considered satisfied when s/he reported *Highly or Moderately Satisfied* thus coded 1, and not satisfied if the respondent reported *low satisfaction* or *never satisfied at all*, thus coded as 0 – hence satisfaction is a binary variable.

The study estimated the community members' socio-demographic characteristics against satisfaction and awareness variables respectively, thus regression models were run for analysis. The socio-demographic factors that were used for this analysis included Community members' main source of income, Age, Location, Gender, Marital Status and Education Levels. All these variables were categorical except for gender which is binary. The reference category for the main source of income is crop farming, Age (15-24), Location (Rural), Gender (Female), Marital Status (Divorced/Separated) and Education (No Formal Education).

A multivariate logit model was used to estimate the combined effect of the community members' socio-demographics on satisfaction and awareness. The coefficients of the variables were computed as percentage changes taking into consideration their marginal effects.

Table 5: Regression Analysis for Awareness and Satisfaction

VARIABLES	(1) Awareness	(2) satisfaction
Main Source of Income		
Formal Employment	-0.433 (0.299)	-0.167 (0.205)
Livestock	-0.484 (0.606)	0.398 (0.455)
Petty Trade	-0.458* (0.257)	-0.170 (0.198)
Remittance	-1.326*** (0.344)	-0.00618 (0.301)
Self-Employed (Business)	-0.515** (0.219)	-0.205 (0.161)
Other (Specify)	-0.260 (0.303)	-0.328 (0.228)
Age		
25-35 Years	-0.371 (0.233)	0.0802 (0.173)
36-45 Years	-0.147 (0.268)	0.0481 (0.198)
46-60 Years	-0.0735 (0.294)	0.0445 (0.215)
Above 60 Years	-1.063*** (0.366)	-0.0935 (0.310)
Location		
Urban	-0.343** (0.166)	-0.0169 (0.123)
Gender		
Male	0.473*** (0.153)	-0.0410 (0.112)
Marital Status		
Divorced/Separated	-0.0441 (0.366)	-0.142 (0.318)
Married/Cohabiting	0.0613 (0.332)	-0.0888 (0.286)
Single/Never Married	-0.173 (0.388)	-0.0206 (0.324)
Education Level		
Primary	0.0324 (0.231)	0.528*** (0.203)
Secondary High School	0.837** (0.346)	0.146 (0.278)
Secondary O'level	0.764*** (0.257)	0.477** (0.214)

	(1)	(2)
VARIABLES	Awareness	satisfaction
Tertiary	1.447***	0.702***
	(0.345)	(0.247)
University	1.486***	0.862***
	(0.376)	(0.266)
Constant	1.643***	-0.651*
	(0.428)	(0.355)
Observations	1,458	1,458
Standard errors in parentheses		
*** p<0.01, ** p<0.05, * p<0.1		

Overall, it is observed that the model for awareness presents a more significant variable in influencing awareness than the one for satisfaction. The results reveal that the main source of income is significant and negatively associated with awareness about crop farming. Table 5 reveals that remittances, self-employment and petty trade as sources of income do negatively and significantly influence awareness of the DTF activities as compared to those relying on crop farming as their main source of income at 99 per cent ($p<0.01$), 95 per cent ($p<0.05$) and 90 per cent ($p<0.1$) respectively. It is revealed that community members whose main source of income was remittances from family and friends either from the cities or abroad were by 1.32 per cent less likely to know or be aware of the activities of the DTFs in their communities. Secondly, we observe that relying on self-employed businesses also negatively influences one's ability to know or be aware of the DTF activities relative to those relying on crop farming by 0.52 percentage points.

Similarly, relying on petty trade relative to crop farming negatively influenced one's ability to be knowledgeable or being aware of the DTF activities in their community by 0.5 percentage points. The above observations could partly be explained by the fact that possibly crop farmers were not much affected by the effects of COVID-19 pandemic including the lockdown since they could easily work on their farms without any limitation unlike their counterparts whose sources of income were somewhat being negatively affected and all their minds were focusing on how to survive and give less attention to the operations of the DTFs within their communities. However, this variable is not statistically significant concerning levels of satisfaction. This implies that being aware of the operations and activities of the DTFs in one's community does not necessarily imply satisfaction with the services that DTFs provide.

Also, age was found to be statistically significant at 95 per cent ($p<0.05$) influencing awareness. Considering this variable, it was observed that as one grows older, one's level of knowledge and awareness goes down. This is evidenced by the fact that community members who reported to be over 60 years of age were found to be less knowledgeable and aware of the operations of the DTF activities by 1.06 percentage points. This is true since as one gets older (beyond 60 years) tends

to be slightly cut off from the common issues of the society. This variable also is not statistically significant in explaining the satisfaction levels of the community members in Uganda.

The geographical location (rural-urban divide) was found to be statistically significant at 95 per cent ($p < 0.05$) in influencing the level of awareness of the operations of the DTFs in Uganda. The results show that community members who reside in urban settings are less likely by 0.34 per cent more likely to be knowledgeable and aware of the operations of the DTF activities in compared to those residing in the rural communities. Further, just like the previous two variables, location is not statistically significant in influencing satisfaction levels.

The results show that gender is positive and statistically significant in influencing the awareness and knowledge of the DTF activities at 95 per cent ($p < 0.05$). The findings demonstrated that community members who are males are 0.47 percentage points more likely to be knowledgeable and be aware of the operations and activities of the DTFs in their respective districts than female community members. This can be partly explained by the fact that males tend to move a lot in communities to provide for their families and in the process, they can be having access to information concerning the activities of the DTFs. Also, this factor is not statistically significant in explaining the observed trends of community satisfaction levels about the activities of the DTFs in Uganda.

On the other hand, the marital status of the community members does not play any role in influencing the awareness or satisfaction concerning the activities of the DTFs in communities.

Furthermore, education was found to be a strong factor in influencing knowledge and awareness levels of the Activities of DTFs. The study results have established that as one's level of education increases, one's awareness and knowledge levels, as well as satisfaction about the DTF operations and activities, increase tremendously. The study observes that completing O' level, A' level, Tertiary and University levels are positive and statistically significant ($p < 0.05$, $p < 0.01$, $p < 0.05$ and $p < 0.01$) respectively. A community member who completed lower secondary education is by 0.76 per cent more likely to be knowledgeable and aware of the operations of the DTFs in the community than the community member who lacks any formal education. Also, a community member who completed high school education is by 0.84 per cent more likely to be knowledgeable and aware of the operations of the DTFs in the community than a community member without any formal education. Similarly, a community member who completed tertiary education is by 1.45 per cent more likely to be knowledgeable and aware of the DTF activities and operations in the community than a community member who never had a chance to attend formal education. Also, a community member who completed University education is by 1.48 per cent more likely to be knowledgeable and aware of the activities and operations of the DTF in the community than one who never received formal education. The percentage increases from 0.76 at the lower secondary level to 1.48 to University level indicate the incremental influence of education in increasing knowledge and awareness as one's education level increases. The

educated community members can easily have access to reading materials and follow current affairs from all sources at their convenient and easily synthesize it for their benefit, which is not likely the case for their illiterate counterparts (without formal education).

On the other hand, education also shows that it is positive and statistically significant in influencing satisfaction levels of community members towards the activities and operations of the DTFs in their communities. The results reveal that community members who completed primary are by 0.52 per cent ($p < 0.01$) more likely to be satisfied with DTF services than their counterparts without formal education. Similarly, community members who completed lower secondary are by 0.48 per cent more likely to be satisfied with DTF activities and services than those without formal education. Also, community members who completed tertiary education are by 0.7 per cent more likely to be satisfied with the activities and services of the DTF than those without any formal education. Similarly, community members who completed university education are by 0.86 per cent more likely to be satisfied with DTF activities and services than those without formal education. This is true because education people tend to be more objective in judgement and tend to need less help from the government since there is a high chance that majority a better off in terms of livelihood compared to those without any formal education.

Regional Disaggregation

Table 6: Regional Disaggregation of Data

VARIABLES	(1) Awareness	(2) satisfaction
Acholi	1.998*** (0.597)	1.178*** (0.257)
Bugisu	0.851** (0.350)	0.310 (0.244)
Busoga	0.179 (0.233)	0.292 (0.201)
Karamoja	0.452 (0.458)	0.0272 (0.375)
Lango	1.074*** (0.409)	2.194*** (0.312)
Mid-Western	0.582** (0.261)	0.961*** (0.197)
Teso	1.607*** (0.432)	-0.264 (0.248)
West Nile	0.413 (0.284)	0.384* (0.227)
Western	1.032*** (0.260)	0.950*** (0.172)

	(1)	(2)
VARIABLES	Awareness	satisfaction
Constant	1.123***	-0.807***
	(0.0946)	(0.0882)
Observations	1,499	1,499
Standard errors in parentheses		
*** p<0.01, ** p<0.05, * p<0.1		

Considering the regional disaggregation, the study ran a bivariate analysis to explore the influence of geographical distribution in explaining the awareness and knowledge as well as satisfaction in terms of the activities and services of the DTFs in Uganda. In this analysis, the reference variable is Central region since we intended to establish how observations varied as one moved out of the central region which constituted Kampala, Wakiso and Mukono, which were the epicentres for the core activities of the COVID-19 containment activities and where the National COVID-19 taskforce was being housed.

Results show that the variable is positive and statistically significant in explaining both awareness and satisfaction. In terms of awareness, the results are a bit surprising because the main activities were done the main central districts of Kampala, Wakiso and Mukono. Possibly, these were overridden by the activities of the National Taskforce and so, the District Task Forces specific activities were overshadowed.

The study observes that community members in Acholi sub-region were by 2 per cent more likely to be informed and aware of the activities of the DTF activities in their respective activities than those community members living in the sampled districts of the central region. Also, it revealed that community members from Acholi sub-regions were by 0.9 per cent more likely to be knowledgeable and aware of the activities of the DTFs in their respective districts than those from the central region. Community members of Lango sub-region were by 1.1 per cent more likely to be knowledgeable and aware of the operations and activities of the DTFs in their respective districts than those in the central region. Similarly, community members living in Teso sub-region are by 1.6 per cent more likely to be aware and knowledgeable of the DTF activities than those in the central region. Also, community members in Western sub-region were by 1.03 per cent more likely to be knowledgeable and aware of the DTF activities compared to those in the central region.

Similar results are observed considering the satisfaction levels. It is observed that community members from Acholi, Lango, Mid-Western, West Nile and Western sub-regions are more likely to be satisfied by the DTF services and activities by 1.18 per cent ($p<0.1$), 2.19 per cent ($p<0.01$), 0.96 per cent ($p<0.01$), 0.38 per cent ($p<0.1$), and 0.95 per cent ($p<0.01$) respectively than those from the central region.



This observation can partly be explained by the fact that community members from upcountry districts tend to be relatively poorer and less exposed compared to those from the central region, and thus something very small in terms of service or contribution can surely make them appreciative compared to those from the central region who are relatively considered to have relatively higher incomes. Further, the level of exposure to relatively better quality services in urban areas in central region, could partly explain the observed results of less satisfaction levels from the central region.



Chapter 6

Key Successes of Taskforces

This chapter documents some of the key successes as registered from the various District Task Forces. The examples of these successes are provided while also discussing the key facilitating factors and the challenges encountered by the DTFs.

6.1 Success Stories on District Task Forces

a) Enforcement of Presidential directive

Constant feedback from the members of the community reveal that enforcement of presidential guidelines on containing COVID-19 was a resounding success in efforts to control the spread of COVID-19. This success was particularly visible in the strict enforcement of the lockdown and curfew.

b) Good Coordination, Leadership and Team Work

The district taskforces had good coordination of their activities. They conducted regular meetings and harmonised their interventions in response to COVID-19. The District Task Force also kept the community updated on every intervention in the community. For instance, it was reported by CSOs in Buliisa District that:

They meet every week and those are the top district officials, the district and security people are good at keeping us updated on what is happening within Buliisa, the coordination is good. We have only had two COVID-19 cases in the district. The task force has managed to contain the spread.

Coordination of the District Task Force on activities of COVID-19 has also been a success. This has been so much on the areas of the technical team and the security. There have always been quick responses to alerts, contacts and suspected cases of COVID-19. The security force has also been able to achieve in terms of ensuring that the SOPs are observed. **CSO Buliisa**

The task forces in several districts formed sub-committees to handle different aspects of the interventions to contain the spread of COVID-19. These sub-committees met regularly with the core DTF to give updates on their activities and harmonise their activities among other things. In Rukungiri District, for example, a member of the district task force reported that:

there were different active sub-committees namely; surveillance committee, security, psychosocial support committee, relief committee, risk communication committee and case management committee. These worked hard to control the



spread of the epidemic. The committees regularly reported to the district task force. This explains why Rukungiri has not registered any COVID-19 positive case for the past 7 months.

c) **Sensitization and Awareness Creation**

Several stakeholders in the Local Governments undertook rigorous sensitisation campaigns about COVID-19, how it spreads and how it should be prevented amplifying the information and communication messages provided by the Ministry of Health. The CSOs, private sector, media, religious leaders all amplified these messages alike to reach out to all segments of the community. Most districts reported having conducted hundreds of radio talk shows about COVID-19 for purposes of sensitising the community to prevent the spread of the virus. The results indicate that sensitisation and awareness creation is one of the successful interventions in containing the spread of COVID-19. For instance, several stakeholders reported that:

*Community awareness creation has been done better and at a wide range because, wherever you go, people know the COVID-19 preventive measures. **CSO Representative, Buliisa District***

*The DTF support to the community on sensitization ha indeed worked well and we appreciate that the community members are adhering to regularly washing their hands. **DTF Member, Masindi District.***

*I feel we have scored highly in the area of creating public awareness on COVID. Sensitization has been our major weapon and strength. This largely explains our success as is seen how have been able to prevent widespread COVID-19. Then we have also received positive reports from the community who have wholeheartedly embraced the struggle. **DTF Member, Nwoya District.***

*We sensitized people about washing hands with water and soap, everywhere we went into the communities we found that people had washing facilities in their homes and also in the public places meaning that people had put it into practice. **A Member of the DTF, Kabarole District.***

*I surely spread the gospel of wearing face masks in public. I went into the communities of Karambi and Karangura and very many people did not have masks and didn't even recognize their importance but we encouraged them to at least spare two thousand shillings and acquire one and after that, there was a very big change and attitude. **Opinion Leaders Representative Kabarole.***

I will say that we have succeeded in supporting both the communities and the district task forces and even government in suppressing the spread of the virus. We have run various spot messages, radio talk shows and had it not been for our contribution the cases of COVID-19 would have been so high in Acholi sub-region. I may not point to a success story but I know that

*the lower cases are associated with the input of the media and why we have been able to achieve this is because of the strong intermediary role that the media plays between the community and those in the position of authority-particular the DTF in this case. let me tell you one thing the community trusts the messages that we pass to them and Mega FM as you may be aware is known for information accuracy. Leaders use it to reach out to the population on key messages on the corona. **Representative of the Media, Amuru District.***

d) **Surveillance and Contact Tracing**

The District Task Force with the assistance of the Health Departments had a surveillance system in place to immediately detect and report cases, alerts, contacts and suspected cases of COVID-19. The members of the community were vigilant to enough to report any new member of the community coming in from hot spots of COVID-19 or countries with high cases of COVID-19. Upon reporting of such cases, there was a rapid response to investigate and conduct initial controls, getting samples and systematic contact tracing. The DTFs relied on health-care facilities, especially regional referral hospitals, and major border crossing checkpoints with already affected neighbouring countries. Also, there has been identification and follow-up of persons who may have come into contact with a person infected with COVID-19. This was done with the help of the security infrastructure including the DISOs and GISOs at the district and the lower local government levels respectively. All close contacts would be put under isolation and monitored for 14 days following their last known exposure to the case, and be quarantined at designated facilities if they become ill. For instance, it was reported in some districts that:

*Surveillance is doing well. All stakeholders are vigilant about alerts, new people coming to the community, and people with symptoms of COVID-19. **DTF Member, Mukono District***

*The district task force has done well on contact tracing for the suspects especially when the district received the first case of COVID 19. The task force has also done well on community sensitization where people can now wash their hands very well, some put on masks and others. **DTF Member Masindi District.***

*The VHTs are working well in the communities, and also the surveillance team is on the ground always. They inform us about any suspects and the team will rush to see the symptoms of COVID and do the needful. **DTF Member Mpigi.***

*We had a case of COVID-19, she was my neighbour. We got information that she came back from abroad and she ran away from the quarantine. We called the task force and they came and picked her, on checking the results, she was confirmed to be COVID-19 positive. The whole community has been alert and that's how we have tried to mitigate the spread of the coronavirus. **Opinion Leaders, Mbale District.***

e) **Collaborations with Different Stakeholders**

*Through communication and feedback in collaborating with the referral hospital and the DTF team, we managed to achieve the success in containing COVID-19 in this community. The hard work by our staff and the VHTs at the community level also contributed a lot in a joint fight against COVID-19. **Health Centre Staff Arua.***

*We also partnered with the district task force and gave them PPEs like handwashing facilities, face masks and sanitizers which we are still giving up to today especially in Nwoya at the border. **CSO Nwoya.***

*This takes us back to the first entry point that we succeeded in using our resources as an organization to sustain our stay in the DTF activities. We gave in our vehicle on the DTF fleet of vehicles supporting the activities of the DTF. We succeeded in delivering services in the rural areas to the widow people, PWDs, children and all benefited from our services. **CSO Mbale.***

*we have registered because when I called the public to assist me with relief, they brought some food, some medicine and so on. NGOs came to assist us in that. Others were assisting us to - you know we have HIV affected people. Therefore, they assisted us to coordinate in supplying this – the medicine for HIV, they were assisting those affected people and so on. Therefore, they have responded. We have received some success. And in fact in implementing the precaution measures. People are now washing hands, people are distancing themselves – especially in the markets, we created some gaps to maintain the issue of social distancing. Mandatory testing has been a problem but at least we started with some organizations. Therefore, at least those are some of the successes we have. **Chairperson LC 1, Luwero District.***

6.2 **Facilitating factors for the success of DTF interventions**

Beyond the challenges discussed above, there were successes registered by the District Task Forces which were attributed to several facilitating factors as follows:

a) **Structure of Local Governments**

From an institutional perspective, the local government hierarchy has been very vital in quickly mobilizing and cascading information across different levels. The administrative structures right from the district to the village levels were effectively mobilized while leadership at district and sub-county levels were constituted into COVID response committees for proper coordination.

The Sub-County is headed by the Sub-County chief as the chairperson

of the task force at the Sub-County level, the town council is headed by the town clerk. Then the LC111 or mayor is the vice-chairperson of the task force, they also look for other members on the committee. They also have the Health inspectors and the CDOs who are also members of the committee at that level plus the District Councillors.

*As a local government we gave in our staff, cars and fuel to support the fight against COVID – 19 and we championed the mobilization and sensitization derive. **CAO, Nwoya district.***

*However, the Local Governments have been positive in as far as providing their human resource and the cars as directed by the president. **DTF Member, Masindi district.***

*Local government plays a very big role because during this time, also vehicles from different departments were collected and handed over to the DHO since he is the head of that department, the vehicles are assembled at the district to be used to carry out different activities to fight covid-19, so that contribution is being extended by the district. **DTF Member, Kaliro district.***

*The LC I, LC III have been engaging in the enforcement of SoPs and presidential directives. **DTF Member, Sheema District.***

“The district task force has done excellently well in terms of surveillance whereby many contacts have been identified especially during the first reported positive case of the policeman. The quick way they started their quarantine centres and how ready they were to receive more was indeed commendable. I will be happy if the schools especially my school Kabalega SS could be thanked for helping to host some contacts. What is not done better is the accountability aspect and if this issue gets worse, it will be hard for them to get more funding from some people like u”.
Member of the Private Sector, Masindi District.

b) Guidelines and standard operating procedures

The district COVID response has been facilitated by the guidelines and standard operating procedures from the line ministries. This has greatly assisted the planning and execution of the district response. Key examples include guidance from the Ministry of Finance, Planning and Economic Development on-budget execution by the technical team and the Ministry of Local Government on operational issues at the district for the political teams. On the other hand, the Office of the Prime Minister and Office of the President guided the overall response to the pandemic.

These guidelines have helped us to always track out working with the different stakeholders and how we can measure our successes but also avoid a collision while executing our work. Some of the issues embedded in the guidelines included; formation of the committees, having regular meetings, reporting, separate roles and ensuring transparency. It stipulates that the task force should sensitize the community on the pandemic, ensure resources are mobilized, liaise and collaborate with the other stakeholders,

liaise with the national level governments and do any other issue as directed by the Central Government from time to time. DTF member, Masindi district.

The guidelines have helped us so much because when we go on radios, we read for them these guidelines and they follow these guidelines. DTF Member, Buliisa district.

c) Good Leadership and Teamwork

One of the facilitating factors for the district response to COVID 19 was the high level of teamwork exhibited by district response teams. The various actors at the district level came together to address the emergency. Beyond teamwork was the leadership exhibited by Chairpersons of the different task forces. Respondents noted having observed a unity of purpose exhibited by the technical, political and community teams such as holding frequent meetings and communicating effectively within the DTF.

The achievements mainly are because of good leadership and coordination. That summarizes everything. You know, to drive the sector, and to fight a pandemic, you need a very well organized and coordinated leadership program, if you are to achieve. DTF member, Mukono district.

The leadership of the task force was spot on as many people believe and respect the office of the RDC other than if it were another office where politics and technical issues would have arisen. The use of the police and the army also helped to ensure that the directives and the SoPs are well respected as this is the language Ugandans are used to today. The little resources which the ministry sent to the district helped to combat the pandemic but more importantly, the support from the CSOs, private sector and the media were crucial. DTF member, Masindi district.

To the best of my knowledge there has been great teamwork among the district task force members, and this was replicated during community sensitisation activities and the speedy response of surveillance team when suspected cases are reported. Health Centre Staff, Nwoya district.

The teamwork of the district task force is commendable for the work and the achievements of the task force. There was no bickering among the members and the health team remained solid and up to the task. They would even work at night some even deserted their homes. The bringing on board of the different stakeholders especially the CSOs, media and the private sector boosted the activities of the task force; otherwise, there was no way the task force would have managed alone. DTF member, Masindi district.

We have been working as a team and not fighting for power; if you are a chairperson of the task force you are expected to play your role, and that applies to DPC, DISO and other leaders in the structure; teamwork

*has helped us then also another factor is having regular meetings, it's in meetings you can discuss matters and issues and it has helped us. We have also been having great synergies with the sub-committees; for example, this issue of telling people to come to the district to pick the permit to transport their patients, we decentralized that to the sub-county it was being done by the Gombolola Internal Security Officer (GISO). So, we thank DPC, we thank everybody it was everybody doing their work, so we have managed to go through. **DTF member, Kaliro district.***

d) Vigorous Awareness Creation Campaign

National and district teams have undertaken mass sensitization about COVID-19, an aspect that led to increased vigilance of community members to fight this pandemic and increased security. Several Information Education and Communication (IEC) materials on signs, symptoms and preventive measures of the coronavirus have been displayed at public spaces while talk shows and adverts on all radio stations have been made in all districts. This has been buttressed by the national addresses and updates by the President of the Republic of Uganda on COVID -19.

*The district task force has done well in the use of the radio especially at the beginning of the pandemic where almost every day someone could appear on radio. They also tried in as far as giving information to the media for the presenters to disseminate to the community, which was well done, and most people at least came to know of the pandemic better. It is common to find someone explaining to you how best they can wash their hands with soap and social distancing issues due to the work done by the district task force. **Opinion leader, Masindi district.***

*The enforcement of the presidential guidelines has been fairly done; the sensitisation of communities through the radio programmes about the MOH guidelines and presidential guidelines has been properly achieved. **Member of the private sector, Rukungiri district.***

*... the district task force has played a vital role in as far sensitizing the masses on COVID 19 is a concern and it is true many people are aware although other factors are stopping them from adhering. Today, if you go to any office, there is a sanitizer, water and soap, officers have masks among others which was not the case today. However, this was especially at the beginning of the pandemic in the country. **Religious leader, Masindi district.***

*Sensitization by the DTF's on media has been very effective due to the great coordination where the talk shows were given to the DHO and RDC however it has greatly faded due to fights over money, fuel and power but they did a great job. On information sharing these people were deprived of sleep between March and may, they were responding to emergencies and creating awareness. **Member of the media fraternity, Lira, district.***



e) Community vigilance and goodwill

The community goodwill has been vital in the process of mobilizing resources to respond to COVID 19. Most district taskforces have been received community contribution in form of cash, food items, vehicles and ambulances to support the COVID response. There is also noticeable cooperation of the community to heed to calls of observing the measures instituted to address the spread of the virus. Furthermore, there has also been vigilance from the community especially in terms of alerting the Task Forces on possible contacts and reporting cases on non-compliance with the SoPs. In districts like Masindi, Rukungiri and Buliisa among others, key informant respondents noted that community vigilance was critical in the containment of Covid 19 as seen in the following responses:

The vigilance of the community on COVID 19 has been a big factor whereby they would use their airtime to communicate to the district task force on COVID 19 related issues in their communities. The dedication of the district task force team and especially the health workers has been such an asset to the containment of the pandemic in the district. DTF member, Masindi district.

Vigilance of the community members to report the community alerts. Vigilance of the community members and well-wishers to donate relief food and other COVID 19 related items. DTF member, Rukungiri district.

The community has been responsible towards adhering to the guidelines, good communication and teamwork among the task force. DTF member, Buliisa district.

f) Support from Different Stakeholders

Stakeholders including the Media, Civil Society Organisations, Private Sectors and Faith-Based Organisations extended support towards the containment of COVID -19. Such support included financial contributions, advocacy, radio airtime, food relief, sanitizers and handwashing facilities, among others. Key informant respondents from many districts noted that such support enhanced the performance of the DTFs. In Bududa, Mbale and Rukungiri, stakeholders supported the DTF with financial resources; in the case of Mbale District, for instance, the DTF received to the tune of UGX 72 million from development partners which was used for procuring additional beds for health centres. A member of the District Task Force in Mbale noted that:

for instance we got UGX 72 million but we agreed that we buy additional beds and blankets in health centres and also improve on the water facilities; even temperature guns, before the government provision, we had already purchased ours.

Prompt support from the Central Government, Support from the president's office where UGX 12 Million was allocated for isolation centres. Support

*from development partners i.e. Rhites and WHO. Support from the Ministry of Water where all the water bills were waved to enable a continuous flow of water through the District. Good working relations with the members of the DTF. **DTF member, Rukungiri district.***

*Good working relationships among the DTF members and other stakeholders like USAID-RHITES, WHO, private sectors etc. **DTF Member Rukungiri.***

*Existence of the development collaborates who have supported us protective gears, advocating for hand washing, risk communication, publicity, UNICEF, and WORLD HEALTH ORGANISATION are funding that and this has helped us minimize the risks of COVID 19, Capacity building by the community because whenever they saw a new person in the community they had to report to the police. **DTF Member Buliisa.***

*The reason we managed was the support of these organizations and factories that helped us manage a lot of things. Because here every sub-county would have one vehicle. We want to support health workers to move to health facilities. Two we managed to help whoever had lost a person or whoever had a sick person because that time there was a total lockdown. So we would pick a sick person who wants to deliver, somebody has lost somebody. So we were here moving people from one place to another. We were with people who wanted to move to different places to pick samples. And it was the toughest, challenging time to us as an office. **DTF Member Jinja District.***

g) Support from the Central Government

The Central Government has been critical in coordinating response mechanisms from the onset of the pandemic. The Central Government issued directives, guidelines, mobilised resources and equipment in the fight against Covid 19, designated testing, quarantine and isolation centres. According to the response from Key Informants from the districts sampled, such supports by the Central Government, especially, the UGX 165 Million for each Local Government was pivotal in surveillance activities, coordination, the establishment of isolation centres and fuel for the Task Force.

In addition to resource provision, Central Government was also instrumental in monitoring and evaluating the performance of the DTFs as noted by a DTF member in Rukungiri:

The role played by the Central Government in monitoring and evaluation, planning and budget and quick decision making can be attributed to these achievements.

This was re-echoed by a member of the district task force in Sheema who noted that the monitoring and evaluation, especially in the areas of how the quarantine centres are being managed, surveillance and contact tracing, was critical in improving the performance of the DTFs as was noted by a member of the DTF in Sheema district:



We commend the national task force, it guided us very well, ours was just to re-echo what the national task force did and here just to customize, basically implementing. Yes, teamwork, we had no challenge in the task force. My technical team-the DHO made the budget, the task force asked a few questions, we explained and we didn't have anybody challenging this expenditure, we implemented it up to now no queries.

6.3 Challenges experienced by the DTF Core Team

In Uganda's history of epidemics, there have been Task Forces formed to coordinate response efforts to contain those epidemics. In 2000, 2014, 2017 and 2018 when the country experienced Ebola Outbreak, the National Task Force and District Task Forces were critical in managing the epidemics. Similarly, the National Task Force and District Task Forces were expeditiously formed to coordinate the responses towards COVID-19 outbreak both at national and district levels. While the Task Forces are critical in managing the pandemic, they were found to be faced with challenges as discussed below.

a) Ill-equipped Isolation and Quarantine²¹ Centres

The guidelines for Quarantine²² is a transparent home or institutional restriction of exposed persons' activities when they are not ill or do not have symptoms of COVID-19 to protect unexposed members of the communities from contracting the disease.

One of the challenges reported about by a cross-section of key informants in various districts was ill-equipped isolation and quarantine centres yet these were critical facilities in managing contacts, alerts, suspected and confirmed cases. In some districts, it was reported that the isolation centres lacked beds, mattresses, gloves, sanitizers and handwashing facilities, among others. There were other reports from several districts that voiced the same challenges particularly in the districts of Arua, Rukungiri, Mbale and Kanungu, among others. Examples of responses from these districts are as follows:

*They have failed to provide Personal Protective Equipment to health workers, yet it was budgeted for hence exposing health workers to the virus. **Opinion Leader Rukungiri.***

Another DTF Member from Arua District recounted:

These facilities exist but the quarantine centres are full now with inadequate beds and sometime back, the patients were complaining about the diet, demanding for chicken, meat, eggs and mineral water yet there is no money

²¹ Quarantine involves the restriction of movement, or separation from the rest of the population, of healthy persons who may have been exposed to the virus. The objective of quarantine is to monitor exposed persons for symptoms and ensure early detection of cases to prevent additional exposures or spread of infection.

²² See Quarantine guidelines Version 2.824 April 2020 <https://www.health.go.ug/wp-content/plugins/download-attachments/includes/download.php?id=3415>

to provide this. PPE's were provided by the Ministry of Health, but more is needed as infection rates are going-up daily.

In Nwoya District, a DTF Member reported that,

Our isolation and quarantine centres are ill-equipped and we lack the necessary facility there is no food and no beds. That explains why we can't keep any victims here because we do not have what it takes.

b) Lack of Isolation Centres in some Districts

The results revealed that most districts did not have isolation centres for alerts, contacts and suspected COVID-19 cases. They thus had to transport most of the suspected cases to the regional referral hospitals. Some of the respondents noted that:

*We are thinking of grading an area adjacent to the hospital to have an independent structure to make it isolation centre. The hospital that is already squeezed and constrained in terms of space. We risk mixing creating a bigger problem by mixing up patients in such a congested facility. That is where we are, we have the tents and only need grading, fencing, install power and water and have security in that same place. **DTF Core Team Member from Buliisa district.***

Also, Media Representative from Bullisa District revealed that:

The District has failed to open up separate isolation and quarantine centres. They have put an isolation centre in front of the Kigoya hospital and there are no separate toilets for the COVID patients and the rest of the other patients.

In the same vein, a member of the District Task Force revealed that:

The health centres generally are ill-equipped to handle complicated cases and as of today, even the small cases cannot be handled. The influx of the people for COVID 19 has made it difficult for the health centres to manage. As for the isolation and quarantine centres, this was possible at the beginning when the number was small; today there are no resources to cater for the food for the suspects in the quarantine and isolation centres

Another Key Informant and a member of the DTF, Arua District noted that:

These facilities exist but the quarantine centres are full now with inadequate beds and sometime back, the patients were complaining about the diet, demanding for chicken, meat, eggs and mineral water yet there is no money to provide this. PPE's were provided by the Ministry of Health, but more is needed as infection rates are going up daily. The plan now is to have a geographical quarantine.

The district did not have any isolation point where people could be taken for isolation for the recommended 2 weeks to elapse to see whether they have



signs of COVID-19 or not. Yet, we had trailers and their drivers passing through the district. We only had one stopover for these trailers from Kenya. The people that were suspected to have COVID-19 were always taken away to other places. **LCIII Chairperson, Mukono District.**

c) **Inadequate Personal Protective Equipment for Health Workers**

There were several reports of inadequate or lack of personal protective equipment for the health work in several Local Governments. This put health workers at the risk of contracting the deadly virus given that most of them had to improvise while handling patients. This was common in the districts of Rukungiri, Kanungu, and Mukono. Some of the responses from key informant interviews demonstrate this thus:

They have failed to provide Personal Protective services to health workers, yet it was budgeted for hence exposing health workers to the virus. **Opinion Leader Rukungiri.**

There is no COVID-19 testing equipment, there is a limited supply of drugs, and there are not enough protective gears. **DTF Member Rukungiri.**

We did not receive enough PPEs. The health centres had no gloves and masks. So, we had that shortage but within our means, we tried to improvise. **LCIII Chairperson, Mukono District.**

d) **Inadequate Medical and Other Supplies at the Health Facilities**

Several stakeholders in Rukungiri, Mbale, Arua, Nebbi, Amuru, Gulu, Hoima, Masindi, and Kaliro Districts further reported about the inadequacy of the of health supplies for the health centres and health workers, and transport. It was noted these affected the response rate of the health workers to situations in the community. This was further affected by a lack of transport and fuel facilitation. Some of the stakeholders responded to these issues as follows:

We still lack enough blankets and mattresses at the quarantine centre given the increasing number of infections. The few trained personnel at the district level do not have all the necessary protective equipment when handling COVID-19 suspects and patients. The isolation centre at Rukungiri HCIV is not independent it is part of the entire health facility for example the toilet and the bathroom are shared. **DTF Member Rukungiri.**

Another key informant from the Media in Kanungu District reported that:

...our health centres were not well equipped in the beginning. There were no sanitizers at Kanungu HC1V and even we were called once to receive chlorine to put in water meaning that if we had got cases those days, it would have been bad. Even doctors never had masks to use. Further, a Health

Worker from Mbale District also reported that *“There was limited facilitation of fuel and there was no for staff in all facilities. This limited movement of staff to different facilities for purposes of surveillance and handling of other cases at different health centres. The COVID-19 response budget did not cater to this.*

There were related revelations from members of the DTF and religious leaders. for instance, a religious leader from Arua District reported that:

*The Task Force has not done follow-ups with many health centres due to limited facilitation. They have not monitored well the Health Centres to see how the facilities meant for COVID 19 treatment are being used”. In Kaliro District, a member of the DTF revealed that; “We have a few beds, a few mattresses, the drugs are usually out of stock, we have inadequate personal protective equipment. The health workers lack some things that are important for example the infrared thermometers are not enough. Not every facility has an infrared thermometer, and even the ones we have usually break down so fast. Personal protective equipment is not adequate. We do not have enough space in our facilities. When you get to our health centre IV it is crowded. We cannot afford to obey the social distancing requirement. We also cannot afford to get a designated room for mainly COVID-19 patients. The equipment are not enough, we have 10 intensive care beds as Bugisu sub-region and if the number increases we can’t handle, we are running out of space for admission. **DTF Member Mbale District.***

e) **Unclear Structure, Guidelines and Roles of the DTF Members**

It was noted from the findings that the structure, guidelines and roles of the different DTF members were not well understood by members of the DTF, other stakeholders and the general public. The results show that the constitution or membership of the COVID-19 district taskforces was not uniform across all districts. In some districts, for example, District LC V Chairpersons and Speakers of Councils were co-opted on the team while other districts did not. This created some challenges in the mobilisation of the community, making decisions, and accountability for resources. In some districts, it was reported that:

*There was a misunderstanding of the whole DTFs concept. Some people came to the task force with an expectation of receiving allowances and when they did not get them, they started complaining. Some attacked the RDC, it was very rough. From that time, some have not been attending meetings of the taskforce which affected its intended purpose. Most of our strategies suggested the needed police enforcement but instead, the police are withdrawing. **Religious Leader, Mbale District.***

Our sub-committee is headed by the District Community Development who is soon retiring and deputised by Assistant DHO who is busy with official work. This means that we do not have a substantive head now. This makes

our sub-committee work difficult because at this time, we need socio-psycho support more than ever before because of the depression. I think there is a problem of leadership too in the DTF, when businesses started opening that is when the real problems begin. **Religious Leader, Mbale District.**

The creation of sub-committees in DTF was done extremely late and this affected the effectiveness of the task force. **CSO Representative, Arua District.**

f) **Inadequate Resources**

Several members of the District Task Forces noted that inadequate resources for the taskforces were a major challenge in executing their mandate. This was reported in all the districts covered by this study. Some of the members reported that:

The biggest challenge was inadequate resources. COVID-19 came towards the third quarter where resources in many Local Governments are already depleted. So, it came in a period when we did not have enough resources to carry out some of our activities. We received education materials, but we could not produce enough copies and distribute them to the pupils in the villages. When the government masks came, there was no facilitation to enable us to distribute them. We had to rely on the voluntary work of LC Is and VHTs. **LCIII Chairperson, Mukono District.**

Furthermore, due to inadequate resources, many district task force members reported about delays in the payment of allowances for health workers and other staff which was demotivating to health staff. It was reported by DTF member from Kabale district that:

There were delays in paying allowances for staff especially those who do screening, and contact tracing.

Similar findings associated with inadequate resources were also raised by other DTF members, thus:

When you look at the breakdown of the COVID-19 response budget, this money is grossly insufficient given the things that it has to do including the facilitation of staff, sensitization, the contact tracing, surveillance and screening. **DTF Member, Masindi District.**

Furthermore, another member of the DTF from Buliisa District reported that:

We don't have enough resources generally. The districts itself does not have an ambulance to help transport samples. It's been us the Task Force transporting both the COVID-19 suspects and the normal patients since public transport was stopped.

This report resonated with another that was raised from Lira District which noted that:

There is no facilitation for us the Coordination staff and even refreshments for meetings. When you look at the budget breakdown the funds to facilitate surveillance, medical workers are not enough, including facilitation of the people on various committees. There is also no Ambulance for the District at all. And the allowance for the staff is always not enough.

Also, it was revealed that,

The turn round time for the Testing Hub is long. Transporting samples to Entebbe also takes long. **DTF Member, Lira District.**

The issues of inadequate resources were further found to have affected the functioning and response rate of the DTF in various ways. For instance, in Buliisa District, it was also reported by DTF member that:

We do not have an Ambulance as a District for your information. The one we had got an Accident and it was written off. So, relying on DHOs four vehicles, are not enough especially given that they are transporting samples daily basis from Buliisa to Hoima and Kampala... When you look at the breakdown of the COVID-19 response budget, this money is grossly insufficient given the things that it has to do including the facilitation of staff, sensitization, the contact tracing, surveillance and screening.

In Kanungu District, the DTF failed to support the activities of the sub-committees due to lack of resources. One of the members of the DTF reported that:

We have failed to support the sub-committees to carry out their duties. We currently lack resources to make follow-ups of all our contacts, we trace them, get them, we even take their samples but then following them up becomes a challenge. We have the challenge of feeding our people at the quarantine centres and maintenance of those quarantine centres. We lack the means of transport for health workers. We do not have an ambulance which is supposed to carry suspected cases.

g) Food Distribution and Coordination

There were challenges associated with food distribution across all the districts which mainly related to criteria for selecting beneficiaries, inadequate proportions, failure to deliver food to some places, and poor quality of foods distributed, among others. In Luwero District, for instance, a Local Council Chairperson revealed that:

The yardstick of distributing the relief was not known to the people. You find that most of the relief was taken to rural areas. These are areas with food and then one takes posho there? We thought that the relief of food was supposed to be for urban centres where people do not have or grow their food and must buy it from shops. Therefore, taking posho to rural areas was the wastage of resources. There was also politics within the distribution.

Another respondent from the Media fraternity in Rukungiri District reported that:

the foodstuffs that were mobilized were not enough and the method of distribution was a bit hijacked by some politicians. Some of the vulnerable groups did not get.

Further, there were reports in some districts that some areas did not receive food as promised by the government and that some local politicians used the food distribution as a politicking tool. In Rukungiri District, for instance, an Opinion leader reported that:

The government didn't honour its pledge of bringing food to all village people. They allowed some politicians to use food relief donations as a way to gain popular vote. In most cases, food was distributed by politicians on big gatherings in total disregard of the Ministry of Health guidelines and Presidential directives on COVID-19.

In Jinja District, it was reported by another opinion leader that,

The food they gave to people was of poor quality. For example, the beans had many foreign bodies and the posho had a bad smell when cooked and were bitter. But because we did not have an alternative, we took what was available.

h) Corruption, Lack of Transparency and Accountability

There were some reported cases of corruption, lack of transparency and accountability by the COVID-19 District Task Forces. There were reported cases of extortion, corruption and lack of transparency, especially in food distribution. For instance, one of the Key Informants from the Media in Rukungiri District reported that:

There has also been a lot of extortion of money by the police from the public and the RDC being the chairperson of security at district level didn't say anything about it.

In the same district, a religious leader report that,

Corruption was witnessed among DTF members in the distribution of relief donated food items. The enforcers also participated in extorting money from the community members. Relief food donated and received from the government at times was not given to the rightful targeted beneficiaries.

It was also reported in Rukungiri District that the individuals on lists of beneficiaries generated by LCIs were not the ones considered while distributing food.

In Masindi District, it was reported by a religious leader that:

Accountability for the resources, food items and other things given to the District task force were not accounted for. The issue of accountability of the donations given to the district task force was noted well handled. This explains why some institutions no longer want to give more.

Similar reports were raised from Mbale District. A Key Informant from the private sector noted that:

what the DTF has not done well is transparency and accountability of the funds and donations that it received. For example, what they distributed to the vulnerable communities cannot reach 10% of what the task force received through donations. Only a few people got the food reliefs. We still want the DTF to furnish us with accountabilities of the donated materials.

Similar concerns about lack of accountability were raised in Apac District. A Member of the District Taskforce representing CSOs reported that:

We were told during the DTF meeting that Apac received up to the UGX 165 million from the Central Government. Some of it was allocated to the office of the RDC for fuel and the rest was supposed to be used by the DTF members to implement the directives of the president. However, up to date, we did not see that money. We do not know how it was used... Also, the district had collected some money from the stakeholders like the businessmen, community members, we did not see this money and do not know how it was used.

Similar findings of issues of lack of accountability were also raised by different stakeholders in the districts of Arua, Wakiso, Rukungiri, Hoima, and Luwero, among others.

i) Non-inclusion of the vulnerable groups

There were reports of neglect of vulnerable groups in some districts of Nwoya, Rukungiri, and Mbale, especially during food distribution. The Key informant representing the Media in Rukungiri district reported that:

During food distribution, some vulnerable groups such as PWDs, Older Persons and HIV positive patients and other special interest groups were neglected and not prioritised.

j) Violation of human rights

Furthermore, the findings also revealed that there were cases of human rights violations especially in the Districts of Rukungiri, Kanungu, Wakiso, Kampala, and Mukono. In Rukungiri District, for instance, it was reported that:

The police personnel have continued to violate the people's rights by beating them up.

In Kanungu District, an Opinion leader reported that:

At the peak of the pandemic around April, the police were abusing people's rights especially beating them up near the shops or bars claiming they

violated curfew time. We discussed this with the DTF to enforce the rules without beating up people.

Also, in Wakiso District, a key informant from the Private Sector reported that, in Nansana, Namusera the security agencies would arrest people, beat them in the name of enforcing the presidential directives. The security organs may have misunderstood presidential directives which led to the severe battering of people.

There was also reported an increase in domestic violence in Kampala. A key informant from Kampala reported that:

There was domestic violence in many families. Men are killing women. Women are beating up their children. Life in families is getting distorted.

k) Delay in the delivery government masks

As a COVID-19 containment measure, the government promised to deliver free face masks to all Ugandans above the age 10. The reports from the study indicate that the government delayed delivering these masks to communities and that those that were delivered were of poor quality. In places where they were delivered, all the targeted beneficiaries did not receive them. In Luwero, Wakiso and Rukungiri Districts there were concerns about the delay and quality of face masks. In Rukungiri District, for example, it was reported that local leaders that:

Many people missed out on government masks although my family got them. Also, the quality of these masks is not what we expected. We have seen other masks better than those issued by the government”.

There were concerns about distributing a few face masks that did not tally with the number of people in each household. In Kanungu District an LCI Chairperson reported that:

In a family say eight or ten members, we would give them like two or three masks. Other members of the family would not get.

Further, in Kanungu District, the religious leader reported that:

The masks were inadequate during the distribution. Around 50% of those people did not get face masks yet they need them.

l) Limited involvement, facilitation and support of the lower local councils

The Lower Local Government structures are required by the National Policy on disaster management to activate their committees and perform their functions as specified. It is envisaged that these committees would have resources to perform as expected. However, the lower local structures complained about the failure to facilitate them and their sub-committees in their response to the containment of COVID-19. Similar complaints were raised in Bulisa, Mpigi, Mbarara, Sheema, Mbale, Kamuli and Kaliro, among others. To illustrate this, An LCIII Chairperson from Bulisa District reiterated that:

Facilitation for the lower local councils has not been done. There should be a provision of facilitation for lower local councils to respond to emergencies of this nature. The government should provide us with ambulances in lower Buliisa like for Butiaba, Kihungya and Biiso, it would reduce expenses on fuel for a vehicle to move from upper to lower Buliisa. This would also reduce the costs of hiring private vehicles by patients.

Another respondent from Mpigi reported that:

The District Task Force did not decentralize some of their powers to the lower local government. All the money that was sent remained at the district. Resources for containment of COVID-19 should be sent to the sub-county level because the sub-counties are nearer to the communities than the district.

m) Slow response to emergency

The district task force was expected to respond to emergencies within the district. As such they pooled all the vehicles for the district and parked them at the district headquarters so that they can be able to respond to any alerts for emergencies. The members of the community were given contacts of the members of the District Task Forces to reach out to them in-case they needed any help, alerts, or emergency. However, the results show that the DTFs were slow to respond to emergencies reported by the communities. These cases were mainly reported in Buliisa, Wakiso, Lira, and Arua, Districts. In Buliisa District, for instance, an Opinion leader reported that:

In case of an emergency they would not respond quickly or they would not act quickly and it's not because of transport but whenever we could call them that we have a suspect they could take their time as two to three days without coming.

Similar reports were also registered from Lira. A CSO leader from Lira reported that,

...there are times when we get calls from communities, but you call the DHO and RDC many times and they would not pick up. Sometimes, when there is no response from the DTF the other structures in the community also abandon their work.

In Arua District, a member of the Private sector reported that,

there is a poor response when a case is reported to the DHO, it can even take 2-3 days before they respond claiming that there is no fuel for the ambulance or they are busy other cases.

n) Limited channels for community sensitization

As part of the interventions to respond to the containment of COVID-19, was to conduct community sensitisation on how to prevent transmission of COVID-19

through channels like Television and Radios. The findings from Kaliro and Mbale Districts revealed that most of the local radios have not intensively popularised the messages on controlling the spread of COVID-19. It was also noted that district leaders were not regular on the local radio stations, yet it was the most common channel that reached the largest proportion of the people.

o) Laxity in the enforcement of the SOPs

The District Task Forces had a mandate to enforce the Ministry of Health Guidelines and presidential directives on containing the spread of COVID-19. There were results showing that enforcement of the results in many districts had relaxed. The onslaught of COVID-19 came at a time when most elected leaders had started electoral campaigns. Political parties, especially, the National Resistance Movement were conducting their political party primary elections. This, therefore, posed a challenge for the DTF in regulating the political gatherings.

In Kaliro District, it was reported by a member of the private sector that:

The District task force somehow relaxed enforcing the social distancing guidelines because politicians have been holding political where people gather and do whatever they want. It is common to find 3000 people are gathered.

Also, in Kabale District, it a member of the CSO revealed that:

...the DTF has not managed the community gatherings as expected because of elections. During the NRM campaigns, people have been gathering in thousands with no social distancing. You would find over a hundred people just in a room sharing money; no one has a mask, no sanitizers and no social distancing. Most of the gatherings had no handwashing facilities but the DTF would not enforce the SOPs and guidelines from the Ministry of Health.

Further, it was reported in Kabale District that:

As of now there has been laxity because when you go to town people are not putting on the face masks, the commercial motorcycle riders ("boda boda") are carrying three people even when you go to these buses, they are overloaded putting more people at risk.

p) Non-Involvement of all Stakeholders

The Policy on prepared and management of Disasters provides for the involvement of other stakeholders such as CSOs, Media, Religious leaders, local leaders and the private sector among others in response to pandemics like COVID-19. The results, however, reveal that some District Task Forces did not bring on board all the stakeholders enumerated in the policy. For instance, in Jinja District, it was reported by a Key informant from a prominent CSO that:


The District Task Force has not involved the CSOs in their interventions. I have been involved with other strong CSOs in the district such as WEED on the side of Gender issues and many others, but none has reported about their involvement or working with the District Taskforce.

In addition, findings from Arua district revealed that there was bad relationship between the DTF and media. It was reported by a key informant from CSOs in Arua that:

Information sharing with the Media in the past created a gap in updating people on Covid-19, the relationship between the DTF and the media is still work in progress.

Further, a media practitioner in Arua reported that:

The DTF expelled the media from all its activities because of the questions that the media raised regarding transparency and lack of accountability by the DTF. But later, the media was integrated into the task force and information flow has been restored. The media had given the DTF a black-out. The RDC now gives information and calls back with the necessary information that is required by the media. This happened after the RDC reigned on the errant DTF members and apologized on behalf of the DTF for chasing the media away.



Chapter 7

Conclusion and Policy Recommendations

7.1 Conclusion

The COVID-19 District Task Forces have largely been hailed for containing the spread of COVID-19 in most Local Governments in Uganda. The Task Forces have however experienced several challenges that constrained their level of performance that include: inadequate funding for their activities; ill-equipped quarantine and isolation centres; inadequate PPEs for health workers; inadequate medical supplies to the health facilities; unclear structure and guidelines and roles of DTF members; lack of transparency, accountability and corruption; and role conflict among others. These challenges notwithstanding, the DTFs managed to register some outstanding achievements. This success is largely attributed to the leadership of the National Task Force that continuously provided guidelines for the Local Governments to implement. The DTFs have been credited for conducting mass sensitisation of the public on COVID-19 and the strategies to prevent it. They have also been instrumental in implementing guidelines handed down from various Ministries, Departments and Agencies. The DTFs have been able to mobilise and bring on board several stakeholders to support their efforts in controlling the spread of the virus and taking care of the vulnerable members of the community. For effective emergencies response, it would important to follow the existing policy and take advantage of the other structures provided. The existing local government structure that is mirrored in the health care structure also demonstrated a high potential to effectively respond to emergencies and pandemics of this nature if well prepared and facilitated.

7.2 Recommendations

This section presents recommendations generated from the data presented in the preceding sections. It is anticipated that the recommendations will improve the process of the effectiveness of the COVID-19 District Task Forces and the DDMCs in handling pandemics and other disasters. It was noted that COVID-19 District Task Forces mainly focused on response and recovery mechanisms at the expense of preparedness measures. There is therefore need for a strategic shift and emphasis from preparedness response to improve efficiency in emergency management. To improve their effectiveness, there is a need to focus on the following:

Response strategies on handling

1. Local Governments should improve road and other communication infrastructure to facilitate timely access and response. Findings indicated that delayed response led to the loss of life.
2. DTFs/ DDMCs should develop effective coordination system with clear procedures for the entire response phase by strengthening the capacity of corresponding DECOCs and DDPCs.
3. DDMCs should establish rapid response teams. A coordination mechanism involving all disaster responders (Governments, CSOs and local community members) should be strengthened and should have standards against which accountability should be based.
4. DDMCs should carry out simulation drills and training programs for local communities to actively respond to pandemics, epidemics and other disasters. Evidence showed that local communities were usually the first responders and were less empowered to intervene in case of need. It is, therefore, necessary to empower local communities to be more effective in supporting efforts for containing such pandemics.
5. There is great capacity and potential within the existing Local Council Government structure including LCI, LCII, LCIII, LCIV and LCV. The utilization of this structure has not been optimal. There is, however, no doubt that resources both in terms of capacities and funding are needed to implement the disaster management plans.

Recommendations for the Office of the Prime Minister

9. The study recommends that government makes use of the institutional framework established by the National Policy on Disaster Preparedness and Management in its disaster response programs. Structures like the National Platform for Disaster Risk Reduction, NECOC, Ministerial Policy Committee, District Disaster Committees, DECOC among others should be relied upon to provide disaster mitigation, aversion and management guidance as they are established with the right technical expertise, competencies and capabilities. Disaster management should not be ad hoc in nature as usually seen through the establishment of ad hoc structures like the National Taskforce on Coronavirus to the detriment of institutional response²³.
10. OPM to ensure that National Disaster Management Policies and Frameworks are prepared and communicated by districts to all stakeholders since they have a direct bearing upon recovery. This will enable awareness creation and preparations against disasters including pandemics like COVID-19.

²³ Mubangizi, P (2020). A Critical Review of the National Policy on Disaster Preparedness and Management: Scenario modelling from the COVID-19 Pandemic in Uganda. CEPA Policy Series Papers Number 20 of 2020. Kampala.



11. OPM and DDMCs should create and provide disaster contingency funds to ensure quick response to landslides disasters. Funding is a key resource in disaster management. Therefore, funds should be made readily available for ease of managing disasters.
12. DTFs should encourage and empower local communities to actively participate in COVID-19 containment measures and all other processes. Local communities, especially, Local Councils have developed surveillance systems that can help in the dissemination of information, locating alerts and contacts and mobilizing communities. The DTFs can draw upon this capital to be more effective in implementing COVID-19 containment measures.
13. DDMCs/DTFs should ensure adequate manpower with technical competences in managing disaster is in place well in advance before landslides disaster occurrence. Findings indicated that technical officers in land management did not assist local communities on housing construction and agricultural practices as necessary mitigation measures in landslides disasters prone areas. Technical competencies are vital in helping people militate against landslides related disasters.
14. Interaction between the national and district level is one of the most important issues in ensuring the establishment of a well-functioning DDMR system. The study has observed a huge commitment and enthusiasm within many of the DTF members interviewed. The study also establishes that there are variations in the levels of capacity among the DTFs. In some districts like Mbale, and Bududa there were reports of regular meetings for planning and response. This could be explained by their previous experience in handling disasters like landslides in their jurisdictions. In other districts capacity is more limited and DTFs rarely meet. Strengthening the capacity of the DTFs should be a priority task for OPM, MOLG and MOH. This has to include a clear ToR for DTFs.
15. COVID-19 has affected all districts in Uganda. In this case, the issue of inter-district coordination is very critical. Therefore, coordinating with other DTFs/DDMCs, each carrying out their parallel planning exercises and requesting the same resources from the national level will be a complex task. This issue can be addressed by cooperation, collaboration and coordination between districts at regional levels. Establishment of regional response teams may register more successes for regional cooperation of the districts.
16. There is need to follow the established for responding to pandemics and disasters. The OPM, that has the mandate to coordinate and manage disaster preparedness and planning response activities, is currently unable to fulfil its responsibilities as it lacks the full support of all key players, including resources. The absence of clear TOR/ legal framework and adequate resources has led to a lack of a unified and coherent system in the districts, resulting in the establishment of ad-hoc and personalized arrangements during disasters. The GoU should ensure that a single institution maintains

the mandate and responsibility to manage disaster response. The chain of command at every level is identified and complied with.

17. There is need for laws to govern disaster risk reduction and management: Currently, Uganda does not have a national law governing disaster risk reduction and management, and its alignment with international thinking although a National Policy for Disaster Preparedness and Management exists. The Uganda National Disaster Preparedness and Management Act, draft Bill should be fast-tracked and enacted into law.
18. There is a need to operationalize the Disaster Preparedness and Management Commission. Uganda's Constitution (Article 249) also provides for the establishment of a Disaster Preparedness and Management Commission "to deal with both natural and man-made disasters". Without a law to govern government's work on disasters, the composition of the Disaster Preparedness and Management Commission and its duties, response to disasters will remain ad hoc and impractical.

Ministry of Finance, Planning and Economic Development

19. There is need to operationalise the Contingency Fund provided for under Section 26 of the 2015 Public Finance Management Act so that both the Central Government and the Local Governments are empowered to effectively respond to pandemics, disasters and other risks adequately. This would also boost financing of Uganda's Disaster response as detailed in the National Policy on Disaster Preparedness and Management.
20. There is a call to increase health sector financing for emergencies. Inadequate funding was reported as a major challenge affecting the functioning of the District Task Forces. It was evident that the country was not adequately prepared to handle the pandemic; most DTFs relied on contributions from individuals, the private sector and civil society to finance its response activities. It is recommended that Government of Uganda through the Ministry of Finance, Planning and Economic Development should increase health financing by increasing the share of Budget allocation to the health sector from the current 5.1 per cent to at least 15 per cent as it committed to during the Abuja Declaration in 2001. Uganda's health sector has to be well funded to quickly deal with such health pandemic. Regional testing labs should be put in place.
21. Establish a Pandemic Response Plan and Contingency Fund. There is a need to operationalize the Contingency Fund as provided for in Section 26 of the 2015 Public Finance Management (PFM) Act so that government efforts to avert risk and manage disasters are adequately funded.

Ministry of Health

22. **Mainstreaming pandemic preparedness and response within the broader context of health systems:** Epidemics could be addressed by making contingency plans and structuring emergency health services. It is also important to establish to develop early warning systems through routine surveillance and training in emergency operations. The success of this will depend on the creation of an inventory of required resources. There is a need to establish emergency units at the district levels like disaster preparedness strategies.²⁴ Have a permanent task response team in place for any emergency which should be well facilitated in terms of allowances and resources to use. This task force should have planning and accountability mechanisms in place. The lockdown magnified the need for local content and the need to develop local capacity.
23. Emergency funds like in the case of COVID-19 should be decentralized across the various levels of Local Governments to enhance response by all actors.
24. To achieve and sustain Universal Health Care (UHC) gains requires resilient health systems that are better prepared and can recover from public health crises. Pandemic preparedness protects people from health threats and UHC reforms ensure that everyone has access to quality health services without suffering financial hardship.

Ministry of Local Government

9. **Revitalise District Disaster Management Committees:** The National Policy for Disaster Preparedness and Management 2011 provides for the District Disaster Management Committee in the district. The committee is chaired by the CAO and comprises of heads of departments, DPC, army representatives and representatives of other relevant government agencies and Partners within the district including Uganda Red Cross Society and relevant NGOs. However, the study revealed that these were largely inactive and in some cases non-existent. It is recommended that these committees be revived and supported to remain functional to coordinate local government responses to future disasters.
10. There is a need for the MoLG to mainstream E-governance in Local Governments. The Ministry of Local Government needs to work hand in hand with the Ministry of ICT to expand the ICT infrastructure across the country. This also calls for investment in the expansion of access and provision of low-cost internet services.
11. Compliance to accountability is often compromised in a bid to attend to emergencies during pandemics that arise now and then as expedient disbursements and procurements are made. To curb this, there is need

²⁴ <https://blogs.worldbank.org/health/what-can-we-learn-uganda-fighting-deadly-disease-outbreaks>

to create a multi-disciplinary teams that gives oversight to the core team, especially, the resource mobilisation /logistics committee.

12. Training law enforcement on human rights. The study revealed that there were reports of human rights violations during the enforcement of the guidelines. This therefore calls sensitisation of the Police and the military on Human Rights issues during such operations.
13. The DTFs should operationalize preparedness mechanisms to empower local communities handle pandemics, epidemics and other disasters.
14. There is need to establish a single and unified preparedness framework by integrating prepared preparedness and management of pandemics and disasters into respective sector plans of government at the local level. Many of the responses indicated a lack of coordination and awareness about contingency plans and activities. This should be strengthened as a cross-cutting issue in local government activities.
15. There is need for clear coordination systems. The Ministry of Local Government needs to set up effective coordination systems with clear procedures governing the entire response cycle. Results showed inadequate coordination mechanisms within and among DTFs, other organizations involved in response activities and affected communities. Coordination is a vital aspect in managing emergencies and needs improvement for maximum effect in handling epidemics, pandemics, landslides, floods and other emergencies.
16. The Ministry of Local Government should ensure facilitation and implementation of emergency response or plans geared towards mitigating their consequences by strengthening resource capacity at the local level. This would be instrumental in providing emergence equipment and materials for handling pandemics, epidemics and other disasters. Empirical evidence revealed inadequate emergency materials and equipment necessary in handling pandemics like COVID-19.

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